Normally, data is further centralised at the provincial level before being passed to the central level where it is forwarded to the supporting programmes and the drug donation programme. There has been an effort to get treatment data integrated into existing health management information systems in countries, but this has been a slow process, and there are many discussions about which indicators to use. As health systems are often weak at the periphery (e.g. remote or rural areas), community data may be collected by a supporting non-governmental organisation (NGO) in a parallel way and then forwarded to the government for their reports. Mectizan® is often donated through NGOs, so they are an important part of the process.

People need to be trained at the respective levels in order to collect this vital information. Once chosen by their community, distributors are trained in a very practical way, as close as possible to their community. Treatment is usually written down for each individual, and by family, in a locally bought exercise book or in specially printed registers. In some remote communities, volunteers may be illiterate. However, even in these circumstances, volunteers can be trained to use a simple tally sheet, which is often used to summarise data in any case. Training at the community level is usually done by the health centre staff who are in turn trained by staff at the district level, who have received their training at a provincial level. This form of 'cascade' training is a very effective process, but care must be taken to make sure the essential messages are relayed correctly at the relevant levels. Close supervision is required as incorrect data leads to incorrect tablet data or information for planning.

During the distribution process, the distributors are often helped by other volunteers to enter data into the exercise book or register. Having one page per household makes it easier to locate individuals for follow-up of the annual treatment or to find people who were absent at the time of treatment.

Adrian Hopkins

**Community distributors can use the data they collect to do a follow-up. BURUNDI**

The treatment summaries are prepared at the community level. These show numbers treated by gender and sometimes by dose (1–4 tablets) and also reasons for not taking the tablets (too young, pregnant, too ill, absent from the village, etc.). The health area nurse then collects data from all the communities and forwards it to the health district where it is centralised, sometimes computerised, and then forwarded to higher levels with their own activity report. Once again, NGOs sometimes facilitate this process.

## How is the information analysed and used?

The data collected by the volunteers are usually analysed at the community level and the following are calculated: total number of people treated, number of tablets used, and sometimes coverage (percentage or proportion of population treated). Volunteers may also use the family treatment sheets to follow up on those who had not received treatment, often revisiting their homes. They may also try to follow up on people refusing treatment. Specially trained community volunteers may also participate in this analysis and may calculate the coverage. Health centre nurses usually discuss the results with community volunteers and will check the coverage levels. At the district level, health centres are compared and the results are tabulated and coverage calculated before the report is forwarded to the provincial or central level.

The information is used in different ways at different levels:

- At the community level, the details of treatment are shared and the coverage is discussed with the community distributors, including the importance of high coverage for control or elimination. Problems or low coverage are discussed to try and resolve challenges. Sometimes, coverage is compared between communities to see "who is doing best."
- At the health centre level, coverage is calculated: people responsible for high coverage are congratulated; discussions are held with those with low coverage and solutions examined. At this time, strategies for the next treatment round will be discussed and the needs for tablets will be calculated.
- At the district level, coverage is again the main issue as well as planning and budgeting for the next treatment round (training, retraining, further health education, etc.).
- At the central (national) level, the reports are used to calculate the next year's tablet request.





# Ten years

**Peter Ackland**
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## An encouraging start

We have just passed the halfway mark for the VISION 2020 global initiative, which was launched in 1999 with the goal to eliminate avoidable blindness by the year 2020. This is a good time to take stock of what we have achieved and what still needs to be done.

The success of VISION 2020 has to be judged against its impact on reducing levels of avoidable blindness in the world. Although still to be finally approved by WHO, some preliminary data on the global prevalence of blindness and visual impairment was presented in a meeting between WHO and IAPB members in October 2010. It suggests a decline of approximately 10% in the overall number of blind and visually impaired. Compared to the 314 million people with visual impairment (≤6/18) from WHO data produced in 2004, the new figures suggest a total of 285 million. Overall, this is a decrease of nearly 29 million. The number of blind people (≤3/60, presenting vision) has fallen from an estimated 45 million to 39.8 million. If these figures are confirmed, and if we take into account that, over the same period, there has been an 18% increase in the population of those aged 50 years and older worldwide, then we have some cause for optimism.

