Human Resources for Health Strategy Consultation: Response from International Agency for the Prevention of Blindness (IAPB)

IAPB welcomes the opportunity to respond to this consultation on a Global Health Workforce Strategy, with our contribution to help develop an adequate and relevant skilled workforce in strengthened and more equitable health systems. **A Global Health Workforce Strategy taking account of country, sub-national, and local needs is imperative to lead to better health outcomes that promote healthy lives and well-being for all at all ages.**

With aging populations more disposed to vision loss and with diabetes prevalence (a major risk factor for sight loss) increasing globally, the prevalence of avoidable blindness is expected to rise without appropriate action. **In many parts of the world, the lack of an eye health workforce is a key factor to the high prevalence of avoidable blindness. In Sub-Saharan Africa, the issue has reached crisis levels.**

Maldistribution of personnel (in rural or remote areas), under-productivity, quality assurance issues, and inefficient referral systems are amongst the problems contributing to the high levels of avoidable vision impairment around the world. However, the draft papers made available for the consultation do not account for specialised personnel, such as eye health and rehabilitation personnel, amongst others.

**In order to respond to needs and promote enjoyment of the right to health for all, it is essential that HRH strategies and plans are comprehensive, incorporating attention to and greater investment in specialised areas such as eye health, dental health, mental health, ear health, amongst others. Further this needs to cover the continuum of care from promotion, prevention, to treatment, rehabilitation, habilitation and palliative care.**

**Why Eye Health Must Be Integrated into the Global Workforce Strategy**

- **About 285 million people around the world have disabling vision impairment or blindness,** 80 per cent of which is preventable or treatable with cost-effective interventions. These figures do not count the additional **517 million people** that do not have adequate eye glasses to correct for presbyopia (1).

- **Although approximately 1 in 4 people in Africa are estimated to have an eye condition at any time** (2) there is a critical shortage of eye health Personnel: in spite of the fact Africa has 24% of the global burden of disease from eye health, 10% of the global population, 4.8 million people blind plus 16.6 million people visually impaired, Africa has less than 1% of all ophthalmologists. In the

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2 The Burden of Eye Disease in Africa, IAPB Position Paper, November 2014
region only 13 countries have met the minimum human resources requirement of 1 eye health professional for every 55,000 people (3).

- **In WHO’s Southeast Asia Region, human resources are a major challenge, impeding progress.** In most countries of this region, there is only one ophthalmologist for every 200,000 people and approximately one mid-level eye-care specialist for every 500,000 people (4). In many countries due to scarce human resources, ophthalmologists carry out even primary eye care and refraction services.

- **In other parts of Asia,** such as the Philippines, Vietnam, Cambodia and Indonesia, the distribution of eye health workers presents a challenge for policy and access. In Timor Leste, the eye health workforce is inadequate and lack of access to preventive or curative eye care services leaves many people vision impaired.

- **In Latin America,** the distribution of ophthalmologists is drastically unequal. (5). The availability of optometrists and allied eye health personnel, vary extensively from one country to the next. In some countries, optometry is not permitted, thus the task of prescribing eyeglasses falls mainly to the ophthalmologists.

- **Eye health conditions are highly prevalent amongst aging populations:** In 2010, 82% of those blind and 65% of those with moderate and severe blindness were older than 50 years of age (6). It has been estimated that 73% of the population of India aged ≥60 years have cataract (7), as well as 50% and 68% of US citizens aged between 75-79 and ≥80 years, respectively (8).

- **There is a close association between blindness and poverty.** Severe vision impairment and blindness can cause reduced income and quality of life. Cost-effective approaches to sight restoration, such as cataract surgery, increase household income and improve individual’s quality of life (9).

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3 The Crisis in the Eye Health Workforce in Africa, IAPB Position Paper, November 2014  
4 World Sight Day Report 2013  
• **Primary eye care is frequently lacking, underdeveloped and not effectively integrated within primary health care in low income countries.** Eye care (including simple conditions), is often delivered at secondary and tertiary hospital based-services. This increases costs to patients and health systems.

• **The 66th World Health Assembly (WHA) unanimously approved Universal Eye Health: A Global Action Plan 2014-2019 (from here called GAP)** (10), a commitment made by the World Health Organization (WHO) member states to improve eye health for everyone, by increasing the number of eye health personnel globally and developing appropriate policies to address the challenges of distribution, retention, and motivation, and by improving efficiency.

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**Economic, Demographic, Epidemiological Transitions and the Future of Health Labour Markets (Task Group 1)**

As the paper describes the global health workforce deficit impedes the Millennium Development Goals and efforts towards universal health coverage in many parts of the world. The point made that there are gaps between the need for services, labour supply, and economic demand (market capacity to employ the labour) is relevant across the entire health workforce including for eye health. If the demographic pressures of aging and population increase without appropriate action, the situation will worsen with greater numbers of people around the world suffering unnecessarily from avoidable blindness. Tackling eye health and broader health needs will require better information and significant increases in health expenditure to close these gaps, with transformations in the way health is financed and made available to populations.

