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Sightsavers

Insight Plus

Developing human resources for eye health

Claudia Janke/Sightsavers

Contents

Front cover photo:
Chellamma, 63, a cataract patient, being examined at Sankara Eye Hospital, India

From the editors

Claire Stevens, Learning Support Officer
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Welcome to the first issue of Insight Plus, Sightsavers' bi-annual learning review.

Working with partners across Africa, Asia and the Caribbean, Sightsavers' aim is to eliminate avoidable blindness and promote equality of opportunity for disabled people. With our partners, we engage in evaluation, research and development activities that seek to improve the programmes that we are involved with, and to advance the fields of health, education, social inclusion and community development, in which we work.

As part of our strategic commitment to quality and continual improvement, this Insight Plus series will collate our research, learning and best practice, and share it with both a wider in-house and external audience. Designed as a practitioner journal, each issue will focus on a different thematic area and will feature contributions from across the countries in which we work, including case studies, opinion papers, policy reviews and learning summaries.

This first issue focuses on human resources for eye health and the challenges presented by the shortage of health workers in developing countries. We hope you find it useful and informative reading, and welcome your comments and suggestions. Please send any feedback or queries to learning@sightsavers.org.

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Foreword

“Urgent action is required within countries to train more eye health personnel and redress the distribution of the available workforce between urban and rural areas”.[8]

It is widely recognised that acute shortages of health workers in developing countries are holding back achievement of the health Millennium Development Goals and reductions of poverty. Over a billion people worldwide have little or no access to health services and the help and advice of health workers. The World Health Organization (WHO) estimates that over four million more health workers are needed, with 1.5 million in Africa alone.

This huge shortage of health personnel is perhaps the greatest problem facing good eye health. As stated by WHO, “despite efforts to strengthen human resources for eye health, a crucial shortage of eye care personnel persists in many low-income countries”.[1] Only 14 of the 45 countries in Africa for which data is available reach the VISION 2020 target of one ophthalmologist per 400,000 population, and in several countries the ratio is more than one ophthalmologist per million. Actual coverage is even lower, due to low population densities, poor communication and transport systems, and the concentration of ophthalmologists in cities.[2]

Where eye health workers do exist, there are often problems of quality and productivity. Inadequate continuing postgraduate education often means that skills and competencies are not updated, and difficulties with equipment, environmental factors and motivational issues frequently reduce work levels.[3] In addition, the structure of the existing eye health workforce is often inefficient, and shortages of mid-level eye health personnel mean the limited number of ophthalmologists spend time and energy on tasks that could be delegated.[4]

Limited ophthalmic training for general health workers is also a critical barrier. Non-ophthalmic staff play a key role in eye health. Eye diseases are often among the commonest health problems presenting to primary level health workers. If they do not have the skills

and knowledge to correctly examine the eyes and identify conditions, the wrong diagnosis and delay in treatment can have serious long term consequences.[5] For example, 70% of conditions leading to childhood blindness demand immediate action and therefore need to be dealt with by midwives or traditional birth attendants, rather than specialist ophthalmic staff.[6]

Despite this, in most countries, most training in eye health for non-ophthalmic personnel is too limited to be of any practical use.[7]

Sightsavers is working to tackle this situation through support for eye health workers in Africa, Asia and the Caribbean. We work with governments to establish and support training institutions for specialised eye health personnel, and courses in eye health for general health workers. We give particular attention to developing cadres of mid-level eye health professionals, who play a critical role in supporting ophthalmologists and creating a more efficient workforce, and to primary eye care workers, who can bring eye care to communities. Recognising the urgency of the task and the need for greater collaboration between all players, we have recently started a continent-wide initiative to strengthen human resources for eye health in Africa. A planned consortium of international NGOs, African governments and international funding partners will run for ten years (2011-2020), pooling resources to strengthen existing training institutions and establish new ones. There will be a particular focus on francophone Africa, where shortages of staff are particularly acute.

