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REPORT

drawn up on behalf of the Committee on Development and Cooperation

on combating and preventing blindness in the Third World

Rapporteur: Mr W.J. VERGEER

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*	= Consultation procedure requiring a single reading	**II	= Cooperation procedure (second reading) which requires the votes of the majority of the Members of Parliament
**I	= Cooperation procedure (first reading)	***	= Parliamentary assent which requires the votes of the majority of the current Members of Parliament

At its sitting of 11 May 1987 the European Parliament referred the motion for a resolution tabled pursuant to Rule 63 of the Rules of Procedure by Mr Vergeer on combating blindness in the Third World and the Community's role therein (Doc. B 2-141/87) to the Committee on Development and Cooperation as the committee responsible and to the Committee on Budgets and the Committee on the Environment, Public Health and Consumer Protection for their opinions.

At its meeting of 23 September 1987 the Committee on Development and Cooperation decided to draw up a report and appointed Mr Vergeer rapporteur on 2 December 1987.

The committee considered the draft report at its meeting of 24 May 1988 and adopted the motion for a resolution unanimously on 28 September 1988.

The following took part in the vote: Mr McGowan, Chairman; Mr Vergeer, rapporteur; Mr Bersani, Mrs Cinciari Rodano, Mr Coderch, Mr Cohen, Mrs De Bachner-Van Ocken, Mr Diaz del Rio, Mr Fellermaier, Mrs Foche, Mrs Pantazi, Miss Pinfasilgo, Mr Pirkl, Mrs Simons, Mr Simpson, and Mr Trivelli.

The Committee on Budgets and the Committee on the Environment, Public Health and Consumer Protection will not be delivering opinions.

The report was tabled on 30 September 1988.

The deadline for tabling amendments to this report will appear on the draft agenda for the part-session at which it is to be considered.

CONTENTS

The Committee on Development and Cooperation hereby submits to the European Parliament the following motion for a resolution together with explanatory statement:

A

MOTION FOR A RESOLUTION

on combating and preventing blindness in the Third World

The European Parliament,

- having regard to the motion for a resolution by Mr Vergeer on combating blindness in the Third World and the Community's role therein (Doc. B 2-141/87),

- having regard to the various reports by Mrs Rabbethge and Mrs Pantazi on the research and development programme in the field of science and technology for development,

- having regard to the report on health policy in the ACP countries (Doc. ACP-EEC/315/88),

- having regard to the report of the Committee on Development and Cooperation (Doc. A 2-200/88),

A. whereas the essential object of development policy is to satisfy basic human needs, health being a key factor in human welfare,

B. convinced that economic and social progress in the developing countries cannot be achieved in the long term unless a satisfactory solution is found to the health problem,

C. whereas, according to the WHO, infectious diseases, chronic parasitoses, and diseases resulting from poor or the wrong diet continue to rank among the most frequent causes of sickness or death in the developing countries,

D. whereas, according to WHO figures, there are between 27 and 35 million blind people in the world, 80% of whom live in the poor countries of Asia, Africa, and Latin America; deeply concerned at the fact that unless far-reaching measures are taken, the number of blind in the developing countries will double in the next two decades,

E. whereas in many developing ountries, poverty, poor hygiene, unavailability of clean water, malnutrition or the wrong diet, the shortage of ophthalmologists and drugs, and the failure to provide vaccinations against infectious diseases, especially measles and rubella (German measles), frequently lead to blindness,

F. whereas cataracts, trachoma, glaucoma, onchocerciasis, xerophthalmia, and leprosy are the conditions leading to blindness most frequently, onchocerciasis, or river blindness, being one of the worst causes of blindness in tropical regions,

G. appalled at the fact that in some West African villages half of the adult male population has aleady gone blind,

H. whereas in 75 - 80% of cases blindness could be prevented or cured by relatively simple measures; whereas the cost-benefit ratio involved is a favourable one, assuming that non-governmental organizations perform what is considered to be their essential role,

I. disturbed at the fact that the large number of blind in the developing countries represents a serious loss to the economic production process of those countries, because millions of people cannot join the normal work process and, secondly, many others are occupied in looking after the blind,

1. Points out emphatically that where aid to the blind is concerned, the foremost goal should be to restore blind people's dignity, so that they may again become full members of the human community; calls for all measures to be directed towards that goal;

