

154th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 16-20 June 2014

Provisional Agenda Item 4.9

CE154/18
2 April 2014
Original: Spanish

PLAN OF ACTION FOR THE PREVENTION OF BLINDNESS AND VISUAL IMPAIRMENT

Introduction

1. According to World Health Organization (WHO) calculations, in 2010 more than 26 million people in the Region of the Americas suffered from a visual impairment. More than 3 million of them were blind and most were over the age of 50. However, nearly 80% of these cases could have been avoided (1). Recent evidence indicates that programs for the prevention of blindness in the Region have reduced the prevalence of blindness and visual impairment. Nevertheless, unoperated cataract remains the leading cause of blindness, with uncorrected refractive error the leading cause of visual impairment (2). Despite the substantial reduction in the prevalence of blindness and visual impairment in the Region and worldwide (3), the burgeoning demand for services from a growing and aging population poses a challenge.

2. In response to these problems, in 2013 the World Health Assembly (WHA) approved the global Action plan for the prevention of avoidable blindness and visual impairment 2014-2019 *Towards universal eye health: a global action plan 2014-2019* (4). The Strategic Plan of the Pan American Health Organization 2014–2019 (5), approved by the Directing Council in 2013, also gives priority to eye health in the context of reducing preventable disability, providing access to rehabilitation services, and promoting better health and living conditions.

3. This Plan of Action for the Prevention of Blindness and Visual Impairment 2014–2019 is the Organization's response to the challenges indicated above, offering concrete action to address the Region's priorities for the prevention of blindness. The Plan of Action 2014–2019 is designed to continue and step up efforts by the Member States, the Pan American Sanitary Bureau, and international partners to continue improving eye health and prevent avoidable blindness and visual impairments.

Background

4. In 2009, seeking to address regional priorities, the Directing Council of the Pan American Health Organization (PAHO), through Resolution CD49.R11, approved the Plan of Action for the Prevention of Avoidable Blindness and Visual Impairment (Document CD49/19) (6). In order to bolster the Member States' political and financial commitment, the PAHO eye health program has generated and utilized evidence on epidemiology and service delivery. It has also prepared documentation on good practices and supported national policy-making, plans, and programs and the improvement of eye health services and systems to achieve universal access to eye health.

5. The global action plan *Towards universal eye health: a global action plan 2014-2019*, approved by the WHA in 2013, urges Member States to: strengthen national efforts by integrating eye health into national health systems, generating evidence, and formulating plans, policies, and other strategies to reduce blindness by 25% by 2019 over the baseline year of 2010 (4).

6. The Strategic Plan of the Pan American Health Organization 2014–2019 (5), approved by the Directing Council in 2013, includes the prevention of visual impairment and blindness as one of its expected outcomes. The proposed Plan of Action for the Prevention of Blindness and Visual Impairment 2014–2019 is an update of the Plan approved by the PAHO Directing Council in 2009 and includes the new commitments established in the WHO Global action plan and the PAHO Strategic Plan 2014–2019. A highly participatory method was used in drafting the Plan, involving input from representatives of the ministries of health of the Americas, who were brought together in a workshop held in Quito, Ecuador, from 23 to 25 April 2013. Input was also received from groups of experts, collaborating centers, and international partners.

Situation Analysis

7. The prevalence of blindness in people of over 50 in Latin America ranges from 1% in urban areas with higher socioeconomic development to over 4% in rural and marginalized areas. The leading cause of blindness is cataract (7), a persistent public health problem in areas neglected by the health systems (8). Other major causes of blindness are diabetic retinopathy and glaucoma (7). In the Caribbean, there is a high incidence of visual impairment; cataract and glaucoma are responsible for 75% of all blindness, and diabetes is a determinant in vision loss (9). Retinopathy of the premature—which occurs in middle-income countries and, increasingly, in epidemic proportions in low-income countries due to less-than-optimal neonatal care (10)—has been identified as a major cause of blindness in the Region (11), the incidence of which varies with the sophistication of neonatal care (12).

