



REPORT ON THE THIRD MEETING OF THE CONSULTATIVE GROUP
OF NONGOVERNMENTAL ORGANIZATIONS TO THE
WHO PROGRAMME FOR THE PREVENTION OF BLINDNESS

Kingston, Jamaica, 17-18 September 1990

INTRODUCTION

The Third Meeting of the Consultative Group of Nongovernmental Organizations to the WHO Programme for the Prevention of Blindness was held on 17 and 18 September 1990 in Kingston, Jamaica. It was arranged to coincide with meetings of the Inter-Agency Coordinating Group and of the Caribbean Council for the Blind (CCB).

The meeting was opened by Dr B. Wint, Chief Medical Officer, on behalf of the Jamaica Ministry of Health. The opening address is given as Annex 1. Mr Alan Johns, Executive Director, Sight Savers, chaired the meeting and Mrs M. Haws (Sight Savers) acted as Rapporteur.

The list of participants is attached as Annex 2 and the agenda as Annex 3.

I. A GLOBAL REVIEW

1.1 Charting the activities of the WHO Programme for the Prevention of Blindness over the past year.

General programme development has focused on the continuing support to the planning and implementation of national programmes for blindness prevention. At present (September 1990), such programmes exist in 66 countries but, in many of these, there is still a crucial need for continuous advice and also for technical and financial support. The present distribution of national programmes for the prevention of blindness is as follows:

| <u>Region</u> | <u>Countries</u> |
|-----------------------|------------------|
| Africa | 18 |
| Americas | 15 |
| Eastern Mediterranean | 9 |
| Europe | 3 |
| South-East Asia | 11 |
| Western Pacific | 10 |

TOTAL 66 COUNTRIES

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There seem to be three key issues in the further development of national programmes, namely:

- Evaluation and publicizing of results must be undertaken in many countries where programmes have been going on for some years.
- Strategies and technologies must be critically assessed from the cost-effectiveness and sustainability points of view.
- The need for future funding support, which is of critical importance in many of the least developed countries.

The WHO Programme has continued to develop its technical documentation in several fields. The report from the interregional meeting in 1988 on "The management of corneal blindness within primary health care" has been widely disseminated and also partially published in the "Weekly Epidemiological Record" of WHO.

A pamphlet on cataract has been elaborated in English and French and distributed to all of the WHO Regions and interested nongovernmental organizations. The long-awaited cataract publication has also become available, in accordance with the recommendations made at the meeting in November 1988 in Tunis on educational material on cataract. Another useful document in a new version, as developed by a working group in Geneva in June 1988, is "The Formulation and Management of National Blindness Prevention Programmes", which will be provided to all interested countries. A wide distribution is also being given to the report of the Eighth Meeting of the WHO Programme Advisory Group on the Prevention of Blindness, which was convened at the WHO/FBL Collaborating Centre in the Dana Center of The Johns Hopkins School of Hygiene and Public Health, Baltimore, in March 1989.

The Programme for the Prevention of Blindness has been represented in, or has organized, the following meetings:

- Symposium on Tropical Ophthalmology, San Francisco, 7-9 March 1989.
- International Agency for the Prevention of Blindness (IAPB) Executive Board Meeting, Bethesda, 10 March 1990.
- Celebration of the 10th Anniversary of the WHO/PBL Programme, Bethesda, 11-12 March 1989, with the National Eye Institute and the International Agency for the Prevention of Blindness (IAPB) Cataract Symposium.
- Programme Advisory Group, Baltimore, 14-17 March 1989.
- Lions Sight Symposium, Singapore, 31 March - 1 April 1989.
- Asia Pacific Academy of Ophthalmology, Seoul, 30 May - 6 June 1989.
- Nordic Ophthalmologists' Congress, Reykjavik, 20-22 June 1989.
- Advisory Committee to the International Council of Ophthalmology, Rio de Janeiro, 27-31 August 1989.
- Low Vision Congress, Turin, 22-23 September 1989.

- A National Seminar on Glaucoma, Malta, 17-21 October 1989.
- IAPB Cataract Research Meeting & IVACG, Kathmandu, 2-8 November 1989.
- A Working Group on the Local Production of Eye Drops, Geneva, 14-17 November 1989. The report of this group will be considered further by a pharmaceutical consultation on 8-10 October 1990.
- Participation in a four-week managerial PBL course jointly with SEARO and WPRO together with the Juntendo University, the PBL Collaborating Centre in Tokyo; this course took place in Korat, Thailand, in February 1990.
- A Colloquium on Blindness Prevention, hosted by the Organisation pour la Prévention de la Cécité, Paris, 15 March 1990.
- Participation in the International Congress of Ophthalmology, Singapore, 19-22 March, with a specific session on blindness prevention and one on ocular trauma.
- A Meeting on Manpower Development for Blindness Prevention in Africa was convened in Lomé, 3-6 April 1990; the report is still in preparation (French), covering 17 French-speaking countries. This symposium was entirely funded by the participating nongovernmental organizations.
- A global meeting on "The Prevention of Childhood Blindness" was convened at the International Centre for Eye Health in London, 29 May - 1 June 1990; Christoffel Blindenmission and Sight Savers funded this meeting on the occasion of the fortieth anniversary of the latter. The meeting was opened by Princess Alexandra (The Honorable Lady Ogilvy) and attracted good media coverage. The report is being finalized for eventual publication.

Other activities have included the following:

- Assessment of blindness and its causes in several countries (Benin, Congo and Turkey with partial support from the National Institutes of Health). Support has also been provided to a glaucoma study in Malta in 1989.
- Advisory services and technical cooperation in national programmes (Benin, Fiji, Haiti, Kiribati, Morocco, Togo, Tonga, Tunisia, Turkey, etc).
- Support to training courses in the two PBL Collaborating Centres (Baltimore and London) through grants and lectures.

In the field of applied research, the following studies are being undertaken:

- A study of maculopathy in the United Republic of Tanzania together with the International Centre for Eye Health (ICEH).
- A study using vanadium-steel sutures for cataract surgery at Aravind Eye Hospital with support from National Eye Institute/National Institutes of Health (NEI/NIH).
- Support to a study of cataractogenesis and possible risk factors to be carried out by the International Centre for Eye Health in India.

- Extracapsular cataract extraction and intraocular lenses (posterior chamber) versus intracapsular cataract extraction and glasses - this study is in preparation for Nepal and Sri Lanka with support from the National Eye Institute in 1991.
- The application of a simplified trachoma grading scheme in 14 countries with support from the Edna McConnell Clark Foundation.

The other current issues in the WHO Programme are:

- The problem of extrabudgetary funds for programme support; there will be no more funds from the Japan Shipbuilding Industry Foundation (JSIF) or from the Arab Gulf for United Nations Development Organizations (AGFUND); the International Association of Lions Clubs will, however, make a contribution for a technical adviser based in PBL/Geneva for coordination with the global "SightFirst" initiative.
- The Deafness Programme (PDH) in WHO is formally linked to the Prevention of Blindness Programme (PBL), but is so far managed as part of the unit of Rehabilitation. It is as yet unclear where the PDH Programme will finally be located but, quite possibly, it may become associated with PBL.