2. Takes the view that measures must address themselves to those who have fallen victim to blindness, as well as to the diseases leading to blindness; is of the opinion that in addition to health measures, efforts must also be stepped up in the specific field of cooperation for development;

3. Considers that initially, preventive measures to tackle the causes of blindness are especially important, in particular:

   (a) organizing and expanding basic and applied research in the field to investigate the nature and treatment of tropical diseases that can lead to blindness;

   (b) vaccinations against various diseases, especially measles and rubella, for they lead to vitamin A deficiency and hence, frequently, to infantile blindness,

   (c) stepping up the fight against hunger in remote rural areas and city slums,

   (d) improving the range of available foodstuffs, providing a better diet, and bringing about a change of eating habits, in particular by setting up food centres in existing hospitals and forming food teams to back up the work of the mobile eye camps,

   (e) inclusion of the necessary health education and instructional work as basic school subjects in order to counter ignorance, both in matters of hygiene and as to the causes and prevention of blindness,

   (f) prompt medical care, to be provided by setting up more mobile eye camps in remote areas, with facilities for performing operations; training of local ophthalmologists and, at grass-roots level, of medical auxiliaries to work in the area of care and treatment of the eyes; setting up eye hospitals at grass-roots level as bases of operations for village work,

(g) setting up more combined irrigation projects (sinking wells, provision of water supplies, reafforestation) to ensure that populations are supplied with clean water;

4. Takes the view that the necessary provision should be made for blindness, even in the most remote areas of poor countries, to be treated by medical means, this to be brought about, in particular, by:

(a) training of ophthalmologists and nursing staff, setting up special eye units in existing hospitals to work in liaison with the mobile eye camps,

(b) setting up dispensaries for the poor, to ensure that, even when they live in the poorest areas, the blind can be supplied with vital drugs; eye drops should, whenever possible, be manufactured in the developing countries themselves,

(c) training of local opticians and opening of spectacle-makers' workshops (in many developing countries there are no facilities for the manufacture of spectacles);

5. Points out that various measures are required to help blind people for whom there is no hope of a cure, the most important goals in this connection being reintegration, mixed schooling (sighted and blind children), and vocational training tailored to the needs of the blind;

6. Is of the opinion that the European Community has various means at its disposal to aid the fight to prevent and combat blindness, especially since the causes are often related to underdevelopment;

(a) the fight against hunger must be continued at all levels,

(b) when rural development projects are drawn up and implemented, both in the ACP countries and in Asian and Latin American countries under the heading of aid to non-associated developing countries, the preventive health care and environmental hygiene components, as well as the promotion of agricultural self-sufficiency, should be taken into account more closely than has hitherto been the case,

(c) where food aid is concerned, greater consideration should be given to areas where blindness is caused by hunger; furthermore, the products supplied should be those required to provide a proper diet; when devising food strategies, increasingly greater attention should be paid to the links between blindness and the wrong diet on the one hand and infantile blindness and vitamin A deficiency on the other;

7. Regrets the fact that when the various Community R & D programmes on the theme of 'science and technology for development' were finalized, the question of the blind was left largely out of account; calls therefore for the scope of that programme to be widened in such a way as to ensure that research and training for prevention of, and the fight against, blindness are also taken into account, especially with a view to the research projects concerned with eradication of river blindness;

8. Welcomes the fact that the organizations for the blind based in the European Community (Royal Commonwealth Society for the Blind (United Kingdom), Christoffel Blindenmission (Federal Republic of Germany), Stichting Blindheid Bestrijding Ontwikkelingslanden (Netherlands), Organisation pour la prévention de la cécité (France)) collaborate to good effect with the WHO in the world-wide fight against and prevention of blindness, and experts are of the opinion that cooperation of all branches of health care to aid the blind works extremely well;

9. Takes the view that these non-governmental organizations, which frequently have to rely on donations to carry out their vital work in the developing countries, should receive financial support from the Community, especially as their tasks are set to increase further in the coming years and the reasons for blindness are often to be sought in untold poverty;

10. Calls upon the Commission, therefore, to determine, together with the above NGOs, which aspects of the fight against blindness should receive priority support from the Community and to submit the necessary proposal;

11. Asserts that the Community-based organizations for the blind, whose work is valued all over the world, should receive annual Community contributions for a set period; is of the opinion that the various financial instruments such as the budget of the European Communities and the European Development Fund should be used for that purpose; calls on the Commission, further, to determine to what extent EIB funds might also be made available;

12. Points also to the need to determine the extent to which more generous financial support might be granted to non-governmental organizations working in the medical field, above all to those giving vaccinations in the developing countries against infectious diseases that frequently cause blindness;

13. Considers, in view of the increasingly higher numbers of blind in many developing countries, that the Community has a moral duty to use every means to support those who are constantly working to develop inexpensive, safe, and, above all, effective new methods of preventing and curing blindness;

14. Instructs its President to forward this resolution to the Commission, the Council, the World Health Organization, the Co-Presidents of the ACP-EEC Joint Assembly, and the NGO liaison office.

