



INTERNATIONAL AGENCY FOR THE PREVENTION OF BLINDNESS

National Eye Health Coordinator Manual

VISION 2020: The Right to Sight
Working together to eliminate avoidable blindness

Acronyms and abbreviations

NEC	National Eye Health Coordinator – the government appointed person responsible for coordination and implementation of national eye health activities
NPBC	National Prevention of Blindness Committee – a group of key stakeholder representatives, with responsibility for the development and implementation of national eye health (VISION 2020) plans
AMO	Assistant Medical Officer
CSR	Cataract Surgical Rate
DMO	District Medical Officer
DP	Disabled Person
DPO	Disabled Persons' Organisation
HRD	Human Resource Development
IAPB	International Agency for the Prevention of Blindness, www.IAPB.org
IEC	Information, Education and Communications
INGO	International Non-Governmental Organisation
KCCO	Kilimanjaro Centre for Community Ophthalmology
M&E	Monitoring & Evaluation
MIS	Management Information Systems
MoH	Ministry/Minister of Health
MoU	Memorandum of Understanding
NGO	Non-Governmental Organisation
OCO	Ophthalmic Clinical Officer
PBD	Prevention of Blindness and Deafness
PBI	Prevention of Blindness
PHC	Primary Health Care
PEC	Primary Eye Care
RAAB	Rapid Assessment of Avoidable Blindness
UN	United Nations
VI	Visual Impairment/Visually Impaired
VIP	Visually Impaired Person
VISION 2020	VISION 2020: The Right to Sight, global initiative for the elimination of avoidable blindness, www.VISION2020.org
WHO	World Health Organization, www.WHO.int/blindness

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Preface to the manual

This manual is intended to help National Eye Health Coordinators (NECs) in developing countries to understand and fulfill their roles. While it is impossible to produce one set of guidelines and suggestions that will be ideal for every country, there are enough similarities in the problems faced that some generalisations are appropriate and useful. It will be up to the individual NECs who use this manual to consider each issue and decide what is relevant in his/her country. Although the text is directed at NECs, much material in the manual will be useful to other members of National Prevention of Blindness Committees (NPBC) and members of NGO/IAPB eye care forums as well.

The material is organised into sections, with the learning objectives described on the contents page. Each section is designed to stand alone so that readers can skip to sections of most interest and this might be a good way to start reading. There is considerable overlap in the topics; for example, job descriptions, supervision, and organisational structures are all related, so readers will gain a deeper understanding of the whole content as they read each section.



Commended entry
to the *Visions of
Children* photo
competition 2003

Photo by
Anita Andersson

Introduction

Since the launch of VISION 2020, IAPB has supported national governments in the development and delivery of their national eye care plans through strategic initiatives. One of IAPB's initiatives is the VISION 2020 workshop programme which is a leading component of the VISION 2020 strategy for human resource development.

The workshops facilitate governments, in partnership with other eye care providers, in the planning and implementation of sustainable eye care programmes which are integrated into public health care systems. One constraint has been that it was often difficult for National Eye Health Coordinators to attend workshops. So to address this constraint and also to allow the materials developed for the workshops to reap benefits further afield the idea of a manual was conceived.

Since then IAPB commissioned KCCO to produce a manual which would support National Eye Health Coordinators in the daily challenges they face in their work. This manual is seen as a standalone document designed to meet the demand from National Eye Health Coordinators for supporting materials to use as a guide and reference to assist them in their role.

To the greatest extent possible IAPB aimed to make this manual generic enough to be useful in most developing countries, and to strike the right balance between enough detail to be useful and too much detail, which might make it biased towards certain countries or regions.

We would like to thank Drs Susan Lewallen and Paul Courtright from KCCO, IAPB Central Africa Co-Chair Dr Joseph Enyegue Oye and Drs Daniel Etya'ale and Amir Bedri Kello from IAPB Africa, who developed the manual for us, and all of you in the regions who reviewed it, provided guidance and suggestions which have helped us develop a manual which we believe will be a valuable tool for National Eye Health Coordinators globally.

Finally I would like to remind you of the importance of the World Health Assembly Resolution 62.1 which adopted in 2009 the 'Action Plan for the Prevention of Blindness and Visual Impairment'. This plan outlines 19 proposed actions that National Governments need to implement to prevent avoidable blindness and visual impairment. More than ever NECs and their Committees have a vital role in advocating for and implementing these actions. I urge you to study the Action Plan, attached in Appendix A, and use the guidance in this manual to help achieve these extremely important activities.



Peter Ackland

Chief Executive Officer, IAPB

1 A functional National Prevention of Blindness Committee (NPBC)

Learning objectives

- Understand roles and responsibilities of the committee you work with
- Understand how to improve the quality of the NPBC's work
- Understand how Non Governmental Organisation (NGO) forums can help the Committee to function better
- Assess how well your NPBC functions

Implementing VISION 2020 requires a partnership between many different stakeholders – government, non-government organisations, service clubs, academic centres, private eye care providers, and others. One of the most effective ways to build and maintain these partnerships is through a well-functioning National Prevention of Blindness Committee. Members of the NPBC should include those listed in Text Box 1.1. The NPBC should not just be a 'talking shop'; nor should it be a 'rubber stamp' for the government. Ensuring that it functions well and enhances the delivery of high quality, equitable eye care services requires a number of steps.

Text Box 1.1

National Prevention of Blindness Committee:

- A representative of the MoH – usually Chairperson
- Other governmental bodies such as Ministries of education, social services, research, development, works, finance, planning –some of these can be on an ad hoc basis when the need arises
- Public health, Child health and Maternal health representatives
- Local Society of Ophthalmology and/or Optometry
- Academic ophthalmic training programme leaders
- Local NGOs
- INGOs
- Bilateral, multilateral and UN agencies

What are the roles and responsibilities of the NPBC?

It is important to define the roles and responsibilities of the NPBC, but there is no single 'best' list of these. The roles and responsibilities will vary in each country depending on whether there is a centralised or decentralised organisational structure (see section on Organisational Structures), the number of stakeholders, and the

presence of focal diseases like trachoma and onchocerciasis. Text Box 1.2 is a general list of possible roles and responsibilities; these can be adapted based upon conditions in the country. It is important for all stakeholders to review proposed roles and responsibilities and, as a VISION 2020 national plan matures, there may be a need to make revisions from time to time. NPBCs might find it helpful to consider their roles and responsibilities by discussing the case studies provided in Figure 1.1.

Text Box 1.2

Roles & responsibilities of an NPBC

- Discussion of national policies
 - Preparation of material by ad hoc task force
- Review of strategic plans and annual reports
 - Preparation of material by trachoma task force, childhood blindness task force, etc.
- Resource mobilisation
- Discussion of management systems
 - Preparation of material by ad hoc task force
- Discussion of approaches to advocacy
- Preparation of material by advocacy task force (includes plans for World Sight Day, etc.)
- Review of human resource issues
 - Preparation of material by human resource task force

Figure 1.1

Four cases to consider

Case 1

An NGO, 'New Sight' has received money for child eye health from an external donor. There is already a child eye health tertiary facility in the town of Banura. Instead of supporting the existing facility, 'New Sight' wants to develop another child eye health tertiary facility, just 10 km away. This is inconsistent with WHO policy, which recommends one child eye health tertiary facility per 10 million population. Should this proposal be brought to the National Prevention of Blindness Committee for discussion?

Case 2

An organisation supporting VISION 2020 in a number of 'districts' in the country requests to become a member of the National Prevention of Blindness Committee. Who should decide if this organisation should be a member of the National Prevention of Blindness Committee?

Case 3

The NEC shifts an ophthalmologist from a hospital in Ndola Region to a hospital in Katanga Region without discussing the transfer with the National Prevention of Blindness Committee. The NGO supporting the hospital in Ndola Region is angry as now there is no ophthalmologist in Ndola. How should this be dealt with at the next national Prevention of Blindness meeting?

Case 4

An American NGO wants to come to the country of Mzimbe and examine everyone in the Millennium Development Village in Mzimbe – it is a village of 5,000 people in the middle of the country. They will bring their own equipment and ophthalmologists. Should this proposal come before the National Prevention of Blindness Committee? What guidance can the NEC provide to the NPBC?

Practical suggestions

Large NPBCs can be unwieldy in terms of ‘getting things done’ and may meet only once each year. Thus, it is not the NPBC that moves things forward throughout the year— instead it is an Executive Committee and specific task forces (permanent or ad hoc), which are authorised by the NPBC to address specific issues or questions. At the NPBC meetings the work of the Executive Committee and task forces is presented and discussed and decisions made accordingly. Text Box 1.3 lists some of the roles and responsibilities of an Executive Committee and proposed membership while Text Box 1.4 lists some potential task forces and their roles. A task force should include people with the technical skills to carry out the tasks and who are known to ‘get things done.’

A task force should not include mere ‘representation’ from various sectors.

Text Box 1.3**Executive Committee of an NPBC****Roles & responsibilities**

- Meet as needed (e.g., related to issues that arise)
- Prepare suggested actions for the NPBC to consider and give activities to task forces
- Finalise national strategic plans, annual reports, etc.
- Meet regularly with key officials/politicians

Suggested membership

- National Eye Health Coordinator
- 1–2 NGO country coordinators
- Academic institution director (e.g., Head of Eye Dept of a training institution)
- MoH representative

Text Box 1.4**Possible task forces****Human resource**

- Develop new schemes of service recommendations (e.g., managers, low vision technicians)
- Assess current deployment and recommend changes to improve retention
- Review current distribution of human resources and make suggestions for improved equity.

Trachoma

- Review the national trachoma plan and annual reports
- Identify and encourage new partnerships
- Discuss trachoma-specific policies (e.g., distribution of Azithromycin after trichiasis surgery, use of Rapid Trachoma Assessment Method (TRA) or district surveys, surveillance)

Advocacy

- Create a communication strategy
- Identify the key advocacy needs
- Develop advocacy material
- Plan national World Sight Day activities

Infrastructure, equipment & consumables

- Work with Ministry of Finance to get specific items on the essential drugs list
- Work with Customs department to facilitate easy clearance
- Identify the possibility of having a national procurement system
- Develop and propose norms for infrastructure, equipment, and consumables at all levels

The National Eye Health Coordinator interaction with the NPBC

The National Eye Health Coordinator should constantly strive to improve the quality of the NPBC's work. A well-functioning NPBC will make the National Eye Health Coordinator's work easier. Text Box 1.5 lists some ways that the National Eye Health Coordinator can help the NPBC work in an effective and efficient way. Many of the suggestions can be based on the concept that the various task forces and the Executive Committee are undertaking activities and feeding information from their work back to NPBC. Summaries of their work should be sent to NPBC members before meetings. It is a waste of everyone's time to have people reading through documents at meetings.

