WSD Report 2013 IWB English_Layout 1 19/08/2013 09:42 Page 1

WSD 2013 REPORT

2013
WORLD SIGHT DAY
10/10/2013



TOWARDS UNIVERSAL EYE HEALTH

GET YOUR EYES TESTED





IAPB
VISION 2020
THE RIGHT TO SIGHT

WSD Report 2013 IWB English_Layout 1 19/08/2013 09:43 Page 2

About 285 million people around the world are visually impaired. Four out of five cases are avoidable[1].

IAPB and its members and partners recognise that governments are the key to ensuring access to quality eye-health services and eliminating avoidable blindness. It is therefore encouraging that the World Health Organization (WHO) and member states are strongly supporting 'universal health coverage' and concomitantly 'universal eye health'.

The WHO defines universal health coverage (UHC) as "ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services[2]".

This means all people should enjoy access to the best quality health care without risk of impoverishment.

Health inequalities and UHC are closely linked; access for all will not be possible unless social determinants are addressed. In 2010, the World Health Report recognised the need to promote equity and acknowledged that some groups can slip through the gaps and that patterns of exclusion from services vary[3]. To achieve UHC, mainstream services must be designed to

All people must have access to care, without financial hardship.



overcome access barriers, and special measures, such as outreach programmes, must be taken to reach the poor and marginalised.

Health financing has a significant impact on access; social protection programmes, health insurance schemes and free point-of-care services are ways to reduce out-of-pocket health shocks.

In May 2013, 'Towards Universal Eye Health: A Global Action Plan 2014-2019[4]' was unanimously adopted by member states at the World Health Assembly in Geneva. By doing so, 194 countries have acknowledged the importance of universal eye health and have committed to reducing the prevalence of avoidable visual impairment and securing access to rehabilitation services for the visually impaired. While this is a remarkable development, formidable challenges remain. Advancing towards universal eye health will require political will and co-ordinated action by stakeholders.

This report sets out what universal eye health should mean in practice, taking into account key components of the Global Action Plan, and includes inputs from experts on the situation globally and regionally, with examples of countries striving towards universal eye health.





The Main Elements a Government Needs to Put in Place to Achieve Universal Eye Health

1. **Comprehensive eye care services: offering a breadth of services covering the range of causes of vision impairment, from promotion, prevention to rehabilitation and care**

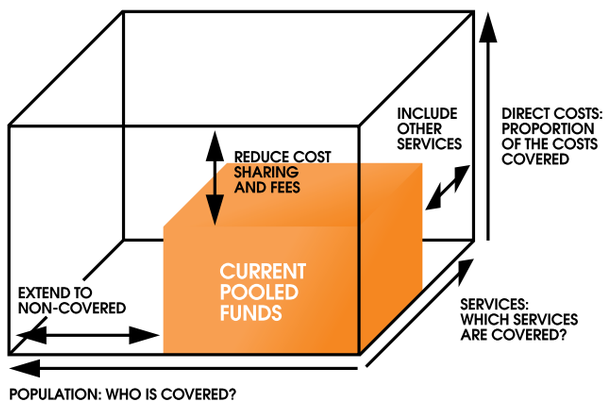
2. **Eye health integrated into health systems, attending to the six building blocks of a health system according to WHO: governance, health financing, service delivery, human resources, medicines and technologies, and information**

3. **Access for everyone, including the poor, minorities, the disabled including vision impaired and people in rural areas. This requires adequate health outreach and promotion including in appropriate technologies and formats, and ensuring main-stream and targeted programmes address barriers**

4. **Point-of-care payment should not prevent access: it should be free for the poorest**

Source: IAPB

Three dimensions to consider while moving towards universal coverage[5]



Preventing blindness increases access to education, employment, and enables greater participation in civil, political and social life.

A Global Momentum

'Towards Universal Eye Health: A Global Action Plan 2014-2019' includes strategies and priorities related to promotion, prevention, treatment and rehabilitation. Its goal is to reduce avoidable visual impairment as a global public health problem and secure access to rehabilitation services for the visually impaired[6]. This should be achieved by improving access to comprehensive eye-care services that are integrated into health systems. Care should be on a continuum from health promotion and prevention to rehabilitation, avoiding vertical approaches and emphasising access. The Global Action Plan sets a specific target of a reduction in the prevalence of avoidable visual impairment by 25% by 2019 from the baseline of 2010.



Eye Health Global Overview: Progress and Challenges

About 285 million people (a quarter of all people with disabilities) are visually impaired – about 39 million of whom are blind. 80% of the total or around 228 million people are avoidably impaired. Women are more vulnerable; in some contexts they are less likely to access services, and they are at greater risk of some conditions such as trachoma.