8. National programs that receive international technical assistance within the framework of PAHO and WHO plans and resolutions have achieved significant results. Countries that have prepared and implemented a national plan on visual health report

reductions in the prevalence of blindness and visual impairment, along with an increase in service coverage (13). Almost half the countries have conducted a survey on avoidable blindness that yielded information on unmet eye health care needs. Cataract remains the leading cause of blindness, with the greatest burden of disease found in rural and marginalized areas (8). Most of the countries have enough ophthalmologists to meet the needs, but they are unevenly distributed, with a higher concentration of practitioners in the areas with the highest per capita gross domestic product, as already documented in some countries (14).

9. Access to services has improved over the past decade, reflected in a higher average access rate in the Region and higher rates of cataract surgery in the countries (15). By 2012, 19 countries had achieved a cataract surgery rate of 2,000 operations per million population per year (5)—a figure insufficient to control cataract-associated blindness and visual impairment (16). Furthermore, the quality of surgery in the Region is less than optimal (17). In Latin America, there is evidence of gender equity in the coverage provided by cataract surgery services (18).

10. The prevalence of diabetic retinopathy, which can lead to blindness, is higher among Latin Americans than other population groups (19), accounting for up to 16% of cases of blindness at the national level (7). In Barbados, 18% of Afro-descendants aged 40-84 report that they are diabetic; 30% of people with diabetes develop diabetic retinopathy, and 1% suffer from proliferative diabetic retinopathy with a very high risk of blindness (20). To date, five Member States have completed a situation analysis of diabetic retinopathy services as the basis for future interventions.

11. The prevalence of glaucoma in Latin America ranges from 1% to 3.4% in people over the age of 50 and represents 15–20% of the causes of blindness in countries with higher numbers of Afro-descendants (7). The prevalence of open-angle glaucoma in the Caribbean is above 7% in people over 40 (9); this is a major cause of vision loss and the leading cause of irreversible blindness (20). In 2013, nine countries having glaucoma information, communication, and education programs in place; notwithstanding, glaucoma surgery rates in the Region remain very low (21).

12. With the increasing survival of premature infants in the Region, efforts have been made to establish programs for the prevention, detection, and treatment of retinopathy of the premature (10); the impact of these interventions in the countries is already being seen in a reduction of blindness from this cause (22). In 2013, nine countries had national policies to prevent blindness from retinopathy of the premature, while 22 reported that they had programs in place, since it is recognized that the burden of blindness on society far exceeds the cost of treating it (23). An estimated 7% of schoolchildren in Latin America may need corrective lenses (24). Currently, most of the countries of the Region have programs to correct refractive error in schoolchildren; however, some studies show poor treatment adherence (25).

13. A person has low visual function when, despite surgery or corrective lenses, he or she does not achieve optimal vision but is still potentially capable of completing a task with that level of vision. It is estimated that nearly 2% of adults over 50 have low visual function requiring treatment, special optical aids, or rehabilitation. Certain infectious diseases, such as trachoma and onchocerciasis, are not major causes of blindness in the Region (7) and are addressed by the PAHO neglected infectious diseases program; as a result, they are not considered in this Plan of Action.

Proposal

14. The general objective of the Plan is to reduce avoidable visual impairment as a public health problem and guarantee access to rehabilitation services for the visually impaired. The purpose of the Plan of Action is to achieve the general objective through improved access to comprehensive eye health services in health systems, thereby contributing to the achievement of outcome 2.4 and indicator 2.4.2 of the PAHO Strategic Plan 2014-2019. The Plan proposes generating evidence to heighten the political and financial commitment to eye health, boost the capacity of the services, and improve the leadership and governance of the ministries of health through policy-making, plans, and standards as they exercise their supervisory role and mobilize stakeholder participation.

15. The Plan's objectives are a combination of treatment, promotion, prevention, and rehabilitation, focusing on populations neglected by the health systems and taking a life course approach that emphasizes premature infants, schoolchildren, and adults over 50 years of age—the population most at risk of losing vision. Activities will be carried out through interprogrammatic cooperation: the cataract program will work with the program on older adults; the program on retinopathy of the premature with that of the Latin American Center for Perinatology's Women and Reproductive Health unit (CLAP/WR); and the program on the management of diabetic patients with the program on noncommunicable diseases.