Text Box 1.5

Improving functioning of NPBCs

- Ensure that reports from all meetings are disseminated widely and in a timely fashion (within one week of the meeting)
- Encourage NPBCs to be inclusive rather than exclusive
- Focus on the work to be done as the first priority. If some people on a 'task force' are not performing, encourage replacement
- Encourage the task forces to provide written reports regularly to the Executive Committee
- Request that each VISION 2020 district establish a VISION 2020 committee and meet at least twice per year. Reports should be submitted to the NPBC.
- Set dates of meetings well in advance (at least 3 months), notify everyone, and do not change the date.
- Send material to review at least 2 weeks in advance of the NPBC meeting and request that everyone read it before coming

Beyond the NPBC

There are instances when NPBCs have been ignored or sidelined. This can happen when politically directed initiatives or activities may not actually fit within the overall objectives of the national plan. Although the NPBC may not have much recourse when this happens, frequent meetings between NPBC members (e.g., the Executive Committee) and government leaders and politicians may help in reducing this unfortunate practice.

Although it may seem counter intuitive, the NPBC can actually be strengthened by NGO Eye Care Forums, which are separate from the Ministry of Health. There is good evidence from a number of countries that NGO Eye Care Forums help governments coordinate the activities of partners more effectively. Such groups can help avoid duplication of efforts by NGOs. An example of terms of reference for such a forum is given in Figure 1.2 (over page). Figure 1.3 (also over page) describes the positive experiences of an NGO forum in Ethiopia.

Figure 1.2**Example of Terms of Reference – IAPB/NGO Eye Care Forum****Background**

The IAPB/NGO Eye Care Forum was initiated in response to the agreement between IAPB members to strengthen NGO eye care coordination at a country level.

Membership

The IAPB/NGO Eye Care Forum consists of representatives of registered local and International Non Governmental Organisations and IAPB members. Criteria for membership are:

- Having a major focus in eye care
- Current or intended physical presence in (country)
- Having a broad geographic scope (not just one facility)
- Having a national interest
- Having a technical expertise in the eye care field

Mandates

This forum has the following mandate areas;

- Support the development and implementation of national eye care plans

- Support and enhance M&E of eye care delivery
- Coordination among members and joint planning
- Share and consolidate information and resources
- Advocacy as regards issues related to eye care
- Joint resources mobilisation
- Address relevant issues arising from various forums

Structure

Quarterly meetings will be organised and hosted by the members on a rotation basis.

Chairperson

The forum chairperson will be elected for a one year mandate. For the year 20XX, the members have requested that (name of organisation) takes on this responsibility. The role of the chairperson is to facilitate communication, organise meetings and circulate the agenda. Notes of the meetings will be circulated among the participants and then shared with the Ministry of Health.

Figure 1.3**NGO Forum structure, democratic process & flexibility**

The NGO Forum has a chair and a secretary, both elected by the members after nominations; they are to be rotational in basis. The terms of reference were developed in 2005; these were drafted, circulated, amended, and finally agreed upon.

The NGO Forum meets on a quarterly basis or on an extraordinary basis. An example of this was the meeting to discuss the problem of variable per diems paid by different NGOs. When a meeting date is set the chair sends around an agenda that any NGO can add to.



Excerpted from IAPB News, Issue 55, April 2008

Thus, although there is structure and a democratic process of working, there is also flexibility in meeting urgent needs. This has enabled the NGO Forum to be more flexible in its working relationships. The structures are well accepted by the Ministry of Health, as they are seen as supportive.

“How do we strengthen the partnership? We are already working as a family and the structures are already in place; we just need to strengthen them”

– MoH representative.

2 Organisational structures

Learning objectives

- Recognise three common ways health systems are organised and understand the way that the National Eye Health Coordinator's role might differ in each
- Be able to draw an organisational chart to describe the system in which you work

National Eye Health Coordinators in different countries work in different organisational structures. The position of National Eye Health Coordinator will be within the Ministry of Health and many coordinators will work full time for the Ministry. However, the structures within Ministries vary from one country to another so there will be variation in the person to whom the National Eye Health Coordinator reports and the people that report to the National Eye Health Coordinator.

Different structures for health care delivery

While it is impossible to detail all of the various ways health care may be structured in different countries, it is helpful to consider some general frameworks and highlight ways in which the National Eye Health Coordinator can effectively contribute to coordination of eye care activities within the country. We have divided systems into 3 types, but a given system may have elements of all.

a. Centralised government health care systems

Although there has been a trend away from centralised government health care systems in the past 15 years, there are still some countries with centralised systems. In most centralised systems the role of NGOs and civil society may be limited. There may be little or no private practice of medicine. National Eye Health Coordinators working in centralised systems should consider:

- The need for positioning eye care within the broader health system¹
- Identifying partnerships with government structures to ensure the inclusion of eye care in each of the health system building blocks: human resources, finance, health information, consumables and technology and service delivery. Examples are:
 - Developing national level systems for procurement for all health facilities in the country.
 - Developing a national level programme for instrument maintenance and ensuring that every eye care institution has a minimum level of infrastructure and equipment.
 - Developing an HRD strategy that will ensure that all eye care personnel have equal access to educational opportunities, whether within the country or outside of the country.
 - Developing an eye care information system that fits within the MIS of health facilities and the Ministry of Health reporting systems.
 - Adapting financial systems and budgeting of eye care programmes to fit into the national procedures and planning cycle for health care at all levels.

¹ **What is a health system?** A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health http://www.who.int/healthsystems/strategy/everybodys_business.pdf (pp 2-3)

- Develop eye care programmes and activities that lie within the broader plans for public health provision.
- Identifying partnerships outside government bodies – such as: NGOs, service clubs, and international academic centres to support national level initiatives.

b. Decentralised government health care systems

Many larger countries have shifted to more decentralised government health systems. The transition from centralised to decentralised is often incomplete and there may be some tension – in some cases, national Ministry of Health staff prefer to retain the centralised system while the districts are keen to take on their own decision making. At the same time, many personnel at the district level do not have the necessary skills for planning eye care services. An additional complication is the fact that, in many countries decisions are made at a 'sub-district level (population 100,000 to 300,000) rather than at the district level (population 1 million). Confusion of terms (a 'district' is referred to as a region, province or zone in many different countries) has only made this more complicated. National Eye Health Coordinators working in decentralised government health care systems should consider:

- As with a centralised eye care system, working closely with district government departments to ensure that eye care is included in the broader health system.
- Encouraging the planning capacity of district personnel so they can develop their own district VISION 2020 plans in collaboration with partners.
- Developing strong, positive relations with partners that encourage the partners to have relationships at the district level for the purpose of planning and implementation.
- Identifying strengths and weaknesses of partners, academic centres, and others and encouraging collaboration between them in order to ensure that districts gain the 'best from the best'.
- Encouraging the adoption of different models of service delivery and reporting of successes and failures to help all districts in the country to learn from these experiences

Remember that no eye care system is static; there will always need to be new lessons to learn and ways to improve services for patients.

c. Mixed models (with large private practice)

In many countries there is a sizeable and growing private practice sector. The role of the National Eye Health Coordinator in this setting may be quite different from centralised or decentralised government systems. In most cases, the mixed model includes countries with a decentralised government system plus a large private service. The National Eye Health Coordinator in mixed model systems should consider:

- Developing strong relationships with key influential ophthalmologists to share ideas and get their buy-in to the concepts of VISION 2020.
- Developing a long-term relationship with ophthalmology training programmes to be able to include aspects of community ophthalmology/VISION 2020 in the curriculum of ophthalmology residents.
- Identifying specific activities and initiatives that will draw attention to the eye care needs of disadvantaged sectors of the population.
- If possible, set up mechanisms to use donated time by private practitioners for marginalised populations.

Organisational charts

The relationships among people or departments in any organisation can be complex and sometimes they are not well defined. It is extremely useful to try to draw an organisational chart or 'organogram' to show the relationships. Organograms should be designed to show positions, and usually include the name of the current position-holder as well. A solid line descending from one box to another indicates a formal and direct relationship between a supervisor and a subordinate. Dashed lines are often used to show advisory or indirect relationships. Arrows may be added to show how communication should flow. You should be able to draw a chart showing the way various positions in your ministry are organised and who reports to whom.

Try it, considering the type of system you work in and perhaps using one of the examples given in the Figures 2.1 or 2.2. If you can't draw a basic chart because there are too many questions about where lines should go or too many lines going in multiple directions, it may indicate that lines of authority and responsibility are not clear. It's worth having discussions within your organisation to sort this out.

Figure 2.1

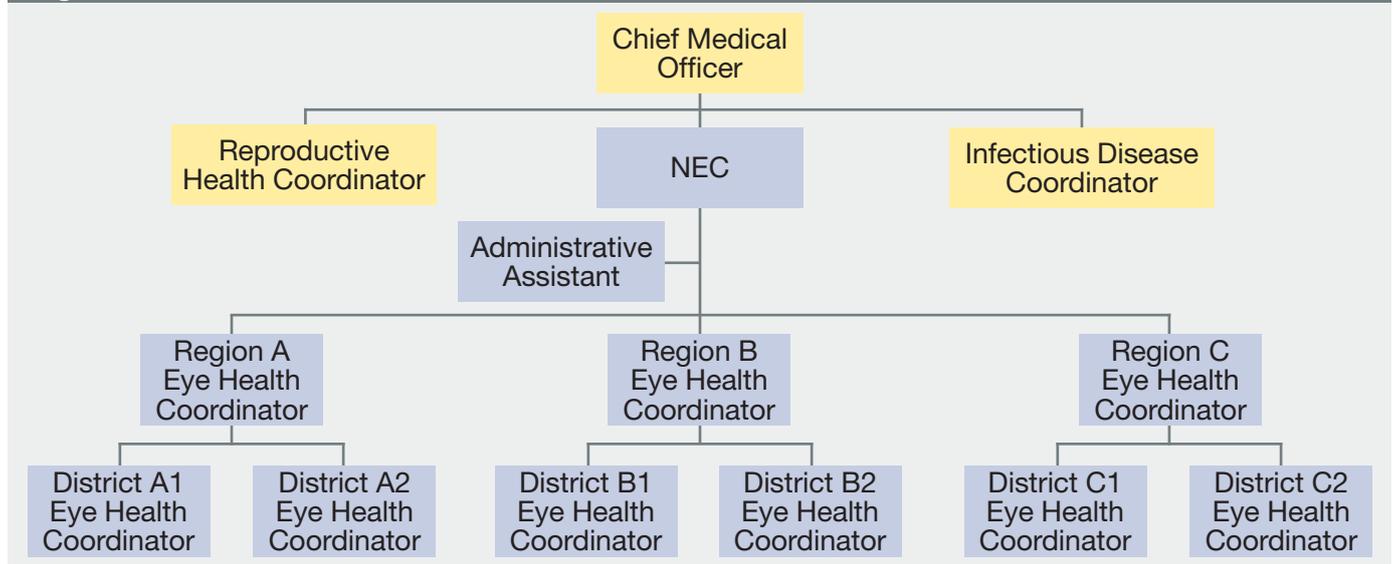
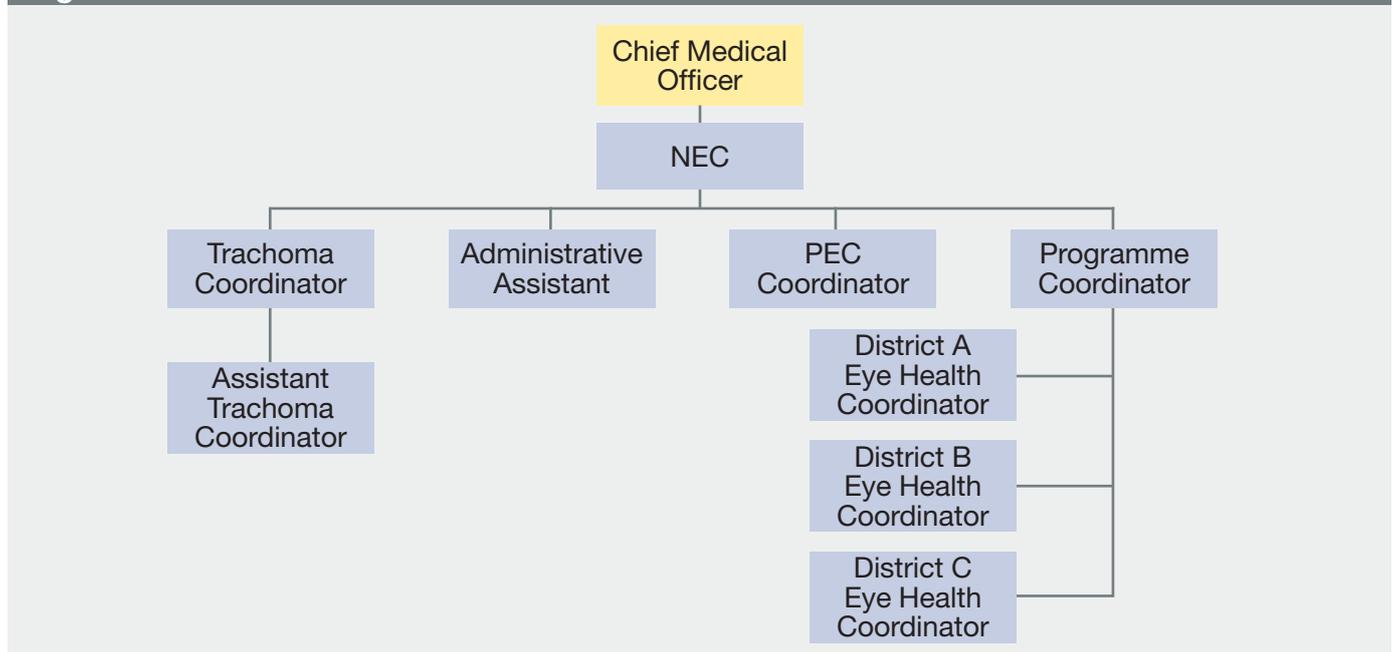


