The Health for Peace Initiative in West Africa

Hannah Faal
Eye Care Programme Consultant, West Africa, Sightsavers International West Africa Regional Office, PO Box 18190, Airport Residential Area, Accra, Ghana.

Ansumana Sillah
Health for Peace Initiative Co-ordinator & Programme Manager, National Eye Care Programme, Ministry of Health, Banjul, The Gambia.

Momodou Bah
Project Officer, Sightsavers International, 2 Sam Brecco Road, Cape Point, Banjul, The Gambia.

Why health for peace?

The usual understanding of the outreach concept is that a team travels from a base clinic to offer services either at another health facility or in a community, in order to increase access to services for underserved populations. Sometimes, teams travel from one country (usually developed) to another (usually far away) for the same purpose.

In West Africa, this concept was expanded to include another aspect – that of Health for Peace. Sixteen countries of West Africa, with a total population of about 250 million, have formed an economic block called the Economic Community of West African States (ECOWAS), which ensures a degree of collaboration between countries, including movement of its citizens across borders. This block of countries has three official languages (French, English and Portuguese), which follow national boundaries, and several local languages that cut across boundaries. National boundaries are recent and artificial. There is a common culture across boundaries and thus a free movement of people.

However, for other reasons, there have been intermittent civil conflicts and instability in the border areas of ECOWAS countries, specifically affecting Guinea-Bissau and Cassamance (southern province of Senegal). Displacement of populations and difficulties with disease control efforts had negative effects on the health status of citizens.

The Ministers of Health of Senegal, The Gambia, Guinea-Bissau and Guinea, four countries with a total population of 19 million, decided in 1999 to work together under a Health For Peace Initiative (HFPI).

HFPI-PBL Team

Guinea-Bissau Health Minister shaking hands with Sightsavers Project Officer at an eye camp in 2004. GUINEA-BISSAU

Which health problems are targeted by the Health for Peace Initiative?

The four main intervention areas targeted by the HFPI are:

- The Expanded Programme on Immunisation (EPI)
- Epidemiological surveillance, epidemic management and complex emergencies
- Roll Back Malaria
- HIV/AIDS/STIs.

Each area was the responsibility of a country; malaria was covered by The Gambia, HIV/AIDS by Senegal, EPI by Guinea-Bissau, and surveillance by Guinea. The HFPI thus allowed cross-border joint activities such as joint immunisation days, and the sharing of experience, expertise and systems.

Adding prevention of blindness as a fifth component of the HFPI

In The Gambia, the National Eye Care Programme had made considerable strides in setting up a comprehensive service. At some centres, up to a third of cataract operations were for citizens from neighbouring countries. Over the ten-year programme period (1986-1996), trachoma blindness had dropped from 17 to 5 per cent and control activities were in place throughout the country. There was a constant risk of re-infection from people moving across the country's long porous border. The Gambia felt that, in the spirit of the Health for Peace Initiative, the neighbouring countries should develop their own eye care programmes. The Gambian Minister of Health at the time, now the Honourable Vice President, then proposed to include the prevention of blindness as a fifth component of the HFPI. In August 2001, at a meeting in Banjul, the Ministers of Health of all four countries signed up to this, under the 'Banjul Declaration'. An eye care programme which served just 1.2 million people in The Gambia, started to reach out to 19 million people living in four countries.

An HFPI project was developed and implemented, supported by Sightsavers International, based on the following components:

1. Sight by Wheels – cataract camps
2. Human resource development
3. Development of district eye services
4. A regional eye centre for referrals, training, technical support and research.

Each component had targets and a time frame. A management structure and monitoring process were put in place and a co-ordinator appointed.

Components of the prevention of blindness strategy of HFPI

1. Sight by Wheels

In the recipient country, an eye camp site is identified, then social marketing, screening and accumulation of cases are carried out. A receiving team co-matching the incoming team is set up. A complete team of surgeons (mainly cataract surgeons), nurses, equipment technician, and drivers from The Gambia, carrying the equipment, consumables and medicines needed, then go to the receiving country. They spend two to three days there, and conduct a cataract camp with the national recipient team. The planning and the post-camp evaluation are conducted jointly. The style of camps is adjusted to the topography, climate, and culture of each country.

