# PROPOSAL FOR IMPROVING PRIMARY EYE HEALTH EDUCATION, CARE AND TREATMENT IN CHILDREN OF TRIBAL AREAS (TRIEYE) THREE ITDAs OF AP

OBJECTIVES

Paramahansa Yogananda Netralaya (PYN) of The Divine Eye Foundation (DEF), Vemagiri objective is to improve and enhance the Comprehensive Eye Care services for children in the tribal communities (TRIEYE). We propose to do this by applying novel solutions that take advantage of developments in harnessing appropriate technology and ITDA presence. Our strategy is to use apt technology to provide effective early medical intervention, deliver expert eye health care, and minimize the inconvenience caused to children from poor logistics and long travel time. An equally important role of Divine Eye Foundation is to provide child eye health education emphasizing prevention.

# OVERVIEW

The long-term goal of DEF has been to provide eye health care to children of tribal communities through ITDAs. However, even with long years of work, these agencies have not been successful for a variety of reasons that include lack of decent facilities, equipment for performing even simple tests, etc. Even more important is a social reality: there just are not enough trained and qualified eye care team to adequately serve the entire tribal populations. Since we believe that the dearth of eye care team willing to practice in tribal areas and their reluctance to travel to, let alone live in, remote areas will continue to exist for a long time to come, we have incorporated this reality into our planning from the start as described in this proposal.

Our plan, therefore, is to increase the effectiveness of eye care team who are willing to work in tribal areas by a large factor. This can be accomplished by reducing the need for specialists in the initial screening of patients, and by allocating eye care team for every Mandal. Simultaneously; we plan to make working of health teams at ITDAs more attractive and satisfying.

The result of non-functioning health system has been that, in many cases, children eye diseases are not diagnosed in their early stages nor treated. The tribal children has to often travel to semi /urban areas when they can no longer bear the suffering caused by the disease, thus increasing the load on hospitals in urban areas and ending up with serious complications that, in many cases, could have easily been treated at their early stages. The need to rectify this problem has become critical especially given the fact that over 25% children live in tribal areas across the three Districts with poor awareness of children eye health issues.

# Main objectives are:

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# To facilitate elimination of avoidable blindness among tribal children as part of our mission of Universal Eye Health and more specifically “Make Vision Count “

**Offer primary eye care services to children(65000) through community Education, Training and Conduct of camps in the cluster of schools and major habitations in tribal Mandals of East , West and Vishaka Districts**

**Extending diagnostic and curative services – Pediatric Cataract, squint, Refractive Errors and other eye problems at our secondary eye hospital at Vemagiri**

**OUR MISSION:**

To give the gift of sight to all individuals suffering from avoidable blindness by delivering dedicated and cost effective eye care in a caring and serene atmosphere

# OBJECTIVES SET OUT BY DEF:

* Since 80% of blindness in India is because of cataract and uncorrected refractive errors, DEF provides this service as a priority
* To work as a team in mission mode with a laser sharp focus - to eliminate avoidable blindness to a level that it ceases to be a public health problem for our citizens residing in our 13 districts in AP.
* Providing comprehensive eye care services to over 500 villages treating annual OPD of 60000 and performing over 15000 surgeries each year.
* The outreach eye screening camps for Children and adults in villages and school screening camps for children are special and on a regular basis.

At the primary level, DEF will play two equally important roles: First, primary diagnosis of eye diseases for children based on symptoms and simple tests, and their treatment either at our base hospital or through referral to Centres of Excellence. Second, Eye health education and Training leading to prevention of eye diseases, especially cataract and refractive errors

The District Administrations of East and West Godavari and Vishaka ITDAs in the government have shown keen interest in finding NGO partners like DEF by designating it as Nodal Agency for Tribal Eye Care (TRIEYE) to revitalize the tribal eye care work. To this end The Divine Eye Foundation, in collaboration with the Government of AP, has initiated a project involving ITDA teams in various Districts. The goal of this is to build ITDAs on the existing “infrastructure” and “Manpower” in Tribal Areas, make them functional and enhance their capability. The Divine Eye Foundation will coordinate and manage this proposed project as a partner with ITDA.