Figure 2.2



3

Job descriptions

Learning objectives

- Know who should have a job description in your organisation and how this can be used
- Be able to list the minimal elements of any job description and know how to develop a job description for anyone in your organisation
- Know how to assess your own job description and improve it if necessary

A job description is a definition of a position, written simply and clearly so that the job holder knows what is expected of him or her. A clear understanding of what is to be done gives confidence to any worker, whether the Chief Executive Officer (CEO) or the building custodian. It serves as an essential document for the person who supervises the job holder and it provides the basis to carry out a performance appraisal. After all, a supervisor can only assess how well a worker is doing if it is clear what the worker is supposed to do.

There is an art to writing a good job description. It requires a balance between listing enough detail to be clear and useful and listing too much detail – which is overwhelming and can become ridiculous. The elements of a job description are shown in Text Box 3.1.

Text Box 3.1

Minimum elements of a job description

- The job title: e.g., National Eye Health Coordinator
- Location of job
- To whom does job holder report and who does job holder supervise?
- A position summary describing the purpose of the job
- Major responsibilities: tasks and essential duties of the job, i.e., those tasks on which the employee will be evaluated
- Any other important aspect of the job the employee may be assessed on
- Working conditions, e.g., amount of travel away from home
- Job qualifications, describing the education, experience, and skills necessary to perform the job.

Who should have a job description?

Ideally, everyone would have a job description – even the top boss. Often, clinical personnel, especially doctors, do not have job descriptions as it is assumed that their job is to ‘take care of patients’. However, they may also run a department or manage a practice. Even if a manager is helping out, the doctor may have final responsibility for signing off on many important issues such as budgets or personnel. These responsibilities ought to be listed in a job description.

How do you develop a job description?

The key to developing any job description, whether it be for a manual labourer or the head of a highly intellectual think tank, is to be familiar with the tasks that must be done. You may think in general terms first and then move to more specific tasks. For example the purpose of a custodian's position might be to ensure a clean, attractive and functional building and grounds – from this will come a list of the specific tasks required to achieve this. An approach for listing the tasks required for a more complex position, such as the National Eye Health Coordinator, is shown in Text Box 3.2. The potential tasks of a National Eye Health Coordinator cover a wide range of activities and some of those listed in Figure 3.1 (over page) might be redundant or not relevant in your country. Think about what each really means.

Text Box 3.2

Developing a job description: try it for yourself

- If there is no job description agreed for your position, this is the time to develop one. If you do have a job description, complete this exercise anyway, then compare the tasks you come up with to the official description of your job to see how well they match.
- Group tasks under different areas of work, for example: planning, monitoring & supervision, reporting, communicating, advocating, etc.
- Note down as completely as possible, all the tasks required in each area
- Rank them in order of importance, or as major & minor
- Does the result form a good description of how you are spending your time?

Areas of work	Task 1	Task 2	Task 3	Task 4	Task 5

Figure 3.1**Potential responsibilities to go into a job description for a National Eye Health Coordinator****Developing policy and planning**

- Draft, review and submit policy documents regarding eye care
- Draft, review and submit documents providing standards or guidelines in provision of eye care
- Identify resources needed for policy and planning activities; mobilise as needed
- Network with all partners and stakeholders regarding policy and planning
- Lead the development of national strategic plans
- Assist, as needed, the development of district/regional implementation plans

Coordination of efforts in the country

- Identify potential partners and encourage them to participate in blindness prevention in the country
- Send out invitations to all groups and individuals for NPBC meetings
- Conduct (serve as secretary, prepare agenda, etc.) NPBC meetings
- Produce minutes from NPBC meeting and disseminate
- Follow up on specific action points from NPBC meeting

Supportive supervision/ improving quality/ monitoring of staff working in the National Eye Health Coordinator office as well as Regional Eye Health Coordinators

- Develop or revise supervisory tools to enable supportive supervision to Regional/District Eye Health Coordinators
- Conduct supervisory visits, as practical, otherwise use email or phone to provide ongoing supervision of Regional/District Eye Health Coordinators
- Create or strengthen the team approach for support and supervision
- Conduct as needed training in supportive supervision
- Prepare staff reports and disseminate, as appropriate
- Prepare or revise the terms of reference for the Regional Eye Health Coordinators and disseminate

Reporting

- Develop or revise the data reporting format (MIS) for the country to ensure relevant data at the regional/district level are collected and submitted to the national level
- Ensure that national data are submitted to appropriate international bodies in an annual report
- Supervise the analysis of the data
- Prepare, as a minimum, an annual report on eye care activities in the country and disseminate

Figure 3.1 (continued)**Advocacy**

- To advocate for the VISION 2020 goal: eliminating blindness from avoidable causes in your country.
- Develop advocacy plans focused on people and parts of the Ministry of Health, national ophthalmic societies and their members, and NGOs that have an interest in eye care.
- Ensure business people and other government departments such as finance, education, or water and sanitation are included in the advocacy plans.
- Develop advocacy expertise as required to deliver the national advocacy strategy

Maintaining good communication

- Identify all partners and stakeholders in eye care and determine mechanisms for routine communication
- Maintain frequent communication with all partners and stakeholders, compiling feedback on issues of mutual interest

Research

- Assist partners, academic institutions, and others to identify priority topics for research
- Assist partners, academic institutions, and others to identify the best teams to carry out research
- Assist, as possible, in the conduct of research
- Assist with the dissemination of findings of research carried out in the country as well as findings from research which is of relevance to the country
- Work with partners, academic institutions, and others to assess the evidence from the research and decide how it can be used to revise policies or programmes

Capacity building of staff and coordinators within the country

- Assess capacity building needs of Regional Eye Health Coordinators and other staff members and identify approaches to improve their skills.

Facilitate procurement of necessary drugs and equipment

- Work with partners and other sectors of government to ensure efficient and effective approaches to procure and provide necessary medicines and equipment for public facilities.

A job description is more than a list of tasks

The list of tasks is the essential starting point, but a good job description is more than this. Who does the job holder report to? Who does he/she supervise? What skills and educational qualifications are required of the job holder? These important details can go into the job description. Don't confuse an academic degree with a competency. A Master's in Public Health may provide excellent background for a health planner but it does not guarantee planning skills. If these are key to the position then list them separately along with a requirement for experience in this area. Most jobs require interaction with people in other positions, so these relationships can also be added to the job description. The template included, Figure 3.2, will be helpful in writing or re writing a job description. Remember, as with many management issues, there is not just one right way to write a good job description.

Figure 3.2

Job title	
Reports to:	
Supervises:	
JOB PURPOSE (briefly describe the overall purpose or function of the job)	
PRINCIPAL ACCOUNTABILITIES: Describe the principal accountabilities of the job, i.e. specify activities and end results.	
Estimated % time	Activity
JOBHOLDER REQUIREMENTS: Identify the essential knowledge, skills and behaviours required.	
Education & experience:	
Special training or competence:	
KEY RELATIONSHIPS (excluding supervisor and those supervised)	
Internal	External

4 VISION 2020 planning

Learning objectives

- Understand differences between National planning and District planning
- Know what information must be on hand before starting planning at District or National level
- Know who should be invited to a District planning meeting and the steps in planning
- Know the differences in 'targets' and activities
- Understand the role of the National Eye Health Coordinator as a facilitator and coordinator in planning at both levels
- Know what information is and is not provided by a RAAB (Rapid Assessment of Avoidable Blindness)²

Planning and facilitating to achieve VISION 2020 will be one of the most important roles of a National Eye Health Coordinator.

Making the real changes called for in VISION 2020 requires a huge amount of planning and work within each country. One person cannot possibly do it alone. Learning how to plan is rarely included in medical or public health training. In this section, the goal is to provide better understanding of the planning process – what is needed in order to plan, and how the National Eye Health Coordinator can facilitate planning. A toolkit for planning for VISION 2020 can be found on the WHO website – 'Developing an ACTION Plan'.³

Two stages of planning are necessary in every country, and both need to be done purposefully: these are national and district planning. A 'district' means an administrative area covering up to 2 million population. It may be called a region or a province or some other name in your country.

Differences in National and District VISION 2020 planning

Before reviewing how planning is done, it is important to make the distinction between a national VISION 2020 plan and a district VISION 2020 plan. For small countries (population less than 3 million) these may be the same. Text Box 4.1 lists some of the differences between national and district planning. There is often some confusion with the term district; for the sake of VISION 2020 planning, a district refers to an administrative area of one half million to two million people (average about 1 million people). Ideally, a national plan would also include an amalgamation of all of the district plans but this is rarely possible.