The articles in this publication highlight the work done by Sightsavers and our partners in different countries, and draw out lessons that we hope will be of use for others working on human resources for health. They highlight the value of primary and mid-level health workers, the need for institutionalised training programmes, and the importance of undertaking thorough human resource development situational analysis and planning within national healthcare programmes. We hope you find them interesting and enlightening.

Lord Nigel Crisp,
Sightsavers Chair

[1] World Health Organization. (2009) Prevention of avoidable blindness and visual impairment: Report by the Secretariat. 62nd World Health Assembly, A62/7, April 2009, p. 8

[2] VISION 2020 Human Resource Development Working Group. (2006) Global Human Resource Development Assessment for Comprehensive Eye Care. Pakistan: Pakistan Institute of Community Ophthalmology

[3] WHO Monitoring Committee for the Elimination of Avoidable Blindness (2006) VISION 2020 - The Right to Sight: The Global Initiative for the Elimination of Avoidable Blindness, Report of the First Meeting, Geneva, 17-18 January 2006. Geneva: World Health Organization and International Agency for the Prevention of Blindness (WHO/PBL/06.100)

[4] Kello, A.B. (2004) Prevention of blindness in WHO/AFRO region. Brazzaville, WHO

[5] Gilbert, C. (1998) 'The Importance of Primary Eye Care Clare', Community Eye Health, 11(26), pp. 17–19

[6] Etya'ale, D. (2008) 'VISION 2020 update: Addressing the challenge of needless blindness in the world', Primary Eye Care Workshop for West Africa, Banjul, 18-20 March 2008

[7] Etya'ale, D. (2008) 'VISION 2020 update: Addressing the challenge of needless blindness in the world', Primary Eye Care Workshop for West Africa, Banjul, 18-20 March 2008

[8] World Health Organization. (2009) Prevention of avoidable blindness and visual impairment: Report by the Secretariat. 62nd World Health Assembly, A62/7, April 2009

Government ophthalmic assistants training in equipment maintenance - a step towards strengthening health systems in India

Dr Rajesh R. Kapse, *Programme Officer: India*

Helen Slater/Sightsavers

Operating theatre equipment, Rotary Netra Eye Hospital, India.

Background / Rationale:

One of the prime areas of concern in India has been the provision of quality eye care to meet the needs of the poorest of the poor and those who cannot afford the typical high quality-high price service provided by the private practitioners.

In any surgery set up, certain parameters must be maintained to achieve quality, and this is more so where the surgical load is higher. In high volume surgery, quality can be achieved through qualified and technically proficient human resources, maintaining all protocols in the proper way and the availability of properly maintained equipment. If any one out of three components is not working properly, quality is compromised and high volume-high quality cannot be achieved. Quality of surgery has been a problem for many set ups across our country and the government is no different.

In India, eye care service providers are broadly classified into three divisions; namely government, NGO / charity and private practitioners. With 42% of India's population living below the poverty line[1], the services of private practitioners are beyond the reach of most of the population. Therefore, the majority are serviced by either government or NGO hospitals. It has been observed after several discussions with district programme managers[2] across the country, and with senior ophthalmic surgeons working with the government, that equipment maintenance is a major issue. Red tape bureaucracy within the government set up often hinders prompt action in dealing with minor equipment repair, which in turn creates problems during surgery. It is also a fact that trained human resources are not available to repair ophthalmic equipment at the district level and remote areas often have to depend on maintenance personnel or technicians

travelling at their will to undertake small repairs. Hospitals (especially those in the government set up) are dependent on the manufacturing companies and their annual maintenance contracts. Following a number of discussions and round table conferences with the district and state level officials, it was agreed that the provision of in-house equipment maintenance training would ensure faster repairs to equipment and help to prevent compromises in the quality of surgery. It was thus decided that ophthalmic assistants working within the government system should receive training in equipment maintenance, the first initiative of its kind in India.