In spite of high numbers overall, there have been many significant achievements over the past decades. More recently, there has been progress in the control of infectious diseases including trachoma and onchocerciasis (river blindness), and in community outreach in retinopathy of prematurity. Multisectoral partnerships in eye health have set standards for collaboration, such as the *VISION 2020: The Right to Sight* and the *Seeing is Believing* initiatives, and the pharmaceutical donations from Merck and Pfizer. In a sign of national policy commitment, more than 100 national



Image: Dean Saffron, Brian Holden Vision Institute



Image: Clare Gilbert



Image: Wanjiku Mathenge

blindness prevention plans have been developed by governments around the world. In many countries there have been gaps in design, and implementation has been piecemeal or failed to reach the poorest.

Reducing avoidable blindness and rehabilitating those who are irreversibly visually impaired have enormous implications for the individual, their families and their communities. Preventing blindness increases access to education, employment, and enables greater participation in civil, political and social life. The economic arguments for eye health are also well known. Research shows that globally, for every dollar spent on improving eye health services there is more than a two-fold return on investment, and in developing countries, the investment generates a four-fold return[7].

However, unacceptably high proportions of people cannot access eye-health services around the world. There are serious shortages in trained personnel, particularly in Africa. Low surgical rates and irregular outreach to the poorest and rural populations are big concerns. For many poor and marginalised people the cost of treatment can be prohibitive. Transport, lack of appropriate technologies and discrimination cause further difficulties in access to eye health for vulnerable groups of people such as the poor, minorities, the disabled (including the visually impaired) and women. These challenges are compounded by changing demographics and health challenges. As populations age there is greater risk of visual impairment and blindness. In 2010, 82% of those blind and 65% of those with moderate and severe blindness were older than 50 years of age[8]. The rapidly increasing prevalence of diabetes, projected to rise to 552 million in 2030[9], will mean greater incidence of diabetic retinopathy and additional strains on health systems and eye-health personnel.

Political leaders and donors need to increase their investments in eye health.





WSD Report 2013 IWB English_Layout 1 19/08/2013 09:43 Page 6



Regional Overview
Africa

The major causes of visual impairment in Africa are cataract, glaucoma, trachoma, childhood blindness, onchocerciasis and refractive error. In recent years there has been enormous progress with the coordinated control of onchocerciasis and trachoma through the African Programme for Onchocerchiasis Control and the Alliance for the Global Elimination of Trachoma by 2020 (GET 2020) programmes. Recently, efforts to eliminate trachoma have advanced with The Global Trachoma Mapping Project.

Many governments in the region are taking strident steps towards universal eye health. Ghana's National Health Insurance System now covers most ocular diseases, and almost every district has an ophthalmic nurse[10]. In several African countries, nurses and medical assistants have been trained to diagnose and to make referrals.

However, challenges remain; the shortage of health workers at all levels in Africa is alarming and without additional ophthalmologists, optometrists and nurses, the targets in the Global Action Plan will not be met[11]. Workforce problems are most pronounced in Francophone and Lusophone countries. Across the region, political leaders, donors and other decision-makers need to increase their investments in eye health.



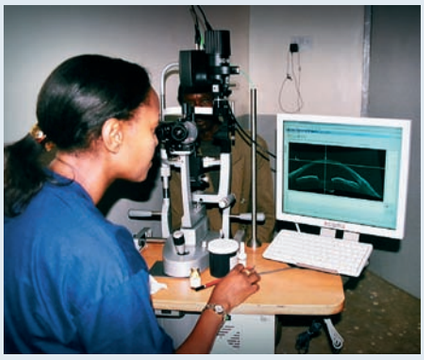
Rwanda: Striding Towards Universal Eye Health

In 2012 Rwanda's Ministry of Health and its partners developed the Third Health Sector Strategic Plan. With the motto, *Universal Coverage*, the plan provides for greater integration and collaboration across the health system. Rwanda allocated 18.8% of its budget in 2011 to the health sector and community-based poverty programmes (including savings and credit) for the rural poor. An improving economy means more Rwandans are capable of contributing premiums to the community-based health insurance scheme, which allows individuals to access comprehensive, subsidised, preventive care. The Minimum Package of Activities (MPA) covers all services provided at the health centres and the Complementary Package of Activities (CPA) covers a limited number of services at the district hospitals, including cataract surgery and all diseases afflicting children under five.