Presently planned activities in the WHO Programme include the participation in the forthcoming IAPB General Assembly in Nairobi, Kenya, 11-16 November 1990. A consultation on the use of intraocular lenses in developing countries will be held in Geneva, 3-7 December 1990, on the request of the WHO Executive Board. The Ninth Programme Advisory Group Meeting will be held in Banjul, The Gambia, in early March 1991. Other work will include the trachoma grading material and the development of an expanded research programme with support from the National Eye Institute/National Institutes of Health, focusing on intraocular lenses, corneal ulcers, outpatient cataract surgery, etc. If possible, there will also be a study set up on the use of anterior chamber intraocular lenses (Kelman multiflex) in two countries; support will be given to low-cost spectacles workshops in Bamako (Mali), in the Central African Republic and in Uganda. A recent demand for surveys in Lesotho, Mauritania, Rwanda and Sierra Leone will be put forward for extrabudgetary funding.

1.2 Reports from member nongovernmental organizations

1.2.1 Christoffel Blindenmission (CBM)

Christoffel Blindenmission is an international, interdenominational Christian mission seeking to help blind and handicapped people who live in poor areas of the world. CBM works in partnership with local churches, missions, self-help groups and government programmes to provide medical, educational and rehabilitational services to disabled people.

At the present time, CBM is supporting over 1000 projects of which approximately 440 are medical projects. Support takes the form of financial and consultative services including the secondment of approximately 200 co-workers; 340 of the medical projects are in the provision of eye care services in 68 countries, constituting an overall medical budget of approximately US\$ 20 000 000.

In medical eye work, CBM's philosophy is to develop comprehensive eye care services emphasizing the importance of training programmes to provide eye care personnel for the secondary and primary levels of eye care. The development of appropriate technology for spectacles and eye drop preparation, together with standardization of equipment and instruments necessary for providing eye care services, has been found of great value in maximizing the cost-effectiveness of available resources and manpower.

CBM is a collaborative organization with the WHO Programme for the Prevention of Blindness, for which a three-year working agreement has been developed. This consists of a general objective to strengthen national prevention of blindness programmes and specific objectives in five areas. These are to promote activities against childhood blindness, to assist in the distribution of ivermectin for patients with onchocerciasis, to promote and evaluate the use of optical workshops for the low-cost production of spectacles, to develop and promote a manual for the local preparation of eye drops, and to assist in developing training programmes for eye care personnel.

There has been very significant progress in all these collaborative activities during 1989 and 1990 (see points 5.1 and 5.2). The manual for the local preparation of eye drops will appear in 1991 as a joint document, with a poster. An optical workshop for the training of personnel from French-speaking countries in Africa will be set up as a joint project at the WHO Collaborating Centre in Bamako, Mali.

CBM's support of projects in developing countries is coordinated through eight regional offices (Penang, Bangkok, Tiruchirapalli, Nairobi, Gabarone, Lomé, Santo Domingo, Asunción). CBM's regional representative in each office has the services of a senior ophthalmologist for a minimum of six weeks per year to advise and help develop the eye care programmes within that region. This team of eight medical consultants meets on an annual basis to discuss regional activities and provide advice on medical policy matters for the organization's executive.

1.2.2 Helen Keller International (HKI)

In 1989, HKI activities with the WHO Programme for the Prevention of Blindness were as follows:

Vitamin A

Workshops: There was WHO participation at vitamin A workshops organized by VITAP in Africa. A WHO resource person was present at workshops in Senegal and Mali and at an East Africa regional gathering in Lusaka to provide technical input and guidance. This helped to influence policy-makers.

Educational/training materials: VITAP has been working with WHO in jointly developing three posters on vitamin A and the eye, vitamin A and measles and vitamin A and child survival.

Collection and analysis of data: There was collaboration with WHO/Geneva in detailing a strategy for systematic collection and review of vitamin A deficiency prevalence data, policies and programmes in countries designated by WHO as having a significant public health problem in vitamin A deficiency. VITAP has undertaken a survey of key contacts to explore the status of vitamin A policies in these countries.

Primary eye care

Training: HKI has collaborated with WHO in training health workers in developing countries to identify, treat and refer blindness and eye problems through an innovative approach known as "PREYECARE" - primary eye care in Morocco, Peru, the Philippines, Sri Lanka and Tanzania.

Trachoma control: HKI and WHO have been collaborating with ICEPO in Tanzania on trachoma control. HKI and WHO continued their collaboration on a trachoma control project in Morocco and Tanzania.

Cataract

Cataract surgical campaigns: The concept of cataract-free zones in Latin America has been developed with the Pan American Health Organization (PAHO), the WHO Collaborating Centres in Latin America, HKI and Ministries of Health in Bolivia, Brazil, Chile, Colombia, Ecuador, Mexico and Peru. HKI and WHO have also been collaborating in Indonesia in a cataract programme on the island of Bali.

Low-cost spectacles production: HKI and PAHO worked together in Brazil and Peru to assemble, produce and distribute low-cost spectacles for cataract patients.

Programme funding for eye care for HKI's fiscal year 1989-1990 was ballpark US\$ 5.3 million.

1.2.3 International Eye Foundation (IEF)

The International Eye Foundation is a private voluntary organization dedicated to the prevention and cure of blindness in developing countries. With a budget of US\$ 2.4 million for the financial year 1991, IEF field operations provide training, equipment and medicines, clinical services, operation research and development of community-based programmes through support for indigenous eye care organizations in 10 countries in Africa, the Caribbean, Eastern Europe and Latin America. IEF has historically worked not only at national but also at regional and subregional levels in the design and implementation of programmes which provide eye care to the needy. IEF's strategy for primary eye care programmes includes the following components:

- (1) Assisting service organizations and ministries of health in developing blindness prevention strategies and services which integrate preventive, promotive and therapeutic activities into the existing health care and social service systems.
- (2) Providing long-term training for all categories of health care workers in eye care appropriate to their level and function. This includes curricula and materials development.
- (3) Carrying out community-based surveys to determine the prevalence and etiology of blinding eye diseases and developing appropriate alternative programme strategies to address needs identified in initial assessment. IEF assistance programmes are designed to complement government activities with government counterparts included in programme planning, development and implementation. In designing and implementing programmes, IEF also works closely with other nongovernmental organizations, universities and multilateral agencies.

IEF is currently beginning its second three-year official collaboration with the World Health Organization, with the specific aim of instituting and strengthening national blindness prevention programmes wherever IEF is working. Specific programme objectives include:

- (a) control of onchocerciasis through ivermectin distribution in Guatemala, Malawi and Nigeria. These training programmes are ongoing and have already resulted in a significant increase of trained personnel for eye care in these areas;
- (d) strengthening of an eye health infrastructure, including training in Bulgaria.