Process:

The process for organising an Ophthalmic Assistant's Equipment Maintenance Workshop began in 2008 during a series of meetings of district programme managers working mainly in the states of Maharashtra[3] and Karnataka[4]. It was discussed in these meetings that equipment maintenance is one of the most important issues in the government hospitals. Senior ophthalmologists felt that, while technical knowhow of doctors could be ensured and maintained, the lack of properly trained staff for equipment maintenance was often hindering progress at the grass roots level. Following the discussions, a key action point was the organisation of an equipment maintenance training programme for paramedical ophthalmic assistants (PMOAs). When this issue was brought to the notice of state government authorities, they were not only interested but also asked for the detailed proposal regarding the programme. After the final approval from the government and Sightsavers, the training agency was finalised at Lions Aravind Institute of Community Ophthalmology (LAICO)[5]. After a rigorous selection process at the state level, both state governments selected ophthalmic assistants who were willing to work in equipment maintenance.

Sightsavers played a detailed role in the selection and orientation of the ophthalmic assistants who were selected for the training programme. Sightsavers liaised with the training agency regarding the schedule and facilitated the process so that it ran smoothly. To aid the process of learning, the programme placed emphasis on hands-on training and the PMOAs were asked to bring with them a piece of equipment in disrepair. During the course of the training programme, the PMOAs were able to repair their piece of equipment and gain practical experience.

The training programme:

The training was conducted over a period of 40 days, during September and October 2009. During the course, the trainees become familiar with basic organisational skills, general maintenance skills, the maintenance of electronic and electrical equipment, the maintenance of optical equipment and skills relating to maintaining the mechanical parts of equipment. In order to make the course more holistic and in line with the job requirements of the PMOAs, they also gained knowledge of the eye and its parts, common refractive errors and their correction, common eye diseases and their treatment, and the working principles of the instruments that they will be handling.

Learning:

This unique training programme was not only the first such programme for government staff aimed at improving quality standards, but it also increased collaboration and joint working between Sightsavers and the state government. The training resulted in several positive outcomes, including improved capacity and increased motivation of the staff involved.

Some important learnings which can be taken from this training are -

1. Innovative ideas, with the proper rationale to solve the existing issues / bottle necks, can help secure support from the government and can strengthen the overall health system in line with the six building blocks of WHO[6]
2. Working with the government might only involve providing technical expertise around eye care issues, but sensitisation also has an important role to play.
3. Selection of appropriate staff for any training programme is crucial. In this case, candidates were selected based on their willingness to take additional responsibility for equipment maintenance.
4. The role of Sightsavers in supporting the control of avoidable blindness has been increased as we move away from a service delivery model to one of replicable and demonstratable approaches. With Sightsavers support, it is envisaged that

some of the other government set ups shall benefit from PMOA training, which in turn shall benefit more needy people in the community.

Challenges:

Like all activities conducted, this training programme not only provides positives, but also some challenges; -

- Post training follow-up/ monitoring is a challenge. Once the training is completed and the PMOAs have gone back to their respective work stations, it remains to be seen how far they actually implement their learning at the field level. It may also prove challenging to monitor this. To address this, Sightsavers has designed a monitoring format and the government has been asked to send regular reports from the PMOAs so that not only the efficacy of the training, but also it's long term impact, can be assessed and monitored.
- The process of approval from the government authorities can be very lengthy. The time gap between the government buying into the idea and their actual agreement to depute their staff was long and tedious, involving lots of paperwork.
- High turnover of key officials in the government set up, and enrolment and subsequent buy-in of new officials.

Outcome of the programme:

Eight trainees have successfully completed the programme and have started equipment maintenance at district hospitals in Karnataka and Maharashtra. This has reduced the hospitals' dependance on external help for minor repairs and maintenance, which in turn means better productivity and better performance from these hospitals. Ultimately it is the beneficiary at the grass roots level who is now able to access a timely, affordable service, instead of potentially being turned away due to a lack of functioning hospital equipment. The government has realised that a small training investment can actually be beneficial in the long run as well as cost effective.