Strategic Line 1: Health authority governance of visual health

16. Governance is achieved through the generation and use of evidence, documenting the epidemiological situation through population surveys and studies on access, the quality of service delivery, and good practices and through the development of eye health plans, policies, and programs. Eye health should be included in national health systems throughout the life course in neonatal care, school health, family health, chronic disease, and older adult health programs, as well as in primary health care. National strategies and plans should be updated periodically, based on a situation analysis and the use of the progress indicators of the information systems. In order to monitor the implementation of policies, plans, and programs, it is recommended that a national coordinator or an eye health committee be appointed to galvanize multisectoral participation and partnerships for national and international collaboration.

17. The Bureau will promote research and the generation of evidence to guide eye health policy and provide tools and technical assistance to conduct population surveys; service evaluations, and studies of good practices; to develop, implement, and monitor national and subnational policies, plans, and programs; and integrate national eye health indicators and goals into national health and information systems. It may also support and foster national, sectoral, and intersectoral policy dialogue, as well as cooperation among countries. International partners will assist the countries and the Bureau, identify and contribute additional resources, produce educational materials, and organize regional and national workshops for training and the sharing of experiences.

Objective 1.1: Increase the epidemiological and service-related data used to strengthen and support the Member States' political and financial commitment to eye health.

Indicators:

- 1.1.1 Number of population studies conducted by the Member States on the prevalence of visual impairments.
(Baseline: 18 in 2014. Target for 2019: 24 completed and published)
- 1.1.2 Number of countries that have completed and published an evaluation of eye health services.
(Baseline: 3 in 2014. Target for 2019: 10)

Objective 1.2: Develop, update, implement, and monitor national and subnational policies and plans to achieve universal eye health during the life course by strengthening health systems.

Indicators:

- 1.2.1 Number of Member States that submit annual reports on the implementation of eye health policies, plans, and programs.
(Baseline: 17 in 2014. Target for 2019: 25)
- 1.2.2 Number of Member States that have a national coordinator or have formed a blindness prevention committee that actively monitors the implementation of eye health policies and plans.
(Baseline: 14 in 2014. Target for 2019: 20)
- 1.2.3 Number of Member States that report on the integration of eye health into national health plans and budgets.
(Baseline: 0 in 2014. Target for 2019: 15)
- 1.2.4 Number of Member States that report that their national lists of essential drugs, diagnostic tests, and health technologies include sections on eye health.
(Baseline: 0 in 2014. Target for 2019: 10)

Strategic Line 2: Available, accessible, attainable, quality eye health services for the entire population

18. Universal eye health means that everyone who needs quality services receives them. This means that the services should be located close to where people live; that adequate facilities, human resources, inputs, and products are available; that costs are not a barrier to users; and that services are high-quality and efficient. The Member States should search for mechanisms to equitably distribute human resources at the subnational level by decentralizing eye health services to regional hospitals, strengthening primary eye care, and maintaining standards of quality.

19. There is an urgent need to strengthen managerial and administrative processes in public eye health services to improve their quality, effectiveness, and efficiency, and also to make cataract surgery a reportable event in national information systems and annual reports. The Bureau will provide technical know-how and support to improve eye health services, as well as strategies to strengthen supervision and performance evaluation. It will also promote the adoption of quality standards and the inclusion of eye health in information systems to monitor and measure progress. International partners will furnish technical support and training and compile information.

Objective 2.1: Create and maintain a trained, productive workforce that is equitably distributed at the national and subnational level.

Indicators:

2.1.1 Number of countries that have conducted periodic evaluations of the availability of eye health care personnel at the subnational level.
(Baseline: 1 in 2014. Target for 2019: 15)

2.1.2 Number of countries that report having a national plan for training human resources specializing in eye health and assigning them to areas and populations neglected by health systems.
(Baseline: 0 in 2014. Target for 2019: 10)

Objective 2.2: Strengthen the organizational capacity of public eye health services to provide efficient, affordable, high-quality eye care services.

Indicator:

2.2.1 Number of Member States that have established a program to strengthen public eye health care services that is consistent with the protocol established by PAHO.
(Baseline: 3 in 2014. Target for 2019: 12)

Objective 2.3: Include eye health indicators in national information systems in order to monitor the delivery and quality of eye health care services.