1.2.4 Operation Eyesight Universal (OEU)

The mission of Operation Eyesight Universal, a small Canadian charity, is to develop, encourage and fund sight-restoration and blindness prevention programmes in the developing world. OEU currently has 72 programmes in 16 developing countries. Over the last three years, the following was spent on those eye care programmes:

| | <u>Cdn \$</u> |
|------|---------------|
| 1988 | 2 543 755 |
| 1989 | 3 598 074 |
| 1990 | 4 056 681 |

The programme budget for 1991 is Cdn \$ 4 415 000.

In 1989, OEU funded 101 567 cataract operations, examined 1 826 266 and treated 1 434 049 people for a variety of eye ailments, and funded 76 068 anti-xerophthalmia treatments. Also in 1989, OEU funded 1117 eye camps in which 70 652 sight-restoring operations were performed.

It is the dream of OEU that the day will come when nutritional education will reach such an advanced stage, when, under the direction of WHO, vitamin A distribution will be so efficient and so well organized, and when eye care organizations and governments will work so well together, that we will have a world where there will be no more blind children.

1.2.5 Organisation pour la Prévention de la Cécité (OPC)

During 1990, OPC supported the national WHO Programme for the Prevention of Blindness in Burkina Faso (Ouagadougou), Mali (Bamako) and Niger (Agadez), and also worked in regional centres in Cameroon (Yaounde), Chad (Abeche), Guinea (Kankan), Ivory Coast (Korhoge) and Senegal (Tambacounda). Immediate assistance was given in Ethiopia, Central African Republic and Mauritania.

OPC's major activities are in France, namely, epidemiological surveys, information and awareness, and in developing countries for the prevention and cure of blindness. The latter take 75% of the resources, and specialized expenditure for overseas programmes in 1990 is approximately US\$ 280 000.

OPC supports the WHO Programme for the Prevention of Blindness by following the guidelines on national programmes and primary health care, by information sharing, and by attending meetings on the prevention and cure of blindness.

1.2.6 Sight Savers

In 1990, Sight Savers (Royal Commonwealth Society for the Blind) celebrated its fortieth year and the granting of a Royal Charter which incorporates a revised constitution, permitting the organization to work for the first time in non-Commonwealth countries. Thus, although the organization's work will always be rooted in the developing countries of the Commonwealth, it has begun to collaborate with the Organisation pour la Prévention de la Cécité (OPC) in distributing the microfilaricide ivermectin in Francophone countries in West Africa, and it has pledged support in co-funding, with the Organización Nacional de Ciegos de Espana (ONCE), the post of Prevention of Blindness Adviser in PAHO for Latin America and the Caribbean.

Sight Savers' major objectives of preventing and curing blindness and support to education and rehabilitation of incurably blind people have not changed and, in 1989, its total programme funding over 40 countries extended to US\$ 8.5 million. A significant aspect of that programme lies in supporting the development of a number of national eye care programmes, both directly with governments and, indirectly, through national partner

organizations. Sight Savers, through the work of its field and liaison offices and its eye care consultants in Africa, the Caribbean and South and South-East Asia, collaborates with the WHO Programme for the Prevention of Blindness and gives it maximum support. Sight Savers is also in the forefront of promoting coordination of programme activities among international organizations working in the same field.

Apart from support to service delivery entailing 250 000 cataract operations annually, Sight Savers is engaged in the training of eye care personnel, particularly in Africa, where it supports government training centres for ophthalmic medical assistants and cataract surgeons in Ghana, Kenya, Malawi, Sierra Leone and Uganda. Support to WHO Collaborating Centres is at its strongest in that to the International Centre for Eye Health in London, where Sight Savers' funding meets a proportion of the administrative costs of the six-month course in community ophthalmology, the activities of the ICEH Resource Centre and sponsorship for four students to the course annually.

Over 150 000 of the operations referred to above are conducted in India in the eye camp programme. More recently, 40% of that number have been conducted in permanent eye units and, in June 1990, the organization's revised eye care policy for India was presented to its Indian partners at their meeting in New Delhi. Over 100 ophthalmologists attended the meeting and gave favourable consideration to the major principles of the new policy, which included a gradual shift from the temporary field hospitals of the eye camp strategy to year-round comprehensive eye care services in permanent eye units, albeit continuing to include cataract surgery as a major component, an increasing emphasis on work in the neediest states and on child blindness, and a deliberate policy of seeking to work more closely with the Government of India and state governments' ministries of health.

Discussion

In giving their verbal reports, the international nongovernmental organizations once again evidenced the geographical and sectoral scope of their work across the majority of developing countries and covering every level of eye health provision.

The most significant trend to emerge from their reports was that of radically stronger support to training nationals of developing countries, mainly in Africa, and in respect of auxiliary personnel.

Again, although it was evident that some nongovernmental organizations were experiencing greater difficulties in maintaining the level of financial resources, overall there continued to be in the region of US\$ 35 million/year being placed into eye care in developing countries.

2. PREVENTION OF BLINDNESS ACTIVITIES IN LATIN AMERICA AND THE CARIBBEAN

2.1 The meeting noted that this subject had been covered in some detail the previous day by those members of the Group who had formed the Inter-Agency Coordinating Group for Eye Care in the Caribbean. In particular, Dr Patricia Visintin, the PAHO PBL Adviser, who had been unable to remain for the Consultative Group Meeting, had given a general review based on her work over the past few months.

2.2 Mr Dorbrene O'Marde, Health Planner, CCB, reported that the areas reflecting concern were those of manpower development, planning and management of blindness prevention programmes and public education and awareness. CCB were involved in two main training initiatives during 1990, i.e., the provision of a community ophthalmology programme and a management/planning programme for managers of PBL programmes. The establishment of a Chair of Ophthalmology at the University of the West Indies is under discussion.

The activities carried out during the period under review consisted mainly of evaluating the actual state of the Arab Gulf for United Nations Development Organizations (AGFUND) project in each of the nine participating countries. This work was possible with the provision of current information provided by national AGFUND coordinators and Pan American Health Organization (PAHO) country representatives.

In the particular case of Belize, PAHO-AGFUND funds allowed the Belize Council for the Visually Impaired to implement eye care services and training of personnel. Upon approval of the 1990-1991 working protocol, funds will be released shortly to ensure the continuation of the activities carried out in the rural areas with support of the Belize Hospital.

In Guyana, PAHO has attempted to develop this project by providing training materials and ophthalmic equipment. However, the shortage of human resources prevented the full development of primary eye care services.

In Grenada, the original project included a low-cost spectacles programme but, despite the considerable effort made jointly with the International Eye Foundation and the WHO Prevention of Blindness Programme Manager, no progress has been made. However, there is great interest by the Government in blindness prevention, and PAHO is now considering funding other priority areas.

In Haiti, the agreement of the cooperation with the Ministry of Health was signed in late September 1989. Due to changes in the Government, a national coordinator has recently been designated. Training materials have been sent and PAHO's country representative will discuss the updated working protocol with the national authorities.