²<https://www.iceh.org.uk/display/WEB/Rapid+assessment+of+avoidable+blindness+survey+methodology>

³WHO website http://www.who.int/ncd/vision2020_actionplan/start.htm

Text Box 4.1**National planning vs. district planning****National plans include:**

- National policies (human resources, deployment, remuneration and incentives)
- National training initiatives and plans to improve capacity
- Recommended staffing at different levels of service delivery
- National reporting guidelines
- National advocacy
- Desired equipment and instrument norms
- Disease priorities (and basic strategies)
- National procurement of consumables
- National supervisory structures
- Overall national targets for service delivery
- National coordination

District plans include:

- Current assessment of service delivery, staffing levels, equipment and instruments
- Targets for service delivery (e.g., cataract surgeries, spectacles dispensed, diabetic patients screened annually)
- Activities needed to achieve each of the targets (including changes needed to infrastructure, management, skills)
- Plans for improving partnership (and identifying new partners)
- Routine monitoring & reporting
- Coordination at the district level
- Time frame for each activity
- Budget

Pre planning activities are essential

Whether facilitating the development of a national plan or a district plan, it is essential to start the planning process with information and evidence. All planning starts by considering the current situation (services provided, personnel and their productivity, current policies, current training and numbers graduating). Thus, it is essential to devote sufficient time to pre-planning. Meeting to plan without having essential baseline information on hand is a waste of everyone's time. Some information to be collected prior to the actual planning session is included in Text Box 4.2.

Text Box 4.2**Information to generate before planning session****National planning**

- Current policies on human resource development, staffing norms, deployment
- Current training capacity (annual graduates, whether being trained inside the country or outside the country)
- Current status of procurement of medicines and consumables
- Evidence (from the scientific literature) that could assist with planning of services
- Current service delivery (district by district) of key indicators (e.g., cataract surgeries, children receiving surgery for congenital/ developmental cataract, presbyopic spectacles dispensed)

District planning

- Current service delivery (sub-district by sub-district and by sex) for priority conditions
- Cataract surgeries
- Presbyopic spectacles
- Childhood cataracts operated
- Glaucoma surgeries
- Diabetic retinopathy patients screened
- Human resources (exact numbers, placement, include active personnel only)
- Equipment (working or not, number, placement)
- Partners (NGOs, companies, service clubs)

National planning

National planning has several purposes:

- Helps to solidify the commitment made by the Ministry of Health towards the prevention of blindness
- Provides an opportunity to gather the stakeholders and have frank discussions aimed at developing a consensus on the priorities for the prevention of blindness in the country (diseases, geographic areas of most need, needs for training manpower)
- Offers an opportunity to develop collaborative relationships amongst stakeholders

The process must be open and transparent. To exclude certain people or organisations may cause resentment and mean the loss of valuable input. Nonetheless, national planning is often best organised by getting a small group of very experienced people together to make the first draft. They should feel free to ask other experts, outside of the group, to draft certain sections. The drafts can then be sent around to a wider group of people for comment. By the time of the national planning meeting, the draft should be virtually finished and most people coming to the meeting should have already provided their input. It is very helpful to have an external facilitator for the national planning session. An external facilitator should be an expert on VISION 2020 and planning; IAPB regional offices are able to advise you on individuals that are experienced in facilitating and planning workshops in your region.

District planning

District planning is organised somewhat differently. Much of the writing of the district plan will be done during the planning session, using information collected ahead of time. The planning session should follow certain steps, which are outlined in Text Box 4.3. Targets (for example, cataract surgeries) should be set for each administrative sub-district by the health team from that sub-district. People often get confused between 'targets/objectives' and 'activities needed to reach the targets'. Remember that:

- A target/objective is a person receiving a service
- An activity is one of the interventions needed to achieve the target

Thus, training 50 primary eye care workers is NOT a target or objective; it is an activity that should be linked to a specific target (e.g., x people are referred for and receive cataract surgery in the next calendar year)

Text Box 4.3

Steps in district planning

- Review the current situation
- Discuss practical and desirable targets
 - The discussion should lead to targets that are both practical and will, with time, enable the team to reach their VISION 2020 goal
- Set targets for service delivery
 - Best to only have 3-4 targets
- For each target decide on the specific activities needed to achieve the target
 - Activities include training of personnel, purchase of equipment and supplies, deciding on a 'bridging strategy' (linking communities with hospitals)
- Determine who will be responsible for each activity and when it will be done

As noted in Text Box 4.4, it is essential to have the ‘right people’ around the table. In most cases this means the health authorities who have responsibility for allocation of budgets or staff at the sub-district level. Note that all current and potential partners should be included: no partner wants to be handed a VISION 2020 plan with a request for funding. Partners need to be part of the planning process.

Text Box 4.4

Who should be involved in district VISION 2020 planning

Attributes of participants

- Good technical skills related to eye care
- Demonstrated leadership skills (preferably, the ophthalmologist)
- Authority to make financial decisions (allocation of resources)
- Understanding of current eye care and general health care in the sub-districts
- Representing all current and potential partners

Potential participants

- Ophthalmologist
- District health director
- ‘Sub-district’ health directors
- Partners
 - NGOs
 - Service clubs
 - Companies supporting eye care services
- Private eye care practitioners
- Other eye care personnel (from hospital or sub-districts, as needed)

Facilitating the process

In most cases, the National Eye Health Coordinator role is to facilitate the planning process. Facilitation is not the same as teaching or directing and Text Box 4.5 reviews the differences. Text Box 4.6 provides practical suggestions for good facilitation. A facilitator might consider having participants read and discuss the case study provided in small groups at the beginning of a planning session. It describes a very common situation and illustrates the need for planning, including collecting baseline data and getting all partners round the table.

Text Box 4.5

How is facilitating different from teaching?

Facilitating

- Empowering
- Guiding
- Motivating

Teaching

- Instructing
- Testing
- Measuring

Where can I get basic information on prevalence and causes of blindness?

In only a few countries have national surveys been done of sufficient scope and quality to determine the magnitude (prevalence) of blindness and visual impairment in the entire country. Sometimes an area or district within a country will have been surveyed and this information may be used to estimate for the whole country assuming that the country is similar to the district. The Rapid Assessment of Avoidable Blindness (RAAB) survey methodology was developed specifically for providing VISION 2020 Districts of 1-2 million people the baseline information that is useful for planning. Guidance on the use of RAAB is shown in Text Box 4.7. Nonetheless the vast majority of districts will not have RAAB data and will have to rely on data from a similar neighbouring district or country, or rely on broad estimates published by the WHO.

Text Box 4.6**Keys to effective facilitating**

- Make sure that the participants are clear about the task(s) to be undertaken
- Make sure that participants have all of the information necessary for the task (clear up any confusion/misunderstanding in advance)
- Give participants a structure for working (e.g., a form to start filling out)
- Have someone putting the information on computer as the group progresses.
- Walk around and listen peripherally to make sure they are on the right track. If not, ask questions rather than give instructions. Do not take over.
- Ask lots of questions, particularly in the problem solving stage
- Try to identify a natural leader in the group. Talk to him/her during breaks to further empower
- Have the group present back to everyone once a day to get confirmation and to pose questions
- Always find something to praise – particularly if the target is going to be a challenge
- Make sure that people feel comfortable in discussing problems. Never criticise
- Watch the dynamics of a group. If a sub-group starts to form (at odds with the main group) make sure their concerns/ideas get included.

Text Box 4.7**Rapid Assessment of Avoidable Blindness**

A RAAB survey, properly done, will provide the following:

- An estimate of the prevalence and causes of avoidable blindness and visual impairment
- The cataract surgical coverage
- Outcomes after cataract surgery

What RAAB does *not* provide

- Information on the type of refractive error or near vision
- Prevalence of rare diseases – sample not large enough
- Limited posterior segment diagnoses. No intraocular pressure and visual fields, needed to confirm the diagnosis of glaucoma
- Cataract surgical rate
- No information on children or anyone <50 years
- No data on resources for planning

It will require a dedicated full time team for 3–4 months (or two teams for half the time or 3 for 1/3 the time.) A RAAB will cost US\$30,000 – US\$40,000.

- Coordinator – must visit each village before exam day to explain to village head, map village, arrange date, select village guide
- Team members
 - Ophthalmologist
 - Assistant to ophthalmologist
 - Village guide
 - Driver
- Equipment per team
 - E chart
 - 6 meter rope
 - Pinhole
 - Torch
 - Direct ophthalmoscope
- Office
 - Data entry clerk
 - Computer

Warning: RAAB is not a simple exercise and it should not be undertaken without the help of an experienced trainer

Exercise 1

Case study

Maachini is a region with 1.2 million people in the country of Linkula (population 28 million). Maachini has one eye hospital in the regional capital. Most of the population of Maachini lives in the two districts around the regional capital. The eye hospital has minimal outside support and relies upon its reputation and revenues to support much of its work. It has one ophthalmologist (Dr. Ndola). She does about 300 cataract operations per year at the hospital. Dr. Ndola works hard, has good quality outcome with her IOL surgery, and has a good team supporting her. The hospital charges \$30 per cataract operation and has a poor fund to pay for people who cannot pay this fee. There are still many people who need cataract services who do not come to the hospital for services and Dr. Ndola would like to set up a community outreach programme to increase utilisation of services. Funding is limited however, and she does not have the resources for setting up the programme.

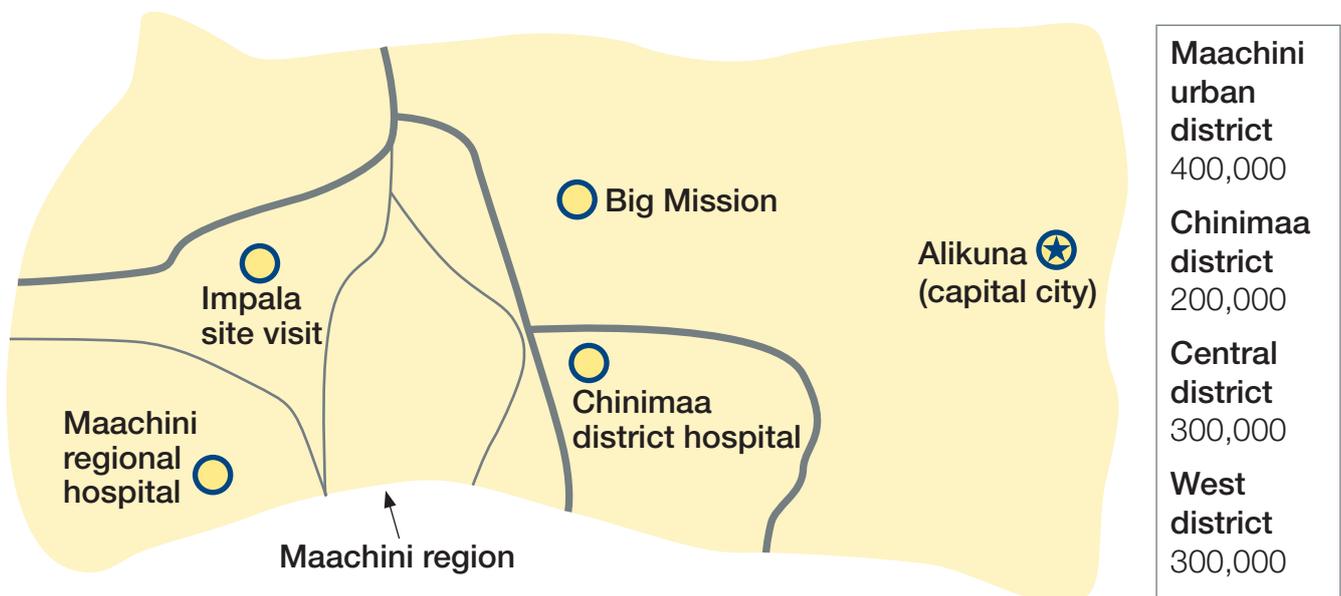
In the eastern part of Maachini there is a District hospital called Chinimaa District Hospital. Chinimaa receives periodic visits from a cataract surgical team (every 3-4 months for the past 3 years) from Big Mission Hospital in the neighbouring region (about one hour away by vehicle). The Big Mission Hospital team (which has support from a Canadian NGO) spends about 5 days per visit, doing about 40 operations each visit. Patients are charged only \$6 since the Canadian NGO heavily subsidises services.

