Comprehensive Eye Care

As part of the position papers approved by the SightFirst Advisory Committee (SAC), the SightFirst Long Range Plan (SFLRP) Working Group has consistently recommended that future SightFirst programming support the development of comprehensive eye care systems. This paper defines comprehensive eye care and explains the impact of such a strategy upon existing SightFirst philosophy.

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Comprehensive eye care encompasses three different domains:

A *comprehensive eye examination* is a realistic and relevant series of tests and examinations conducted with a patient with an eye problem. It is evaluation and treatment or reference of all eye conditions requiring systematic examination (visual acuity, anterior segment, posterior segment). Also vital is the appropriate recordkeeping of all patients, whether they are "walk-in" or "outreach" patients. This examination presupposes availability of appropriate equipment (slit lamp, aplanation tonometer, direct and indirect ophthalmoscope).

Comprehensive eye care services includes eye health promotion, prevention, diagnosis and treatment of all relevant eye diseases and rehabilitation of those with irreversible blindness and low vision, according to the existing evidence-based recommendations and guidelines as well as available resources.

A *comprehensive eye care system* is one that provides the abovementioned services to different groups (age, sex, location, genetic tract, etc.). It requires the development and maintenance of infrastructure, training and prudent use of human resource at all levels, (ophthalmologists, optometrists, mid-level personnel, technicians, etc.) monitoring and evaluation of performances and targeted operational research.

In addition, the comprehensive eye care system is based on **six building blocks**:

1. *Comprehensive eye care services* that deliver effective, safe, high-quality interventions (including prevention, diagnosis, management and rehabilitation) to those that need them, when and where needed, with minimum waste of resources, and with continuity of care across levels of care, settings, and providers.
2. *Reorientation of the eye health workforce towards more long-term care and support* with the necessary skills and knowledge to adopt a patient-centered approach and with training to help patients initiate self-management techniques and adhere to long term management regimens. (This is especially important when managing diseases like diabetic retinopathy and glaucoma, where patients need to comply with life-long treatments and follow-up.)

3. An *eye health information system*, which ensures the production, analysis, dissemination and use of reliable and timely information on eye health determinants, eye health status and on eye health system performance.
4. *Equitable access to essential medical products and technologies* of assured quality, safety, efficacy and cost effectiveness.
5. An *eye health financing system*, which raises adequate funds for eye health, in ways which ensure that patients with eye conditions do not suffer from catastrophic expenditures due to protracted illness and extended treatment, and which expand insurance schemes to cover costs associated with treatment and drug costs.
6. *Leadership and governance* to strengthen existing national prevention of blindness policies and plans and ensure that they are incorporated in national health plans and broader development frameworks with strong links across government, between different providers and between medical care and social services.

How does comprehensive eye care align with public health strategies for eye care in underserved communities?:

Comprehensive eye care is the *only way to eliminate avoidable blindness* in a given community. If comprehensive eye care services are not delivered, eye care will continue to linger behind other types of health care and will never develop the confidence and capacity to effectively intervene. This is especially true in neglected communities, where the patients' collaboration, in terms of self-mobilization to seek care, is fundamental.

What resources are needed to establish comprehensive eye care systems?:

In terms of human resources, it is necessary to have a *well-trained ophthalmologist* able to diagnose all eye diseases, provide or initiate medical treatment for a majority and conduct surgical treatment up to secondary level services including cataract, some glaucoma and minor procedures. The ophthalmologist should be able to judge appropriately those cases which should be referred for advanced care. He/she is supported by a range of *mid-level personnel* (MLP) including nurses, technicians and administrative staff who aid with surgery, rehabilitation, primary eye care and administrative support. The comprehensive eye care system requires *equipment* needed for basic diagnosis of eye disease – including a slit lamp, aplanation tonometer, direct and indirect opthalmoscopes) as well as some operating room equipment. Attachment A lists equipment in detail.

The resources needed to deliver eye care services may vary as a result of the rules, practices, and laws of different countries and the service level where the comprehensive eye care is delivered (i^{ry}, ii^{ry}, iii^{ry} level). It is important to highlight that even at the primary level, comprehensive eye care services can be delivered through implementation of good practices and coordination of the screening/diagnosis and referral system.

How are comprehensive eye care systems established?:

Ideally, a secondary or tertiary level *referral facility* should serve a *network of primary eye care centers.* It is important to refrain from the "model" approach, as it has never been replicated as expected and requires more adaptation than developing an approach from scratch within each local context. It is important to have a "methodological" approach, with expected outcomes, definitions of the standard in terms of quality and quantity. Attachment B outlines the design of a LV Prasad secondary eye care center.

How might the comprehensive eye care strategy change current SightFirst efforts?:

Projects, which once focused on the treatment of a single eye disease, should now include components that point towards the development of more comprehensive eye care systems. This should include efforts to *fill gaps in existing programs,* including deficiencies in human resources, physical space and equipment. In general, the most significant change will be fewer, more expensive projects. It should be noted, those centers which already perform cataract surgery, can often be transitioned to provide comprehensive eye care in 3-5 years with adequate support management.

The various position papers approved by the SAC provide a roadmap to this new approach. It will be critical to adhere to the newly approved policies in reviewing future project proposals, perhaps with the use of a weighted evaluation grid. And, it may even be prudent to redirect current, long-term grant projects towards this approach.

Finally, what else should SAC members know about CEC?

Comprehensive eye care is not a "new" idea, but it is what has occurred in the places of the world where eye care works. It is the only one ethically and morally acceptable approach forward by which to link the Lions Clubs International service organization name and reputation with eye health care.