B

EXPLANATORY STATEMENT

I. Specific features of the health situation in the Third World, with particular reference to blindness

1. The actual object of development policy should be to satisfy basic human needs, health being the most important factor in human welfare. Economic and social progress in the developing countries cannot be achieved in the long term unless a satisfactory solution is found to the health problem. Much has happened in previous years, great strides have been made, but there is still a lot to be done.

2. WHO studies clearly show that infectious diseases, chronic parasitoses, and diseases caused by poor or the wrong diet are among the most frequent causes of sickness and death in the developing countries. Given that the terms 'developing countries' and 'tropical countries' are practically synonymous, the typical diseases of the developing countries are, on account of the biology of obligate carriers, virtually non-existent in the earth's cooler zones. Such diseases include filarial diseases, schistosomiasis (bilharziasis) and malaria; other diseases such as measles and rubella (German measles), if they strike undernourished populations, assume the proportions of high-mortality epidemics. 3.5 million infants die each year in the developing countries of diseases from which they could have been protected by vaccination. Most of them, about 2 million in all, die of measles. According to WHO estimates, 67 million children a year contract this viral infection which, if not fatal, can lead to loss of sight. Owing to poor drinking water supplies and inadequate drainage, the incidence of infections such as cholera is near epidemic. The regular outbreaks of malaria, meningitis, and other viral diseases divert health personnel from other tasks, and paralyse economic development in the regions concerned. It typically happens that most inhabitants of the Third World's poor areas are permanently infested with several species of parasites at once. Coupled with malnutrition, this inevitably leads to a serious reduction in labour productivity. To make matters worse, most health care institutes are concentrated in a few towns and cities, while rural areas, where 60 - 80% of the population live, are frequently underendowed with medical facilities. Even when they have health stations staffed by medical auxiliaries, the necessary supervision and provision of drugs and other supplies are often lacking.

3. The body's ability to function properly is severely impaired by tuberculosis, leprosy, blindness caused by onchocerciasis, and serious liver and bladder damage caused by schistosomiasis. In some areas, where the environment is particularly adverse, a large percentage of the population is infected with schistosomiasis, onchocerciasis, hookworm, and malaria.

4. According to the WHO, there are between 27 and 35 million blind people living in the world. Definitions of blindness vary. These figures are based on the WHO criteria: vision less than 3/60 in the better eye. The exact number is not known, because the figures for most developing countries are only approximate and in many countries, especially in Africa, the partially sighted (i.e. with severely defective vision) are counted along with the blind. That is why most official documents assume the total number of blind to be 42 million. The main problem is that 80% of blind people live in the

poor countries of Asia, Africa and Latin America. Every day 2 000 people in the world go blind. 90% of all blind children receive no schooling, and 70% of blind people who are actually fit to work live by begging, because no one helps them. Every hour 60 children in the world go blind, and the ranks of blind child beggars swell by 150 000 each year. In some villages in West Africa half the adult male population is blind. Over wide areas of Asia one per cent is blind. Most blinding diseases are curable in Europe or North America, but in Asia and Africa lead to blindness, because the nearest medical post is too far away. In India up to 6 million blind people live in the most abject poverty. Out of Bangladesh's population of 103 million, 1.6 million are blind; the numbers of blind increase by about 50 000 each year, including as many as 17 000 children. This is hardly surprising, for 50% of the population suffer from malnutrition and there is just one doctor for every 11 000 inhabitants.

5. These are frightening figures, especially bearing in mind that in some places, as a result of poverty, ignorance and, frequently, religious prejudices, the blind are branded the outcasts of society. What is even more frightening is that the number of blind will double in the next two decades unless appropriate measures are taken to counter the threat. There is no inevitability about this, since in 75 - 80% of cases, blindness could be prevented or cured by fairly simple intervention. What is more, the cost-benefit ratio involved is an unusually favourable one, assuming that non-governmental organizations perform what is considered to be their essential role.