In Alikuna, the capital of Linkula, there is a group of well-meaning people who are part of the Impala Club. They want to help blind people. One of them is originally from Maachini. They decided that they will conduct a free eye camp, bringing an ophthalmologist from Alikuna to one of the district hospitals between Maachini Regional Hospital in the west and Chinimaa in the east. They hold the free eye camp and do about 70 cataract operations.

Following the free eye camp the number of patients coming from this area for surgery at the Regional Hospital and at Chinimaa decreases. People in this central area report that they will wait until the Impala Club comes back, for free cataract surgery. The Impala Club has no plans to return to this area, however Dr. Ndola hears that they want to go to another district in Maachini since they were so successful and she is worried about the impact this may have on service at Regional Hospital and Chinimaa District hospital.

As national eye health coordinator, how can you assist?

Map of country of Linkula



5 Monitoring and reporting

Learning objectives

- Understand the role of the National Eye Health Coordinator in collecting national statistics for reporting
- List some strategies to improve reporting from District to National level

The National Eye Health Coordinator has a primary role in monitoring and reporting of eye care services for the country. Monitoring and reporting has been a major source of problems for many NECs, particularly in large countries with decentralised government health systems. With improved communication systems around the world it need not be so frustrating, however, it may require that the National Eye Health Coordinator and the NPBC explore new systems for monitoring and reporting.

Establishing an information superhighway to get national statistics

Monitoring and reporting at the national level is often complicated by the demands of different groups—government, WHO, NGOs, service clubs. The NPBC (which ought to include many of these groups) should determine the minimum set of indicators⁴ and the reporting period. This is best achieved through an ad hoc task force. These minimum indicators need to be communicated to all relevant personnel throughout the country and specific people need to be made accountable for providing this information. One reason information flow has been inadequate is that many district staff have not received any feedback from the reports they submit. Accountability is a two-way street: personnel who are expected to submit information routinely need to feel that their work is valued and their reports used. Improved monitoring and reporting can be achieved through a number of methods and the NEC will likely need to use a variety of the following:

- An annual meeting (usually early January or July) to review progress achieved the previous year. Text Box 5.1 includes some pointers taken from annual meetings that have been very successful in some countries.
- Use of cell phones to contact district health personnel who have failed to submit reports in a timely fashion.
- Use of web-based or email reporting formats can save much time. But if these are not available to your district coordinators, paper reports sent by post are just as useful.

⁴ Annex 4 of the VISION 2020 Action Plan 2006–2011, WHO provides a comprehensive list of potential indicators to monitor VISION 2020 programmes. It is not recommended to adopt all of these but to make a selection appropriate to your country. http://www.who.int/blindness/Vision2020_report.pdf

Text Box 5.1**What happens at an annual review meeting**

- National health official to preside
- Each district presents its progress against its targets
- Awards given to districts. For example:
 - For greatest improvement
 - For best coverage
 - For gender equity
- NGOs and academic centres are invited as observers
- Districts receive feedback from national health officials.
- Challenges identified by the districts and discussed by the large group.

What if they just don't respond?

Consistent failure to submit reports in a timely fashion will require documentation and perhaps some form of reprimand. This is part of the supervisory role of the National Eye Health Coordinator. Of course, the supervisor needs to ensure that the reporting function is clearly stated in the job description of those at the district level who are supposed to report.

Monitoring at the district level

Monitoring at the district level may include additional information to that reported to the national level. Each district may choose to adopt specific indicators relevant to its own VISION 2020 plan. It is necessary, however, for each district to use the national indicators too. At the district level, the development of a monitoring plan should be part of the development of the VISION 2020 plan. That is, for each of the targets/objectives and activities, there need to be indicators for monitoring. The steps for determining these are laid out in Text Box 5.2.

Text Box 5.2**Steps in determining indicators for monitoring at the district level**

1. For each target, decide upon the indicator and frequency of reporting
 - Consider breaking down by sex or by sub-district
2. For each activity, identify whether you need a process or outcome indicator
3. Decide upon the frequency of reporting.
4. Review the forms for reporting
5. Determine reporting parameters
 - Who will prepare and submit the reports
 - When reports will be due
 - Who will compile the findings from the reports
6. Determine how feedback will be provided.

6 Leadership

Learning objectives

- Understand three basic leadership styles
- List characteristics of good leadership
- Evaluate your own reaction to crisis as a leader
- Understand how leadership differs from management

“Leadership is action, not position”

– Donald H. McGannon

The leadership provided by the National Eye Health Coordinator may be the single most important factor in how well prevention of blindness activities function in a country. The National Eye Health Coordinator may have to navigate an array of political realities, special interests of donors, bureaucracy, egos and other aspects of human nature. Doing all this in the face of scarce resources makes it more difficult. A key job of the National Eye Health Coordinator is to help guide all the ‘players’ in a country to work together towards the goal of VISION 2020 – this requires leadership.

Leadership styles

There are many different theories and description of leadership styles. Whichever description of styles is used, there is no one ‘best’ style and good leaders are those who can show flexibility depending on the situation. In determining which style is right you need to consider the work involved (i.e., is it routine or is it new, requiring creative solutions?) and the skills and experience of the team you are leading. An example of one of the early and simpler attempts to classify leadership styles is shown in Text Box 6.1.

Text Box 6.1

Leadership styles

The 1930s, Kurt Lewin described three types of leaders:

- **Autocratic/authoritative leaders** provide clear expectations for what should be done, when it should be done, and how it should be done. These leaders make decisions independently with little or no input from the rest of the group. This may be appropriate when decisions genuinely need to be made quickly, when there’s no need for input and the leader is the most knowledgeable member of the group, and when team agreement isn’t necessary for a successful outcome. As a long term day in and day out approach it will result in dissatisfaction among the team members and it does not encourage creativity. Abuse of this style is controlling, bossy, and dictatorial.
- **Democratic/participatory leaders** allow the team to provide input before making a decision, although the degree of input can vary from leader to leader. This type of style is important when team agreement matters, but it can be quite difficult to manage when there are lots of different perspectives and ideas. If relied on exclusively it may result in too slow a change or maybe no change at all.
- **Laissez-faire/delegating leaders** don’t interfere; they allow the team to make many of the decisions without interference. This style is most useful when the group members are highly qualified in an area of expertise, strongly motivated and don’t need close monitoring or supervision. It may foster some of the most creative results. In the wrong situation, however, it can lead to poorly defined roles, lack of motivation and very poor productivity.

There are tools on the internet to help you understand your own style of leadership; an excellent resource is www.mindtools.com where there is a wealth of material on leadership. Whatever style of leadership you use, the characteristics of good leaders shown in Text Box 6.2 are universal.

Text Box 6.2

Characteristics of good leaders

✓ Openness	✓ Lead by example
✓ Honesty	✓ Trust
✓ Consistency	✓ Mutual respect
✓ Fairness	✓ Communication
✓ Ethics	✓ Strategist
✓ People person	✓ Change agent
✓ Team builder	

A good test of leadership

How do you react when faced with a problem, when things don't go as you'd hoped? You can choose to act 'above the line' or 'below the line' as illustrated in Text Box 6.3.

Text Box 6.3

<ul style="list-style-type: none"> • Personal power • Future • Solution 	Take personal responsibility So what can I/we do about it?	"us" "I" "we"
'Above the line'		
<ul style="list-style-type: none"> • Victim • Past problem 	Blame others Justify Deny Defend Quit	"you" "they" "them"
'Below the line'		

Good leaders react by taking personal responsibility. They feel a sense of personal power, assume responsibility and start asking, "What can I/we do about the problem?" They look for solutions and they look towards the future.

Inadequate leaders hastily start to assign blame to others and deny their own responsibility. They spend time justifying and defending their actions. Sometimes they just quit or disappear from the scene for a while. They focus on the past, on their perceived position as a victim. It's always someone else's fault.

Can you think of situations when you've acted "below the line"? Acting "above the line" is not usually the easiest way – but it is a choice you can make.

Does a leader differ from a manager?

Although it isn't always black and white, the roles of leader and manager differ in some ways, described in Text Box 6.4. Most National Eye Health Coordinators will be called upon to act as both leaders and managers at different times.

Text Box 6.4

Leaders	versus	Managers
Create		Implement
Develop		Advance
Inspire Trust		Control
Think long term		Think near term
Ask what and why		Ask how and when
Watch the horizon		Watch bottom line
Challenge the status quo		Enhance the status quo
Are their own people		Are good soldiers
Do the right thing		Do things right

7

Supervision

Learning objectives

- Understand the purpose of supervision and know of several strategies to provide supportive supervision
- Design a supervision plan for those you supervise

The role of the National Eye Health Coordinator as a supervisor depends on the job description of the National Eye Health Coordinator and the organisational structure that has been agreed upon by the partners and the Ministry of Health. The organisational structure defines how people in different positions report to each other. Generally, a person supervises the person in a position who reports to him or her, but the degree to which supervision is required can vary.

What is supervision?

Before considering the role of National Eye Health Coordinator as supervisor, it is worthwhile to consider the role of a supervisor in general. Unfortunately, many people have not had the experience of being well supervised themselves and may think of supervision as a controlling and even punitive function. Sometimes supervision has been so formalised that it is just a routine matter of a formal visit during which higher-ups appear with scowls and check lists. On the other hand, good supervision can be key to increased productivity and better morale among staff. Consider the key behaviours in Text Box 7.1 that should define a supervisor's role.

Text Box 7.1

What is the role of a supervisor?

- Assess and guide
- Support
- Encourage/motivate
- Evaluate
- Correct
- Recommend
- Clarify instructions, tasks

What is the role of National Eye Health Coordinator as supervisor?

This will vary considerably depending on the organisational structure of health care in the country and the degree to which eye health services are provided through government or non government (private practices or mission clinics and hospitals) systems.

Consider two very different situations

Country A

Most eye services are delivered through non-governmental institutions, e.g., private solo practitioners or ophthalmologists working for non government clinics. The country has laws regulating provision of eye care but doctors mostly work privately and set up practices as they choose. In this setting one of the most important roles of the National Eye Health Coordinator may be to keep track of service provision for reporting service statistics to the ministry, the partners and the WHO. The National Eye Health Coordinator needs to know where services are offered, but 'supervision' may consist mostly of keeping in contact annually with all the providers to collect statistics. This may be done in collaboration with a national ophthalmologic society if it exists.

