Eye health for all by the year 2000 in Nepal*

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It was in 1977 when World Health Assembly decided that the social target of governments and of WHO should be the attainment by all the people of the world, of a level of health that will permit them to lead a socially and economically productive life by the year 2000. This is now popularly known as "Health For All By The Year 2000". This strategy was further endorsed by 134 member countries at an International Conference on Primary Health Care organized by WHO and UNICEF, held in Alma-Ata, USSR, in 1977 and Nepal was one of them to endorse it. Let it be clear to all that health for all does not mean that in the year 2000 medical care will be provided to everybody in the world by doctors and nurses for all their illnesses; nor does it mean that in the year 2000 nobody will be sick or disabled. But it does mean that people will use better approaches than they do now for preventing disease and alleviating unavoidable disease and disability, and have better ways of growing up, growing old and dying gracefully. It does mean that there will be an even distribution among the population of whatever resources for health are available.

Nepal Blindness Survey of 1981 has indicated that ocular problems in Nepal are one of major health problems in Nepal. So to attain the goal of "Health For All By The Year 2000 in Nepal" we have to have eye health for all by the year 2000 as well. As no universal blueprint of a health system can be imposed on countries, we too have to develop our own plans and programmes suitable to our national circumstances to solve the eye problems of Nepal. The health system should be based on the principles of primary health care and should encompass the entire population on a basis of equality

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and responsibility and should include components from the health sector and from other sectors whose inter-related actions contribute to health. In such system there should be the establishment of a well-coordinated infrastructure, starting with family and community care, and continuing with intermediate and central support and referral levels. This infrastructure should deliver well-defined health programmes using appropriate technology in the context of Nepal.

With our present knowledge of ocular status in relation to its magnitude, geographical distribution, and cause of eye diseases within the country, intervention programme at the following level and pattern should be brought into effect to attain the goal of eye health for all by the year 2000 in Nepal.

Primary level

Service for common eye conditions should be provided as a part of primary health care by persons belonging to the community concerned and it should include suitable self-treatment as well when indicated. Primary eye care must include curative and preventive activities and the promotion of eye health. Treatment should be easily available for conditions such as conjunctivitis, trachoma, superficial foreign bodies, minor trauma and xerophthalmia. Village health workers or panchayat based health workers should be provided with drugs like tetracycline eye ointment, sulfacetamide eye drops, vitamin A capsules (200,000 IU) and bandages & eye shields. These persons should be trained enough to recognize, give first aid treatment or refer, and request consultation for more serious eye injuries, painful eyes and visual loss or impairment.

They should take part in screening for xerophthalmia, trachoma and cataract and organize and participate in regularly scheduled local eye clinics.

All the concerned sectors should promote eye health education by the provision of materials to improve nutritional status, personal hygiene, maternal and child health and environmental sanitation.

Secondary Level

Management for conditions such as trauma, corneal ulceration, intraocular infection, severe recurrent trichiasis and/or entropion, pterygium, cataract and glaucoma should be provided at the secondary level. Eye hospitals or departments in ten Zones out of 14 Zones of Nepal are already providing such services and it is believed that the four zonal eye centres are to be established, one per every zone very soon will be equipped and staffed to provide such services in Nepal. The organizational set up of these centres can be and should be readjusted to suit the community need once the backlog of ocular problems like blindness due to cataract or trachoma is cleared in due course of time.

Training, support and supervision of primary health workers or paramedics like ophthalmic assistants should also be carried out at this secondary level.

Tertiary Level

A tertiary centre should be developed in the capital with a good referral system to conduct more elaborate procedures that are less frequently needed, to achieve self-reliance in dealing with the eye problems in Nepal. Such centre will provide sophisticated eye care such as retinal detachment surgery, corneal grafting, and other complex and expensive types of management not available at secondary level. Such centre should also become more involved in the development of community ophthalmology and the promotion of eye health throughout the country.

Applied research relevant to the sociological, economic and geographical condition of Nepal should also be conducted at tertiary level.

Such tertiary centres should be developed at regional levels in due course of time.

Mobile Activities

To deliver the diagnostic and therapeutic services to the people of remote areas of Nepal, mobile eye services will have to be provided for another few years to deliver secondary care in a primary eye care area. To make these mobile services more effective the present good liaison with the community, community participation, continuity of health care and regularity of the service should not only be maintained but also be enhanced. High surgical standard, careful follow up and time to time evaluation is equally important.

Let the eye health for all be attained in advance to take our nation in the forefront to achieve the global goal of Health For All By The Year 2000.

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