Figure. 1. The four African countries taking part in the Health for Peace Initiative

"The Heads of State of The Gambia, Guinea, Guinea-Bissau and Senegal, taking cognisance of the fact that peace and security are essential for the preservation and promotion of the health of their populations, and also taking into consideration the traditional ties of friendship, fraternity and good neighbourliness that unite their countries, have decided to reinforce their health co-operation through these concerted efforts towards their common health problems."[1]

The objectives of these camps were:

- To provide services, mainly cataract operations, in the underserved areas
- To transfer skills to the receiving team
- To mix the team with members from the different countries to foster personal and working relationships between teams across borders
- To gradually reduce the number and change the composition of the visiting team in order to eventually replace it with the trained receiving team
- To raise the awareness of the population
- To demonstrate the capacity of well-trained cataract surgeons
- To demonstrate the strategy of cataract camps as a way of reducing the cataract backlog.

So far, 3,854 cataract operations have been performed (with posterior chamber intraocular lens implant, except for a selected few) in 26 camps conducted in the four countries. Screening in health facilities, the community, and television/radio announcements have been used to encourage patients to come for surgery. Other services, such as treatment, minor surgery and mop-up surgery for those who missed the dates, were also carried out. Follow-up postoperative care was provided and, where possible, the visual outcome was estimated. An estimated 11.5 million of the 18 million population have been sensitised. This has lead to:

- Increased demand for outreach surgery
- Increased public awareness of available services
- Increased use of eye care services
- Increased awareness that our peoples are working as a team, which serves as a contributory factor to peace and stability in our sub-region.