Never have the chances been so great to employ simple, strategically targeted medical measures to save the sight of millions of people or help those who have already gone blind. But, at the end of the day, what use are the best drugs, surgical techniques, or other aids if out of reach of those who urgently need them?

II. Factors, related primarily to underdevelopment, that cause blindness or can lead to loss of sight

6. In many developing countries, poverty, poor hygiene, lack of clean water, malnutrition, the wrong diet, a shortage of ophthalmologists and drugs, and the absence of vaccination against infectious diseases such as measles and rubella frequently lead to blindness. Health education and medical check-ups do not extend to the victims, who mainly live in the country. They for their part are neither physically nor financially in a position to cover the vast distances to the nearest health station.

The most widespread causes of blindness are: CATARACTS, TRACHOMA, GLAUCOMA, ONCHOCERCIASIS, XEROPHTHALMIA, and LEPROSY.

(a) CATARACTS

7. Approximately 55% of all blindness in the developing countries is caused by cataracts. About 17 million people in the Third World are blind from cataracts, with 3.5 million in Africa and 4-5 million in India. It is said that the number of people affected by cataract blindness rises by 1 million each year.

A cataract is a gradual clouding of the eye's lens, which progressively reduces visual acuity. In contrast to the situation in the developing countries, cataracts mainly affect older people in Europe and North America. The causes of cataract formation are still only partially known, making active prevention of blindness difficult. However, through current research, risk factors are now being identified which begin to open prospects for prevention. When the patient has lost significant vision in the eye the now opaque lens can be removed by a routine surgical operation. The surgical techniques that have been developed for cataract take no more than 20 minutes and can also be carried out at very low cost in the mobile eye camps.

(b) **TRACHOMA**

8. 500 million people all over the world suffer from TRACHOMA, also known as Egyptian Ophthalmia. Of that total, 100 million have some defect of vision and about 6 million are blind. The disease occurs chiefly in Africa, the Middle East, India and parts of South-East Asia, Central and South America, and in Australian aborigines. TRACHOMA is the second biggest cause of blindness in the world (accounting for a quarter of all cases). Women and children are particularly susceptible to this disease. Poverty, over-population in built-up areas, lack of clean water and inadequate sanitation are the main causes. Up to 80 million children are already suffering from this blinding disease. Prevention would basically be simple if the following were promoted: Provision of clean water, daily washing of the face, covered disposal of rubbish and faeces, education in hygiene and relatively inexpensive treatment with tetracyclene eye ointment.

(c) **GLAUCOMA**

9. Glaucoma usually results from intraocular pressure raised above normal levels. Early identification of this disease is very important otherwise vision may be irretrievably lost. Diagnosis and treatment are difficult and can be undertaken only by trained medical personnel. Glaucoma is the cause of 10 - 15% of blindness in Africa.

(d) **ONCHOCERCIASIS**

10. Onchocerciasis, or river blindness, is one of the worst tropical blinding diseases. The disease results from infection with the filarial worm (Onchocerca volvulus), and the symptoms are sub-cutaneous nodules, containing the fully grown parasites, and chronic cutaneous inflammation and itching due to migration of the larval worms. There is gradual loss of vision due to optic nerve damage, which after many years of infection, may end in total loss of sight in about 5% of infected persons. The carrier is the black fly, which breeds in fast flowing rivers with high oxygen concentrations.

20 - 30 million people are infected with onchocerciasis, and around 600 000 are blind. This dreaded blinding disease occurs especially along the rivers of West Africa (in Cote d'Ivoire, Ghana, Togo, Benin, Mali, Burkina Faso, Niger, Senegal and Sudan) and in certain regions of Central America. In Africa alone, 20 million people have onchocerciasis. Entire villages are in danger of dying out, because whoever stays risks blindness. In some regions lying along a river, for instance in Ecuador, between 90 and 100% of the population suffer from river blindness. Measures, such as spraying of

insecticides along rivers and treatment with drugs, can be taken to counter the disease. The drawbacks of earlier drugs were the potent side effects, but a newly applied drug Ivermectin appears to be much safer and shows great promise. Nevertheless, many years of treatment are required.