Indicator:

- 2.3.1 Number of Member States that include cataract surgery in their national information systems.
(Baseline: 1 in 2014. Target for 2019: 7)

Strategic Line 3: Reduce blindness and visual impairment in adults

20. In order to reduce blindness in adults, the Member States should strengthen the primary eye care system's capacity to detect and refer people over 50 with visual impairments, motivate diabetic patients to have an annual retina examination, and patients over 40 with risk factors for glaucoma to have periodic eye examinations. In order to shorten waiting lists, high-volume, high-quality centers for cataract surgery should be set up to deal with most of the cases; eye health care should be decentralized, with cataract surgery services in the regional hospitals. All cataract surgery services should establish a surgical quality and productivity system. Depending on the demographics of each country, annual cataract surgery rates should range from 3,400 to 9,000 per million population (16); current rates in many countries in the Region remain below 2,000 per million.

21. Laser treatment slows or prevents the progression of diabetic retinopathy in 90% of cases; the detection and management of diabetic retinopathy should therefore be part of comprehensive care for diabetic patients. Eye health services for the diagnosis and treatment of diabetic retinopathy and glaucoma should be strengthened; moreover, the drugs for treating these conditions should be added to the list of essential drugs. Campaigns should be launched to educate the population with risk factors through the primary care system and the media. The Bureau will provide cooperation and, jointly with the ministries of health and international partners, prepare standardized models for procedures, technology, human resource training, management, and research and assist countries with data collection, analysis, and publication. International partners will develop educational materials and training programs for human resources and provide assistance to identify and procure the appropriate technology.

Objective 3.1: Reduce blindness and visual impairment caused by cataract through greater cataract surgery coverage for all segments of the population and adherence to quality standards.

Indicator:

- 3.1.1 Number of countries that have a cataract surgery rate above 2,000 per million population per year.
(Baseline: 19 in 2014. Target for 2019: 27)

Objective 3.2: Reduce the prevalence of blindness from diabetic retinopathy through metabolic control, early detection in asymptomatic at-risk individuals, and timely, appropriate treatment.

Indicators:

- 3.2.1 Number of countries that have prepared a situation analysis of their diabetic retinopathy services.
(Baseline: 5 in 2014. Target for 2019: 11)
- 3.2.2 Number of countries that report having health care models that include programs for the early detection and timely treatment of diabetic retinopathy as part of comprehensive diabetes care.
(Baseline: 0 in 2014. Target for 2019: 7)

Objective 3.3: Reduce the incidence of blindness from open-angle glaucoma through detection and treatment, especially in high-risk groups such as Afro-descendants, the Caribbean population, adults over 40, and people with a family history of glaucoma.

Indicators:

- 3.3.1 Number of countries with programs to raise community awareness about glaucoma.
(Baseline: 9 in 2014. Target for 2019: 15)
- 3.3.2 Number of countries that report an increase in the glaucoma surgery rate.
(Baseline: 0 in 2014. Target for 2019: 7)

Objective 3.4: Reduce visual impairment through the detection and treatment of uncorrected refractive error and presbyopia in adults.

Indicator:

- 3.4.1 Number of countries that include detection and treatment of presbyopia in adults in their national plans for both eye health and older adults.
(Baseline: 0 in 2014. Target for 2019: 10)

Strategic Line 4: Reduce blindness and visual impairment in children

22. In order to reduce the incidence of blindness in children, programs must be developed to improve the quality of neonatal care and the prevention, detection, and treatment of retinopathy of the premature through compliance with international standards, guidelines, and protocols at all levels of neonatal care. Human resources, procedures, quality of care, equipment, and the coordination of work in neonatal intensive care units must also be strengthened. To ensure quality, surveillance and monitoring systems based on neonatal care, information systems must be developed, and optimal care standards included in the certification criteria for neonatal units

23. Effective visual health programs for schoolchildren are long-term intersectoral programs that are part of school health programs and follow protocols to improve the effective, correct use of glasses—which should be both available and affordable. The

Bureau will take action to promote the inclusion of retinopathy in neonatal care program, along with human resources development and the implementation of regional guidelines for neonatal and eye health care. It will also conduct research and generate evidence to boost the effectiveness of programs on refractive error in schoolchildren and facilitate intersectoral dialogue between the health and education sectors. International partners will identify new tools for developing programs such as the use of telemedicine for diagnosis and of drugs to treat retinopathy of the premature; they will also produce training and educational materials and provide training courses and workshops for human resources.

