Chapter

6

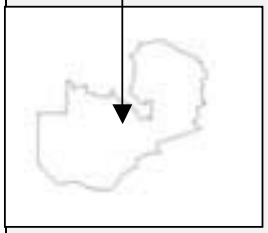
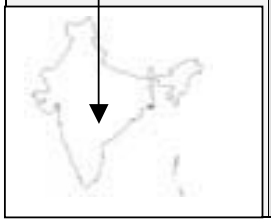
Summary – Designing a District Programme for VISION 2020

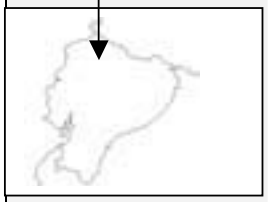
6.1 Three case studies

The purpose of this manual has been to highlight what has been achieved in district planning in three different situations. No attempt has been or should be made to compare these developing programmes, although it is clear that they have adopted many similar priorities. The emphasis must rest on noting their local circumstances and understanding how that context has led to the measures described to advance VISION 2020 and to reduce blindness in each district. These procedures have hopefully offered possible ideas for you to adopt or modify when planning a programme in your own district.

Before suggesting some planning steps for you to follow (in 6.2, 6.3), a brief summary of the three studies is given on pages 97-98. This emphasises both the negative and positive circumstances and the key elements in the design of each programme. **Some blank bullet points have been included for you to make additions to the lists given after reading and considering each case study.**

On page 99, using the blank table you can chart the circumstances and structure of your own current programme. This will help you to evaluate where you are now and assist the process of moving forward.

SAMPLE STUDY	LOCAL CIRCUMSTANCES	PROGRAMME ELEMENTS
KITWE **Zambia** 	• A high level of national and individual poverty • Other major diseases compete for scarce finance • Recruitment problems for suitably qualified staff and a lack of training provision in the country • Little movement from national to district planning for VISION 2020 • National eye care infrastructure that leaves very many people unreached • Some advantages in the selected district, regarding centrality in Zambia, literacy, hygiene and reduced poverty • Government support (national and provincial) and personnel investment • Considerable support from NGOs (financial and programme ideas) and the parent tertiary hospital • Independence of management despite financial dependence •	• Individual skills of the appointed medical director leading the programme • A well motivated and stable team, supported by the MD and a trained administrator • Two specific, measurable objectives and an annually reviewed programme of activities with monitored targets, efficiently planned and implemented • Improvement of human resources in all cadres to (1) increase output while ensuring quality of outcomes and (2) broaden available skills and achieve a more comprehensive service • Extension of outreach to serve people in more distant locations and reduce their travel for treatment • Provision of primary eye care through the existing PHC network, well coordinated with the satellite and base hospitals • Poorest people targeted for eye care both through active health education and screening programmes and through subsidised or free treatment • Community involvement to reduce barriers, enhance patient numbers and secure a caring reputation • A realisation that economic sustainability has to be sought but as a long term objective •
MUDHOLE **India** 	• High prevalence of blindness in a context of rural poverty, low literacy and scattered villages • Strong government and state support for prevention of blindness • Excellent human resource provision through the state's Right to Sight Society but distribution is unequal with regard to need in more inaccessible locations • Secondary satellite hospital within the LVPEI NGO service	• Individual skills of the clinical and administrative managers, as part of the wider ICARE - LVPEI structure • A well motivated, stable and optimally used staff team • Two specific objectives with clearly defined strategies – comprising a range of activities with measurable targets and a regular programme of monitoring to evaluate progress and promote growth • Concentration on the improvement of service efficiency by, for

	structure that provides set up support, leadership and management expertise, and comprehensive eye care of internationally recognised quality • Some NGO support for expensive equipment additions or replacement • Hospital location that is accessible and minimises the friction of distance for patients •	example, adopting day care surgery, improving surgery techniques, extending refraction services, targeting the patients most in need and broadening the range of treatable pathologies within the district • Extension of accessible eye care coverage in the district through such low cost initiatives as vision centres, vision guardians and PEEP volunteers • Drive to economic sustainability through a tiered charging structure that enables cost-recovery to support poorer patients and finance the salaries and running costs of the entire eye care programme • Good community liaison supporting eye health education, reducing barriers and providing personnel •
YARUQUÍ **Ecuador** 	• High levels of rural poverty but with advantages of high literacy and good water/hygiene conditions • Strongly centralised health care system with a poorly resourced public health service and little eye care • Political instability and low professional support have not brought national community eye health initiatives • Fee paying private eye care clinics away in Quito, above the income levels of most local people but not competitive with the services of Yaruquí clinic • Restricted national training opportunities below ophthalmologist level • Human resources nationally plentiful but selective in employment location • Clinic site very accessible through public transport and locally well populated to promote high usage • Excellent INGO support at set up and for ongoing equipment needs •	• Individual skills of the appointed medical director for the programme • A well motivated and stable team, fully supported by the MD and clinic administrator • A warm patient environment that welcomes, reassures and supports throughout the treatment process • Concentration on three measurable objectives – improving the services at the base clinic and in expanding outreach especially for poor people; improving HR training and health education; seeking financial sustainability – each defined and monitored through targeted activities, reviewed annually • Provision on site of CEH and VISION 2020 training as a national and international model • Strong community involvement – encouraging professional and volunteer recruitment, promoting health education and the removal of barriers to treatment acceptance – and so reaching more of the poor •

YOUR DISTRICT	LOCAL CIRCUMSTANCES	PRESENT PROGRAMME ELEMENTS

6.2 Steps in planning

Chapter 1.3 (page 3) in this manual listed the essential characteristics of a district programme for VISION 2020. Chapter 2 set out a generic model for designing and implementing such a programme.

