UNITY AS A TOOL TO GROWTH IN EYE HEALTH SECTOR IN UGANDA

PRESENTATION TO OSU MEETING
4TH DEC 2021

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THEME: UNITY & GROWTH FOR EYE CARE

- **Overall purpose:**
- To promote Unity and strengthen cross collaboration in delivery of eye health programmes in Uganda.

DEFINITIONS

Eye Health is maximised vision, ocular health, and functional ability, thereby contributing to overall health, wellbeing, social inclusion, and quality of life. Based on the International

Universal health coverage is ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship.

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DEFINITIONS

- Assistive devices and technologies are those whose primary purpose is to maintain or improve an individual's functioning and independence to facilitate participation and to enhance overall well-being. They can also help prevent impairments and secondary health conditions. Examples of assistive devices and technologies include wheelchairs, prostheses, hearings aids, visual aids, and specialised computer software and hardware that increase mobility, hearing, vision, or communication capacities.
- Rehabilitation is defined as 'a set of interventions designed to optimise functioning and reduce disability in individuals.
- Visual Rehabilitation is a set of services that assists individuals who experience disability from visual loss to achieve and maintain optimal functioning. Visual rehabilitation services assist people with activities of daily living, accident prevention, and general physical and psychological wellbeing. They include orientation and mobility training and support services such as providing trained assistants and dogs; providing assistive devices, technologies and training as well as counselling and modification of the physical environment.

What principals can guide eye health care growth?

- **Universal access and equity**: all people in Uganda have equal access to eye health services;
- **Life course approach**: eye health services will be available to and cater for all age categories from before birth to old age;
- **Evidence-based practice**: interventions will have proof of safety and effectiveness;
- **Inclusion**: eye health services that promote full access and participation of Persons with Disabilities in all their diversity, thus promoting their rights by consideration of disability-related perspectives and needs in compliance with the Convention on the Rights of Persons; and
- **Gender equality in access**: every intervention will take into consideration the gender difference between girls and boys, men and women.

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Rehabilitation

- (d) Vision rehabilitation is a set of services that assists individuals who experience disability to achieve and maintain optimal functioning. Services assist people with activities of daily living, accident prevention, and general physical and psychological wellbeing. Rehabilitation services include refraction and provision of visual aids, training in mobility and orientation for the irreversibly blind.

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BUT WHO IS AN OPHTHALMOLOGY CADRE/WORKER??

- BRAINSTORM

STEPS TO INCLUSIVE EYE HEALTH

- The World Report on Vision recommended that eye care is built on WHO's existing framework of 'Integrated People-Centred' (IPEC) health services. As a result of the World Report, the World Health Assembly of 2020 (WHA 73.4) called upon member states to:
- • make eye care an integral part of universal health coverage;
- • implement integrated people-centred eye care in health systems;
- • promote high-quality implementation and health systems research complementing existing evidence for effective eye care interventions;
- • monitor trends and evaluate progress towards implementing integrated people-centred eye care; and
- • raise awareness, engage and empower people and communities in respect of eye care needs.
- Our strategies apply the WHA 73.4 resolution to respond to Uganda's eye health needs.
- Reducing blindness and low vision will advance Uganda's bid to attain SDGs by contributing to poverty reduction (SDG 1), reducing hunger (SDG 2), promoting education (SDG 4), good health and well-being (SDG 3) and access to decent work (SDG 8) as demonstrated in Figure 6 below.

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SDGs & EYE HEALTH

- Linkage between Eye Health Plan and Advancing Government's SDG Agenda
- SDG Contribution made by the impact of the National Eye Health Plan
- Goal 1: Poverty reduction
- Blindness and low vision which are associated with poverty will be reduced
- People who would otherwise have become blind and dependent will be productive
- Family members who would have taken care of a blind family member will be free to contribute to family income
- Rehabilitated blind/persons with low vision will participate in family income activities
- Goal 2: Reducing hunger Interventions to reduce childhood blindness will include Vitamin A supplementation which will contribute to availability of this micronutrient
- With fewer people blind, more hands will be available to contribute to family food chain
- Goal 3: Health and wellbeing Reduction in childhood blindness and blindness among older persons will reduce CMR and early death among the 60 years+.
- Goal 4: Education Prevention of Blindness, rehabilitation of the Blind and children with low vision will ensure greater access to education opportunities.
- Goal 8: Decent work and economic growth With less people Blind and the young Blind rehabilitated dependency is reduced and more people available in the workforce.
- Goal 10: Reduced inequalities A reduction in blindness and low vision will reduce discrimination.
- All the rehabilitated persons will face less discrimination
- Regional referral eye health departments will be accessible and friendly to people with disabilities, children and refugees.
- Eye health data will be disaggregated by sex during collection and at analysis.
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Upcoming Ugandan strategies 4 inclusive eye health

- A major shift is to expand eye health services to lower level health facilities and the community. To achieve this, a curriculum for training Primary Eye Care Workers (PECW) has been developed. Frontline clinicians and nurses will be trained in screening and basic eye care. The target is to have at least one PECW in selected HC III, all HC IVs and General Hospitals. Intense advocacy with Local Governments will promote the recruitment or training of OCOs so that mid-level services are within districts. The OCO will cascade eye health training to PECW and nurse trainees. The OCOs and VHT designated trainers will use the Primary Eye Care Guide to sensitise VHTs on identification and referral of eye conditions.