Objective 4.1: Reduce blindness from retinopathy of prematurity through the prevention of premature births, optimal neonatal care, and timely detection and treatment, which can prevent over half the cases of blindness in children from this cause.

Indicator:

- 4.1.1 Number of Member States implementing a national policy on the prevention of retinopathy of the premature.
(Baseline: 9 in 2014. Target for 2019: 14)

Objective 4.2: Reduce visual impairment through the detection and treatment of uncorrected refractive error in schoolchildren and adolescents through effective screening and management programs.

Indicator:

- 4.2.1 Number of Member States with effective models of intersectoral visual health programs for schoolchildren, in keeping with the standards promoted by PAHO.
(Baseline: 1 in 2014. Target for 2019: 7)

Strategic Line 5: Reduce the burden of blindness and low visual function in all age groups

24. Strategies to address low visual function and blindness can be strengthened through national partnerships between the health sector and the legislative and education sectors, in keeping with the human rights instruments applicable to health and disability. Care should be improved by including low visual function in health, social security, and information systems. It can also be accomplished by training multidisciplinary teams, prioritizing areas that lack services and facilitating the procurement of optical aids, while making the provisions of the human rights instruments applicable to health and disability part of the learning tools. Ministries of education should be encouraged to offer educational programs that include children and rehabilitation (adaptation to blindness) for adults with visual impairments, in keeping with the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities.

25. The Bureau will promote the inclusion of low visual function in the ICD-10 review and evaluate the status of visual rehabilitation services and education for people with low vision or blindness in the Region. It will also advocate for the development of policies, plans, and legislation based on the Convention on the Rights of Persons with Disabilities to promote inclusive education and rehabilitation programs. International partners will train human resources and promote activities related to low vision among ophthalmologists and optometrists and the inclusion of this topic in the educational curriculum for visual health professionals. They will also promote the creation of regional training centers and establish a procurement system designed to make low vision aids affordable.

Objective 5.1: Provide comprehensive care and services to people with low visual function through comprehensive clinical eye care, specialized low vision care with optical aids, rehabilitation, and educational services.

Indicators:

- 5.1.1 Number of countries that have services to treat low visual function by 2019.
(Baseline: 21 in 2014. Target for 2019: 25)
- 5.1.2 Number of countries that include the subject of low visual function in the ophthalmology residency curriculum and certification examinations for ophthalmologists and optometrists.
(Baseline: 1 in 2014. Target for 2019: 7)

Objective 5.2. Ensure that people with blindness and visual impairments have access to rehabilitation programs and opportunities for education, in keeping with universal and regional human rights instruments such as the Convention on the Rights of Persons with Disabilities.

Indicator:

- 5.2.1 Number of Member States that have drafted and/or amended legislation and national plans to promote inclusive education for children with visual impairments, in keeping with the Convention on the Rights of Persons with Disabilities and the Convention on the Rights of the Child, by 2019.
(Baseline: 10 in 2014. Target for 2019: 15)

Evaluation and Monitoring

26. The achievements of the present Plan can be measured by indicators that have a baseline and a target for 2019—the final year of the Plan. Data collection will be based on the national information systems and on other methods that have been used with the Member States, trade associations, scientific associations, and national visual health committees that respond annually to a PAHO questionnaire. Monitoring and analytic reports will be submitted at the end of each biennium to PAHO’s Executive Management and, in 2019, a report will be prepared for the Organization’s Governing Bodies.

Financial Implications

27. The total estimated cost of implementing the resolution over its lifecycle from 2014 to 2019, including expenses for staffing and activities, is US\$ 1.7 million,¹ US\$ 1.4 million of which corresponds to PAHO and \$300,000 to the associated entities.

Action by the Executive Committee

28. The Executive Committee is requested to approve the Plan of Action for the Prevention of Blindness and Visual Impairment 2014–2019 and to consider the corresponding proposed resolution (Annex A).