# STEPS IN THE PROCESS:

* + Community mobilization through network of NGOs for Comprehensive Children Eye Care
  + Conduct complete Community Out Reach –Eye Health Awareness with help of tailor made IEC
  + Training of Master Trainers (MTs) among Teachers on Primary Eye Care.
  + Developing a great pool of Teachers as Primary Eye Care –Givers (PECs) to undertake preliminary Eye Screening Camps for School Children
  + Conducting Focused Camps for Referred School Children (RSC)-84 camps in a year in three districts
  + Optical and Pharmacy Services
  + Serving Out Patient and Inpatients in base hospital with provision of clinical services with newly established Pediatric Ophthalmology Department at DEF
  + Sub Specialty Ophthalmic Care and other special support services at the Center of Excellence like LEVPEI

# HEALTH EDUCATION AND EYE DISEASE PREVENTION

*ENHANCING THE CAPABILITIES OF THE TEACHERS IN EYE CARE AMONG CHILDREN*

Tribal children face many very serious eye problems. Notable amongst them are pediatric Cataract, **strabismus** , refractive errors, squint, congenital cataract, amblyopic, nutritional deficient and other chronic infections.

One cannot expect to upgrade the tribal children’s eye health without simultaneously making an impact on these issues, and vice versa. We will, therefore, train and empower the staff- the teachers at the ITDA to spread awareness on some of these issues, build trust within the community, and to take a holistic approach to children eye health care.

Using the participatory processes, relevant training and educational material and specific eye health instructions will be periodically shared at all ITDA locations and the status of various educational programs will be monitored.

The first step is to **train Masters Trainers among Teachers** who in turn shall train all teachers as Primary Eye Care Catalysts (PECs)

Each Two Member Teachers Team- as Primary Eye Care Catalysts (PECs), from each school under the guidance of a Master Trainer and Faculty of DEF perform initial screening of children. We anticipate that a trained Master Trainer will be shared between 8-10 schools in a given area. Training of these Teachers in the novel eye care technology and in the holistic approach we are proposing will be extensive and continuous, and their performance will be monitored constantly.

In addition to the primary eye testing capability, the Duo Teacher Team shall offer history of all eye patients and refer them to DEF if found necessary to evaluate possible causes based on the symptoms displayed or the description given by the patient. Then DEF will incorporate the medical history in making the further probable diagnosis. In addition, based on this diagnosis, it will also prescribe medicines for minor eye illnesses or glasses for Refractive Errors, which will be supplied by ITDA at cost to the DEF. In cases of probable major illnesses will propose a future course of action—further tests and possibly a visit to our Base Hospital. We anticipate that the majority of cases will be handled at the camp level of DEF, thus drastically cutting down the burden placed on hospitals and doctors.

Children visiting DEF camps will also be provided eye health education by the staff through posters and through audio-visual demonstrations. Providing information and help with awareness on eye diseases will be a key role of the ITDA and DEF staff. Community programs and Mobilization for which we shall form collaborations with Non-Governmental Agencies (NGOs) and social workers will supplement these activities.

We plan to connect each ITDA school to its assigned Camp. Over a three -year time frame we propose to connect all schools through to a central coordination/support centre of DEF. The central facility will then be able to collect and update the data

from all schools within its jurisdiction, and perform pattern detection thereby predicting and exposing widespread eye health problems in their early stages.

As a final step in teachers as Primary Eye Care Catalysts (PECs), we anticipate enhancing the diagnostic capability of Teachers through off line and on line consultations wherein the patient (through the PHC) will access an eye care specialist from DEF.

# COMMUNITY INVOLVEMENT FOR IDENTIFICATION OF TRIBA CHILDREN WITH EYE PROBLEMS

For the DEF/ITDA to be effective Service Providers, people have to believe that the DEF /ITDA are there to serve them and to provide value. To facilitate this we plan to involve the local population mostly the CBOs, Village Leaders, Government Staff in the operation and in the community outreach programs particularly the Camps (see the brief below). We also plan to encourage cultural activities, self-help programs, and Eye health education through the ITDA network. The monitoring role of The Divine Foundation will be to evaluate the performance of ITDA Network developed and to provide guidance. Evaluation will be based on one simple criterion — whether the ITDA Teams have significantly improved the eye health and wellbeing of the community.