Advocacy:

The success of this initiative was shared by both Sightsavers and the government authorities at state and national level forums. This helped in sensitising government authorities about the significance of this initiative. Based on the learnings from this unique training, the agency for blindness control - National Programme for Control of Blindness (under the Ministry of Health and Family Welfare, Government of India) – have sought more details of the training and have shown a keen interest in replicating this programme for ophthalmic assistants working in their set ups across the country. To start off with they have already proposed that some of the staff based at the various regional ophthalmic institutes in the country be sent for similar training. What started as a one-off training exercise for two state governments has now been successful in advocating the need for such initiatives to the decision makers in the country. This has further strengthened our working with the state government and fits with our organisational objective of strengthening health systems.

Future plans:

A reporting format has been designed by Sightsavers and the trained ophthalmic assistants have been given instructions to complete it on a quarterly basis and submit it to the government authorities at the state level. At the end of the year, a detailed analysis of the reports will be conducted and successes and feedback will be shared with the concerned government authorities. The training institute, LAICO, has also agreed to provide technical support to the ophthalmic assistant during their first year. This will help in sharpening their skills in equipment maintenance. This project is due to be replicated by the national government in different states.

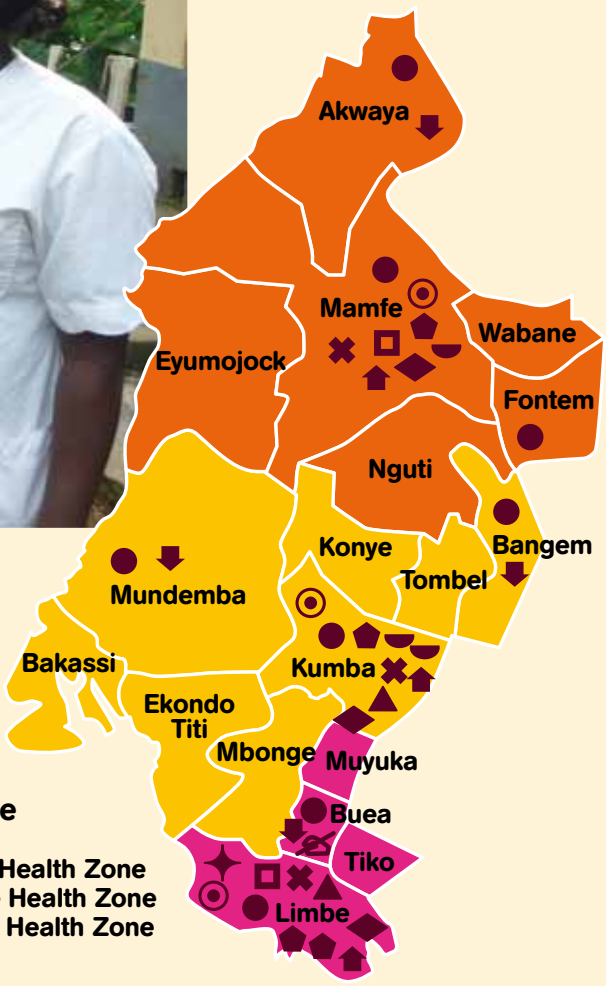
1 Source -- http://www.unicef.org/infobycountry/india_statistics.html
2 District programme managers are the responsible authority in charge of the national blindness programme at the district level. A district is an administrative division of an Indian state or territory.
3 It is India's third largest state by area and second largest by population (96,752,247) comprises 35 districts. 712305 cataract surgeries performed in yr 07-08 Cataract Surgical Rate 6664
4 It is the eighth largest Indian state by area, the ninth largest by population (52,850,562)and comprises 29 districts. 314989 cataract surgeries performed in Yr 07-08 and Cataract Surgical Rate is 5488
5 Lions Aravind Institute of Community Ophthalmology (LAICO) started in 1992 is a World Health Organization Collaborating centre for prevention of blindness
6 http://www.who.int/healthsystems/strategy/everybodys_business.pdf

Case study: A comprehensive approach to eye health workforce development in the South West Region of Cameroon

Dr Joseph Oye, *Country Director: Cameroon*

Joseph Oye/Sightsavers

M Florence Bawa of Fontem satellite eye unit examining a patient in the community during an outreach visit