Many development initiatives impact on eye health. Access to drinking water increased from 77% of the population in 2005 to 87% in 2011, and this has contributed to Rwanda being the only country in the region without trachoma. The incidence of childhood blindness has also fallen dramatically, with greater coverage of Vitamin A supplementation (92%) and measles vaccination (82%).

The review of healthcare 'packages' for different levels was a great milestone and saw the development of eye-care treatment protocols, adoption of eye indicators in the Health Management Information











All Images: Wanjiku Mathenge

The shortage of health workers at all levels in Africa is alarming.

System and more eye-health consumables added to the national procurement system. A central eye fund was established and workforce issues were also reviewed to support the health system.

The importance of free healthcare for the poorest

User fees in public health facilities are a barrier to access, and a major obstacle to achieving universal health coverage. Many countries, such as Burkina Faso, South Africa, Mali, Niger and Ghana have introduced exemption policies, targeting specific population groups (e.g. children under five years) or specialised services (e.g. caesareans). In Burkina Faso, 80% of poor households go into debt or sell assets to pay healthcare costs. The introduction of user fee exemption has had a very noticeable impact: the number of children under five consultations in health facilities increased six-fold. By increasing access and utilisation of health care, it is estimated that free healthcare can save the lives of around 20,000 children every year in Burkina Faso. In a recent national study, it was found that universal health coverage through free healthcare will cost only £3 per child per year[12].

WSD Report 2013 IWB English_Layout 1 19/08/2013 09:43 Page 8



Regional Overview
Eastern Mediterranean Region

The Eastern Mediterranean is a diverse region covering nations in the north of Africa as well as countries such as Pakistan, the United Arab Emirates, Palestine and Yemen. Cataract and glaucoma are two of the major causes of visual impairment and with diabetes prevalence rising across much of the region, diabetic retinopathy is an increasing threat. In response, Jordan and Saudi Arabia are replacing inflexible hospital-based programmes with comprehensive community-based screening initiatives. Trachoma is also prevalent in some areas; however, Morocco, Oman and Saudi Arabia are close to eliminating the disease. An EMR Trachoma Alliance Taskforce has been set up to map prevalence and support community-based interventions in countries where blinding trachoma remains a public health concern. Low vision is also a concern and recommendations have been made to expand access and improve low vision and rehabilitation services.



Image: IAPB EMR

Morocco, Oman and Saudi Arabia are close to eliminating trachoma.



Saudi Arabia: leading the way in eye care

The Kingdom of Saudi Arabia has made great strides in improving eye health domestically, and has galvanised political and economic support in the region and at a global level, culminating in the approved Global Action Plan[13]. Saudi Arabia is committed to evidence-based planning for eye care. The Ministry of Health (MOH), in collaboration with the National Prevention of Blindness Committee (NPBC), conducted rapid assessments of avoidable blindness and diabetic retinopathy in three regions of the country[14] and the results from these assessments were used to develop a national plan for screening and control of diabetic retinopathy[15].

Prevention of blindness and deafness has been incorporated into Saudi Arabia's new primary healthcare policy with a dedicated budget line and training schedules. To maintain a continuum of eye care, a 5-10 year programme that encompasses screening for Retinopathy of Prematurity (ROP), pre-school vision, diabetic retinopathy, glaucoma and cataract are being developed within existing health structures. The MOH is currently establishing four additional eye centres across the country to deliver these services.

With new data demonstrating that blindness, primarily from diabetic retinopathy, is increasing, the MOH has reactivated its Prevention of Blindness (PB) unit and moving operational responsibility to areas responsible for Public Health and non-communicable disease (NCDs). For the first time ever in 2013, USD 2.66 million was allocated to blindness prevention specifically for diabetic retinopathy screening, the development of protocols for glaucoma, ROP and pre-school screening and additional research.



Regional Overview
Europe

Data on the prevalence of blindness and visual impairment in Europe is sparse. According to 2010 data from the WHO, there are around 3 million blind and 28.7 million severe and moderately visually impaired people across the 53 countries of the region. Diabetic retinopathy and age-related macular degeneration are major causes in Western Europe, while cataract and refractive error are also of focus. As the population ages in Europe, these threats are increasing and in Eastern Europe, ROP is a major cause of blindness among children. The region includes developing, middle-income and fully industrialised nations, and as such eye health provision, financing, payment, and access vary considerably. Lack of awareness of the need for routine exams, outreach issues, problems with referral pathways and inadequate training are key challenges to ensuring universal eye health in Europe.





Images: UK Vision Strategy

In England, 1000 extra buses are to become Talking Buses.