Country B

Most eye health care providers work for the government and there is a well defined system of referral hospitals and clinics from the rural dispensaries or health centres up through district and regional (provincial) hospitals to national referral hospitals. Surgical and medical eye care may be delivered by ophthalmologists or paramedical workers. The National Eye Health Coordinator may be in charge of (or advise the Ministry of Health on) placing ophthalmologists in various hospitals. There will probably be some additional eye services provided by non government clinics or hospitals, which contract with eye care providers. In this setting the National Eye Health Coordinator is also responsible for keeping track of service statistics from both government and non government providers. In addition, however, the National Eye Health Coordinator may have responsibility for ensuring that providers, especially paramedical workers who work in isolation without other ophthalmologists, receive technical supervision.

The job descriptions of the National Eye Health Coordinator in these two settings will be very different and so will be their supervisory responsibilities, with the National Eye Health Coordinator in country A required to provide far more oversight and coordination. A sample of a supervisory plan for such a country is provided in Table 7.1 (over page).

Table 7.1

A sample supervision plan for country B to ensure technical supervision and collection of statistics

VISION 2020 district	Coordinator of V2020 plan	Comments	Supervision plan
1	District government hospital ophthalmologist	Also has a new cataract surgeon at mission hospital 6 hours from district hospital.	NEC arranges that the government ophthalmologist visits the cataract surgeon every 3 months to operate together (technical supervision) and collect statistics. Government ophthalmologist reports service statistics to NEC every 6 months.
2	District government hospital ophthalmologist	Senior ophthalmologist in position for many years	No technical supervision required. Ophthalmologist reports statistics to NEC every 6 months.
3	Mission hospital cataract surgeon	No government eye surgery service. The cataract surgeon has been in place for many years and does not report statistics regularly	The NEC believes the cataract surgeon does not need technical supervision. The NEC marks in his diary to call this cataract surgeon every 3 months to see if there are any problems and to collect statistics at that time.
4	Mission hospital ophthalmologist	Cataract surgeon at district hospital	NEC arranges with ophthalmologist to make quarterly visits to cataract surgeon (technical supervision). Mission hospital ophthalmologist reports statistics to NEC for entire District every 6 months
5	No coordinator	No static services. The cataract surgeon from district # 3 and the ophthalmologist from district # 9 both make outreach visits occasionally	The NEC's challenge is to get the statistics on people operated in District #5. This must be arranged with the cataract surgeon in district #3 and the ophthalmologist from District #4. Note that these statistics should be reported separately from those reported by the surgeons from their own districts in order to accurately know what the CSR is for each District.
6	District government hospital cataract surgeon	New position recently filled by new graduate, 5 hours from capital city.	NEC arranges to visit to provide technical supervision every 6 months and shows cataract surgeon how reports are to be made. May arrange additional technical supervision if needed
7	District government hospital cataract surgeon	No other surgical services	This cataract surgeon works in isolation but is too far from NEC to visit. The NEC arranges to have ophthalmologist from District #4 visit to provide technical supervision twice per year. The district government hospital cataract surgeon is responsible for reporting statistics to the NEC every 6 months.
8	Mission hospital ophthalmologist	Cataract surgeon at district hospital	NEC arranges with ophthalmologist to make quarterly visits to cataract surgeon (technical supervision). Mission hospital ophthalmologist reports statistics to NEC for entire District every 6 months
9	District government hospital cataract surgeon	1 other cataract surgeon at a mission hospital	NEC visits district to provide technical supervision for both cataract surgeons once each year. Government cataract surgeon reports statistics for entire district every 6 months.

Regardless of the actual role of the National Eye Health Coordinator as a supervisor, there are some general strategies for good supervision; these are listed in Text Box 7.2.

Text Box 7.2

Key supervision strategies

- Supervision should be supportive and active in nature. Make a habit of asking, “how can I help you?” or “how is it going?”
- Supervision should be linked to job description – be sure the person understands what is expected of him/her
 - What, when, and to whom should he/she report
- Make a plan to keep up with relevant activities of those you supervise. This can be by phone, email, or in person. Discuss progress and challenges
- Empower and support those you supervise
- Prepare for all supervisory visits by
 - reviewing the job description
 - checking before the visit to see if there are needed supplies/equipment that you can take with you
- Remember that supervision is not limited to visits only. Daily interactions in the office or regular phone calls are also part of supervision.

8 Team development and conflict resolution

Learning objectives

- Know the advantages and disadvantages of working in teams to solve problems
- Understand why teams sometimes fail
- Define a task force; know who should be on one and how it should work
- Define some of the teams you need to develop as the National Eye Health Coordinator
- List the steps needed to resolve a conflict and assess whether you used these in the last conflict you encountered

“Teamwork divides the task and doubles the success”

– *anonymous*

Everyone has experience as part of a team. With teamwork, much is possible that cannot be accomplished individually; big tasks such as the VISION2020 initiative certainly require teamwork. Teamwork may be defined as agreed upon actions by members of a group to achieve a common goal. Andrew Carnegie called it “the fuel that allows common people to attain uncommon results.”

As the National Eye Health Coordinator, you will need to help develop a number of teams at different levels. One of the tests of your leadership will be how well you can develop teams and get them to produce results. Some of the advantages of working in teams as opposed to individually are listed in Text Box 8.1

Think of a satisfying experience you’ve had as a member of a team

- What did you accomplish?
- What made the team work well together?

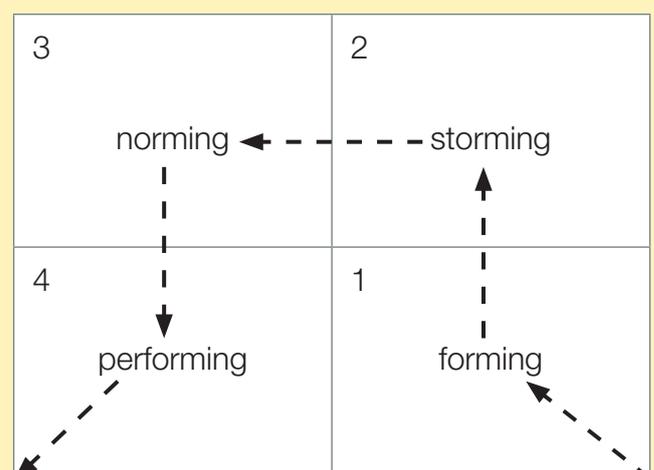
Text Box 8.1

Why work in teams?

- Provide a variety of skills and experience
- Come up with more ideas or solutions
- Opportunity to brainstorm
- Opportunity to develop a consensus of opinion
- Shared responsibilities
- Increase motivation through support and encouragement

Text Box 8.2

Tuckman’s team development model



How do you develop a team?

One of the tasks of many National Eye Health Coordinators is to develop a unit or team within the government to accomplish certain activities related to prevention of blindness and visual impairment. Listing all the specific tasks that need doing, and organising these into job descriptions for staff is a good way to go about this if you are starting from nothing. More often a leader or head may inherit staff or leadership in an organisation that has already defined positions. In this case it will be necessary to review job descriptions and assess whether they are appropriate or need revisions; this should be done with the basic list of specific tasks related to organisational goals in mind.

Team development often starts with a single leader. In the 1960's Bruce Tuckman described the way that many groups develop through 4 stages: forming, storming, norming, and performing (Text Box 8.2). The dynamics within the team are different in each stage, as shown in Text Boxes 8.3-8.6. As you read these, notice that the role of the 'leader' changes throughout.

“It is amazing how much you can accomplish when it doesn't matter who gets the credit”

– *anonymous*

“Teamwork: Simply stated, it is less me and more we”

– *anonymous*

“There is no ‘I’ in ‘TEAMWORK’”

– *anonymous*

Text Box 8.3

Stage 1: Forming

- High dependence on leader for guidance and direction
- Little agreement on team aims other than what is received from leader
- Individual roles and responsibilities are unclear

Text Box 8.4

Stage 2: Storming

- Clarity of purpose evolves though many uncertainties persist
- May be competition among team members to establish themselves
- The team needs to be focused on its goals to avoid becoming distracted by relationships and emotional issues
- The leader coaches

Text Box 8.5

Stage 3: Norming

- Agreement and consensus largely forms among team
- Roles and responsibilities are clarified and accepted
- Commitment and unity is strong
- There is general respect for the leader and leadership becomes more shared by the team
- The leader facilitates and enables

Text Box 8.6

Stage 4: Performing

- Team has a shared vision and high degree of autonomy
- There is a focus on achieving goals
- The team is able to attend to relationship, style and process issues along the way
- Team members look after each other
- The team receives delegated tasks and projects from the leader. But does not need instruction or much assistance
- Leader delegates and oversees

Sometimes a leader may find that it is worthwhile to keep an especially good team together after they have completed the task for which the team was formed – but the leader will need to be certain the team has been delegated a new task. Teams need a clear purpose.

A **task force** is a special type of team, usually developed for the short term to accomplish one specific discrete goal. Many task forces work together for a few days or months, then disband. If you decide that a problem requires a task force, then consider carefully who should be part of the team. Including people with technical skills is critical. For example if you need a task force to come up with suggestions of critical research to be carried out in your country, be sure you include people with demonstrated research skills who are active in research. This is not the time for including ‘representatives’!

Is teamwork always better than individual work?

The answer to this is, “no”, but what determines whether a problem is better tackled by a team or an individual? Text Box 8.7 provides some examples of when team problem solving is useful and when it may not be. Text Box 8.8 lists some of the obstacles that prevent us from using teams when they might be productive.

Text Box 8.7

Team problem solving

Is useful for

- Understanding work processes
- Solving group problems of quality, service, and cost
- Group cooperation

Is not useful for

- Defining department mission
- Budgeting
- Hiring, evaluating training of individuals
- Exercising final authority

Text Box 8.8

Obstacles to team problem solving

- No time to get people together to work on the problem
- Habit of receiving all instruction from the boss
- Fear of speaking in front of peers or superiors
- Lack of patience and confidence in the process

Resolving conflicts

Inevitably, conflicts will arise when people and groups work together. As a leader you will sometimes have to mediate when conflict occurs. Or you may find yourself in a conflict with partners. There are some useful ways to approach these conflicts.

First, when you are in a conflict with another, try to understand the adversary’s point of view before asking to be understood yourself. Asking questions about the other point of view shows interest and caring. You need to know how the other person feels or thinks and it may soften your own emotional reactions.

Do not react; pause consciously and choose your response. A short pause will re-orient your thinking from yourself to the whole situation, which deserves consideration. Try to avoid “You” statements that are accusatory.

Understanding the person and the situation and avoiding major blow ups may allow win/win solutions.

It's worth thinking about why conflicts arise in the first place. A large number of them are due to poor communication, either among people working on the same team or among partners. Consider some basic tenets of communication listed in Text Boxes 8.9 and 8.10.

Conflict resolution: 9 Steps

1. Don't put it off – get the facts as soon as possible
2. Discuss the problem with the staff member – let him/her explain first to you what happened
3. Reach agreement between supervisor and staff member as to the problem.
4. Help staff member understand how his/her under-performance is affecting performance of the team
5. Encourage the staff member to discuss how to solve the problem and avoid similar problems in the future
6. Jointly agree on plan of action
7. Follow up to see that the actions are being taken
8. Follow up again!
9. Follow up again!