# Objectives of Our Community School Eye Screening Camps

* + - To identify children mainly with pediatric cataract and offer surgery to restore sight
    - To create awareness among the blind and motivate them utilize the existing facilities
    - To prescribe and provide glasses for refractive errors (at affordable prices )
    - To detect and treat (referring for surgery when required) cases with strabismus Squint and other chronic infections
    - To identify and treat / refer school children in the villages with refractive errors, squint, congenital Cataract, amblyopic, nutritional deficient etc.,
    - To provide children eye health education on proper eye care- preventive, in the community
    - To develop and maintain partnership with the Community

# Our Community Eye Care Team

|  |  |
| --- | --- |
| * Senior Optometrist/ Pediatric Ophthalmologist | 1 for 200 patients |
| * Ophthalmic Officers | 2 |
| * Preliminary Vision (AR) & IOP & Duct | 1 |
| * Optician | 1 |
| * Camp Organizer/ Counselor | 1 |
| * Transport Assistant | 1 |

**An over view of the Eye Screening Camp process**

* + - Patient Registration
    - Preliminary Vision testing
    - Refraction
    - intraocular pressure and tear duct function
    - Preliminary diagnostic examination
    - Final examination
    - Optical shop
    - Patient counseling and IP Admission

# Now, let us share the costs to execute such an impactful partnership work.

The following 2 types of costs are associated with the project:

# COST BREAKDOWN

The following 2 types of costs are associated with the project: (1)*Catalyst Development Cost:*

The Divine Eye Foundation has the design, development, and enhancement eye care programs for ITDA team.

Further development/enhancement costs are also likely to be minimal. We have included these development costs in our estimates and in the funding request.

DEF will train 250 **Master Trainers** in **TOT (2 Day duration )** :Theory & Practical's) in 10 Batches who in turn shall train 15 teachers from cluster of schools -a total of 3750 teachers from 1875 **Schools** , to do the preliminary eye screening for Children

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| --- | --- | --- |
| **1. Trainers** | | |
| Master Trainers \* 2 Days Duration Training | **Training and Course Materials MTs 250 X Rs 200** | **50,000** |
| 2 Faculty from PYN for 2days to train 250 MTs in TOT and 10 ToTs in real 4 days | **TOTs 10x Faculty 4 X Rs 2500** | **100000** |
| Supply of IEC and Eye Screening Material to 3750/2 Teachers Trained as Primary Eye Care -Givers(PECs) | **Teachers /Schools 1875 X 150** | **375000** |
| Sub Total | **525 000** | |
| PYN Over Heads 5% | **26250** | |
| **Total** | **551250** | |
| To train 250 MTs and empower 3750  Teachers as PECs it costs nearly = 113/- rupees only Per Head | **\*TA, DA, BOARDING BY ITDA**  **PYN supports on job training done by MTs in 25 Locations** | |

|  |  |
| --- | --- |
| **2. Operational costs for Referred School Children Camp for 200 children in a camp - Requirements** | |
| **COST PER CAMP** | |
| **Services/Items** | **Unit Rate** |
| Medicines (40%) | 80 Members \* 25/- = 2000 |
| Spectacles POSO / TEENAGER (Make) with CR  Lens (20%) | 40 \* 350/- = 14000 |
| Camp Crew (6 no's) | 6 \* 1500/- = 9000 |

|  |  |
| --- | --- |
| TRANSPORTATION Pre –camp and post camp | 5000 |
| **Total** | **30000** |
| **Note: Per RSC-Child Eye Examination Cost works out to be rupees 150 /-(2500 amount/200 Ref**  **School Children)** | |
| **60 camps in 5 months (Oct , Nov , Dec , Jan and Feb ) covering 12000 children@ Rs 18, 00,000i n three tribal districts in a year for three years 36000 children and @ total out lay of 54,00,000**  **Grand total of 1&2 is Rs 54,00,000 + 551250 = 60 lakhs** | |

# PROJECT OUTCOME

Our goal is to incorporate three ITDAs into the program of Comprehensive children Eye care of Tribal (TRIEYE) in phased manner spanning years: 20018-2021. This will be accomplished in coordination with State agencies and NGOs. Based on the calculations presented above, we anticipate a total outlay of Rs 50 lakhs toward this. Since ITDA and DEF reach between 60,000-80 ,000 children , this modest start will address issues of primary eye health care of 100,000 children indirect beneficiaries and direct 36000 in tribal areas of the three districts . It is hard to believe that investing Rs 125 .00 ($ little less than two dollars) per child per year will make such a BIG difference in the lives of so many children with sight gifted. We feel confident that it will.

