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The role of international non-governmental organisations in dealing with cataract blindness in developing countries

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Abstract. The international non-governmental organisations (INGOs) dealing with the prevention and cure of blindness in developing countries are closely networked with each other and are an integral part of the International Agency for the Prevention of Blindness (IAPE and the World Health Organization (WHO) Global Programme for the Prevention of Blindness. As operable cataract accounts for more than half of world blindness. As operable cataract accounts for more than half of world blindness the INGOs have a particular interest in this blinding condition which took on major proportions with the eye camp movement in South Asia from the end of the 1960s. Despite this initiative, and the use of paramedic cataract surgeons in many African countries, the volume of cataract surgery is being outstripped by increased incidence arising from greater longevity as a product of improved general health. Among the options facing the INGOs in the 1991s are the increased utilisation of eye beds through year round surgery in South Asia and shorter post-operative hospital occupancy and the possibility of putting lens implantation surgery within the economic reach of INGOs and partner NGOs and governments.

Service delivery

The most visible indicator of the work of the international non-governmental organisations (INGOs) in dealing with cataract blindness in developing countries is the number of cataract operations they sponsor annually. This has been in excess of 400,000 for at least the past five years, with over 85% being conducted in South Asia and Africa.

The size of the problem

When viewed against an estimated global figure of 17 million people blind from cataract, with incidences of over 1 million in India alone and 500,000 in Africa, this support from the international organisations looks puny. When it is measured, though, against a probable total of 1.4 million cataract operations conducted annually in the same countries, and the continuity and scale of the INGOs work over the past 25 years in helping to build the infrastructure of eye care services which support all surgical procedures, it

can be seen as a determined pledge on the part of those organisations to reducing both curable and preventable blindness.

Who are the international non-governmental organisations?

The different groupings, and relation of the INGOs to UN agencies and other international umbrella-type organisations, are often bewildering to the outsider. In essence, the INGOs referred to here are 10 in number and constitute the service delivery arm of the International Agency for the Prevention of Blindness, whilst forming the Consultative Group of Non-governmental Organisations to the WHO Programme for the Prevention of Blindness.

In turn, that Group is a member of a larger group of international organisations engaged also in promoting education and rehabilitation ser-

Table 1.

Organisation	Country	Membership of		
		Partnership Committee	Consultative Group	European Partners for Blindness Prevention
Christoffel-Blindenmission	Germany	*	*	*
Foresight	Australia	*	*	
Helen Keller International	USA	*	*	
Help-Age International	UK	*(A)		
International Eye Foundation	USA	*	*	
North African Centre for Sight	Tunisia	*(A)		
Norwegian Assn. of the Blind & Partially Sighted	Norway	*	*	
Œil sur Les Tropiques	Belgium	*(A)		*
Operation Eyesight Universal	Canada	*	*	
Organizacion Nacional de Ciegos de España	Spain	*		*
Organisation pour la Prévention de la Cécité	France	*	*	*
Perkins School for the Blind	USA	*		
Orbis International	USA	*	*	
Seva Foundation	USA	*	*	
Sight Savers	UK	*	*	*
Society Against Blindness Overseas	Netherlands	*		*
Swedish Federation of the Visually Handicapped	Sweden	*		

(A) signifies Associate Membership.

vices for incurably blind people in developing countries. This group is known as the Partnership Committee, which relates to the World Blind Union and the International Council for the Education of the Visually Handicapped, and thence to UNICEF, ILO and UNESCO. Whilst the IAPB was established in 1975, the network of INGOs described above has been built over the past decade and the latest permutation is the group of such organisations based in EC countries, known as European Partners for Blindness Prevention. This latter group was formed in 1989 to attract the Community's attention to the need for financing blindness prevention activities in developing countries.

Table 1 lists these organisations, the countries in which their headquarters are based and their membership of the groups referred to above.

How are the international organisations financed

The majority of INGOs rely on private sector funding from a variety of sources. Inputs from government funding, usually on a co-funding basis, range from 5% to over 80% of total income. Annual programme funding varies from over $50,000 for the smallest organisation to over $18M for the largest and, in total, the group of INGOs funds eye care services to the extent of $40M annually.

How do the INGOs work?

Within the objectives of the WHO programme, parallel by those of the IAPB, these organisations are intent upon co-ordinating their activities in a rich variety of approaches from supporting a single one-off national NGO project to major components over 3 to 5 years in a fully integrated national eye care programme. The largest among them employ ophthalmic consultants and health planners to render technical assistance in planning programmes and in their implementation, monitoring and evaluation.

Whilst cataract blindness has to be a major preoccupation, the promotion of comprehensive eye care programmes addressing all ages and the major causes of blindness is paramount.

Thus, it is not uncommon to find one organisation working on two continents in over 40 countries; strengthening the work of national NGOs in working with their governments; helping to train national ophthalmic personnel, particularly the ophthalmic paramedics; building and equipping eye hospitals and clinics; and providing and maintaining mobile eye units for screening, health and referral in rural areas. As remarked earlier, it is this comprehensive approach to the infrastructure of eye care which provides the underlying support to dealing with cataract blindness.

History of INGO involvement with cataract blindness

INGO interest in this major cause of operable blindness took on major

proportions with the Asian Eye Camp movement in the late sixties, almost wholly in partnership with national NGOs. By contrast, the majority of INGOs working in Africa fund government programmes, either directly or through national NGOs, and have always promoted a referral chain from the deepest rural areas to district hospitals via which the cataract patient can be identified and referred to the nearest surgical facility. Whereas, in Asia, full utilisation of existing ophthalmic professionals would bring about a significantly higher number of operations, in Africa, the average ratio of one ophthalmologist to one million people has dictated first the introduction of a cadre of ophthalmic medical assistants (OMAs) as the pivotal human resource in the eye care infrastructure and, second, over the last decade, the training of a proportion of these OMAs as cataract surgeons.

The future for INGO involvement

Despite all the initiatives described above, the volume of cataract surgery is being outstripped in the majority of developing countries by a growing incidence, arising from greater longevity of their citizens as a product of improvement in general health. Since the real funding of INGOs in relation to needs is not likely to rise significantly and their inputs have always been no more than catalytic in the larger countries, their options are limited to those measures which will achieve the greatest impact for lowest possible cost. Much greater co-ordination between agencies, between them and their national partners and the entire NGO effort and that of governments is called for, in policy, information, strategy and implementation, to improve the utilisation of human and material resources and so to expand the volume of cataract surgery. In South Asia, in particular, greater use of eye wards through year round surgery and shorter post-operative bed occupancy have to be achieved. In Africa a means has to be found of significantly expanding the surgical capacity whilst the training of African ophthalmologists and paramedic cataract surgeons continues apace. Among other options, that indicates the need to reconsider sensitive planning for the use of collegiate groups of ophthalmologists from North America and Western Europe on short-term surgical assignments with the involvement of the INGOs and the International Federation of Ophthalmological Societies. Additionally, the INGOs have to consider the possibility of placing lens implant surgery within the economic reach of their partner NGOs and their respective governments.

Notwithstanding, the INGOs have to remain the advocates, too, of retaining a comprehensive approach to eye care in developing countries and, particularly, to raising the level of priority for combating child blindness.

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