World Health Organization

Non-State Actor submissions on the draft discussion paper -

"Proposed global targets for 2030 on integrated people-centred eye care"

Contents

Association of Portuguese Optometrists

Regarding the proposed tracer indicators and its characteristics:

1. There could be considerable uncertainty due to the fact the RE prevalence is still undetermined, even for high-developed countries, as with the claimed national eye care coverage by the Member States. Fact that could impair the purpose of these tracer indicators serving as a reasonable proxy. Would it be helpful to highlight this information gap and the strong need for the Member States commitment to move this forward;
2. We take good note of a specific measure to deal with the mentioned uncertainty in prevalence and coverage, as it is referred to the need to not exclusively depend on Member State Reporting. However, it isn't clear how and in what way this could be implemented. We believe that any definition, example or strong suggestion how the independence is safeguarded, would give guidance to the national stakeholders and MoH as to deal with this;
3. We suggest taking it further a notch by mentioning the benefits of the inclusion of civil society and all eye care professional groups, in the commissioning of the monitoring system;
4. We recognize the massive work underlying the proposed tracer indicators. Therefore, a 5-year cycle makes sense. Nevertheless, it could not be motivating enough for any Member State to adopt a long lasting planned strategy to achieve the proposed global targets. The same global targets could be claimed as achieved, with a set of special short term measures on the eve of each deadline. Although, it would also guarantee eye care every 5-year, it wouldn't translate into real universal coverage.

Fred Hollows Foundation

General comments

The Fred Hollows Foundation (The Foundation) commends the World Health Organization (WHO) in it's efforts to deliver on the request by Member States under WHA73.4 'Integrated People-centred Eye Care, including preventable vision impairment and blindness', to prepare 'recommendations on feasible global targets for reporting to the 74th World Health Assembly in 2021. Providing clear targets to monitor and report on progress, is an essential component of setting a course for change and establishing a quantum of expectation for action over the next decade.

The Foundation generally supports the targets for cataract surgery and refractive error correction as outlined in section 4 and the respective definitions of Annex 1 of the discussion Paper entitled, 'Proposed global targets for 2030 on integrated people-centred eye care – 13 October 2020'. We recognise the delicate balance of setting an ambition for change for eye health in-line with the spirit of the 2030 Agenda for Sustainable Development, while also grounding this ambition in a level of pragmatism. The Foundation believes the WHO has struck this difficult balance well.

The Foundation draws attention to the critical need to safeguard against the potential unintended consequence of excluding those traditionally disadvantaged and in harder to reach places, in favour of those easiest to access, easiest to treat and in maximising volume in pursuit of these targets. This would undermine the central principle of equity intrinsic to both UHC and the Sustainable Development Goals in leaving no one behind.

The Foundation therefore recommends as a matter of importance, elevating part of the sub-clause of the respective target narratives determining that 'Countries should aim to achieve an equal increase effective coverage in all population sub-groups, independent of baseline estimates', to be contained within the respective primary target statement. Appending a clause to each primary statement to the effect of 'across the population and sub-groups', would serve to ensure the principle of equity remains front and centre.

The Foundation also recommends the statement contained within the respective target definitions related to disaggregation by 'Age, gender, socio-economic status, geography and other relevant sociodemographic stratifiers', to be elevated to the main target narrative. This would ensure the importance of disaggregation is paramount to the central message.

The Foundation further wishes to highlight the reality that a major shift in both scale and approach in global eye health will of course be required to meet this ambition, particularly in low and middle income resource settings where coverage rates are already very low with existing challenges in achieving acceptable quality outcomes. A significant global program reaching into national and sub-national settings to increase human resources across the board of specialist, Allied and community health professionals (including teaching, training and mentoring), strengthening Continuous quality improvement and health information systems, infrastructure development and equipment provision, affordable consumables and procurement systems (Lens and spectacles) and a major increase in financial resources across the board, will be required. While this is an important and essential step and

we encourage all Member States to endorse these targets, it will take the combined and proactive effort of all stakeholders, governments, multi-lateral institutions, non-government, the private sector and the community working together and in new ways, to shift the dial in this direction.

To this end, The Foundation recommends under section 5 on "Next steps' to signpost the development of further strategic guidance for Member States and other stakeholders, related to:

a) Development of an implementation strategy that clearly and succinctly situates these targets and sets out the pathway to making eye health part of Universal Health Coverage (UHC) and implementing IPEC within health systems; and
b) Indicate WHO support for the development of a new global initiative in the guise of Vision 2020 to promote the strategy for change.

Additional comments

In addition to the above general comments, The Foundation makes the following observations and recommendations with respect to the discussion paper. We do so in recognising the objective is not to critique the document, however, we offer these comments in order to maximise the strength of the paper to be submitted for consideration by the WHO Executive Board and in turn the World Health Assembly in 2021.

1. Recommend changing the statement under the 'Monitoring framework' section on global, regional and national level data, to emphasise the importance of 'national level data. We do acknowledge the paucity of existing data and the cost of undertaking population health survey's, these targets are however most important for use within countries and should be emphasised, notwithstanding the value of regional and global level data for monitoring trends.
2. It may also be the case that an ongoing dialogue remains as to the frequency of data collection, as surveys are often undertaken within a 5-8 year interval in order to measure the efficacy of interventions. Conversely, the ability to utilise process level indicators and data will also be essential to maintain regular tracking of progress on an annual basis during the intervening periods.
3. Recommend updating the statistics cited under section 2 'Background' with the 2020 Vision Loss Expert Group data, rather than the data from the 2019 World Report on Vision. this is important to ensure consistent and the most up to date data is being promoted.
4. Recommend elevating the visibility of the change in definition of good cataract surgical outcome to better than 6/12 to the main target narrative. This is a significant shift and warrants greater emphasis and attention.
5. Recommend using the terminology for the cataract surgery target of 'Effective Cataract Surgical Coverage' (ECSC) rather than "Effective Coverage of Cataract Surgery" (ECCS). CSC is a long-standing indicator in eye health and therefore is likely to be more easily socialised with the additional quality dimension, particularly among non-English speaking countries, rather than introducing unnecessary new language. This would also then match the use of EREC.
6. Recommend double checking the evidence for the qualifying statement against the EREC target noting lower cost and greater workforce availability and/or providing an additional qualifier for this statement. It is the case that RE involves repeated cost over lifetime (eye examinations,

refraction, replacement spectacles) and the largely unchartered investment for compliance. Cataract surgery in contrast is by and large a one-off intervention.

7. Recommend changing the title of point 2 “The cost-effectiveness of interventions for cataract and refractive error’ under Annex 2, as the productivity loss described does not by definition fit with the ‘cost effectiveness’ identifier. Suggest adjusting to ‘Health economic rationale’.

Department of Noncommunicable diseases

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