# MANAGEMENT OF OPERATIONS

A Steering Committee consisting of representatives from the ITDA, The Divine Eye Foundation, Non-government officials, and local communities will oversee the project. A District Advisory Board will assist this committee in setting priorities and policies. Day-to-day operations will be carried out by a management team under the supervision of The Divine Eye Foundation. Funds received will be credited to a Trust account in a bank(s), and will be operated by The Divine Eye Foundation**. The Divine Eye Foundation, Donor and ITDA shall enter into an MOU for the project** and DEF will have the overall responsibility for executing the project, and will coordinate its activities with ITDA and other government agencies and other NGOs participating in the program.

# CONTACTS

This proposal is being submitted by The Divine Eye Foundation for funding toward Rs 50 Lakhs required for the project over a three-year period. Since the project involves the participation of non-governmental organizations, central and state governments, national institutions and private citizens, it is anticipated that several experts will contribute toward the necessary technical while ITDA offers the financial resources. For further information, please contact Swami Kamala Manohar or Dr Rajendra the Pediatric Ophthalmologist at addresses noted below.

**Swami Kamala Manohar** Dr Rajendra the Pediatric Ophthalmologist

# Divine Eye Foundation CEO, Divine Eye Foundation Foundation Address:

**The Divine Eye Foundation, Vemagiri, Rajahmundry Rural, EG District Date: Sep 25 , 2018**

**Appendix A: Support and Training Centres**

Ongoing Support and Training of ITDA personnel are the responsibility of the Nodal Office established for ITDA by DEF. Support activities consist of recruiting trainees, set-up of facilities, supply of IEC materials, testing Materials’, coordination of transportation, interaction with local community, etc. Arrangements with doctors and hospitals will be made for handling referrals from ITDA. Involvement of local NGOs will be encouraged.

Support activities will be coordinated and made efficient through on-line and off line communications, tracking procedures/systems, periodic status review meetings, and other techniques. The goal is to ensure that ITDA and DEF Teams are fully operational at all times to serve the community.

Training of ITDA staff covers the following areas: a) administration of Eye Care Programs, b) use of Preliminary Eye Testing system, c) conducting simple tests, d) proper understanding of the preventive and curative aspects of the eye café, and e) how to carry out eye health education. Comprehensive training for the above will be conducted at the Vision Centre, which will be followed by on-site training at the ITDA centres under the supervision of DEF coordinators. Training materials and User Guides will be supplied.

The Trainer is expected to have basic understanding of Telugu, enough to read and translate the info shared into the vernacular. We believe that individuals with good high school education or with higher education can be trained to carry out this task. The complete training course material for the lab technician and the EYE Care Testing Kit will also be made available at each Trainee as package. One of the most important aspects of the training will be the communication skill of the staff. In additional to Telugu, they will need to be fluent in the language of the community they serve. Since gaining the trust of the community is the foundation stone of our approach, we feel that communication skills are very important. Using the feedback we receive from the ITDA, illustrative examples of good communication with patients and the community will be developed in an audio -visual format, and will be included in the training.

Training to provide eye health education will be an integral part of the program. The initial scope of this program and the current status in the development of the material are described in Appendix C. We will supplement this by initiating an active program to attract visiting experts, and public health officials. Their recommendations will be incorporated where appropriate, and additional training and educational materials will be developed with their assistance.