Legend of personnel

- Ophthalmologist
- Senior Ophthalmic Nurse
- Community Ophthalmic Nurse
- Optical Technician
- Manitenance Technician
- Regional Programme Manager
- Auxillary Nurses
- Optometrist
- Refractionist
- Low Vision Technician

Legend of infrastructure

- Eye Units
- Satellite Eye Units

Legend Zone

- Limbe Eye Health Zone
- Kumba Eye Health Zone
- Mamfe Eye Health Zone

The South West Region of Cameroon is one of ten regions in the country, and one of two English-speaking regions. It is located in the Gulf of Guinea at the border with Nigeria. The ecology of the region is that of rain forest and mountains, of which Mount Cameroon culminates at 4,100 metres of altitude. The weather is characterised by a long rainy season, which lasts for up to seven months in some divisions. Due to heavy rains and the bad condition of the mostly earth roads, accessibility is a major challenge, with some communities being cut off from the rest of the region for several weeks in the year. The total population of the South West is 1,400,000, most of which is rural and mainly living on farming and fishing.

The South West Comprehensive Eye Health Programme was started in 2001, based on

a Memorandum of Understanding between the Ministry of Public Health and Sightsavers. The project was designed in line with the VISION 2020 strategy. Disease control, human resource development, and infrastructure and technology are the three pillars of the project. At the beginning of the project, there was no national eye health plan and the South West plan was subsequently used as a model in developing a national plan.

At the outset of the project, there was only one obsolete eye unit in the Regional Hospital at Limbe, with no resident eye health specialists. Eye health services in the region were delivered by visiting teams from neighbouring regions. Patients needing eye surgery were referred to the base hospitals of the visiting teams, which involved significant travel and time costs for the patients and their families.

The project unfolded in phases to achieve a comprehensive geographical coverage of the region. The region was divided into three eye health zones namely Limbe, Mamfe and Kumba (Figure1), which were consecutively started over time. Each eye health zone comprises of an eye unit and satellite eye units. A team was trained for each eye health zone, led by an ophthalmologist in the eye unit. The ophthalmologist and the ophthalmic nurses were trained in a synchronised manner so that they were ready to commence eye health activities in their zone at the same time. All the eye health specialists were trained out of the country, as there was no training programme available locally.

The distribution of eye health workers within each eye health zone was based on the distribution of the population and their distance and accessibility to the main eye unit. The ophthalmologist at the main eye unit is assisted by ophthalmic nurses and the satellite eye units also have an ophthalmic nurse. Refractive error and low vision personnel were subsequently trained for each eye health zone. Instrument technicians were also trained in later phases of the programme. Figure 1 shows the distribution of eye health force categories within eye health zones. In addition to specialist eye health workers, primary eye care workers and community members were trained at all levels to include eye health into their activity package.

Thanks to a good mix of skills in the eye health teams; promotion, prevention, clinical, surgical, refractive, optical and low vision services are delivered both at base and on outreach. The ophthalmologist is in charge of the eye health of the catchment population of the eye health zone, and ophthalmic nurses supervise primary and community eye care workers. In addition to clinical work, the eye health personnel also carry out financial management and health information activities. There is a regional eye care manager who sees to the day-to-day coordination of the programme and reports to the regional delegate for health within the regional health team.

The impact of the eye health workforce training and deployment is mainly characterised by an increased geographical coverage of eye health services that trickles right down to the most remote communities. Services can be accessed at an affordable cost and lesser opportunity cost and are financially sustainable thanks to the a user fee system with provision for services to poorer people. Hospitals have more clients due to the availability of eye health services and the South West Comprehensive Eye Health Programme is a model within the Ministry of Health setting.

However, the programme does face some challenges in its human resources component. Refractive error and low vision personnel are not currently included in the Ministry of Health system and this poses problems with enrolment. We are advocating for this to change and for these positions to be included as a cadre in the MoH. The motivation of staff for the extra work (outreach, financial management, drugs management, health information) is also a challenge to the programme.