(e) **XEROPHTHALMIA**

11. This disease is a consequence of vitamin A deficiency. The cause is not just inadequate food, but the wrong diet. The most susceptible group is children under five. The serious eye damage is incurable and the most frequent cause of infantile blindness. In addition to malnutrition, factors which enhance the risk of this blinding condition include measles, diarrhoea and other infections. The WHO estimates that between 400 000 and 500 000 children a year lose their sight as a result of malnutrition. In Asia alone, 150 000 infants remain incurably blind, because vitamin A deficiency destroys the cornea; each year 5 million children begin to display symptoms of xerophthalmia. The vast majority of the children affected live in rural areas or city slums. Some years ago the Helen Keller International conducted an informative study on infantile xerophthalmia in Bangladesh. This shows that millions of children suffer the effects of malnutrition or the wrong diet and, as a result, 100 000 of them are in the advanced stages of xerophthalmia (1 million display early symptoms). 70% of these children die shortly after going blind; the other 30% remain blind for life. This study suggests that the number of children suffering from xerophthalmia in Bangladesh is ten times higher than the WHO had supposed. Out of Bangladesh's population of 103 million, 82% are living below the poverty line and as many as 42% in absolute poverty, in other words they can obtain less than 85% of the minimum food needs required to ensure survival. A 1984 WHO report on Bangladesh concludes by stating that xerophthalmia is the principal cause of loss of sight in infancy. In world terms it is thus one of the four main causes of avoidable blindness (the others being cataracts, trachoma and river blindness).

(f) **LEPROTIC BLINDNESS**

12. Leprosy is a particularly devastating disease, which not only mutilates limbs but can also destroy eyesight. Paralysis of the muscles of the eyelids frequently occurs as a result of leprosy. As the sufferer can no longer close his eyes, the cornea which becomes insensitive is permanently exposed, and consequently becomes dry and ulcerated, leaving a scar. At present there are estimated to be 12 million leprosy sufferers in the world (Mali and Nigeria are among the countries with the highest incidence of leprosy), over half of whom have some eye problems. Up to 250 000 have gone blind. Leprosy is also frequently accompanied by cataract blindness.

III. The economic consequences of blindness for the developing countries

13. There are virtually no figures on the economic consequences of tropical diseases and blindness in the developing countries. However, taking into account the fact that 80% of blind people live in the developing countries, the scale of the loss to the economic production process becomes clear. Firstly, millions of people cannot join the normal work process and secondly, thousands of others are called upon to look after the blind.

14. River blindness in particular does great damage economically. Sociographic studies clearly show that onchocerciasis is the most serious obstacle to an improvement in agricultural productivity in large parts of West Africa. The reason is that, apart from blindness, general performance declines in many infected persons. As this applies first and foremost to the age groups that do most agricultural work, capacity for work and crop yields fall so low that communities have to be abandoned. The population dies or migrates. Since the rate of transmission of onchocerciasis is particularly high in the vicinity of rivers, where carriers find suitable breeding grounds, fertile areas close to rivers are eventually abandoned due to the endemic spread of the disease. When entire villages in fertile tracts of land come to be deserted, the effects on food supplies are serious.

15. The study conducted by Helen Keller International revealed some interesting figures about Bangladesh. The total number of blind is approximately 1 million. Not only does this represent immeasurable human suffering, it also has social consequences. Blindness costs the country some 4.32 bn taka a year (DM 432 m), a colossal amount given the country's economic situation. A shortfall of 2.232 bn taka (approx. DM 223.2 m) results from lost labour; care of the blind costs their relatives 4.896 bn taka, more than twice that sum.

About 70% of the blind could be cured by medical treatment or surgery. Curing a blind person is not just a question of human happiness, but contributes at the same time to the economic recovery of the country concerned, since two people can go back to work: the person who was once blind and the person who once looked after him. Conversely, when a person in the Third World's poor regions goes blind, the hardship increases. In Africa, if a son who is also the family breadwinner goes blind, the entire family is often reduced to abject poverty.

IV. Aid measures required to help the blind or prevent blindness

16. Blindness should have little or no chance to strike. Prevention is therefore better than cure. Or, to put it another way: curing the blind is the immediate priority, but preventing blindness is far better. In view of the rising numbers of blind people, it is not enough merely to look after the victims of blindness without at the same time taking measures to combat blinding diseases. The causes of tropical diseases that lead to blindness must be uncovered and tackled. However, if blindness is to be countered effectively, it is not just medical measures that are required: efforts also have to be stepped up in the specific area of cooperation with the developing countries.