# Appendix C: Health Education and Community Activities

Initially we shall concentrate on the following community eye health education related activities:

1. Training of local Teachers /Staff as Primary Eye Catalyst (PECs ) to work for avoidable Blindness
2. Conduct complete Community Out Reach – Children Eye Health Awareness with help of tailor made IEC
3. Community mobilization through network of NGOs for Comprehensive Eye Care
4. To work at Community level Vision Centres
5. To act Patient counselors
6. To Facilitate Transportation for specific Surgeries for children at Base Hospital in Vemagiri
7. To help in Excellent Follow up Support
8. To Facilitate Pharmacy and Optical services onsite and off site

An educational course on eye health and hygiene has already been developed by DEF which it would present as a resource organized by topics with examples illustrating the points to be drawn using local people and situations. Offering eye health education and learning how to communicate the message in a simple manner will be an integral part of the training for the entire Team. It will be available at our Nodal Office so that the staff can refresh their understanding as needed.

Instructions will also be offered to the community at the time of visit to the ITDA areas. We plan to use possibly a television with a video player to continually provide this information while patients/families wait for their check-up.

Local community centers and village meetings are other forums for presenting the information. NGOs and social workers will be provided the necessary tools to enable them to educate the tribal population on eye health issues. The field coordinators will organize the above activities with the assistance of local NGOs and community leaders.

# Appendix D: List of Diseases

1. **NUTRITION RELATED**

* Malnutrition
* Vitamin A deficiency

# EYE

* Pediatric Cataract (including Congenital)
* Conjunctivitis
* Refractive errors
* Glaucoma
* Blindness
* Squint

# Appendix E: Reasons for Our Optimism

This is an ambitious proposal, yet, we are very confident of success. In fact, failure is not an option for us. We list here the most important reasons for our optimism.

1. The timing is right. India is undergoing a tremendous transformation. The potential for India to emerge as a modern developed nation, however, depends on its ability to close the economic and literacy gap between its tribal and urban populations and manage health pandemics more specifically eye health . For this to happen, a long-term sustained investment in tribal development, with children eye health care and eye health education as the foundation stone of this initiative, is essential.
2. Governments are key partners in our proposed activities. They have long-term vested interest in seeing this project succeed. We are proposing to build on what it has already developed and support by international agencies like WHO which talks about Universal Eye Health with Make Vision Count spree. Therefore, a significant start has already been made.
3. We bring together new paradigms that fully exploit modern technology and incorporate anticipated developments in both human and material resources.
4. The approach is holistic. It is designed to be sustainable and yield long-term changes in tribal children eye health care and welfare. The basis measure of success will be winning the trust of the local populations, making significant behavioral changes in their daily lives, and improving their understanding of, and involvement in, a modern technological society. Right to sight is expected to be a major result of this strategy.
5. The people involved in the development of the concepts and for providing the overall vision are also going to be intimately involved in its execution and monitoring. We shall bring to bear all the tools and strategies that make project succeed. Accountability and efficiency will be incorporated at every level.
6. We believe proper training of the ITDA staff is the key to success. To achieve this we shall develop material in a tailor-made format with simple examples that people can identify with. We shall involve the best minds to act as advisors to help in the continuous development and refinement of the training program and deliverables. We shall establish collaborations with local NGOs to facilitate the next higher level of eye health care for the tribal population and involve Teachers and schools to help us implement health seeking behavioral changes.
7. The Divine Eye Foundation and its senior management have previously demonstrated their ability to organize and manage such projects, and coordinate their activities on a wider scale. In particular, for many years Dr. Swami Kamala Manohar had been the Chief Executive of The Vision 2020: The Right to Sight –India that has hundreds of Inter/national I/N/GOs (150) in nearly 30 States fighting avoidable blindness as movement.

# Appendix F: Advisory Board

1. Program Manager of Funding Agency
2. PO ITDA
3. DMHO
4. DPM
5. Dr Rajendra, Pediatric Ophthalmology, DEF
6. Dr. KV Rama Rao, DEF

# Appendix: G A Collaborating Partner with AP Government DEF

* + Registered with DBCS (District Blindness Control Society) in both East and West Godavari and Vishaka districts.
  + An MoU with AP Government –DME for NPCB work
  + Authorized by both Godavari Districts to conduct Outreach Eye camps for children and adults
  + District Administration of EGD Designated PYN as a Nodal Agency for EG District for Comprehensive Eye Care for Tribal and Children
  + Conducted 2500 camps covering 5,00,000 children and adults and 50000 surgeries