Looking forward in terms of the eye health workforce, the programme will be focussing on upgrading the overall skill level of eye health staff in the zone, including sub-specialities such as posterior segment. The Bakassi Penninsula was recently granted back to Cameroon and there is now a need to expand the eye care programme there, alongside other health programmes and services.

The main lesson learnt from the South West Region is that it is possible to set up a sustainable comprehensive VISION 2020 programme within the government setting. The refractive error and low vision services have attracted interest from other regions in Cameroon and the overall model is being promoted for replication by the Ministry of Health and partners.

Developing human resources for eye health: the Nigeria experience

Sunday Isiyaku, *Country Director: Nigeria*
Safiya Sanda, *Programme Manager: Nigeria*
Elizabeth Elhassan, *Regional Director: West Africa – West*
Dr Hannah Faal, *Programme Development Advisor*
Dr Kolawole Ogundimu, *Head of Programme Development: West Africa – East*

Three year old Ambali Yusuf, who has bilateral congenital cataract, being examined at Sobi Specialiast Hospital, Kwara State, Nigeria.

Background

Nigeria, with a population of about 150 million people, is the most populated country in Africa. The results of the National Blindness and Visual Impairment Survey conducted from 2005 - 2007 puts the prevalence of blindness and visual impairment at 4.2% for people 40 years and above, and 0.78% in people of all ages. Because of the size and structure of the country, eye care programmes are developed at state levels.

The Nigeria VISION 2020 strategic plan (2007 – 2011) indicates that there are over 400 ophthalmologists in the country, which exceeds the VISION 2020 ratio of one ophthalmologist to a population of 500,000. The problem is that the majority of ophthalmologists are in tertiary institutions, with their emphasis on teaching, and in private practice. Few states have state-employed ophthalmologists and it is at this secondary level where service delivery is crucial.

Sightsavers supports four eye care programmes in Nigeria, in partnership with four state governments (Cross River, Kaduna, Kwara and Sokoto). These states, with a population of over 15 million, have poor indices for human

resource development and infrastructure and technology; the critical factor being the lack of of human resources for eye care.

Process

A participatory strategic planning method was used to develop VISION 2020 plans for the four states. As part of the process, stakeholders identified gaps in the eye health workforce in these states. The lack of human resources, particularly ophthalmologists and ophthalmic nurses, was identified as a major constraint in the delivery of eye care services. This is because it takes time to train eye care workers. Also, in the few areas where the workforce was available, the infrastructure and technology to provide services were non existent, leading to underutilisation and misdistribution of eye health workers to other areas of need.

In 2004, Kwara and Cross River States each had one state-employed ophthalmologist, while Sokoto had none compared to the 30 needed for the population of all four states. This was way below the VISION 2020 recommended eye care personnel to population ratio for sub Saharan African (ophthalmologist – 1:500,000 people and ophthalmic nurses – 1:400,000 people). The ophthalmologists were also not providing full time service delivery because they were involved in administration within the Ministries of Health. Similarly, there were 127 ophthalmic nurses compared to the 150 required. In addition, most of these nurses were not providing eye care services because of a lack of eye units and basic equipment and instruments to work with. Consequently, they were deployed to other health units, such as maternal and child health and general nursing services. This was a de-motivating factor for most of the staff.

In the past, Sightsavers had relied on state governments to train or recruit eye care personnel, particularly ophthalmologists and ophthalmic nurses. In spite of the large number of ophthalmologists in the country, recruitment was difficult to achieve because remuneration at the state level is poor in comparison to the tertiary institutions or to private practice. Encouraging doctors to train in ophthalmology was equally difficult, due to poor knowledge of eye health, the lack of available opportunities, and a lack of infrastructure and technology for the delivery of services post-training. The establishment of an eye care programme therefore encouraged doctors and nurses to avail themselves for training as eye health workers.

Approach

As one of WHO's six building blocks for effective health systems[1], a well-performing health workforce that is responsive, fair and efficient is essential in order to achieve the best health outcomes possible, given available resources and circumstances. The lack of of human resources for eye care service delivery was identified by stakeholders as a major obstacle during the development of state level VISION 2020 plans in Nigeria. This therefore became a key strategic objective if the programmes were to attain their overall purpose.