The United Kingdom: The UK Vision Strategy[16]

The UK Vision Strategy (UKVS) is designed to ensure fair and equitable access for all to eye health and sight loss services. Led by civil society, the national strategy was developed following consultations with over 650 organisations and individuals. The strategy provides a national framework for reducing sight loss, integrated service provision and building an inclusive society. It promotes the need for more research into eye health and research priorities for 10 key areas have been agreed after consultation with patients, the public and the professions. The strategy aspires for person-centred delivery



models, excellent services and support appropriate for each individual, in line with their personal preferences.

The strategy will work to a) ensure that everyone in the UK looks after their eyes and their sight; b) everyone with an eye condition receives timely treatment and, if permanent sight loss occurs, early and appropriate services and support are available and accessible to all; c) a society in which people with sight loss can fully participate.

Recent achievements in the UK include:

- In 2012, an indicator on eye health was included in England's Public Health Outcomes Framework to track the rates of three major causes of avoidable sight loss.
- The Royal College of General Practitioners (RCGP) has selected eye health as one of its four clinical priorities for 2013 – 2016.
- In England, 1000 extra buses are to become Talking Buses, which will make travel safer and more accessible for those with visual impairment. A similar commitment has been made in Wales.



Regional Overview
North America

The North America region includes Canada, the United States and most of the Caribbean countries. Major threats to eye health in North America include chronic conditions such as glaucoma, diabetic retinopathy and macular degeneration, as well as refractive error. In the Caribbean, many countries still have high rates of cataract and low surgical rates. Haiti is a focus country for IAPB and a national plan for blindness prevention was developed at a recent workshop. Research by Prevent Blindness America has drawn attention to the high economic costs of eye health in developed countries, with the total economic burden in the US estimated to be around US$ 139 billion in 2013[17].



Barbados: increasing access to Glaucoma screening

With a population of around 284,000, the majority of the people in Barbados are Afro-Caribbean. The Barbados Eye Study, completed in the 1990s, recognised glaucoma as a public health problem and this remains so today. A population-based study found that black Barbadians had the highest rates of primary open-angle glaucoma, around 7.0%. Given the significant impact that glaucoma makes on blindness in the country and the fact that half of those with vision loss due to glaucoma were unaware of their condition, a public outreach effort was initiated by Dr Dawn Grosvenor from the Queen Elizabeth Hospital in Bridgetown.

In World Glaucoma Week, held in March each year Dr. Grosvenor and her team organise a week of awareness-raising activities. In 2010, the Glaucoma Foundation in New York joined the campaign and since then, the event has grown exponentially.

In March 2013, the team organised a media campaign to encourage at-risk individuals to take up free screening. Ophthalmologists and optometrists from around the country were recruited and many opened their practices for free screening during the week. A Glaucoma Expo was held offering free screening, lectures and display booths all day in one location, and estimates suggest over 1000 people were screened in one week. Approximately 7% of those screened were found to have signs of glaucoma and some were previously diagnosed but defaulted from care. The campaign identified new cases and encouraged people with glaucoma to return to follow-up care. As a result of this initiative, the vision of hundreds has been saved. The government of Barbados continues to run glaucoma awareness pieces on television.





All Images: Dr Dawn Grosvenor-Blackman

WSD Report 2013 IWB English_Layout 1 19/08/2013 09:43 Page 11

Dr Margaret Chan, Director General, WHO, has asserted that "universal coverage is the single most powerful concept that public health has to offer".

Integrate eye care at every level of the health system and into other health programmes.

For every dollar spent on eye health in developing countries, there is a four-fold return.







2013 WORLD SIGHT DAY
10/10/2013

WSD Report 2013 IWB English_Layout 1 19/08/2013 09:43 Page 12



Regional Overview
Latin America

Cataract, diabetic retinopathy, glaucoma and ROP are the major causes of blindness and visual impairment[18] and these are priorities in the Pan American Health Organization's (PAHO) Action Plan on Eye Health. VISION 2020 Latin America was officially launched in 2004 as a three-way partnership between PAHO, Pan American Association of Ophthalmology (PAAO) and IAPB bringing together professional associations, governments and the NGO sector[19]. Over the years, the body capitalised on its partnerships to catalyse change and now, every country in the region has a blindness-prevention committee. Cataract surgical rates have increased with most of the region's 19 countries now reporting rates of 1500 or above. However, eye-health providers are concentrated in major cities and there is very little government support for surgeries on patients who are underinsured or have no coverage. In most countries, there is a shortage of mid-level personnel.

Chile guarantees free eye health to the poor.