Annexes

References

1. World Health Organization. Global data on visual impairments 2010 [Internet]. Geneva: WHO; 2012 (Document WHO/NMH/PBD/12.01) [consulted 25 November 2013]. Available at: <http://www.who.int/blindness/GLOBALDATAFINALforweb.pdf>
2. Leasher J, Lansingh V, Flaxman S, Jonas J, Keeffe J, Naidoo K, Pesudovs K, Price H, Silva JC, White R, Wong T Y, Resnikoff S, Taylor H, Bourne R. Prevalence and causes of vision loss in Latin America and the Caribbean: 1990-2010. *Br J Ophthalmology* 2014;98(5):619-628. doi:10.1136/bjophthalmol-2013-304013
3. Stevens GA, White RA, Flaxman SR, Price H, Jonas JB, Keeffe J, Leasher J, Naidoo K, Pesudovs K, Resnikoff S, Taylor H, Bourne RR; Vision Loss Expert Group. Global prevalence of vision impairment and blindness: magnitude and temporal trends, 1990-2010. *Ophthalmology* 2013 Dec;120(12):2377-2384.
4. World Health Organization. Draft action plan for the prevention of avoidable blindness and visual impairment 2014-2019. Towards universal eye health: a global action plan 2014–2019 [Internet]. Sixty-sixth World Health Assembly; 20–28 May 2013; Geneva (Switzerland). Geneva: WHO; 2013 (Document A66/11) [consulted 25 November 2013]. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_11-en.pdf

¹ Unless otherwise indicated, all monetary figures in this report/document are expressed in United States dollars.

5. Pan American Health Organization. Strategic Plan of the Pan American Health Organization 2014–2019 [Internet]. 52nd PAHO Directing Council, 65th session of the WHO Regional Committee for the Americas; 30 September–4 October 2013; Washington, D.C. Washington, D.C.: PAHO; 2013 (Official Document 345) [consulted 25 November 2013]. Available at: http://www.paho.org/hq/index.php?option=com_content&view=article&id=8833&Itemid=40033&lang=en
6. Pan American Health Organization. Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment [Internet]. 49th PAHO Directing Council, 61st session of the WHO Regional Committee for the Americas; 28 September–2 October 2009; Washington, D.C.: PAHO; 2009 (Document CD49/19) [consulted 25 November 2013]. Available at: <http://www2.paho.org/hq/dmdocuments/2009/CD49-19-e.pdf>
7. Furtado JM, Lansingh VC, Carter MJ, Milanese MF, Peña BN, Ghersi HA, Bote PL, Nano ME, Silva JC. Causes of Blindness and Visual Impairment in Latin America. *Surv Ophthalmol* 2012 Mar-Apr; 57(2):149-177.
8. Limburg H, Silva JC, Foster A. Cataract in Latin America: findings from nine recent surveys. *Rev Panam Salud Publica* 2009 May; 25(5):449–455.
9. Leske C, Wu SY, Nemesure B, Hennis A, and Barbados Eye Studies Group. Causes of visual loss and their risk factors; an incidence summary from the Barbados Eye Studies. *Rev Panam Salud Publica* 2010 Apr;27(4):259-267.
10. Zin, A, Gole GA. Retinopathy of prematurity-incidence today. *Clin Perinatol* 2013 Jun;40(2):185-200
11. Gilbert C, Fielder A, Gordillo L, Quinn G, Semiglia R, Visintin P, Zin A; International NO-ROP Group. Characteristics of infants with severe retinopathy of prematurity in countries with low, moderate, and high levels of development: implications for screening programs. *Pediatrics* 2005 May;115(5):e518-525.
12. Carrion JZ, Fortes Filho JB, Tartarella MB, Zin A, Jornada Jr ID. Prevalence of retinopathy of prematurity in Latin America. *Clin Ophthalmol* 2011;5:1687-1695.
13. Duerksen R, Limburg H, Lansingh V, Silva JC, Review of blindness and visual impairment in Paraguay: changes between 1999 and 2011. *Ophthalmic Epidemiology* 2013 Oct; 20(5): 301–307.
14. Carvalho Rde S, Diniz AS, Lacerda FM, Mello PA. Gross domestic product (GDP) per capita and geographical distribution of ophthalmologists in Brazil. *Arq Bras Oftalmol* 2012 Nov-Dec;75(6):407-411.