Text Box 8.9

Communicate, communicate, communicate

- Just because you know something, doesn't mean you mentioned it to your staff.
- Just because you said it doesn't mean they heard it
- Just because they heard it, doesn't mean they understood.
- Even if they understood it, they may not do it—so you need to hear and understand them!

Text Box 8.10

“Praise loudly, blame softly”

- Criticise in private, you may not know the whole story
- Use facts, not assumptions
- Public blame shames
- Public praise energises
- 5 compliments to 1 criticism

9 Advocacy

Learning objectives

- Determine what advocacy means in your own setting
- Understand the need for different messages for different groups
- Know how to develop an advocacy plan

As National Eye Health Coordinator, advocacy is one of your chief responsibilities. Advocacy is defined in many different ways, as shown in Text Box 9.1.

Text Box 9.1

What is advocacy?

Many definitions, different insight

1. **Advocacy** is an action directed at changing the policies, positions or programmes of any type of institution.
2. **Advocacy** is pleading for, defending or recommending an idea before other people.
3. **Advocacy** is speaking up, drawing a community's attention to an important issue, and directing decision makers toward a solution.
4. **Advocacy** is working with other people and organisations to make a difference.
5. **Advocacy** is putting a problem on the agenda, providing a solution to that problem and building support for acting on both the problem and solution.
6. **Advocacy** can aim to change an organisation internally or to alter an entire system.
7. **Advocacy** can involve many specific, short-term activities to reach a long-term vision of change.
8. **Advocacy** consists of different strategies aimed at influencing decision-making at the organisational, local, provincial, national and international levels.
9. **Advocacy strategies** can include lobbying, social marketing, information, education and communication (IEC), community organising, or many other 'tactics.'
10. **Advocacy** is the process of people participating in decision making processes which affect their lives.

For what and to whom are you advocating?

In simplest terms, you will need to advocate for the VISION 2020 goal: eliminating blindness from avoidable causes in your country. At the country level, your advocacy will obviously be focused on people and parts of the Ministry of Health, national ophthalmic societies and their members, and NGOs that have an interest in eye care. It should also include business people and other government departments such as finance, education, or water and sanitation.

How do you develop a plan for advocacy?

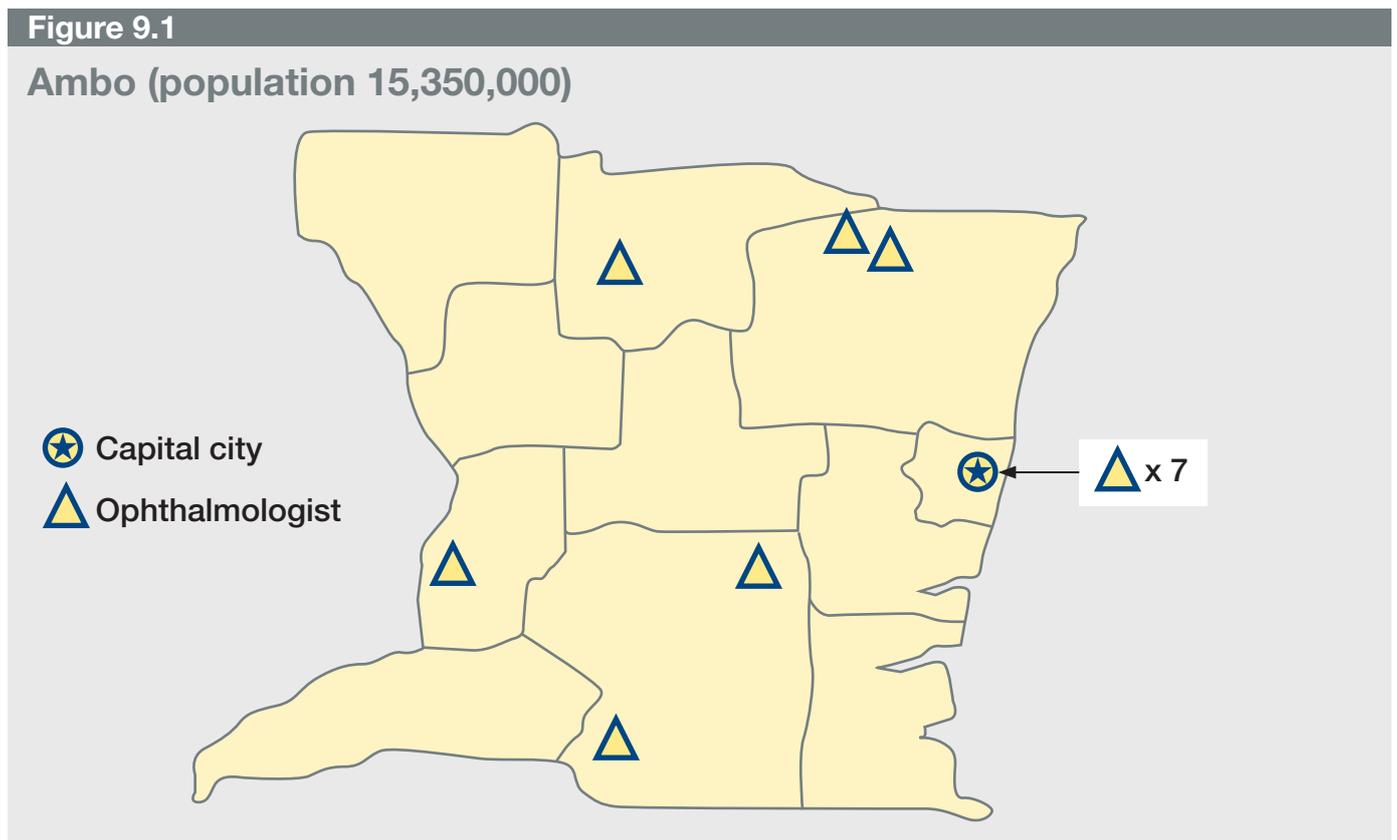
Consider the following case study, which illustrates the steps in developing an advocacy strategy:

Dr. D is the National Eye Health Coordinator of Ambo, a country of 15 million people with limited resources. She is concerned that services are very unevenly distributed in her country. People in the capital can get good service but there are large populations without any eye services. Her job as National Eye Health Coordinator includes advocacy for VISION 2020 priorities. What can she do?

An analysis of the situation reveals the following:

Ambo is divided into 11 administrative districts with 1-2 million in each. Each district has a government hospital and some have NGO hospitals and clinics as well. There are 13 ophthalmologists in the country located as shown in Figure 9.1, some in government practice and some working for NGOs. Dr. D is lucky to have some reliable data from 2 recent surveys in the country, one in the capital city and one in a more remote area with no ophthalmologist. Text Box 9.2 shows findings from the surveys in these 2 districts. There is one university programme in the capital training medical doctors and nurses; this includes ophthalmic nurses but there is no training programme for ophthalmologists.

The problem is apparent from the map and the survey findings. Prevalence of cataract blindness is much higher in the rural district of the country than it is in the capital district. There are almost no services available in 6 districts of the country, and inadequate services in others, while the capital has many ophthalmologists. The goals of VISION 2020 would be much better served by a different distribution of services. Dr D begins to envision a situation where the resources of the country for eye care are both increased and also distributed in a more equitable fashion. This will require some major changes. When change is needed, advocacy is required.



Text Box 9.2**Hypothetical survey findings in people > 50 years from 2 Districts in Ambo**

	Capital district	Rural district
Prevalence blindness	0.9%	3.1%
Causes	Cataract: 42% Posterior seg: 30%	Cataract: 64% Posterior Seg: 15%
Prevalence VI & SVI	3.2%	10.1%
Causes	Cataract: 40% Posterior seg: 20% RE: 10%	Cataract: 65% Posterior seg: 10% RE: 20%
CSC by person at 6/60	78%	35%

How can Dr D help bring about the changes envisioned?

She cannot work alone. It will be important to find allies and build a team. She identifies the stakeholders as Ministry of Health, NGOs, and ophthalmologists.

Dr. D figures that the main stakeholders are all the NGOs working in eye care in the country, a large European ophthalmologic society that wants to help the country, the heads of main referral hospital for each district (whether government or NGO) and the ophthalmologists in the country.

She organises a few one-on-one meetings with members of stakeholder groups that she expects to become allies. At these meetings she reviews the situation and the problem and suggests the need for more equitable distribution of eye health resources. Some of the people are enthusiastic initially but later are too busy for follow up conversations. Dr D persists and after a number of meetings over several months she believes she has a group of committed individuals, representing the key stakeholder groups. Now is the time for them to meet to **plan their advocacy**.

The group gets together and **agrees on an objective**: to ensure a comprehensive eye service in each District of Ambo with an ophthalmologist and proper support structure in each District. This will require that some new resources be identified but it also means they need to re distribute the country's existing resources, particularly the ophthalmologists themselves.

Achieving this objective will require that they bring together diverse groups.

They identify the main ones that will need to be convinced. One member suggests that they include the ophthalmic nursing training programme since this is a powerful programme in the country.

They begin to develop specific messages that they want to get across to each group and discuss the best way to convey these messages. The group begins to formulate an advocacy plan, which looks like the example in Text Box 9.3

Text Box 9.3

Target	Message	Approach	Comments & budget
MoH – high levels	<ol style="list-style-type: none"> 1. Government can influence deployment of scarce human resources through policy 2. MoH needs to sponsor training for more ophthalmologists 	<p>Concise PowerPoint presentation detailing uneven blindness prevalence rates, reasons for this, and need for proactive planning in placement of ophthalmologists. Consider ‘bonding’ after training, or ‘hardship’ pay in rural areas</p> <p>Will help MoH locate funds for more training</p>	<p>One initial meeting. Will require follow up phone calls, memos, meetings</p> <p>No extra funds needed. Arrange meetings between National Eye Health Coordinator and appropriate MoH officials</p>
NGOs	Ophthalmologists will work in rural areas if properly supported	Analysis of what is needed to support an ophthalmologist in a comprehensive district programme. This may be packaged as a proposal left open enough so that an NGO can take a role in designing the strategy	<p>May need to meet some NGOs separately or perhaps can discuss as a group. Can use PowerPoint, proposals, discussion</p> <p>Can be discussed at regular NPBC meeting or ask NGO to come for meeting in capital city</p>
National ophthalmologic society	Work in rural areas can be rewarding	Will enlist help from any successful rural practitioner in the country and NGO who has supported if applicable.	<p>Engage the practitioner first, and then start with one presentation at society meeting</p> <p>Travel and accommodation may be needed</p>
European ophthalmologic society	Support is needed to get national ophthalmologists to work in rural areas	General proposal to build up several rural centres. Leave open enough for partners to contribute ideas	Initial proposal to be developed by National Eye Health Coordinator. Invite speaker from society for annual national meeting?
Head of Ophthalmic nurse training	Ophthalmic nurses need more emphasis on practical skills in order to provide services	Presentations, discussion. Use evidence to show problem and need	Head nurse tutor may need support to travel to relevant MoH offices

Notice that the messages are not the same to every group. Note also that effective advocacy requires long term planning and actions if it is to lead to real changes. ‘One time only’ activities are not enough. The National Eye Health Coordinator and her team will have to engage in a number of meetings and continually follow up until the goal is achieved.