National Perspectives

In early 2013, IAPB brought together government, industry, insurance companies and the national society of ophthalmology to develop a new national plan for the **Dominican Republic**. It focuses on modifying criteria for reimbursement and coverage of cataract surgery, which is currently restricted to only 40% of the population. Potential means to improve access include networking of hospitals and large providers to cover underserved areas, and introducing codes for procedures not yet covered (such as cataract surgery not using phaco), to make reimbursement processes more efficient.

Mexico's *Seguro Popular* (popular insurance) has increased awareness of cataract blindness, and the CSR has





All Images: IAPB Latin America

risen in the last three years from around 100 to over 1600.

Mexico has played a key leadership role in sponsoring resolutions on avoidable blindness at the WHO Executive Board and the World Health Assembly.

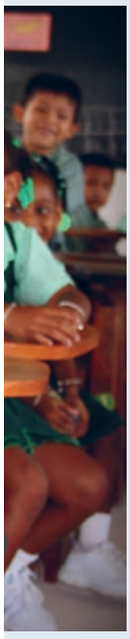
Chile has one of the strongest healthcare systems in Latin America. Treatments for eight ocular diseases, including diabetic retinopathy, spectacles for vulnerable age groups and ROP, are funded by the government and in 2012, Chile's CSR reached a median of over 4000. While 70% of the population is not covered by private insurance, Chile guarantees universal eye-health coverage through financing methods including full fees if the patient is unable to afford care. All children receive eye examinations and spectacles are provided; all health services covered for indigenous people and people living with diabetes are entitled to an annual dilated eye examination. In areas where government institutions cannot provide care, private organisations offer services paid for by the government.



Dylan's Story

Seven-year-old Dylan was referred to the Corporacion Evangelica De Hualpen's Low Vision programme. Dylan had been withdrawn from elementary school as he was unable to read from his schoolbooks, the blackboard or use other educational materials. Dylan stayed at home awaiting a miracle treatment. A functional assessment of vision was carried out by professionals from the programme who prescribed appropriate low-vision aids, and with training Dylan was able to read school-books and see what was on the blackboard. However, Dylan's family could not afford the aids prescribed for his benefit. JUNAEB's 'Provide Loupes and Bookholders' Project, donated a 12.5x loupe and a book-holding table that makes it easier to read up close.

Dylan's parents now have the joy of knowing that he will be able to continue his studies and live a normal life.











WSD Report 2013 IWB English_Layout 1 19/08/2013 09:43 Page 14



Regional Overview
South East Asia Region

South East Asia has one quarter of the world's population, but as much as one third of the world's blind people. Half of the world's 1.5 million blind children live in the region[20]. Cataract, childhood blindness, refractive error, glaucoma, and diabetic retinopathy are the leading causes of blindness. Human resources are a major challenge, impeding progress. In most countries, there is only one ophthalmologist for every 200,000 people, and about one mid-level eye-care specialist for every half million people. Most of the eye-care personnel are based in cities and towns; however around 75% of the population live in rural areas. The reduction in the cost of intraocular lenses (IOL) has had a major impact in increasing cataract surgical rates in India and surrounding countries. There are also good examples of pro-poor financing, such as Bangladesh, where cataract surgery is subsidised.



India: Towards Universal Eye Health

Most eye-care programmes in India have been structured around cataract, initially through surgical eye camps and then building the hospital base. India now has a good network of secondary eye hospitals in the voluntary and government sector. Over decades, ophthalmology has developed a strong community orientation and promoted robust intervention programmes, largely through outreach and screening eye camps.

While screening camps identify and refer millions of people for cataract surgery annually, a study[21] conducted a decade ago showed that only 7% of those in need of eye care were attending camps. The focus on cataract was limiting the diagnosis and management of refractive errors, glaucoma and retinal disorders.

Primary Eye Care (PEC) was then adopted as a more effective approach. Permanent centres were established in communities covering a population of approximately 50,000 people. Trained ophthalmic technicians and screening protocols were key to the approach.

The experience at Aravind Eye Hospitals has been most encouraging. Vision Centres, established for four years, have registered close to 20% of the population as unique patients. This represents almost the entire need for eye care services in the area. For the first time we have evidence of a model that can help achieve the elusive goal of universal coverage. This will be the key for managing chronic conditions like glaucoma and diabetic retinopathy, ensure regular follow-up and represent the last mile connection for uncommon medications.