Migration has a significant impact on available human resources (supply), and as the consultation paper states the human resources for health (HR) data/analysis available on migration is generally limited to doctors and nurses. Regarding eye health, there are large gaps in data on the numbers of personnel at all levels, those who exit from practising eye health, or migrate elsewhere.

Distribution of personnel is a major challenge for eye health. Many countries, even middle and and high income countries, do not have have adequate services in rural and remote areas. In Brazil, research found that the higher the Gross Domestic Product per capita in any given state, the more the number of ophthalmologists were found working in that state, indicating a direct and significant correlation between wealth access to eye services (11). Approaches to tackling internal distribution should include recruitment and

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11 A recent Brazilian study found a direct, significant correlation between wealth and access to eye health services.3 The higher the Gross Domestic Product per capita, the more ophthalmologists were found working in each state (P <0.0001). Carvalho Rde S, Diniz AS, Lacerda FM, Mello PA. Gross Domestic Product (GDP) per capita and geographical distribution of ophthalmologists in Brazil. Arq Bras Oftalmol. 2012;75(6):407-411.
incentives for staff to remain in rural areas (as mentioned in the *Transformative Education* paper), and appropriate investment in appropriate levels of eye health personnel. Task-shifting where there are significant shortfalls in the numbers of appropriate level of staff to meet the population’s need can help offset HRH supply gaps. In Africa distribution is highly uneven across and within countries. The table below shows that many countries in Africa have adopted a policy of task-sharing. This has proven a successful means to addressing low cataract surgical rates and it has had the added benefit of reducing inequities in terms of access to eye care services by evening out the urban-rural distribution of these cadres, as cataract surgeons were more often based in rural areas (12).

<table>
<thead>
<tr>
<th>Country</th>
<th>Ophthalmologists</th>
<th>Cataract Surgeons</th>
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<tbody>
<tr>
<td></td>
<td>Urban %</td>
<td>Rural %</td>
</tr>
<tr>
<td>Senegal</td>
<td>89</td>
<td>11</td>
</tr>
<tr>
<td>Tanzania</td>
<td>59</td>
<td>41</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>81</td>
<td>19</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>59</td>
<td>41</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>67.4%</strong></td>
<td><strong>32.6%</strong></td>
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**Transformative Education (Task Group 2)**

The *'Transformative Education Paper'*(Task Group 2) rightly acknowledges that much needs to be done to adapt health personnel education so that it responds to inequities in health access, increasing aging populations, the need for greater emphasis on social determinants, risk factors, promotion, and prevention. It draws attention to the fact that gaps include ‘inadequate capacity, inadequate numbers, quality/responsiveness, and distribution of HRH’. It is essential that these challenges are tackled taking a holistic approach accounting for burden of disease, and also the country’s economic situation. Doctors, nurses, managers and other allied health personnel need to have multidisciplinary knowledge and the right skill sets, including for eye health, given their essential role in ensuring the health system responds to the eye health needs of the population. Training strategies are needed to offer adequate numbers of formalised, regulated training opportunities and develop the right combination of specialised staff, including the right combination of eye health personnel delivering eye health services (including ophthalmologists, optometrists, mid-level personnel including ophthalmic nurses and ophthalmic clinical officers, technicians, and community health workers, and low vision and rehabilitation workers, amongst others). In Africa, for example, it is estimated the number of ophthalmologists needs to double and a nine-fold increase is needed in the number of general primary health workers with eye health competencies (13). Training should emphasize a multidisciplinary joined-up approach to service delivery and strategies need to account for the quality of training institutions. Sub-Saharan Africa has a substantial number of eye health training institutions, but many programmes have curricula that do not adequately respond to health needs, are poorly resourced, and

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12 The Crisis in the Eye Health Workforce in Africa, IAPB Position Paper, November 2014; Addressing the eye health workforce crisis in Sub-Saharan Africa: Business as usual is not an option, IAPB Policy Paper, October 2014

function below capacity. There is also an imbalance in capacity between linguistic regions (with a poorer training environment in Francophone countries). In Latin America, certification and credentials vary greatly. In some countries, there is no training available for specialized ophthalmic nurses. Optometry is not even an option in some countries.

While health care workers including eye health workers should have freedom of movement, IAPB agrees that policies that support appropriate remuneration and job satisfaction, as well as career development, need to be developed to encourage individuals to remain in rural areas or in their countries. Where governments invest significant resources to train and develop health professionals, there needs to be a return on investments for society. An example would be a scholarship agreement, in which education is subsidized in return for a minimum number of years of service (14). The Malawian government for example expects new graduates in optometry to serve a year in the public service before taking on other jobs (15). In Mexico, all doctors must perform a year of public service upon completion of medical school.

