

Workshop on Community Ophthalmology, Peshawar, Pakistan

8-10 September, 1997

September 8, 1997, was a milestone in the history of prevention of blindness in Pakistan. The first International Conference on Community Eye Health in Pakistan was held at the recently established Pakistan Institute of Community Ophthalmology (PICO), Peshawar. This is the centre of expertise for community ophthalmology, both in Pakistan and in the WHO Eastern Mediterranean Region. It now runs the first ever one year MSc Course in Community Ophthalmology for this Region. The eye care infrastructure of the area offers many opportunities for students to observe and participate in actual community eye health programmes.

Pakistan is a developing country with an estimated population of 140 million. The prevalence of blindness is high, at 1.78%. There are 1,500 ophthalmologists, which means one ophthalmologist for just under 100,000 people. However, the situation becomes more complex when we consider that more than 80% of ophthalmologists practice in urban areas which constitute only 25-30% of the country's population.

Cataract accounts for 66% of blindness. Other major causes of blindness in adults are glaucoma and corneal opacity. The major causes of blindness in children are cataract, buphthalmos and hereditary retinal disorders. Vitamin A deficiency has not received due attention so far.

The participants in this conference represented leading ophthalmologists involved in community eye health in Pakistan, together with Dr Murray McGavin and Dr Clare Gilbert of the International Centre for Eye Health (ICEH), London. A World Health Organization (WHO) representative was also present during the opening session. The conference focused on the issues involved in the development of a sustainable primary eye care infrastructure in Pakistan, utilising both curative and preventive methodologies.

In the opening session, the scope and limitations of community ophthalmology were highlighted. Community ophthalmology is considered to be 'eye health of the people, by the people, for the people'. It leads to

self-reliant and healthy communities. However, the lack of

professional and political commitment, financial restraints and public lack of awareness are major barriers to its development.

Dr Clare Gilbert very clearly demonstrated that Pakistan needs a cataract surgical rate (CSR) of 2,300 per million population for cataract blind people per year, and 5,000 per million population for those who are visually impaired each year. These figures contrast with the current CSR of 1,050 cataract operations per million per year. Dr Gilbert stressed that cataract services need to be made more accessible and affordable, backed up by strict quality assurance.

Cataract surgical camps have been popular in Pakistan since its independence in 1947. However, quality control has remained a major issue. A report was presented of an eye camp where suitable facilities were available and, therefore, appropriate surgery was carried out, using an operating microscope with intraocular lens (IOL) implantation. It not only created an awareness in the community about the advantages of IOLs, but also resulted in sustainable activation of an otherwise under-utilised rural health centre. Participants also stressed that, along similar lines, we must strengthen our district level eye care services to make them accessible to all. In this regard, it was also highlighted by one of the speakers that training of community health workers and other paramedical staff at primary eye care level is an essential step towards making a community self-reliant. The general outline of such a programme was presented.

An interesting discussion focused on various management issues relating to eye care delivery at primary, secondary and tertiary levels. It was agreed that the population and service ratio at present is inadequate in terms of personnel, money and materials. Criteria should be laid down for the appointment of various levels of eye care providers, ensuring, at the same time, both an adequate service structure and job satisfaction. It was suggested that the district health service should act as a management unit and a full



Participants in the Community Ophthalmology Workshop, Peshawar, Pakistan, chaired by Professor M Daud Khan.

time non-professional programme manager should be recruited. At tertiary level and beyond, the important development of subspecialties was stressed. It was also agreed that community participation in primary health is an essential component of eye care service delivery. Students, teachers, physicians, community leaders, multipurpose workers, etc. can all play effective roles.

Apart from cataract surgical services, other major blinding diseases - glaucoma, trachoma, diabetes, vitamin A deficiency and trauma - were also discussed. Methodologies in screening for glaucoma and diabetic retinopathy, and preventive measures against vitamin A deficiency and ocular trauma were amongst the topics discussed.

A very important and interesting review of the current status of childhood blindness in Pakistan was ably presented by Dr Clare Gilbert. The prevalence of childhood blindness in Pakistan is probably about 1/1,000 children which amounts to 60,000 blind children and another 180,000 with low vision. Based on this, it can be calculated that for one million population, about 450,000 children need surveillance and screening services, while about 1,000 will need rehabilitation in the form of special education and low vision devices. For the same population, curative services will be needed for 3 glaucoma cases and 10-12 cataract cases per year, while genetic counselling will be required for another 10-15 children, blind from genetic disease.

Dr Murray McGavin, apart from his useful contributions during discussion, provided the participants with very valuable information regarding the various non-governmental organisations fighting against blindness.

On the last day, recommendations made earlier were summed up, finally amended, and approved by the delegates for necessary action.

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