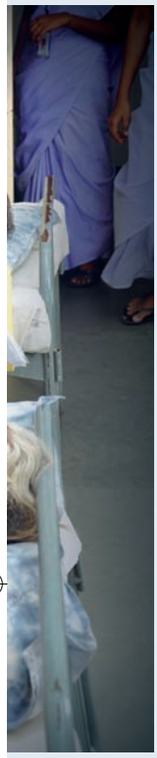


Image: Mr. Rajkumar, Aravind Eye Hospital



Image: Mr. Jacques Vekermans, Aravind Eye Hospitals

Half of the world's 1.5 million blind children live in the region.

The PEC approach has become part of India's National Programme for Control of Blindness. Funds have been allocated to establish 5,000 primary eye-care centres during the 12th Five-Year Plan. While there has been some progress in both government and voluntary sectors, more infrastructure is required. Enabling policies, minimum standards and technologies are also needed to expand eye-care services at the community level.

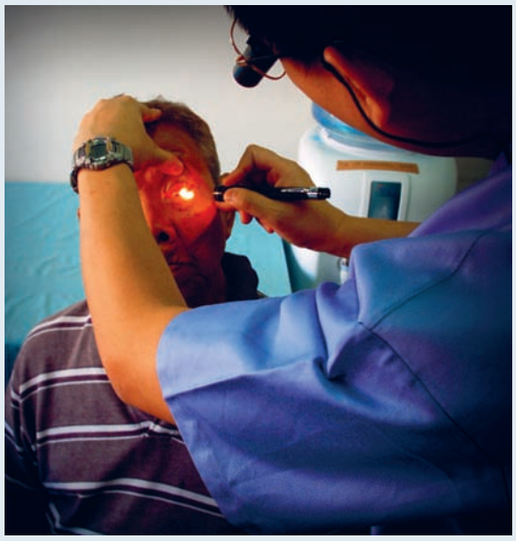
With the Vision Centre model, India is closer to the elusive goal of universal coverage.

WSD Report 2013 IWB English_Layout 1 19/08/2013 09:43 Page 16



Regional Overview
Western Pacific

The Western Pacific is a large and incredibly diverse region. While causes of visual impairment differ widely, the two main causes are cataract and refractive error. New disease priorities are emerging with the prevalence of diabetes growing fast in many Pacific Island countries and industrialising countries of Asia, as well as Australia and New Zealand. In resource-poor settings with weak infrastructure for water and sanitation, endemic pockets of trachoma remain, especially in the Pacific. In high-income countries, age-related retinal diseases are the most common causes of blindness. In this context, challenges for national programmes vary greatly. In small Pacific Island states, strengthening effective clinical services which rely on effective primary care networks, referrals and outreach programmes remain an ongoing challenge. Many countries of Asia have massive workforce challenges; particularly in the distribution of specialists in rural areas. Encouragingly, Vietnam, China, the Philippines and Cambodia are strengthening social protection programmes and working within their means to provide universal access to eye health. Lao PDR – one of the poorest countries of the region – is committed to establishing a national health insurance authority with universal coverage in the next few years. Countries such as Singapore, Brunei, Australia and Malaysia have long-established universal health agendas. Universal eye care in the Western Pacific region will only be achieved with adequate resources to expand and sustain these financing schemes, and additional funding for good-practice blindness-prevention programmes.





The Philippines: Eye health for every Filipino

The government of the Philippines has made a strong political commitment to ensuring that every Filipino receives affordable and quality health care and early in 2013, the Department of Health (DOH) issued an Administrative Order to make eye health and blindness prevention part of the country's ambitious health agenda. Recently, the Congress passed long-contested legislation for reproductive health and agreed to a new tax on tobacco and alcohol. The funds from that levy will be allocated to expanded health promotion programmes and the national health insurance programme, PhilHealth. These reforms are very timely for eye health.

A 2002 national survey of blindness in the Philippines found 362,000 people blind from cataract and 59,000 blind from refractive error, which put the prevalence of blindness at around 0.58%. To update this, the government is planning to undertake a rapid assessment of avoidable blindness in 17 regions later this year. Previously, eye health programmes were vertical in nature and often



All images: Tanggal Katarata Foundation

The Philippines has made a strong political commitment that every Filipino receives affordable and quality health care.

Many Asian countries have massive workforce challenges.

relied on international organisations and the voluntary sector.

Now, key eye-health objectives contained in the draft national strategic plan for blindness prevention sit within a broader national strategy for non-communicable and degenerative diseases. The DOH blindness-prevention officials work collaboratively with those responsible for diabetes, disability and rehabilitation and other conditions linked to ageing and chronic disease. Programmes and services, particularly at primary level and in provincial settings, will be able to make the most of shared referral and delivery infrastructure.