(a) Measures to prevent blindness

17. The following measures are required:

- health care and research institutes for the study of tropical diseases must be set up in the field. In the Third World there is not enough basic research being done in the disciplines of parasitology, microbiology, biochemistry and pharmaceutics. Also of high priority is epidemiological research to identify major causal risk factors that may be amenable to control;

- vaccinations against infectious diseases, in particular measles and rubella, must be stepped up considerably. Apart from malaria, measles is still the major cause of death in children. Studies on blind schoolchildren in Tanzania have shown that 50% of them had measles before they went blind. Measles contributing to vitamin A deficiency is the main causes of infantile blindness in Africa. When mothers catch rubella in the early months of pregnancy, children are born blind or physically damaged in other ways. Back in 1983 the Royal Commonwealth Society for the Blind (RCSB) established that rubella is a major cause of blindness in the Caribbean;

- the fight against hunger must be stepped up; children in rural areas and city slums must be saved from malnutrition and the wrong diet;

- although vitamin A capsules are a useful means of preventing and treating vitamin A deficiency, they do not provide a lasting solution. In the long term, the range of available foodstuffs must be improved, the priorities being the right diet and a change of eating habits. Food centres and teams should be set up. Once they return to their villages, trained mothers will pass on the benefits of their knowledge to their neighbourhood. Self-sufficiency in agricultural produce rich in vitamin A is a key factor. In that way, undernourished children will be restored to a normal state of health. A diet of green vegetables, which are rich in vitamins, should take the place of meals consisting of rice only;

- provision of suitable health education and publicity campaigns to combat ignorance in matters of hygiene and explain the causes and means of prevention of blindness;

- provision of prompt medical care through additional mobile grass-roots health services, training of medical workers in eye care for the most remote village districts; low-level training of medical personnel in the field and training of ophthalmologists in the actual developing countries; sending ophthalmologists from the industrial countries is merely a stopgap solution. Since, in many developing countries, there is a shortage of persons wishing to qualify as ophthalmologists and training in the industrial countries is undesirable on several counts, grants for medical studies must be made available in the places concerned;

- the availability of clean water is essential in order to prevent blindness. That is why combined irrigation programmes (sinking wells, feeder supply programmes to replenish groundwater and reafforestation of woodlands) are so important. This example clearly shows how closely rural projects and measures to combat blindness are interlinked. Integrated structural and territorial planning would do much to help prevent blindness.

(b) **Measures to aid the blind**

18. The overriding objective of aid for the blind must be to restore a blind person's dignity, so that he may once again become a full member of the human community. All measures to aid the blind must be directed towards that goal. Blind people are just as talented or untalented as sighted people, the only difference being that for them, the odds are less favourable; the blind should be viewed as equal partners, and what must be done is to awaken awareness of that fact.

The following is required:

- central hospitals and annexes must be set up as bases for mobile eye camps in rural areas, where eye patients and the blind can be examined, treated and undergo surgery. Dispensaries for the poor should be set up to ensure that, even if they live in the poorest rural areas, blind people can be supplied with essential drugs;

- training of local ophthalmologists and auxiliaries with elementary knowledge of ophthalmology (training takes only 3 - 4 months);

- adequate provision of drugs and other aids absolutely essential for treatment of the sick (ideally, eye drops should be manufactured locally);

- training of local opticians and opening of spectacle-makers' workshops (spectacles are unobtainable in Bhutan, for example); it is perfectly possible to make spectacle frames and grind lenses using inexpensive appropriate technology;

- reintegration of blind people for whom there is no hope of a cure must begin as early as possible. In mixed school systems, sighted and blind children are taught together. Sadly, 90% of blind children in the world still receive no schooling, because there is a shortage of suitable establishments. Special schools for the blind only are not the answer, because they lead to segragation of the blind. Since the idea is to reintegrate the blind into society, vocational training to suit their needs is a top priority. Blind people too are teachable and quite capable of doing useful work. To name just a few examples, vegetable growing, weaving mills, basket making, small-scale animal husbandry and, in particular, training in simple farming techniques such as store management all qualify for vocational assistance. Farms and cooperatives for the blind have proved very successful in the reintegration of blind people.