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Monitoring, Evaluation and Research

- Critical research to determine the CSR for the different regions was conducted. A research agenda was developed to guide eye care workers to conduct research relevant for Uganda's eye health service. Priorities on the research agenda include baseline studies for this strategic plan, Rapid Assessment of Avoidable Blindness (RAABs). The main challenge is improving the collection of data at the OPD/clinic level, especially in lower health facilities for better quality data.

Required Strategic Shift to make Eye Health Universally Available

- Despite the gains made by the previous strategies, eye care is still more available in urban centres whereas those who need the service most are in rural areas. Access to eye health information is still low and rarely integrated in district health education activities. It is rarely provided in local languages. Eye health workers who should provide the information are busy and, when available, do not un-package information for appropriate communication. The advocacy strategy remains centralised and eye health workers have received minimal training in advocacy. Eye care costs remain prohibitive for majority of patients. In a bid to increase services to lower levels, we propose s continuation of training of eye care workers and increased resources to ensure community eye care workers are trained. Among these are VHTs, retired health workers and lower cadre health workers on the frontline, such as nurses.

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ICT

- Currently there is minimal application of ICT in eye care at the district level. OCOs send prescriptions for glasses via sms to the NIURE workshop. Advances in digital medical care have simplified care and promoted access to complex care at lower levels. In line with the National Development Plan for 'digital transformation', every eye care worker should be trained in using phone/computer applications for diagnosis and management. A trial involving eye care workers in Mbarara health regions shows good outcomes.

UPCOMING PRIORITIES &OBJECTIVES

- • To strengthen delivery of quality, inclusive and equitable eye care services that are integrated in the health system based on the PHC approach for effective control of eye diseases and visual impairments.
- • To enhance the capacity of Human Resource for eye health at primary, secondary and tertiary levels and promote their equitable distribution, drive for quality care and motivation.
- • To improve availability of accessible infrastructure, functional equipment, essential medicines, diagnostics, assistive devices and digital health technologies at all levels.
- • To improve utilisation of Management Information Systems and promote research for evidence-based planning, resource mobilisation and advocacy for improved quality and efficiency of eye health services.
- • To strengthen coordination, effective partnerships and leadership for eye health services at National, regional referral, district and HSD levels.
- • To increase funding to eye health programmes, with a shift towards Primary Eye Care.

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Strategic Interventions

- The following interventions will strengthen eye health programme organisation and system development. Through a unified multi-sectoral and multi-level coordinated plan, the interventions will deliver the plan's outcomes and goals.
- **1.Quality Inclusive Equitable Eye Health Service**
- Quality, inclusive and equitable eye health services that are integrated in the health system and are provided at primary, secondary and tertiary levels and based on the PHC approach

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2.Equitably Distributed and Highly Motivated Human Resource for Eye Health

- Capacity of Human Resource for eye health at primary, secondary and tertiary levels enhanced and eye health workers are equitably distributed, highly motivated and have a drive for quality care.

3.Accessible Infrastructure, Functional Equipment and Adequate Supplies at all Levels

- Improved, accessible infrastructure, functional equipment, essential medicines, diagnostics, assistive devices and digital health technologies made available at all levels.
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4.Monitoring, Evaluation and Learning

- Monitoring, evaluation and learning (MEL) processes are essential functions to ensure that the eye health strategy delivers on its outcomes as planned. The evidence gathered through the M&E framework will be used to:
- • Direct implementation of plans by providing information on progress and results;
- • Provide a basis for strategy alteration/redirection;
- • Learn about innovations and guidelines for review and national adaptation;
- • Provide information and lessons for lobbying and advocacy for all the strategic objectives;
- • Guide mapping for allocation of resources, partners, advocacy and intensified supervision;
- • Provide a unified approach to monitoring progress by all stakeholders in the eye health sector, including development partners at national, regional and district levels.

- An integrated and comprehensive approach for monitoring and evaluation will measure progress towards universal eye health care. The M&E system will emphasise and demand quality data for decision-making, measurement of progress, accountability, learning and policy dialogue.
- Monitoring data will be from two information management systems:
- • The HMIS will collect data on the 51 eye health indicators which will contribute to the analysis of the strategic outcomes. It will also contribute to monitoring and mapping the 'capacity to deliver' indicators such as bed capacity, availability of tracer equipment and medicine and availability of eye care workers; and
- • The Eye Health Programme Information Management System will collect the indicators that the HMIS is not able to collect, especially process and output indicators. This system will make a major contribution to performance management.

5.Coordinated partnership, resource mobilisation allocation and advocacy for efficient service

- Coordinated effective partnerships and leadership for integrated eye health services at National regional referral, district and HSD levels for efficient service delivery

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6.Strengthened HMIS and increased research for advocacy

- Management Information Systems and research provide evidence for planning, resource mobilisation and advocacy for improved quality and efficient eye health service

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Linkage between Eye Health Plan and Advancing Government's SDG Agenda

SDG	Contribution made by the impact of the National Eye Health Plan
Goal 1: Poverty reduction	Blindness and low vision which are associated with poverty will be reduced
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Goal 10: Reduced inequalities	A reduction in blindness and low vision will reduce discrimination.
	All the rehabilitated persons will face less discrimination
	Regional referral eye health departments will be accessible and friendly to people with disabilities, children and refugees.
	Eye health data will be disaggregated by sex during collection and at analysis.

Thank you