10

Partnership development

Learning objectives

- Understand fundamentals of good partnerships.
- Know how to establish, maintain, and strengthen partnerships

The cornerstone of VISION 2020 is partnership; that is, two or more people or organisations working together to reach the same goal. Achieving VISION 2020 will not be possible without strong partnership between government, NGOs, service clubs, academic centres and individuals dedicated to the prevention of blindness.

What makes good partnerships?

Developing strong partnerships is not easy; it requires that everyone has, as their overriding interest, the needs of the population for high quality and equitable eye care services. Thus, the first step in the development of a partnership is a clear understanding of the mission of organisations. Second, it is important to ask what you want from a partnership. If all that is desired from an organisation is money, equipment, or a building then you are not looking for a partner—you are looking for a donor. Features of strong partnerships are listed in Text Box 10.1.

Partnerships need to occur at multiple levels; there may be partnerships that are primarily at the national level while there may be partnerships that only happen at the district level. This is particularly true in countries where governments have sought to decentralise decision-making. The National Eye Health Coordinator can play an important coordinating role by identifying districts with few partners and encouraging new or existing partners to get involved in planning and supporting these districts.

Text Box 10.1

Features of healthy partnerships

- Sharing of information
- Sharing of credit for goals accomplished or activities done
- Sharing of ideas for improving the services provided
- Honest and respectful interaction
- Frequent communication and reporting
- Sharing of resources (personnel, office space, finances, etc.)

Getting started and building partnerships

Informal meetings are useful when starting new partnerships. During these meetings, the potential partners can establish their areas of interest and start creating a common vision. Depending on how 'formal' the culture is, it may be advisable to have someone external to both organisations provide the introduction, although this is often not necessary. Bear in mind the following points when establishing and building partnerships.

- Partnerships take a long time to build and effort to maintain
- Share documentation of past and current activities. Potential partners need information about your organisation to share within their own organisations

- Partnerships should not be based on financial resources alone
- Partners must recognise that lines of accountability vary among organisations
- Partners should be involved in all major aspects of planning
- Be willing to admit that most of the reasons for poor output are not financial in origin; potential partners should not be viewed as ‘cash cows’
- Share ideas and be willing to let others ‘take the credit’
- Good partnerships do not develop overnight. Persist, even when it appears that there is little interest.

What happens when you have no partners or partnerships fail?

Failing to develop partnerships, being exclusive in partnerships, or favouring some partners over others will often lead to failure of mission—that is, the provision of high quality, equitable eye care services to the people in your country. Egos must be set aside. Failed partnerships in many countries have led to mistrust, duplication of effort, costly or inefficient systems, and frustration. Successful partnerships are not built only on Memorandums of Understanding (MoU) or contracts. Once they are formed they must be maintained and strengthened and the strategies in Text Box 10.2 can help with this.

Text Box 10.2

Strategies for strengthening existing partnerships

- Have a well-functioning NPBC/executive committee
 - Frequent meetings of executive committee
 - Flexible organisation and communication
 - Task Forces (e.g., trachoma, HRD) to deal with technical issues
- Rotate responsibilities (chairing, recording, etc.) between partners
- Always encourage inclusiveness; avoid any exclusiveness
- Frequent reporting and communication
- Celebrate events together (World Sight Day)
- Set dates for meetings well in advance; do not change dates.
- Provide regular reporting (use email) from all activities held (by working groups, etc.) in a timely fashion.
- Open up meetings to all willing to contribute
- Regional and national Task Force should meet with the Regional Medical Officer and Minister for Health periodically (help him/her appreciate the idea of a ‘partnership’)

Exercise

Consider some of the partnerships your organisation is engaged in. How healthy are they according to the criteria in Figure 10.1?

Appendix A

Excerpt taken from the WHO :

ACTION PLAN FOR THE PREVENTION OF AVOIDABLE BLINDNESS AND VISUAL IMPAIRMENT 2009 – 2013

Full document can be found at http://www.emro.who.int/cpb/pdf/action_plan_blindness_prevention_2009_2013.pdf

OBJECTIVES AND ACTIONS – listing only the suggested Member States actions for each of the 5 objectives.

OBJECTIVE 1. Strengthen advocacy to increase Member States' political, financial and technical commitment in order to eliminate avoidable blindness and visual impairment

- International advocacy for the preservation of visual health aims to increase awareness of current blindness-prevention plans, especially the cost-effective interventions available and international experience in their implementation. This advocacy effort should target health-care professionals and policy-makers in order to encourage the intersectoral action needed to improve eye health-care systems, to integrate them in national health systems, and incorporate eye health in broader health-care and development plans. It should also target potential donors and those who set research priorities and funding levels so as to accumulate evidence on prevention of blindness and visual impairment and their impact.
- Further research is needed on the impact of risk factors such as smoking, ultraviolet radiation and lack of hygiene. Inequities in access to eye-care services also need to be further researched.
- Special attention should be paid to raising public awareness and finding appropriate ways of communicating information on prevention of visual loss and ways of treating eye conditions.

Proposed action for Member States

- Establish and support national coordinating mechanisms, such as national coordinators posts for eye health and prevention of blindness at health ministries and other key institutions, as appropriate.
- Consider budgetary appropriations for eye health and prevention of blindness.
- Promote and integrate eye health at all levels of health-care delivery.
- Observe World Sight Day.
- Integrate eye-health preservation in health promotion agendas.

OBJECTIVE 2. Develop and strengthen national policies, plans and programmes for eye health and prevention of blindness and visual impairment

- National policies, plans and programmes for eye health and prevention of avoidable blindness and visual impairment are essential instruments for coordinated, evidence-based, cost-effective, sustainable interventions. Integration of eye health into relevant national health policies, including those relating to school and occupational health, facilitates a coordinated multidisciplinary approach and development of comprehensive eye care, with emphasis on primary eye care.
- Evidence-based WHO strategies for tackling several main causes of avoidable blindness and visual impairment have been designed in order to support the formulation of policies and programmes. Some strategies are already in place for the control of trachoma, onchocerciasis, vitamin A deficiency, diabetic retinopathy and some aspects of cataract-related visual loss, but strategies for emerging major causes of visual loss need to be developed.

Proposed action for Member States

- Where sufficient capacity exists, develop national strategies and corresponding guidelines for the prevention of blindness and visual impairment; otherwise consider adapting those recommended by WHO.
- Review existing policies addressing visual health, identify gaps and develop new policies in favour of a comprehensive eye-care system.
- Incorporate prevention of blindness and visual impairment in poverty-reduction strategies and relevant socioeconomic policies.
- Involve relevant government sectors in designing and implementing policies, plans and programmes to prevent blindness and visual impairment.
- Develop an eye-health workforce including paramedical professionals and community health workers through training programmes that include a community eye-health component.

OBJECTIVE 3. Increase and expand research for the prevention of blindness and visual impairment

- Public-health action to prevent blindness and visual impairment needs to be evidence-based and cost-effective. International collaboration in promoting multidimensional and multisectoral research is essential for developing eye-care systems that are comprehensive, integrated, equitable, high-quality and sustainable. Further research is needed on ways to capitalize on available evidence. Special emphasis should be placed on evaluating interventions and different strategies for early detection and screening of the causes of blindness and visual impairment in different population groups, including children.

Proposed action for Member States

- Promote research by national research institutions on socioeconomic determinants, the role of gender, the cost-effectiveness of interventions, and identification of high-risk population groups.
- Assess the economic cost of blindness and visual impairment and its impact on socioeconomic development.

- Determine the impact of poverty and other determinants on the gradient of socioeconomic disparity in individuals' access to eye-care services.
- Promote participation in, and actively support, existing national and international partnerships and alliances for the prevention of avoidable blindness and visual impairment, including coordination with noncommunicable disease control programmes and neglected tropical disease prevention and control.
- Promote partnerships between the public, private and voluntary sectors at national and subnational levels.
- Include epidemiological, behavioural, health-system and health-workforce research as part of national programmes for eye health and prevention of blindness and visual impairment.

OBJECTIVE 4. Improve coordination between partnerships and stakeholders at national and international levels for the prevention of blindness and visual impairment

- Large international partnerships and alliances have been instrumental in developing effective public health responses for the prevention of blindness and visual impairment. Member States, United Nations agencies, other international institutions, academia, research centres, professional health-care organizations, nongovernmental organizations, service organizations, civil society and the corporate sector are key stakeholders in this process. The challenges are to strengthen global and regional partnerships and to incorporate the prevention of blindness into broader development initiatives that include efforts to establish new intersectoral forms of collaboration and alliances.

Proposed action for Member States

- Promote participation in, and actively support, existing national and international partnerships and alliances for the prevention of avoidable blindness and visual impairment, including coordination with noncommunicable disease control programmes and neglected tropical disease prevention and control.
- Promote partnerships between the public, private and voluntary sectors at national and subnational levels.

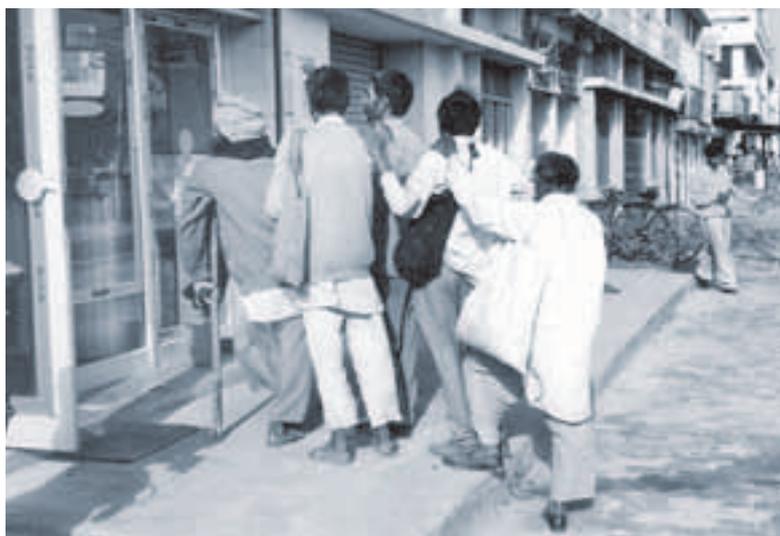
OBJECTIVE 5. Monitor progress in elimination of avoidable blindness at national, regional and global levels

- Information on causes, the magnitude and geographical distribution of blindness and visual impairment, together with their trends, is essential for evidence-based advocacy and planning. Likewise, understanding the constraints and gaps in current service delivery and monitoring how these are corrected by Member States are crucial to successful implementation. Necessary and timely adjustments can only be made on the basis of continuous monitoring and periodic evaluation of action to prevent blindness.

Proposed action for Member States

- Provide regularly updated data and information on prevalence and causes of blindness and visual impairment, disaggregated by age, gender and socioeconomic status.

- Strengthen standardized data collection and establish surveillance systems using existing WHO tools (for example, those used for cataract, trachoma and onchocerciasis).
- Provide regular reports using the WHO standardized reporting system, on progress made in implementing national blindness-prevention strategies and plans.



Commended entries to the *Visions of Children* photo competition 2003

Photo by
Dr G S Bajwa



Photo by
Bjorn Steinz

Working together to eliminate avoidable blindness

The many successes of VISION 2020 have been achieved through a unique, cross-sector collaboration which enables public, private and non-profit interests to work together, helping people to see, all over the world



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