The success of such enterprises for the blind depends primarily on their ability to integrate themselves smoothly into the local market process. Aid for trades and industries employing blind people must be tailored to the local economic structure, because the requisite raw materials must be to hand and the products also have to be sold. Interesting experience has been acquired with blind people who have been specially trained for a trade. Their productivity is often very high, higher than that of a good many sighted people.

(c) **Measures to be taken by the European Community**

19. The European Community as such can do various things to step up the world-wide efforts to combat and prevent blindness:

- the fight against hunger must be intensified, given that hunger in childhood almost invariably leads to lifelong disabilities and loss of sight. Development projects to promote agricultural self-sufficiency must be given priority;

- Community food aid should give greater consideration to areas where the incidence of blindness is particularly high; when food strategies are drawn up, priority must be given to crops that will help remedy vitamin A deficiency, so as to prevent corneal damage in infants;

- when rural development projects, especially in the ACP countries, are drawn up and implemented, greater consideration must be given to the medical and environmental components;

- when the Community R & D programme on the theme of 'science and technology for development' was finalized, the question of the blind was left largely out of account; the scope of this programme consequently needs to be widened in such a way as to ensure that research into and training in the means of preventing and combating blindness are given particular consideration; this applies most of all to the current research projects to combat river blindness;

- the importance of food and its nutritional value as factors in economic progress and human development must be taken more closely into account than has hitherto been the case, because the two main consequences of poor or the wrong diet, namely low capacity for work and physiological sequelae, seriously impede development measures;

- the Community should grant more funds to the non-governmental organizations that give vaccinations in the developing countries against infectious diseases, especially rubella and measles, which frequently cause infantile blindness or death;

- the Community-based organizations for the blind, which collaborate to good effect with the WHO in the world-wide fight against, and prevention of, blindness and frequently have to rely on donations to carry out their vital work in the developing countries, should be financially supported by the Community. Among the main organizations concerned are the Royal Commonwealth Society for the Blind (United Kingdom), the Christoffel Blindenmission (Federal Republic of Germany), the Stichting Blindheid Bestrijding Ontwikkelingslanden (Netherlands), the Organization pour la Prevention de la Cecite (France) and the Norwegian Association for Prevention of Blindness. The Commission should begin discussions with these NGOs with a view to determining which activities in the fight against blindness should receive priority support from the Community, and submit an appropriate proposal. Various financial instruments, such as the general budget of the European Communities and the European Development Fund, could be used to finance a special Community programme for the blind. The Commission should also consider what financial contribution might be provided by the EIB.

20. Since, despite all that is being done, the number of blind people in the world is rising (in the developing countries the number of over-55s will increase fivefold by the year 2030 and, with them, the incidence of age-related diseases that cause blindness), aid measures and, logically, the funds to finance them must be stepped up. In recent years the financial resources of the WHO and the non-governmental organizations involved in relief work for the blind have increased continually. The base of operations should, in all cases, be the WHO. Attention should be drawn here to the excellent cooperation and coordination between the WHO and the non-governmental organizations that work to prevent blindness. The NGOs keep regularly in touch with the WHO through the 'Partnership Committee' and the International Agency for the Prevention of Blindness. The leading NGOs (Royal Commonwealth Society for the Blind, Helen Keller International, the Christoffel Blindenmission, the International Eye Foundation, Operation Eyesight

Universal, Seva Foundation, Stichting Blindheid Bestrijding Ontwikkelingslanden (SBO), Organisation pour la Prevention de la Cecite) also hold joint conferences to coordinate their activities. Experts are of the opinion that cooperation of all branches of health care in the provision of aid for the blind works extremely well. The guidelines for this cooperation were laid down at the 1985 World Health Assembly in Geneva. The NGOs are constantly seeking to develop inexpensive, safe and, above all, effective new methods of preventing and combating blindness. Great strides have been made here, especially in the fight against XEROPHTHALMIA.

Blindness is a terrible thing. That is why our foremost task should be to prevent blindness in the developing countries and aid the blind in their infinite need, because the large number of blind people is hampering the development process.