Besides the AGFUND project, another important activity developed during this period of time was the publication of a *Bulletin on Public Eye Care*. This *Bulletin* promotes an exchange of information and facilitates access to current studies, not always available in many areas of Latin America and the Caribbean. Selected articles are of interest to the ophthalmologists as well as to other members of a health team.

The publication is in Spanish and English. The *Bulletin* will contain studies in the field of eye care conducted by professionals in the Region of the Americas. Each edition also offers bibliographic references taken from numerous sources such as:

- (a) Chibret Iris, the data base of the Documentation Centre of Chibret International in France;
- (b) Medline, the data base of the National Library of Medicine of the United States; and
- (c) LILACS, the data base of the Information Centre for Latin America and the Caribbean on Health Sciences and the Regional Library of PAHO/WHO in Sao Paulo, Brazil, among others.

It is hoped that this bulletin will stimulate eye specialists and others to participate in programmes for the prevention of blindness in the Region of the Americas. It should facilitate the dissemination of information about the many organizations working in the field, all of them essential if the increasing public health problem of blindness is to be efficiently approached. In order to continue the publication of the *Bulletin on Public Eye Care* on a continuing basis, PAHO hopes that many other organizations will join in its efforts to increase the amount of material and to disseminate the *Bulletin* so that it would be available to the prevention of blindness personnel working in urban, suburban or rural areas. It should also be mentioned that, thanks to the financial support of the Royal Commonwealth Society for the Blind and the National Organization of the Spanish Blind (ONCE), a Regional Adviser will be designated soon in the office of PAHO.

3. TRAINING OF OPHTHALMIC PARAMEDICAL PERSONNEL

Dr Allen Foster (CBM) gave an overview of training programmes for ophthalmic assistants whom, he noted, have a role in providing eye care services at the primary and secondary level of eye care in countries where the ophthalmologists/population ratio is high, resulting in limited eye care services.

In Africa, at the present time, the overall ratio of ophthalmologists/population is approximately 1 per 1 000 000, while in Asia the figure approaches 1 per 100 000. In Latin America, there is approximately 1 per 250 000 in rural areas but 1 per 20 000 in large capital cities.

These figures vary from country to country within the regions but, overall, demonstrate that the requirement for training ophthalmic assistants is greatest in Africa.

Most training programmes for ophthalmic assistants are of one year's duration and recruit personnel who already have a general medical education, either as medical assistants or general nurses.

Established training programmes in Africa exist in Ethiopia, Ghana, Kenya, Malawi, Mali, Sierra Leone, Tanzania and Uganda. These training programmes are recognized by the appropriate Governments, from which they receive support, together with assistance from various international nongovernmental organizations.

There are also many short, informal training programmes, varying in duration from one week to three months, which are given in different African countries on an in-service training basis.

Recently, a one-year training programme for selected ophthalmic assistants to learn cataract surgery was developed in Kenya.

In Asia, training programmes exist for ophthalmic assistants in Bangladesh, Nepal and Sri Lanka and are usually of one year's duration.

Over the last 10 to 15 years, many successful courses for ophthalmic assistants have been developed in East and West Africa to provide eye care manpower for areas lacking the services of ophthalmologists. These programmes need to continue and to be further developed and, in particular, an emphasis should now be placed on strengthening training programmes for French-speaking countries in West Africa and on further developing officially recognized training programmes for selected ophthalmic assistants to learn cataract surgery.

4. AN OVERVIEW OF THE USE OF IVERMECTIN AND NONGOVERNMENTAL COORDINATING MECHANISMS FOR THE DISTRIBUTION OF IVERMECTIN

4.1 An overview of the use of ivermectin

It is estimated (WHO Expert Committee on Onchocerciasis, Technical Report Series, No. 752, 1987) that more than 95% of onchocerciasis, including the most severe cases, prevails on the African continent. Remaining foci are distributed in Latin America and Yemen (Annexes 5 and 6).

Severe onchocerciasis is always found in the most remote communities where any prophylactic or therapeutic treatment is unattainable. It is said that onchocerciasis is a disease of "the end of the track". For this reason, ivermectin is presently missing its target in most of the countries.

Populations at risk to be treated promptly are localized in the following areas/countries:

In Africa

- OCP: Western Extension area includes western Mali, eastern Senegal, eastern Guinea-Bissau, northern Sierra Leone and northern Guinea.

South-eastern Extension area includes southern Togo, southern Benin and south-eastern Ghana.
- Nigeria: North of junction Niger-Benue rivers/up to 12°N; Gongola; Kwara
- Cameroon: All areas located north of Adamaoua; Sanaga river.
- Chad: South, up to 12°N.
- Central African Republic: North-west; north; east, along M'Bomu river and tributaries.
- Congo: Along Congo and Djoué rivers, exclusively.
- Gabon: Onchocerciasis has not yet been demonstrated as being a serious public health problem in Gabon.
- Angola: Same remark.
- Zaire: Sankuru (Lusambo); Equateur; Uele and tributaries; Tshikapa (River Kasai and tributaries).
- Sudan: South-west: south of Darfur; Bahr el Ghazal; west Equatoria.
- Ethiopia: South-west.
- Uganda: Localized foci along border with Zaire.
- Burundi: Localized focus in the south.
- Tanzania: Tukuyu, Mbeya, north of lake Nyassa; Mahenge.

In America

- Mexico: Chiapas.
- Guatemala: Huenuetenango; Atitlan; Yepocapa.
- Equator: Esmeraldas (major focus on the Santiago river basin).
- Venezuela: Two foci in the north; state of Bolivar; among Amerindians of the Yanomami, Makiritari and Piaroa tribes.
- Brazil: Yanomami and Makiritari Indians, adjoining Venezuela (certainly same focus).

In all of these hyperendemic foci, the most affected populations to be treated first are always located in the most remote areas.

Dr R. Le Berre's presentation concentrated on high prevalence areas of onchocerciasis in African countries not covered by the Onchocerciasis Control Programme. He was pleased to note in subsequent discussion among members that several of those areas were already the focus of their support to ivermectin distribution.

Dr Gaxotte gave some valuable statistics on applications received and numbers of tablets shipped to date from Merck Sharp & Dohme. He reminded members that, although mass distribution programmes necessitated application to the Expert Committee established by Merck Sharp & Dohme, his office, for humanitarian use, had been empowered to provide a maximum of 1000 tablets per physician per year for hospital-based distribution. On the basis of the latter, a total of 546 333 tablets had been shipped to date to 58 countries. In Annex 4, Tables 1 and 2 indicate the number of treatments given as a result of applications for mass distribution, and Tables 3 and 4 for "humanitarian requests".