The Philippines is working to ensure the cost of accessing health is no barrier, and PhilHealth is the key to reducing costs for the individual and expanding access. Through PhilHealth, 40 per cent of the individual allocation goes to the professional (usually the surgeon), and 60 per cent to the hospital (usually a private facility). Reforms are planned to ensure that this is progressively adopted in government hospitals. A recent study commissioned by IAPB found PhilHealth was underutilised for eye health treatments, with rates as low as seven per cent among marginalised population groups. The Department of Health has committed to further promoting PhilHealth and increasing awareness in disadvantaged communities.

Through the National Committee for Sight Preservation, key stakeholders in the Philippines are working to ensure eye-health professionals in private and public practice are equipped to provide quality, comprehensive eye health services for everyone. Like many countries, a key challenge for the Philippines is workforce distribution, and most specialist health providers are located in urban centres. The DOH is guiding reforms to ensure access for people in more remote areas, and considering ways to support professions to contribute to government health programmes.

WSD Report 2013 IWB English_Layout 1 19/08/2013 09:43 Page 18

Translating the Global Action Plan into Reality; Factors for Success

There is considerable variation in the state of eye health and the progress being made towards universal eye health. The breadth of services offered, fees charged and how services are financed differ greatly. Even within countries, there are huge disparities and differences. Positively, there are many good examples around the world, of countries adopting pro-poor approaches. Efforts to integrate eye health into insurance schemes and increase outreach demonstrate that possibilities exist even in resource-poor settings. However, much more needs to be done and the Global Action Plan sets out a useful framework.

Consistent with Objective 1 of the Global Action Plan, there needs to be greater understanding of the context and evidence for appropriate policies and programmes. More information is needed on the prevalence of visual impairment and its causes, and the availability and take up of services. In many countries, there is a lack of data on eye health, and a lack of systematic reviews on eye care and access[22]. More needs to be done to understand means to attract and keep staff in remote areas and review how task-shifting may improve productivity and service use, learning from those cases where a flexible approach to labour was



Image: Tanggal Katarata Foundation

taken to increase coverage.

In many contexts, eye health tends be delivered in programmes and facilities separate to other health services, although there is a growing recognition of the value of integration and shared delivery systems. By embedding eye health in the broader health system, efficiency and access gains can be made.

Objective 2 of the Global Action Plan calls for integrated eye health, in line with WHO's framework for strengthening health systems to improve health outcomes[23]. Partnerships have proven to be enormously successful in the eye health sector, across government, businesses and NGOs, and with the WHO. It is essential

Partnerships have proven to be enormously successful in the eye-health sector.



that these partnerships be strengthened and that new ones are brokered to achieve the targets of the Global Action Plan. Stronger links can be forged with areas such as Non Communicable Diseases, Neglected Tropical Diseases and maternal and child health. Beyond the health sector, there are common priorities in water and sanitation, housing, education, ageing and disability. Close links with disabled peoples' organisations will continue to be important.

Access for everyone is the central goal. Special effort must be made to reach the poorest and most vulnerable. Most critically, point-of-care payment should be free for the poorest. Human resources and appropriate budget allocations on eye health will be major factors in the push for universal eye health. Without significant investment in eye health the goal will not be achieved.

Acknowledgements

IAPB gratefully acknowledges the contributions of Zoe Gray, Advocacy Manager, IAPB; Sanjeev Commar, Consultant, The Fred Hollows Foundation; B V Tejah, Communications Manager, IAPB and with editorial support from Damian Facciolo, IAPB Western Pacific, in putting together this report. The various regional reports were put together with contributions from Wanjiku Mathenge (The Fred Hollows Foundation), Ronnie Graham (IAPB Africa), Karl Blanchet (International Centre for Eye Health) and Halli Manolakos (IAPB Africa) for the Africa section; Mansour Rabiu (IAPB EMR) for the Eastern Mediterranean; Nick Astbury, Anita Livingstone and Katherine Huntly (UK Vision Strategy) for Europe; Louis Pizzarello (Chair, IAPB North America) and Dawn Grosvenor-Blackman for North America; Van Lansingh (IAPB Latin America), Patricia Ramos González and Ferdinand Barria (COALIVI) for Latin America; R D Thulsiraj (Aravind Eye Care System) for South East Asia; and Damian Facciolo for the Western Pacific.