MOTION FOR A RESOLUTION ANNEX

on combating blindness in the Third World and the Community's role therein (Doc. B 2-141/87)

tabled by Mr VERGEER

The European Parliament,

A. whereas the purpose of development and cooperation policy is to foster social and economic progress in the countries concerned and the welfare of their people, with the most underprivileged meriting the greatest attention,

B. whereas good health is one of the most important factors in human welfare,

C. whereas social and economic progress are determined first and foremost by the extent to which the healthy can play an active part in the life of society, while the sick - by force of circumstances - have to rely on the solidarity shown by others,

D. whereas, according to the WHO, there are at present over 50 million blind people in the developing countries and this figure will double within twenty years if no action is taken; whereas, however over 75% of cases of blindness can be prevented or cured at relatively low cost by appropriate ophthalmological treatment thanks to an extremely favourable cost-benefit ratio, to which end the WHO considers the collaboration of non-governmental organizations to be essential,

E. whereas approximately half of all blindness in the developing countries is caused by cataracts; whereas surgical techniques have been developed in these areas that, within just a few minutes, can give the patient a good chance of recovery; whereas, furthermore, costs per operation in 'eye camps' are around Fl 15 and in a number of countries these operations are performed by specially trained nurses and strong encouragement is given to the training of nurses to carry out cataract operations as 'barefoot eye-doctors' (e.g. in East Africa),

F. convinced that human welfare is advanced by the curing of cataracts, which makes it possible for both the patient and his or her 'guide' to re-enter the work process,

G. whereas each year approximately half a million children under five become incurably blind unnecessarily because of their parents' unsound dietary habits, whereby vitamin A deficiency is a major factor, and whereas information campaigns and provision of vitamin A can prevent this tragedy,

H. whereas, furthermore, in the great river basins of West and Central Africa many millions of people live under the threat of river blindness, which eventually leads to migration and the depopulation of land that is in itself fertile, with all the attendant economic consequences,

I. whereas, in the developing countries, blindness not only prevents those affected from living any kind of normal life but is in many cases permanent - even when, from a medical point of view, it need not be so,

J. whereas the World Bank has put into operation regional preventive programmes (aimed at controlling the larvae that cause river blindness) and the European Community also contributes financially to preventive programmes in West Africa (aimed at reducing the susceptibility of people liable to infection),

K. gratified that a new drug has now been developed that holds out hope that the incidence of this form of blindness (river blindness) can be significantly reduced,

L. whereas trachoma, which is responsible for some 2 million cases of blindness, can be prevented by improving health conditions and cured by eye ointment containing antibiotics,

M. whereas the International Year of the Disabled 1981 was brought to a close with the Leeds Castle Declaration, which noted that rubella epidemics in developing countries cause large numbers of children to be born with disabilities because their mothers contract rubella in the first few months of pregnancy, and whereas the Declaration therefore calls urgently for rubella vaccination in all countries,

N. convinced that genuine development of rural areas and their inhabitants ought to include a medical component and that the transfer of appropriate medical knowledge is one way of ensuring this,

O. convinced that strong encouragement must be given to 'barefoot eye-doctors', who are nurses trained in ophthalmology,

P. whereas a number of private and semi-private organizations, in addition to the World Health Organization, are active in the prevention and treatment of blindness in the Third World,

Q. whereas consultative groups were recently set up composed of non-governmental organizations collaborating on the WHO blindness prevention programme, and whereas this has helped to bring about a high level of coordination, which can only enhance the effectiveness of the work done by each of the individual organizations,

R. recognizing that, particularly where combating blindness involves preventive programmes, it is a prime example of a long-term undertaking and calls for programmes covering a number of years,

S. whereas setting up and running multiannual programmes is an enormous undertaking for the NGOs concerned in that the bulk of their funding is derived from one-off contributions from private donors,

T. whereas it is reliably estimated that worldwide some £24 million are being devoted to combating blindness through NGOs under rolling multiannual programmes,

1. Believes that the Community should make a significant contribution to fighting blindness in the Third World as part of a strategy to develop rural areas and to enable local people to contribute to their own development;

2. Requests the Commission, therefore, to consider how a Community contribution can be made most effectively, having regard to the work of the WHO consultative groups of NGOs;

3. Declares that consideration should be given to providing a financial contribution of 2-3 million ECU per year over a period of, say, five years towards the work of such organizations as Stichting Blindheid Bestrijding Ontwikkelingslanden (Foundation for Combating Blindness in the Developing Countries - Netherlands), the Royal Commonwealth Society for the Blind (United Kingdom) and Christoffel Blindenmission (Christoffel Mission for the Blind - Federal Republic of Germany) and that the Community's various financial instruments such as the EC budget, the European Development Fund, etc., should be used for this purpose;

4. Instructs its President to forward this resolution to the Commission, the Council and the World Health Organization.