4.2 Nongovernmental coordinating mechanisms for the distribution of ivermectin

The nongovernmental organizations, in reviewing this issue, decided to seek the collaboration of WHO in holding a meeting (Meeting on Strategies for Ivermectin Distribution through Primary Health Care Systems) in 1991 of all organizations currently involved with ivermectin distribution and those which had plans to do so in the short term. Subsequently, the following agenda was agreed upon between Dr Thylefors, Dr Le Berre, Dr Gaxotte and the nongovernmental organizations for a meeting in April 1991:

- (a) Overview of the present status of onchocerciasis and ivermectin distribution including nongovernmental programmes
 - in the Onchocerciasis Control Programme (OCP) area
 - outside of the Onchocerciasis Control Programme area
- (b) Strategies for community-based and hospital-based distribution systems
 - Target population
 - Diagnosis
 - Monitoring and surveillance
 - Management of adverse reactions
 - Records and reporting
 - Retreatment schemes
 - Evaluation
- (c) Procurement, storage and stock-keeping of ivermectin including logistics of distribution
- (d) Training of personnel
 - at community level
 - at hospital level
 - at management level
- (e) Public awareness and health education
- (f) Structures at national and intercountry level for ivermectin distribution systems

- (g) Country reviews and plans of action
 - Nigeria
 - OCEAC countries
 - Zaire
 - OCP countries
 - Other countries
- (h) Planned commitments and budgets by interested nongovernmental organizations
- (i) Coordination of programmes executed by nongovernmental organizations
- (j) Conclusions and recommendations

It was agreed that the participating nongovernmental organizations would share between them the costs of inviting representatives from selected endemic countries in Central and West Africa. In view of this, it was decided to run the meeting as a bilingual (English/French) meeting. The total cost for the meeting would be worked out by the WHO Programme and forwarded to the Chairman of the Consultative Group, for his further action. The venue for the meeting would be WHO in Geneva and the dates from 22 to 25 April 1991. These dates would still allow the nongovernmental organizations involved to meet with the Director of the Onchocerciasis Control Programme (OCP), Dr E. Samba, in case it were necessary to discuss further the ongoing collaboration in the distribution of ivermectin in the OCP area.

5. PLANNING IN EYE CARE FOR THE NEXT FIVE YEARS

5.1 Conclusions and recommendations from the WHO Meeting on the Prevention of Childhood Blindness, London, May 1990.

The World Health Organization held a global meeting on the prevention of childhood blindness which was co-sponsored by Christoffel Blindenmission and Sight Savers. The aim of the meeting was to review the epidemiology, causes and control strategies for childhood blindness. A draft report has been written which will later become available as a WHO publication.

The main conclusions of the meeting were as follows:

- (1) There are an estimated 1.5 million blind children in the world, and a further 0.5 million become blind each year, of whom 60% die within one year.
- (2) The major causes of childhood blindness are:
 - (a) nutritional (vitamin A deficiency);
 - (b) infections (measles, rubella, ophthalmia neonatorum);
 - (c) inherited genetic diseases;
 - (d) problems related to birth (cerebral hypoxia, retinopathy of prematurity);
 - (e) problems related to the delivery of eye care services:
 - inappropriate: harmful eye practices by non-trained personnel;
 - deficient: lack of facilities, e.g., treatment of congenital cataract.

(3) The report concluded with a number of recommendations of which two directly mention the role of nongovernmental organizations:

Many of the nongovernmental organizations working in blindness prevention are already playing a significant role in controlling blindness through the strengthening of eye care provision in public health and specific measures in combating xerophthalmia. It is recommended that they give much greater emphasis to creating awareness of how childhood blindness can be prevented in all sectors of society. The development of appropriate health and eye care services in programmes that nongovernmental organizations coordinate between themselves and with other agencies is to be encouraged.

Priority should be given to epidemiological research that has the following aims:

- To identify the major risk factors in certain types of childhood blindness and to evaluate the relative importance of these risk factors.
- To assess the impact on childhood blindness of various interventions, some of which may be alternatives.
- To evaluate the cost-effectiveness of these interventions.

Nongovernmental organizations may consider collaborative support for these activities.

5.2 Member nongovernmental organizations' presentations on planned programme support

5.2.1 Christoffel Blindermission (CBM)

(1) The CBM Medical Consultant Committee will be meeting from 7-10 November in Nairobi, immediately preceding the IAPB Assembly.

(2) CBM is initiating a programme to identify treatable blind children, particularly those with congenital cataract attending blind schools.

(3) New programmes for the mass distribution of ivermectin are being developed for 1991. These will concentrate on countries not being covered by the Onchocerciasis Control Programme (OCP) in West Africa.

(4) An evaluation is being conducted of the efficiency and role of optical workshops in Africa. Assistance is being given in developing new workshops in collaboration with the WHO Programme for the Prevention of Blindness, particularly in French-speaking countries of Africa.

(5) CBM is investigating the possibility of developing and supporting training programmes for ophthalmic assistants/nurses in French-speaking countries of Africa.

(6) Overall, CBM is assisting and encouraging its partner organizations in the voluntary sector of medical services to integrate their programmes and work into the planning of national prevention of blindness committees.

5.2.2 Helen Keller International (HKI)

(1) Asia: HKI has recently received a five-year grant from the USAID mission in Bangladesh to develop a nutritional surveillance system in collaboration with the Government of Bangladesh and other nongovernmental organizations. New eye care programmes are anticipated in Asia, for Cambodia and Viet Nam and, ultimately, China.

(2) Latin America: The primary eye care programme, focused on children and based on the Peru, Philippines, Sri Lanka and Tanzania models, is to be extended to Brazil, where an encouraging start to the cataract programme was noted. The organization will seek to continue to work in Haiti, with other nongovernmental organizations. HKI's project in Peru is Primary Eye Care in 3 Departments.

(3) Africa: The United States Congress has approved funding for the extension of the Vitamin A Programme (VITAP) for the treatment of nutritional blindness. HKI seeks to extend its current vitamin A activities in Burkina Faso, Mali and Niger.

5.2.3 International Eye Foundation (IEF)

(1) Malawi: In September 1989, IEF began a two-year programme to control vitamin A deficiency in the Lower Shire Valley, focusing on nutrition education, vitamin A capsule distribution to children and women, and ocular screening. A three-year onchocerciasis control/ivermectin distribution programme is planned in collaboration with the United States nongovernmental organization ADRA in the southern region of the country. The programme is expected to begin at the end of 1990.

(2) Nigeria: IEF, in collaboration with the United States nongovernmental organization Africare, is in the second year of the three-year community-based ivermectin distribution programme in Kwara State. The programme has tested various delivery strategies and has produced a field manual on setting up such programmes which is due to be published by the end of 1990.

(3) Guatemala: IEF is beginning a second three-year programme to distribute NutriAtoI to preschool-age children. In collaboration with CeSSIAM, the organization is also investigating the beta-carotene content of indigenous plants. In addition, IEF is currently in the second year of a three-year ivermectin distribution pilot programme in the Yepocapa region.

(4) Honduras: A second eye clinic is being established at Santa Barbara. A three-year vitamin A deficiency control programme is being implemented in the peri-urban areas of the capital, Tegucigalpa.