We also know that:

- The prevalence of blindness is decreasing in some countries that have adopted VISION 2020 strategies. The most recent national studies done in Pakistan, India, and The Gambia have all shown significant declines in prevalence rates compared to earlier surveys.
- The number of cataract operations done in India has increased fivefold over the past 25 years, to more than 5 million per year, and the lessons learnt are having a major positive impact in other countries.
- Blindness due to trachoma and onchocerciasis has decreased significantly and the possibility of the elimination of transmission of these two diseases by the year 2020 is within reach.
- Childhood blindness is decreasing due

# to VISION 2020: how are we doing?

to vitamin A supplementation, measles immunisation, and the focus on blinding conditions such as retinopathy of prematurity.

- Half of the world's visual impairment is due to uncorrected refractive error, and significant progress has been made in bringing refraction and spectacle making to the poorest communities.

Stefano De Luigi/VII Network

**Checking a patient for cataract. BURUNDI**

## Scaling up and adopting new strategies

But much more needs to be done if we are to achieve our overall objective. The way forward will require us to build upon existing success, to 'scale up' what we are already doing (by going from project level to full country-wide programmes), and to adopt new strategies where progress has been slower than hoped.

For VISION 2020, increasing the available financial resources to implement national VISION 2020 plans and to bring good quality, equitable eye health services to the poorest communities is one very obvious area that requires our focus going forward. This will require extensive advocacy work, itself based on sound evidence, to influence and change the minds of policy makers around the world, most of whom presently see blindness as a low priority. More advocacy and more targeted research to prove our case (see article on page 43) are vital to our future progress.

But even if we were able to get more money, would countries have the capacity to absorb it and actually deliver the much-needed eye health services? Sadly, the answer is no in many countries – because of the chronic shortage of eye health workers. Human resource development for eye health must receive even greater emphasis in the second decade of VISION 2020. Training is an important aspect of this but only one part of a complex jigsaw that includes wider policy issues such as staff retention and motivation, deployment to rural areas, the 'brain drain' to high-income countries and/or private practice, and so on.

Another important area to consider is the creation of consumer demand for eye health services. Why do so many people still turn to traditional treatments rather than seek out the eye units that VISION 2020 has so busily promoted? There are many reasons and this is not the place to investigate them in detail.

> **'We have to look for opportunities to promote VISION 2020 within the wider health development world'**

But quality and access have to receive even greater attention than previously. For example, the quality of outcomes for cataract and trichiasis surgery is unacceptable in many countries and standards of surgery have to be improved.

We also have to look for opportunities to promote VISION 2020 within the wider health development world. For example:

- The current emphasis of many of the big donor agencies is to support the strengthening of health systems, rather than fund individual vertical initiatives. At the very least, we shall need to consider how current VISION 2020 approaches align with broader health system development.
- The global shortage of health workers is a very serious problem that extends far beyond eye care – we cannot resolve our own need for more eye health personnel without taking account of initiatives such as the Global Health Workforce Alliance.
- There are opportunities for us to engage with the reawakened global interest in primary health care.

All of the above will require us to make new partnerships that take us outside our traditional comfort zone within our own profession.

This may all seem rather daunting, but we must remember that there has been a huge amount of innovation and progress within VISION 2020. We have much to contribute to the world of health development and others can learn as much from us as we can from them.

### Scaling up

'Scaling up' is a commonly used term in development circles – but what does it mean? Recently, interesting work has been done to think through what scaling up really means in terms of international health. One approach is to consider the barriers that are currently preventing health approaches from being taken to scale. Take a look at **www.expandnet.net** for more information on this interesting topic.