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Regional Policy Brief: *Strengthening Human Resources for Eye Health in SADC Countries*

Regional Eye Health Advocacy Group

- *Sub-Saharan Africa carries a high burden of about 16.6 million people who are visually impaired, and 4.8 million are blind, proportionally more of whom are women. About 20% of the population could at one time have an eye condition that impairs quality of life and functionality.*

- *Blindness causes poverty, and it is often the poorest people, and those who live in rural areas, who go blind due to a lack of access to quality eye care. Eye health is often not prioritised by governments as a health condition for resource allocation. Yet, it is estimated that every dollar spent on improving eye care services provides a four-fold investment return in productivity in lower income countries.*

- *Despite being treatable by cost-effective interventions, the leading causes of blindness and visual impairment in sub-Saharan Africa remain cataract and refractive error respectively, with diabetic retinopathy increasing as a cause of irreversible blindness.*

- *Although about 80% of visual impairment is avoidable, there are insufficient human resources for eye health (HReH) especially in the rural areas, with gaps in their capacity, motivation and performance, to provide quality eye care. Investment in HRH is one of the best buys in public health, and it has a broader socio-economic impact: improving synergies with education, creating career opportunities for women, facilitating formal sector employment and stimulation economic growth.*

SADC can play a key role in addressing the critical need for quality eye health care by prioritizing eye health in its non-communicable disease and conditions (NCDC) strategic plan and to develop a regional strategic plan for eye health with particular emphasis on HReH. It can also advocate and catalyze country and regional actions to address HReH, and, so doing, contribute towards universal eye health coverage (UeHC).

A regional strategic plan for eye health would provide a framework for governments, training institutions, civil society organizations and various other agencies to work together, individually and collaboratively, to address the eye health crisis in SADC countries, to ensure all people have access to a skilled, motivated and supported health work force which can provide quality eye care, within a robust health system. A number of recommendations, in line with the International Agency for the Prevention of Blindness (IAPB) Human Resources for Eye Health Strategic Plan for 2014-2018, follow.

How to overcome the eye health and HReH crisis

Eye health policies and strategies

- *HReH are central to translate the vision of universal eye health coverage into improved eye health care on the ground.*

- *Eye health policies and strategies need to be responsive to people's eye health needs, rooted in socio-economic realities and take into account country differences. Targeted action is needed to reach women, rural and vulnerable groups.*

Coordinate health teams to provide primary eye care

- Traditional models of HReH education, deployment, and remuneration need to be revisited and performance assessed.

What would be the key components of a regional strategic plan for eye health, focussing on strengthening human resources?

Strong national and local political leadership and long-term commitment

Adaptive and resilient leadership is required to build political support and ensure sufficient funding for effective and responsive eye care. Governments should lead the drive to address eye health needs by enacting policies and investment decisions to improve and scale up and HReH, partnering with civil society and the private sector.

Countries need a coordinated approach to strengthen and motivate HReH as a part of their HRH strategies

HReH should be included as part of wider government HRH strategies and service provision. For example, deployment strategies to enhance rural retention by providing health budgets for incentive schemes, scholarships, recruiting from rural areas, rural service components in curricula, improving working conditions and supervision.

Innovative skill mix/task shifting approaches, broadening the recruitment pool and flexible career opportunities should be considered to expand and develop HReH in a relatively short time. Identify the appropriate skill mix, which should include eye health competencies of eye health team members, such as primary care and community health workers (CHWs) and specialist eye health workers (ophthalmic clinical officers/nurses, optometrists, ophthalmologists).

In addition to increasing HReH numbers, it is crucial to provide decent salaries, clinical mentoring and support, opportunities for continuing professional development and a safe, well-equipped, supportive working environment.

Appropriate training is needed to develop, maintain and improve essential eye health competencies of HReH

A key action is to strengthen the initial training and continuing professional development. Fundamental to this is for WHO and IAPB, together with governments, training institutions and professional bodies to agree on roles and responsibilities for different cadres in the eye health team, and use these to develop and validate

- *Specialist mid-level eye health workers (MLHWs), such as ophthalmic nurses/clinical officers, can fill some of the rural eye health need.*
- *Nurses, doctors and non-physician clinicians, can provide basic eye care at primary health care facilities,CHWs can play a major role in primary eye care.*

Coordinate stakeholders, sectors

- *Many crucial drivers of health system change lie outside of the traditional boundaries of the health system, thus, it is vital to engage with wider development, health and HRH initiatives.*

Meet information needs

- *Policy makers and planners require information about eye health and poverty alleviation and economic growth; costs of various scenarios of HReH reforms, factors that influence scaling-up of eye health programs in different contexts.*

Regional Eye Health Advocacy Group is part of the EC-funded Programme Advancing Healthy Communities - Affordable, Accessible and Quality Eye Care in Malawi, Mozambique and Zimbabwe.

competency frameworks. If agreement can be reached on a methodology for situation analysis of HReH training content and institutions, training needs can be determined for planning improvements, and to monitor and evaluate their quality.

Countries need to invest in a robust and resilient primary care systems to improve access to eye care services

Primary health care systems need to be responsive to population needs, inclusive and representative to provide comprehensive and people-centred eye health care. Not only is curative and rehabilitative care required, but also health promotion and the prevention of eye conditions, with links to other development and health sectors. This depends on competent, coordinated health teams and effective referral pathways to adequately resourced services.

Community participation and mobilisation are vital components of primary eye care that need to be strengthened and supported.

Coordination and synergy is essential for effective and sustainable eye health care coverage

The alignment of stakeholders, systems and sectors is vital to provide responsive eye care services, especially to vulnerable population groups. Moreover, sectors that contribute to eye health need to unite and forge links with other health and social initiatives. For example, collaboration of the eye health sector with the Global Health Workforce Alliance and networks of organisations involved with NCDs and NTDs and with other aspects of disability services in the emerging post-2015 Social Development Goals framework.

HReH research as a strategic action

Operational research that includes identifying, documenting and sharing best practice for HRH development can provide a more informed understanding of HRH in general and HReH in particular, and valuable information for advocacy. For example, understanding how middle level eye health workers can most effectively be empowered and supported to provide quality care andhow to assess their impact.

Table: The cost of visual impairment to the individual

Employment	**Disability results in loss of employment and reduced productivity.**
Material wealth	**Households affected by disability have lower average incomes, lower savings and higher debt.**
Education	**Access to education is limited resulting in children less likely to enter, remain or succeed in school.**
Health	**Physical access to services can be limited. People with disabilities have a greater risk of accidents.**
Poverty alleviation	**Access to development assistance, such as micro-credit and training opportunities is more limited.**
Social well being	**Stigma, social isolation and vulnerability to domestic violence are all associated with disability.**

An integrated and comprehensive strategy to secure the commitment of governments to strengthen country health systems is vital to develop and support HReH as part of the HRH system.

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