Figure 2. Trend of number of camps and countries covered

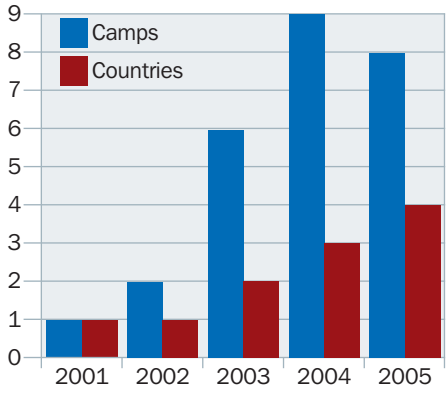

Figure 3. Trend in number of operations performed

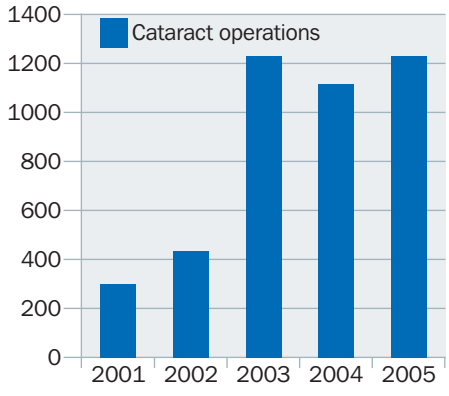

Table 1. HFPI eye camps and cataract operations

Country	Place of surgery	Period	Number of persons operated on
Senegal	Kaolack	Oct. 2001	298
	Djourbel	26-28 Feb 2003	171
	Thiadaye	6-8 Aug 2004	160
	Louga	21-23 Feb 2003	198
	IPRES	12-14 Dec 2003	151
	Rufisque	8-11 Oct 2004	202
	Kolda	8-11 Oct 2004	258
	IPRES	12-13 Feb 2005	73
	Kolda	28 July-1 Aug 2005	352
Total for 9 sites in Senegal			1,863
Guinea-Bissau	Bissau	24-27 June 2002	260
	Gabou	22-24 Oct 2002	171
	Canchungo	24-27 Oct 2003	191
	Bissau	27-29 Dec 2003	240
	Catio	26-30 April 2005	60
Total for 5 sites in Guinea-Bissau			922
The Gambia	Brikama	15-18 Dec 2004	150
	Bansang	15-18 Dec 2004	92
	Farafenni	28-30 Dec 2004	68
	Farafenni	April 2005	150
	Basse	Nov 2005	97
	Soma	Nov 2005	56
	Farafenni	Nov 2005	64
Total for 7 sites in The Gambia			677
Guinea	Koundara	25-29 Nov 2004	149
	Mamou	15-16 Dec 2005	59
	Faranah	17-19 Dec 2005	65
	Dabola	20-21 Dec 2005	52
	Kouroussa	22-23 Dec 2005	67
Total for 5 sites in Guinea			392
TOTAL for 26 sites			**3,854**

The experience of participating in the camps has profoundly increased awareness amongst ophthalmologists of a number of issues: the high degree of unmet need; the acceptance of the cadre of cataract surgeon; and the need to set up regional cataract services.

Another significant effect of the camps was to promote the establishment of permanent facilities. The location of camps catalysed the development of eye units.

The camp team was initially made up only of personnel from the National Eye Care Programme of The Gambia. As the project progressed, members from the other countries replaced The Gambian staff, so that at the end the team would be made up of members from at least two to three of the four countries.

2. Developing human resources for HFPI

The Gambia's national eye care training programme was expanded to become a regional ophthalmic training programme (ROTP) to provide primary- and middle-level eye care workers for the HFPI countries. The courses attracted candidates from other countries, up to Cameroon in the east and Mauritania in the west.

The courses offered are:

- The Diploma in Ophthalmic Nursing (DON) – part of the HFPI project
- The Advanced Diploma in Ophthalmic Surgical Nursing (ADSON), i.e. cataract surgery course – part of the HFPI project
- The Community Health Nurses/State-Enrolled Nurses Ophthalmic Nursing course (CON)
- Optical attendants and refractionists course
- Training in the local production of eye drops (LPED)
- Instruments technician practical exposure
- An English language course to train the candidates from the French- (Senegal and Guinea) and Portuguese-speaking countries (Guinea-Bissau).

Selection criteria were agreed and the qualifications fitted with the receiving countries. Candidates were selected from districts and

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HFPI-PBL Team

The day after surgery: patients start to see the world again. GUINEA

HFPI-PBL Team

Day after surgery: a patient reads his paper with joy. GUINEA

trained, then sent back to their place of work and equipped to function.

Another objective of the HFPI was to help countries set up their own training programmes, starting with the community ophthalmic nursing course (CON). Guinea-Bissau has set up a CON course and Senegal has held discussions to do the same.

In addition to the above, the ROTP also offers practical training for doctors for the West African College of Surgeons' (WACS) diploma and fellowship in ophthalmology training programmes who have in turn provided support for the courses and promoted the building of the team concept. Intraocular lens conversion training has been provided to two doctors from Guinea and one doctor from Guinea-Bissau. The cross-border concept was also used for faculty, in that external examiners of the ROTP courses were invited from the HFPI countries. In total, 121 mid-level eye workers have been trained.

3. Developing district eye services

As part of the HFPI training strategy, eye care workers are given post-training support by outreach from a peer in The Gambia. The peer supporter helps them set up services. An outreach from their trainer provides a follow-up on their settling down, performance and local support.

As a result, four Senegalese cataract surgeons have set up services in the districts of Thiadaye, Rufisque, Dakar and Bindiona, all equipped with a Scan Optics slit lamp and cataract sets. District services have also been established in Biyumbo, Gabou, and Chanchungo in Guinea-Bissau.

This has catalysed the development of national eye care plans by these countries and the commencement of implementation of plans at regional/district level. Senegal and Guinea-Bissau have conducted trachoma prevalence surveys and Guinea is running a training programme for the WACS's diploma in ophthalmology for doctors.