IAPB supports the paper’s recommendation that instruction should include a focus on social accountability, equity, social justice and human rights. Unfortunately, as the paper acknowledges, health gains have failed to reach certain population groups. The paper should also recommend that HRH training should incorporate focus on sensitisation to different patient’s needs, promoting inclusive approaches to health to people or groups that can be vulnerable to exclusion, such as persons with disabilities.

**Data and Measurement of HRH Availability, Accessibility, Acceptability, and Quality (Task Group 3)**

There is a need for more comprehensive collection and use of data at national and sub-national levels to inform policy-making. This applies to eye health. Globally, there are considerable data gaps in eye health, especially in regard to personnel, access to services, and availability of rehabilitation and assistive devices. This has been recognised by WHO member states. Evidence is one of the objectives of the WHO GAP, and member states are now mandated to report data on global indicators for eye health. Attempts to assess the gaps in supply of health workers, such as using the Workload Indicator and Staffing Needs (WISN) tool, need to incorporate specialised areas of health, including eye health, so that it becomes possible to calculate health personnel targets including eye health personnel targets at the local level. It is essential that this occurs in a manner involving eye health stakeholders from the beginning to ensure this assessment is undertaken rigorously and provides the information needed (16).

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14 Addressing the eye health workforce crisis in Sub-Saharan Africa: Business as usual is not an option, IAPB Policy Paper, October 2014
15 Ibid
16 Ibid
Leadership and Governance for Enhanced HRH Contributions to Health Systems Strengthening (Task Group 5)

IAPB agrees that governments need to give appropriate focus to the importance of HRH, improving working conditions/health care facilities, developing sustainable evidence-based financing strategies, and building up planning systems, which are all issues tackled within the Governance and Leadership Paper (Task Group 5). IAPB supports the call for multi-year evidence-based health financing. A major challenge for eye health is that at national levels in many countries, eye health is currently not incorporated into HRH strategies. The recently endorsed GAP calls on governments to support eye health as an integral part of the health system in policies and at every level of service delivery, with a dedicated budget line to provide a mechanism to increase coverage and affordable eye care services. The task group paper also calls for investment to enhance planning and information systems, in which, it is essential that eye health be incorporated. Comprehensive eye care should be integrated into the primary health care system planning with strong referral systems, which ensure that all people have access to preventive, promotive, and rehabilitative services.

Improving Health Worker Productivity and Performance in the Context of Universal Health Coverage: The Roles of Standards, Quality improvement, and Regulation (Task Group 7)

Although context-specific, many blockages which impact eye health service delivery and access relate to the lack of or inadequately implemented regulations and surveillance. For example, the existing regulations for refraction and dispensing of eyeglasses means many children and adults fail to get screened or don’t get the right glasses in Vietnam, Cambodia and China. At the national level, there needs to be clearer guidelines for monitoring of surgical outcomes and standard procedures for follow-up to ensure good quality. Unclear guidelines contribute to weakened referral and feedback systems, resulting in delayed detection of eye conditions, which can increase both cost and burden of blindness. Approaches should be considered on a country-by-country basis. Stakeholders at all levels of eye health delivery should be involved in the development of relevant national strategies and plans. As the paper states, strengthened health systems will be an essential basis for improved performance. With regard to eye health, there is a need to address motivation, enhance the regulatory system, and improve credentialing. The strategy should promote innovation in national HRH policies regarding incentives, career paths, retention and task-shifting, enhanced supervision, clinical mentoring, continuing education and peer support networks, and should provide a safe working environment with adequate infrastructure, equipment, and consumables (17).

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17 The Crisis in the Eye Health Workforce in Africa, IAPB Position Paper, November 2014
Recommendations

1. The Strategy must place emphasis on tackling the global health workforce crisis within strengthened equitable health systems and multisectoral integrated approaches, via significantly greater investment and more sustainable approaches to health financing.

2. The Strategy must guarantee the adequate levels and distribution of well-trained personnel to tackle health comprehensively across diseases, taking account of national, sub-national and local health needs. This must include specialised personnel including personnel involved in delivering eye health at all levels.

3. The Strategy should involve broadening the eye health recruitment pool, by developing flexible routes into the workforce, and generating more and better data for workforce planning.

4. The Strategy must promote the inclusion of specialised health areas, including eye health, so that they become integral to Ministry of Health HRH plans.

5. The Strategy should promote the participation of eye health (and other specialised health) stakeholders in design, delivery, and the monitoring of national health and HRH strategies and policies that include task-shifting, training, and retention efforts.