5.2.4 Lions International

Mr John Stewart, representing Lions International as an observer to the meeting, was invited to outline the Lions SightFirst Programme which had been announced at the Lions Clubs International Convention in July. He described the proposed initiatives at local and at national level and the interaction with WHO, national committees for the prevention of blindness and nongovernmental organizations. The Programme had been developed under the guidance of an international panel of experts, led by Dr Carl Kupfer, President of IAPB and Director of the National Eye Institute in Bethesda.

5.2.5 Organizacion Nacional de Ciegos de Espana (ONCE)

Mr R. Mondaca and Ms J. Varsavsky, attending as observers, outlined ONCE's work in Latin American areas, including the implementation of a national eye care plan for Guyana, in cooperation with Sight Savers, and the provision of technical and financial support for an eye care adviser for Latin America, through the Pan American Sanitary Bureau (PAHO), co-financed by Sight Savers.

Following the success of the Low Vision Rehabilitation project in Sao José, Brazil, which included the provision of the equipment and staff training, it was hoped soon to set up a similar scheme in Montevideo, Uruguay. This had already commenced by the purchase and adaptation of a building.

1991 projects included a Low Vision Rehabilitation Centre in Cordoba (Argentina); the first steps for another in Concepcion (Chile); and equipment for eye care work and financial support for specific eye treatments in Florianopolis, Santos and Porto Alegre (Brazil), Bucaramanga (Colombia), Guyaquil (Ecuador) and Arequipa and Lima (Peru).

5.2.6 Operation Eyesight Universal (OEU)

The emphasis in the next five years will be on training more ophthalmologists in India, with the target being to raise the current total of 48, all of whom were trained in Manipul, to 100. Modern principles of advertising and promotion will be used to promote vitamin A education and these programmes will be increased with the theme of "No More Blind Children". OEU hopes to establish two paediatric eye care units in India in the next five years and to fund research. Also in India, OEU will continue to co-finance the cataract extraction programme with the emphasis being on underserved areas.

5.2.7 Organisation pour la Prévention de la Cécité (OPC)

OPC's proposed activities include:

- continuation of support to programmes already in existence in Burkina Faso, Guinea (Conakry), Mali, Mauritania, Niger, Senegal and Viet Nam;
- continuation of support to eye care services in Cameroon, Central African Republic, Ethiopia, Ivory Coast and Nepal;
- distribution of ivermectin in Guinea (Conakry), Mali and Senegal, in collaboration with Sight Savers;
- establishment of an ophthalmological mobile unit in Bobo Dioulasso, Burkina Faso;
- establishment of a rural secondary eye care service in Ziguinshor, Senegal;
- commencement of eye care services in the Abeche Hospital, Chad.

5.2.8 Project Orbis

Dr James Martone, representing Project Orbis as an observer to the meeting, was invited by the Chairman to indicate his organization's plans for 1991. Dr Martone responded by drawing members' attention to the Symposium that was to be sponsored by Project Orbis in collaboration with the Cameroon Government in January 1991. He also drew the Group's attention to the forthcoming publication by Project Orbis of a Manual of Teaching Materials.

5.2.9 Sight Savers

(1) Asia: In Pakistan, an agreement has been signed for the establishment of a community health programme in North-West Frontier Province. In India, the organization is gradually moving the focus of its support from states where it had been very active to those such as Bihar, Orissa and Assam, where eye camp services are relatively undeveloped. Sight Savers will seek to provide good, permanent facilities in these states, working closely with their health authorities, for comprehensive service delivery, thus lessening dependence on the eye camp strategy.

(2) Africa: It is anticipated that the distribution of ivermectin in West Africa will cause the infrastructure to grow, thus improving eye care services in underserved areas. Nigeria will be strongly targeted over the next five years and the community outreach programme in Kaduna will be further developed. Ivermectin distribution, co-financed with OPC, will commence in Guinea, Mali and Senegal.

(3) In the Caribbean, eye care services will be developed in Guyana, in cooperation with ONCE, and in Belize and Jamaica, working through the Caribbean Council for the Blind.

(4) In the Pacific area, a national eye care plan for Papua New Guinea will be developed and supported, including training for medical auxiliaries, based in Port Moresby.

Overall, Sight Savers will continue to support national comprehensive eye care services and will seek to develop manpower training in conjunction with service delivery.

The granting of the Royal Charter, incorporating a revised constitution, in February 1990, enables Sight Savers to work outside the Commonwealth.

6. THE INTERNATIONAL AGENCY FOR THE PREVENTION OF BLINDNESS

6.1 Fourth General Assembly

Dr Carl Kupfer thanked nongovernmental organizations for their support and guidance during his eight-year term as President, and outlined the programme and arrangements for the General Assembly in Nairobi. He noted that the theme of "Sustainability" needed to include the issue of funding for IAPB.

The subject of nomination for a successor to Dr Kupfer as President of IAPB came under discussion and the recommendations of the Nominating Committee were considered in detail.

6.2 Consultative Group Chairman

Mr Johns reminded members that his term of office as Chairman of the Consultative Group would come to an end at the General Assembly and asked them to begin considering which nongovernmental organization among them should take on the task for the next four years.

OPENING ADDRESS

by

Barry Wint, M.D.
Chief Medical Officer, Ministry of Health, Jamaica

on the occasion of the

THIRD MEETING OF THE CONSULTATIVE GROUP OF NONGOVERNMENTAL
ORGANIZATIONS TO THE WHO PROGRAMME FOR THE PREVENTION OF BLINDNESS

Kingston, 17 September 1990

Thank you, Mr Chairman. Distinguished ladies and gentlemen, good morning.

It is certainly a pleasure and a privilege for me to be participating in your meeting this morning and to be part of such an august body of organizations with an interest in and caring about the question of blindness prevention.

1990 is the start of the final decade towards the year 2000 and, in Jamaica, we recognize that the question of the goal to which we all strive - Jamaica being a signatory to the WHO mandate of Health for All by the Year 2000 - means that we are running out of time and, with respect to eye care, we are particularly concerned in Jamaica that we have not yet addressed basic issues in terms of planning for the eye care of the Jamaican populace.

We still need to determine what the major problems are; we have not yet done a basic survey. However, we know, and certainly the ophthalmologists tell us, that the major problems that we face in terms of prevalence relate to basic problems like cataract, glaucoma, and complications in the eye from chronic diseases that are prevalent in Jamaica. In the younger age group, we have roughly a 10% prevalence of sickle cell anaemia in the Jamaican public and, in the older age group, after age 40, we all start to suffer from hypertension and diabetes mellitus. These are some of the more pressing problems that face us and all of those have an impact on the status of eye care in Jamaica and contribute to the development of blindness.

In terms of access of the Jamaican public to care, there are also problems. Again, the ophthalmologists assure me that we have enough ophthalmologists in Jamaica. However, the way in which they are distributed is a problem: mainly they are in the big towns and here, in Kingston which is the capital of Jamaica, you will probably find 75% of the technology, both human and machinery, to deal with the problems.