15. Lansingh VC, Resnikoff S, Tingley-Kelley K, Nano ME, Martens M, Silva JC, Duerksen R, Carter MJ. Cataract surgery rates in Latin America: a four-year longitudinal study of 19 countries. *Ophthalmic Epidemiol* 2010 Mar;17(2):75-81.
16. Lewallen S, Perez-Straziota C, Lansingh V, Limburg H, Silva JC. Variation in cataract surgery needs in Latin America. *Arch Ophthalmol* 2012 Dec; 130(12): 575-1578.
17. Limburg H, Barria von-Bischhoffshausen F, Gomez P, Silva JC, Foster A. Review of recent surveys on blindness and visual impairment in Latin America. *Br J Ophthalmol* 2008 Mar;92(3):315-319.
18. Carter MJ, Limburg H, Lansingh VC, Silva JC, Resnikoff S. Do gender inequities exist in cataract surgical coverage? Meta-analysis in Latin America. *Clin Experiment Ophthalmol*. 2012 Jul;40(5):458-466.
19. Sivaprasad S, Gupta, B, Crosby-Nwaobi R, Evans J. Prevalence of diabetic retinopathy in various ethnic groups: a worldwide perspective. *Surv Ophthalmol* 2012 Jul-Aug;57(4):347-370.
20. Pan American Health Organization. Health Services Organization Series: Eye Diseases in People 40-84. The Barbados Eye Studies: A Summary Report. Washington, D.C.: PAHO; 2006. (Document THS/OS/06).
21. Mansouri K, Medeiros F & Weinreb R. Global rates of glaucoma surgery. *Graefes Arch Clin Exp Ophthalmol* 2013 Nov;251(11):2609-2615.
22. Gordillo L, Villanueva AM, Quinn GE, A practical method for reducing blindness due to retinopathy of prematurity in a developing country. *J Perinat Med* 2012 Sep 4;40(5):577-582.
23. Dave HB, Gordillo L, Yang Z, Zhang MS, Hubbard GB, Olsen TW. The societal burden of blindness secondary to retinopathy of prematurity in Lima, Peru. *Am J Ophthalmol* 2012 Oct;154(4):750-755.
24. Maul E, Barroso S, Muñoz S, Sperduto R, Ellwein L. Refractive error study in children: results from La Florida, Chile. *Am J Ophthalmol* 2000 Apr; 129(4): 445-454.
25. Castanon Holguin AM, Congdon N, Patel N, Ratcliffe A, Estes P, Toledo Flores S, Gilbert D, Pereyra Rito MA, Munoz B. Factors associated with spectacle-wear compliance in school-aged Mexican children. *Invest Ophthalmol Vis Sci* 2006 Mar;47(3):925-928.

154th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 16–20 June 2014

CE154/18
Annex A
Original: Spanish

PROPOSED RESOLUTION

PLAN OF ACTION FOR THE PREVENTION OF BLINDNESS AND VISUAL IMPAIRMENT

The 154th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the proposed *Plan of Action for the Prevention of Blindness and Visual Impairment* (Document CE154/18)

RESOLVES:

To recommend that the 53rd Directing Council adopt a resolution written in the following terms:

The 53rd DIRECTING COUNCIL,

Having reviewed the *Plan of Action for the Prevention of Blindness and Visual Impairment* (Document CD53/__);

Observing that visual impairment is a major problem in the Region associated with poverty and social marginalization;

Aware that the majority of the causes of blindness are avoidable and that current treatments are among the most successful and cost-effective of all health interventions;

Appreciating the efforts of the Member States in recent years to prevent avoidable blindness but aware of the need to consolidate the achievements;

Recalling Directing Council Resolution CD47.R1 (2006), *Disability: Prevention and Rehabilitation in the Context of the Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health and Other Related Rights*,

RESOLVES:

1. To approve the *Plan of Action for the Prevention of Blindness and Visual Impairment 2014-2019*.
2. To urge the Member States to:
 - a) strengthen national initiatives to prevent avoidable visual impairments through better integration of eye health into national health plans and the delivery of health services, among other actions, as appropriate;
 - b) implement the actions proposed in the Plan of Action 2014–2019, in keeping with national priorities and universal access to services;
 - c) consider the related budgetary implications;
 - d) promote partnerships among the public sector, nongovernmental organizations, the private sector, civil society, and communities in programs and activities geared to the prevention of blindness;
 - e) promote cooperation among countries in the prevention and treatment of blindness and visual impairment;
 - f) protect the human rights of persons with disabilities and update laws on disability, as appropriate, adapting them to the applicable regulations and international standards.
3. To request the Director to:
 - a) support implementation of the Plan of Action 2014–2019 in order to maintain and strengthen collaboration between the Pan American Sanitary Bureau and the Member States in the prevention of blindness;
 - b) provide technical assistance to the Member States for implementing the measures proposed in the Plan of Action for the Prevention of Blindness and Visual Impairment 2014-2019, in keeping with national priorities and the universal and regional human rights instruments applicable to health and disability;
 - c) support implementation of the Plan of Action for the Prevention of Blindness and Visual Impairment 2014-2019, especially with respect to the inclusion of universal and equitable access to services;
 - d) continue to prioritize the prevention of avoidable blindness and consider the possibility of allocating resources for implementing the Plan of Action for the Prevention of Blindness and Visual Impairment 2014-2019;
 - e) promote technical cooperation among countries and forge strategic partnerships to carry out activities for the protection of eye health.



Report on the Financial and Administrative Implications of the Proposed Resolution for PASB

1. Agenda item: 4.8 – Plan of Action for the Prevention of Blindness and Visual Impairment

2. Linkage to Program and Budget 2014-2015:

a) Categories:

- Chronic noncommunicable diseases
- Determinants of health and promoting health throughout the life course

b) Program areas and outcomes:

- Program area: Disabilities and Rehabilitation.
- OCM 2.4: Increased access to social and health services for people with disabilities, including prevention.
- Program area: Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health.
- OCM 3.1: Increased access to interventions to improve the health of women, newborns, children, adolescents, and adults.
- Program area: Aging and Health.
- OCM 3.2: Increased access to interventions for older adults to maintain an independent life.

3. Financial implications:

a) Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US\$ 10,000, including staff and activities): US\$ 1.7 million.

b) Estimated cost for the 2014-2015 biennium (estimated to the nearest US\$ 10,000, including staff and activities): US\$ 600,000.

c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? The Bureau has internal human resources in all the identified areas; furthermore, some activities under this initiative are also included in the PAHO Strategic Plan 2014-2019.

4. Administrative implications:

a) **Indicate the levels of the Organization at which the work will be undertaken:** This work will be carried out at all levels of the Organization—country, subregional, and regional.

b) **Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):**

N/A.

c) **Time frames (indicate broad time frames for the implementation and evaluation):**

The proposed resolution covers the period 2014–2019 and requires effort and commitment on the part of all the Member States and the Pan American Sanitary Bureau.

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. **Agenda item:** 4.8 – Plan of Action for the Prevention of Blindness and Visual Impairment
2. **Responsible Unit:** Family, Gender, and Life Course (FGL/HL)
3. **Preparing officer:** Dr. Juan Carlos Silva
4. **List of collaborating centers and national institutions linked to this Agenda item:**
FIOCRUZ Collaborating Center for the Prevention of Childhood Blindness, Rio (Brazil)
5. **Link between Agenda item and Health Agenda for the Americas 2008-2017:**
 - Increasing social protection and access to quality health services.
 - Reducing the risk and burden of disease.
6. **Link between Agenda item and the PAHO Strategic Plan 2014-2019:**
Prevention of blindness is related directly to categories 2, 3, and 4 of the PAHO Strategic Plan 2014-2019:
Category 2: Noncommunicable diseases and risk factors
Category 3: Determinants of health and promoting health throughout the life course
Category 4: Health systems
7. **Best practices in this area and examples from countries within the Region of the Americas:**
 - Generate data and evidence on epidemiological issues, services, and good practices.
 - Collaborate with the Member States in the implementation of national plans and policies on eye health, and participate in the evaluation of achievements.
 - Establish and maintain national and international strategic partnerships.
 - Include eye health in other health issues such as neonatal health.
8. **Financial implications of this Agenda item:**
 - The total cost of the proposed resolution for the implementation of the plan over a five-year period (2014-2019) is US\$ 1.7 million.
 - The estimated cost for the biennium 2014-2015 is approximately US\$ 680,000.