We all acknowledge that to achieve a real change in eye care provision and blindness prevention there is an essential need to plan service provision at the district level – where needs are known, resources are measurable and community support is present. To move forwards from this awareness to a plan of action can be more difficult. At a meeting of involved professionals in 2005 in Uganda, in East Africa, it was agreed that this progress was often impeded by uncertainty over just how to proceed. How can we approach a planning exercise in such a way that successful outcomes should be guaranteed and eye care provision sustainably improved? It was suggested that some essential steps need to be taken:

- Determine who are the key decision-makers in the district and ensure their involvement from the beginning
- List the different eye care workers and determine the gaps in skills
- Review the available clinical data and list the information on service delivery for the previous year
- Ask the eye care leaders to list their priorities for a VISION 2020 plan (for example for disease control, , management systems and bridging strategies)
- List the potential donors and partners
- Divide the district into sectors based upon population and distance to the hospital, remembering the ideal population size for a district programme – 0.5 to 2 million.

These steps reflect the real concerns of key individuals wishing to promote district planning in one country, Uganda – but their relevance is global. These steps are also explicit and fundamental in the development of the generic model in Chapter 2. It is therefore now necessary to think how any district can work through this process. What practical steps should be taken?

Suggestions follow on both building up the necessary body of knowledge and shaping your planning strategy – so providing a framework around which you can build a secure programme for district eye care development. Many of the practical procedures suggested are available in the appendix to this manual and the numerical cross references are to the relevant sections in Chapter 2.

6.3 Planning exercises

Before beginning the district plan, it may be helpful to remind ourselves of the main differences between the purposes of **district and national plans**. These are given in **Ap1**.

2.2, 2.3 – Where are you now? A situational analysis of needs and resources – Only consider information you will need in your planning – it is too easy but wasteful in resources to exceed this.

A. Prepare a MAP of your district, as closely scaled as possible. Show key features in planning eye care services, for example:

- population distribution
- relevant environmental information – especially physical barriers
- transport routes
- eye health service units
- links with external service units

B. Collect and tabulate information on population indicators where known, for example:

- number and density in each sub-district
- gender and age structure
- economic groups
- levels of literacy
- health problems
- cultural and religious norms

C. Collect and tabulate information on eye diseases and blindness, for example:

- the prevalence and incidence of blindness and low vision in the district based on agreed levels of visual acuity
- the main causes of preventable and treatable blindness and their magnitude

A possible recording sheet is given in **Ap2**.

D. Make an assessment of the available resources – personnel and infrastructure

Two alternative exercises are given in **Ap3**, **4.** They are quite exhaustive and may need modification to meet your local situation.

It will also be helpful to complete **Ap5** that provides an overview of institutional resources and HR in relation to need.

As outlined in Chapter 2.3 (page 6), the district planning committee, comprising the key decision-makers and stakeholders, will then be able to identify gaps in the provision and initiate a discussion on the key objectives to be met.

2.4, 2.5 – Where do you want to get to? Setting aims and objectives

Ap6 provides one approach in considering how to improve the present service for tackling blinding eye diseases. Shortfalls are highlighted, targets are set and remedial activities proposed. Achieving the desired objectives will relate to human resource developments, infrastructure improvements and disease control strategies. The three case studies described in this manual have shown the need to target improved base clinic/hospital and outreach provision through these strategies.

2.6, 2.7 and 2.8 – How will you get there? Agreeing a plan, timetable and budget

Ap7 demonstrates a completed action plan to target the most prevalent treatable disease, cataract – through a fictitious example. The ideas are readily usable / modifiable to meet your own situation. It is important to remember that while National Plans will cover a 5-year span, District Plans should be drawn up for one year at a time and be subject to an annual reviewing programme.

2.10 – Monitoring progress and the management of resources

One tool used is the Gantt Chart. This sets out the activities and sub-activities (the strategy) to achieve a programme objective, displaying intended and actual progress through a year. It therefore enables progress to be monitored and provides a tool to make possible an evaluation of the programme and suggest adjustments if necessary for the following year.

The approach set out in **Ap8** is just one way of presenting this Chart. It builds on the example introduced in Chapter 2.4 (page 8) and followed up in Chapter 2.10 (page 13).

6.4 Final thoughts

Our global problem

The prevention of avoidable blindness by 2020 through VISION 2020

The obstacles repeat themselves

Governments without the drive or means to invest in eye health services

Professionals without the understanding or inclination to contribute to community eye health

Training opportunities that are inadequate in providing the leaders, managers and professionals to get things done

Communities that need to be involved in overturning a community problem

I/NGOs that are overstretched and of whom too much is expected

Resources that are unequal in their distribution and accessibility

Outcomes that fail to match expectations

Outreach that leaves many people unreached

People who should be patients but fail to come forwards

Collaboration that fails to materialise and lets populations down

And many, many more

Some of these obstacles we now know are being reversed

MUDHOLE **KITWE** **YARUQUÍ**

You have read of the achievements in these three eye health programmes. Their problems were not unique; their solutions at district level can be repeated. Preventable blindness is beginning to decrease globally and will do so more sustainably through the approaches of these and other model programmes.

What must you do?