At the other end of Jamaica - the western end - we have another unit at the Cornwall Regional Hospital, where I happen to have worked for about 15 years, and about 10 years ago we did a small survey there to look at the question of access. Though that hospital and that eye service serve roughly three-quarters of a million population in the western five parishes of Jamaica, I decided to look at exactly who were being served in the Centre. It turned out that within a 20-mile radius of that service, the main urban populace were being relatively overserved, in that they were accessing that Centre for relatively mild eye problems, and when you looked into another 20-mile radius around that Centre, there were a significant number of people going blind with very critical problems that were not being reached by that eye service.

Annex 1

So we established from that small study that the whole question of access was a critical one; that establishing an eye centre and an eye service, and staffing it with highly trained ophthalmologists and up-to-date equipment, does not necessarily answer the problem, because often we find that in the urban setting and in the Jamaican scenario, a lot of that service is now available in the private sector as opposed to the public sector. With that kind of model, it means that those who can afford it have access, and they have access to an ophthalmologist if an eyelash gets into their eye, and I think that is an abuse of an ophthalmologist's time in terms of the global need. It means, therefore, that one of the challenges we face is to adjust this access. Taking the words of the ophthalmologists that we do have enough ophthalmologists - and that even I need to double-check - means that we have to set up a system which will ensure that those people who need that level of care can get to see the ophthalmologist, but that those who have simpler problems can be dealt with at a more peripheral level.

And this whole area is what I refer to as primary eye care because, in Jamaica, the structure of our service relates to the primary health care model. We have a fairly widely distributed network through 360 health centres across the country, including some of the rural areas, staffed by a variety of health workers, from a simple midwife and a community aide, all the way up to a nurse practitioner and, in some cases, a doctor, and, by and large, the populace bypasses that whole network with respect to eye care and heads for the eye centres, and especially those centres that they know will have a slitlamp for examination and might even have a laser service for some of the fancier treatments. We do have a laser machine in a couple of our centres.

This, we have to address, we know, and one of the mechanisms that we are looking at is the whole question of transferring some of that technology and knowledge from the ophthalmologists to the primary eye care providers in the field: at least at the level of the doctors in the field, the general practitioners in the field and the nurse practitioners in the field that are fairly accessible to the public because, again, John Public goes to these people if they have an eye problem, and immediately the patient is referred to the ophthalmologist. I think we have to stop that by arming these people to be able to deal with some of the basic problems. Cataract surgery in Jamaica, for example, is still sophisticated here. You still have to line up on a waiting list to get into a major operating theatre, with a lot of bottlenecks in terms of anaesthetic time. At this particular time, we have a problem with brain-drain of our manpower and theatre nurses are short, so the whole question of full utilization of our operating rooms is a problem. So we have these long waiting lists for something that is, I am told, now demystified technique to a large extent and which, in some countries, seems to be taking place at the periphery.

This is going to need a lot of work; it is going to need a lot of commitment and resources but I think that the will in Jamaica is there because, already, we have started to work with the nongovernment organizations and eye care is one of the areas in which I think the nongovernment agencies are making quite an impact. I heard, as you introduced yourselves, mention made of Project Orbis and the Lions Club and other people who have been working with us in Jamaica but, structurally, I need to mention a particular relationship that has emerged where we have formed a National Committee on Blindness Prevention, in 1986, with the Jamaica Society for the Blind and with other interested parties in the private sector, collaborating with us in the Ministry of Health. Together we plan to look at a determination of the real needs of the population, determine what resources are available and what the resource gaps are and then to develop a strategic and programmatic plan and approach to deal with those needs effectively. This will include the much-needed research and, very importantly, effective coordination of the activities of the various agencies, because we find that many agencies working in isolation are overlapping some of their functions and their activities and, with effective coordination, we think that we can recognize and realize some efficiencies to our efforts.

Annex 1

So, Mr Chairman, it has been very timely that your Consultative Group decided to meet here in Jamaica and we really look forward, as you interact with the Jamaican and the Caribbean groups, to our being able to move forward and make great strides to deal with what is needed here in Jamaica. Therefore, it is left to me just to welcome you and I hope you came in early enough on the weekend to have had a chance to see a little bit of Jamaica before getting down to your meeting, especially those of you who are here for the first time. I would like to wish you successful deliberations for your two days and I hope that at the end, you will see a meaningful product from your deliberations. We welcome your assistance as we struggle here in Jamaica to develop an eye service and to provide reasonable levels of eye care for the people of Jamaica. It is a pleasure to declare your seminar open. Thank you.

THIRD MEETING OF THE CONSULTATIVE GROUP OF
NONGOVERNMENTAL ORGANIZATIONS TO THE WHO PROGRAMME
FOR THE PREVENTION OF BLINDNESS

Kingston, Jamaica, 17-18 September 1990

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Annex 2

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THIRD MEETING OF THE CONSULTATIVE GROUP OF
NONGOVERNMENTAL ORGANIZATIONS TO THE WHO PROGRAMME
FOR THE PREVENTION OF BLINDNESS

Kingston, Jamaica, 17-18 September 1990

AGENDA

Opening Ceremony

1. Global review of the activities of the WHO Programme for the Prevention of Blindness over the past year and verbal reports from nongovernmental organizations for the same period
2. Prevention of blindness activities in Latin America and the Caribbean
3. Training of ophthalmic paramedical personnel
4. An overview of the use of ivermectin and nongovernmental coordinating mechanisms in its distribution
5. Planning in eye care for the next five years:
 - Conclusions and recommendations from the WHO Meeting on the Prevention of Childhood Blindness
 - Nongovernmental organizations' presentations on planned programme support in eye care
6. The Fourth General Assembly of the International Agency for the Prevention of Blindness, Nairobi
7. Any other matters

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TABLE 1. NUMBER OF TREATMENTS PROPOSED IN APPROVED MECTIZAN DONATIONS,
 BY YEAR OF APPLICATION APPROVAL, 1988-1990*

| Year | Initial | | Continuation | | Total treatments |
|-------|--------------------------|------------------------|--------------------------|------------------------|------------------|
| | Applications Approved | Treatments Proposed | Applications Approved | Treatments Proposed | |
| 1988 | 1 | 255 000 | --- | --- | 255 000 |
| 1989 | 16 | 239 220 | --- | --- | 239 220 |
| 1990 | 9 | 467 035 | 2 | 357 247 | 824 282 |
| Total | 26 | 961 255 | 2 | 357 247 | 1 318 502 |

*September 1988 through June 1990.

TABLE 2. NUMBER OF APPROVED INITIAL AND (CONTINUATION) MECTIZAN APPLICATIONS,
 BY APPLICANT CATEGORY,* BY YEAR OF APPROVAL, 1988-1990**

| Year | Applicant category | | | | |
|-------|--------------------|---------|-----|----------|----------|
| | MOH | OCP/WHO | NGO | Academic | Industry |
| 1988 | 1 | 1 | 1 | 1 | 1 |
| 1989 | 8 | 0 | 4 | 0 | 0 |
| 1990 | 6(1) | 0(1) | 2 | 1 | 0 |
| Total | 15(1) | 1(1) | 7 | 2 | 1 |

* Category of principal applicant.