References

1. **www.who.int/mediacentre/factsheets/fs282/en/** accessed 04 July 2013
2. **www.who.int/healthsystems/universal_health_coverage/en/** accessed 04 July 2013
3. The world health report – Health systems financing: the path to universal coverage; WHO 2010
4. Towards Universal Eye Health: A Global Action Plan 2014-2019. **apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R4-en.pdf** accessed 04 July 2013
5. Figure "Three dimensions to consider when moving towards universal coverage", reproduced with permission from page 13, The World Health Report, Executive Summary. Health Systems Financing; The path to universal coverage
6. Towards Universal Eye Health: A Global Action Plan 2014-2019. **apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R4-en.pdf** accessed 04 July 2013
7. Investing in Vision: Comparing the Costs and Benefits of Eliminating Avoidable Blindness and Visual Impairment; The Fred Hollows Foundation 2013, **www.hollows.org.au/our-work/the-price-of-sight,** accessed 4 July 2013
8. Towards Universal Eye Health: A Global Action Plan 2014-2019. **apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R4-en.pdf** accessed 04 July 2013
9. The IDF Diabetes Atlas Fifth Edition, **www.idf.org/diabetesatlas**
10. Potter, A., Debrah, O., Ashun, J., Blanchet, K., 2013, *Eye Health Systems Assessment (EHSA): Ghana Country Report*, Ghana Health Service, Sightsavers, International Centre for Eye Health.
11. Palmer, J. Blanchet, K. Chinanayi, F. Jaggernath, J. Naidoo, K. Graham, R. 2013. Human resources for eye health in sub-Sahara Africa: deficit and maldistribution, International Centre for Eye Health, AVRI.
12. Yameogo, P. Blanchet, K. Etude de faisabilité de l'exemption du paiement des soins curatifs chez les enfants de moins de 5 ans au Burkina Faso, Ministry of Health, Burkina Faso
13. **www.iapb.org/blog#WHA2** accessed 10 June 2013
14. **www.pbunion.org/blinddata.html** accessed 11 June 2013
15. A strategic frame work for Diabetic retinopathy screening program developed by local and international experts in diabetic retinopathy screening program for implementation by the Saudi Arabian Ministry of Health. Directorate of Public Health. Ministry of Health Riyadh, Saudi Arabia. February 2013.
16. The UK Vision Strategy is a VISION 2020 UK initiative with leadership from RNIB, **www.vision2020uk.org.uk/ukvisionstrategy/**
17. **costofvision.preventblindness.org/** accessed on 04 July 2013
18. Causes of blindness and visual impairment in Latin America. Furtado JM, Lansingh VC, Carter MJ, Milanese MF, Peña BN, Ghersi HA, Bote PL, Nano ME, Silva JC.Surv Ophthalmol. 2012 Mar-Apr;57(2):149-77. doi: 10.1016/j.survophthal.2011.07.002. Epub 2011 Dec 2. Review.
19. See **www.v2020la.org**
20. See **www.iapb.org/about-iapb/regions/global-network-south-east-asia**
21. "Low uptake of eye services in rural India"; Astrid E. Fletcher et al; Archives of Ophthalmology Vol 117, Oct 1999
22. How to achieve universal coverage of cataract surgical services in developing countries: Lessons from systematic reviews of other services, December 2012, Blanchet, K
23. Towards Universal Eye Health: A Global Action Plan 2014-2019. **apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R4-en.pdf** accessed 04 July 2013

Reviewing the Global Action Plan and implementing priority activities at a national level

2013 WORLD SIGHT DAY 10/10/2013

Recommendations for governments, donors and other decision-makers

1. **Invest in eye health, increasing budget allocations to address need.**
2. **Address the human resources crisis, through investments in training and personnel and using innovative means, based on learning from good practices and research.**
3. **Withdraw user fees for the poorest.**
4. **Integrate eye care at every level of the health system and into other health programmes (e.g. child health checks, diabetes screening)**
5. **Increase access to health and eye health for all communities, including the disabled, addressing discrimination, geographical, mobility, sensory and built environment barriers.**
6. **Conduct blindness-prevalence surveys, carry out eye-health system assessments, and develop methods and indicators to measure and evaluate universal eye health.**
7. **Develop national eye-health plans, and integrate eye-health issues within broader health plans, and other relevant sectors.**



World Sight Day report and material produced with support from:

Alcon® a Novartis company

OPTOMETRYGIVINGSIGHT
Transforming lives through the gift of vision

IAPB

International Agency for the Prevention of Blindness
London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT. United Kingdom
Tel: +44 (0)20 7958 8394 • Email: communications@iapb.org
www.iapb.org

The International Agency for the Prevention of Blindness (IAPB); Registered Charity No: 1100559
Company Limited by Guarantee No: 4620869; Registered in England and Wales.