4. Planning for the Regional Eye Centre

The tertiary level service delivery of The Gambia and all the HFPI activities were conducted in the very limited infrastructure of the Royal Victoria Hospital, Banjul and the eye care secretariat. A regional centre is now being developed to provide facilities for clinical referral services, quality assurance through supportive supervision for the national eye care programme and for the newly set-up district services, training as detailed in the ROTP, and research links with international institutions. The centre is scheduled to have: wards for adults, children and 40 beds for private patients; an operating theatre suite with three operating theatres; a training block; an administrative block; a hostel for 30 students; a staff duplex bungalow, and a visiting lecturers' bungalow. It is hoped that the centre will be operational by the end of 2006.

Challenges faced by the HFPI eye care programme

How sustainable is the HFPI eye programme?

Tuition fees from students are being paid into a separate ROTP account. Funds generated will be used to sustain the training programme.

The Gambia and Guinea-Bissau are implementing cost-recovery programmes and the Bamako Initiative (BI), with a view to ensure the availability of all the essential drugs at all levels of health service delivery. BI is an initiative that aims to strengthen the primary health care services through cost-sharing and co-management. Under this initiative, essential drugs are provided and made available to health facilities. Funds generated from the respective facilities are banked by their respective health committees and subsequently used to replenish drugs.

Sightsavers International (SSI) and Christian Blind Mission International (CBMI) were the main supporters. Funds for the construction of the Regional Eye Centre (REC) were provided by the Sheikh Zayed Foundation. The project will face the challenge of meeting the running costs of the REC.

The impact of free services

The population is now aware and will be demanding services. Under the HFPI, the cataract surgical services were provided free. For this special type of camp, the purpose was to target the least-served populations. This was not always the case but, in the majority, it reached the unreached. The political involvement had its advantages in raising the profile of and the need for eye care services and accelerated the intention by governments to establish eye care services.

Languages

Official correspondence needed to be in the language of the recipient. All involved had to acquire language and communication skills. Teaching was done in English. The advantage was that the students acquired the ability to communicate in a second official language. Educational materials in languages other than English were acquired. On the other hand, it was easy to communicate with the patients in the local languages.

Conclusion and future development

The Health for Peace Initiative has not been the usual outreach. It has achieved its original hope of 'health for peace', as on more than one occasion eye teams ran security risks and fostered peace between populations. The enemy factions came to recognise the teams and facilitated secure movement. It started personal working relationships between eye care and health workers, peer-to-peer, across the borders.

The strategy was adapted in each country: for example, minicamps were introduced in The Gambia, extended camps were introduced in Guinea, and trichiasis surgery camps were introduced to all. Collaboration was established to facilitate access to consumables: Guinea-Bissau established a local production of eye drops unit, The Gambia imported intraocular lenses for the camps and the district services.

Before HFPI, the cadre of cataract surgeons was unacceptable to Senegal; post-HFPI, they are part of the eye care team at the regional level, strictly within the public sector, under the responsibility of an ophthalmologist. The capacity for intraocular cataract surgery has increased and is equitably distributed.

The HFPI demonstrates the power of political will and commitment to achieve development; it could not have happened without the vision, political support of the Ministries of Health and the regional West Africa Health Organisation. It also demonstrates the power of partnership between the governments, the two NGOs, SSI and CBMI and the peoples of the four countries.

The receiving countries hopefully developed their capacity to independently continue their own activities, develop new bases and cascade down outreach to lower levels, and thus achieve more coverage. Senegal has now started its own outreach activity. HFPI has been implemented by locally-trained personnel.

Based on the success of the HFPI, more countries have applied to join the initiative: Mali, Mauritania, Liberia and Sierra Leone. The programmes supported by SSI in contiguous areas of Liberia and Sierra Leone, Nigeria and Cameroon are exploring the possibilities of cross-border collaborations. By coincidence, these have been areas of conflict and would qualify to be part of the Health for Peace Initiative.

References

1. The Health for Peace Initiative Inter-Country Action Plan 2000-2001. 1999.

See also Health for Peace PowerPoint presentation under useful resources.