** September 1988 through June 1990.

TABLE 2. HUMANITARIAN REQUESTS IN ENDEMIC COUNTRIES

| <u>Country</u> | <u>Number of requests</u> | <u>Number of tablets requested</u> |
|--------------------------|---------------------------|------------------------------------|
| Togo | 22 | 87 748 |
| Cameroon | 104 | 87 292 |
| Nigeria | 53 | 61 072 |
| Central African Republic | 38 | 39 792 |
| Ghana | 23 | 35 650 |
| Zaire | 32 | 31 062 |
| Sierra Leone | 16 | 28 100 |
| Liberia | 22 | 26 762 |
| Tanzania | 15 | 25 210 |
| Guinea | 8 | 19 000 |
| Mali | 9 | 9 176 |
| Uganda | 7 | 7 504 |
| Benin | 12 | 7 190 |
| Malawi | 1 | 4 000 |
| Ethiopia | 4 | 2 400 |
| Chad | 4 | 2 310 |
| Equatorial Guinea | 9 | 1 792 |
| Côte d'Ivoire | 15 | 1 572 |
| Sudan | 4 | 1 510 |
| Congo | 7 | 1 248 |
| Venezuela | 2 | 800 |
| Gabon | 3 | 700 |
| Guinea-Bissau | 1 | 500 |
| Senegal | 5 | 472 |
| Colombia | 2 | 430 |
| Guatemala | 1 | 300 |
| Niger | 3 | 220 |
| Brazil | 3 | 204 |
| Burundi | 1 | 200 |
| Angola | 1 | 100 |
| Burkina Faso | 2 | 40 |
| Yemen | 1 | 2 |

Annex 4

TABLE 3. HUMANITARIAN REQUESTS IN NON-ENDEMIC COUNTRIES

| <u>Country</u> | <u>Number of requests</u> | <u>Number of tablets requested</u> |
|--------------------------|---------------------------|------------------------------------|
| EUROPE | | |
| Germany | 31 | 38 380 |
| France | 201 | 34 263 |
| Netherlands | 24 | 14 032 |
| Switzerland | 10 | 4 980 |
| Spain | 9 | 4 842 |
| United Kingdom | 16 | 2 106 |
| Belgium | 12 | 1 670 |
| Denmark | 1 | 1 000 |
| Italy | 4 | 282 |
| Finland | 1 | 100 |
| Norway | 2 | 50 |
| Sweden | 1 | 50 |
| AFRICA | | |
| Kenya | 5 | 3 600 |
| Rwanda | 2 | 520 |
| Gambia | 1 | 200 |
| Mauritania | 1 | 100 |
| Réunion | 3 | 16 |
| Egypt | 1 | - |
| OTHERS | | |
| United States of America | 9 | 1 212 |
| French Guyana | 1 | 200 |
| French Polynesia | 1 | 100 |
| New Zealand | 1 | 20 |
| India | 2 | 22 |
| Japan | 2 | 22 |
| Martinique | 1 | 4 |
| Sri Lanka | 1 | 4 |

Fig. 1. Geographical distribution of onchocerciasis in Africa and the Arabian Peninsula

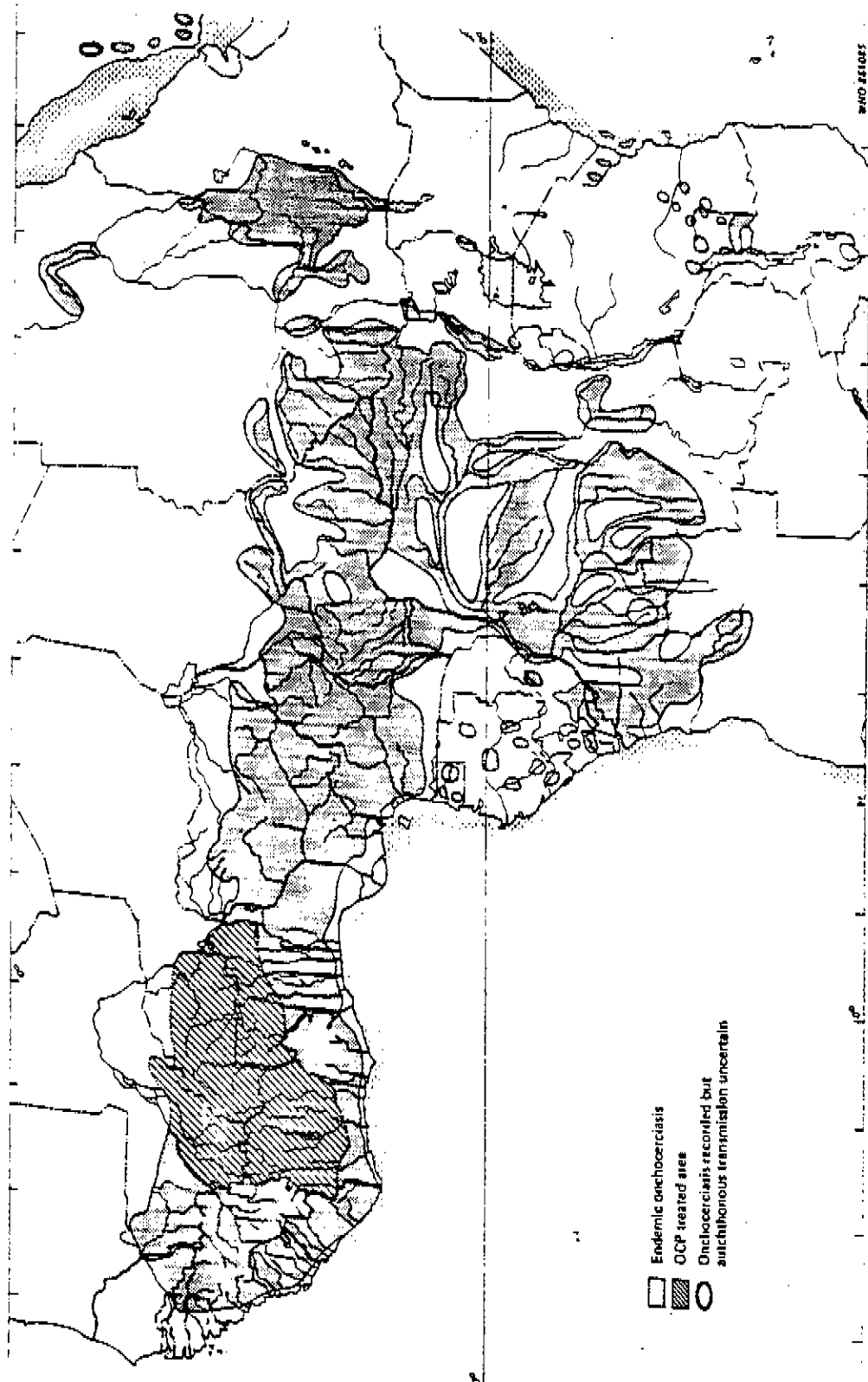


Fig. 2. Geographical distribution of onchocerciasis in Latin America