To address this, one of the main objectives of the state level VISION 2020 plans was to support the training of eye care personnel in line with VISION 2020 requirements.

The West African College of Surgeons trains ophthalmologists at diplomate level for service delivery at secondary facilities. This training lasts for 18 months with an additional six month internship. The programmes opted for this training as it promised them a quick return compared to the fellowship training. The latter could take as long as five years and would result in no ophthalmologists being available to deliver services during the entire first phase of the programme. Doctors were therefore nominated by each of the state governments and trained as diplomates. To ensure retention of staff, the states nominated indigenous doctors who were bonded to ensure that they came back and remained in the programme after their training.

There are five institutions offering an ophthalmic nursing programme in Nigeria and two of the states (Kaduna and Kwara) had a good number of trained ophthalmic nurses. However, many of these nurses were either no longer practicing or were maldistributed, with most of them refusing to be deployed to rural areas. The programmes therefore decided to train ophthalmic nurses, but place an emphasis on nurses from local government areas (districts) and the aim of having qualified ophthalmic staff nearest to the underserved populations for service delivery.

An important aspect was the need to link the training to the partners' strategic human resource development plan for health. This was


Jenny Matthews/Sightsavers

A patient being examined as part of the Kwara State Eye Care Programme

in order to strengthen the general workforce and promote integration and sustainability of eye care amidst other competing health needs of the population.

In addition, it was advocated that the various Ministries of Health should recruit ophthalmologists for their states. This resulted in the recruitment of two ophthalmologists in Kaduna and one in Sokoto States. The necessary motivation and incentives for eye care staff were provided.

Outcome

A total of 26 ophthalmologists (up from only two in 2004) and 60 ophthalmic nurses were trained in batches from 2004 – 2008 in the four states. Service delivery increased, with eye surgeries increasing from 6,487 in 2004 to 24,713 in 2008, giving a 300% increase in just five years. Cataract surgeries increased from 2,629 in 2004 to 9,136 in 2008.

Way forward

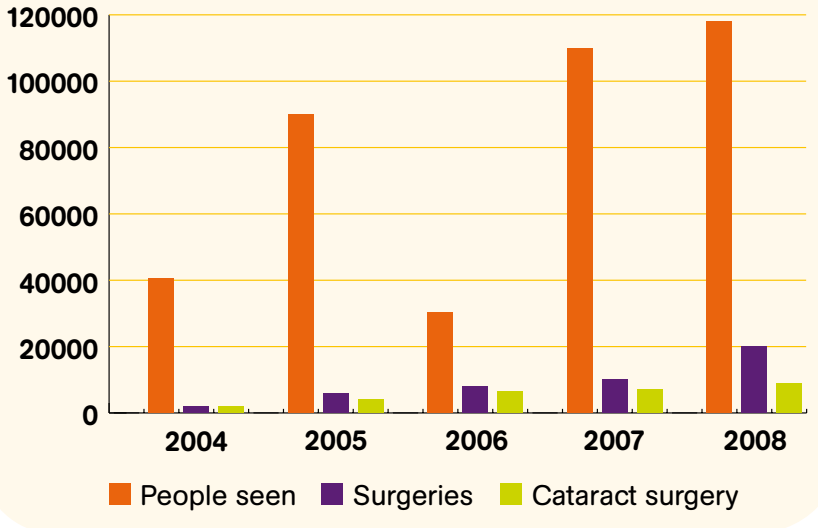
The programmes plan to continue training eye care workers to meet the recommended VISION 2020 requirement for sub Saharan Africa; namely, one ophthalmologist to a population of 400,000 people and one ophthalmic nurse to a population of 100,000 people. The target is to attain this by 2013 for all the states.

The continuous success of these programmes in terms of service delivery will to a large extent depend on the provision of quality eye health services at the community level. Future efforts will therefore focus on the training of integrated eye care workers and primary health care workers to improve community eye health, recruitment and referral of patients for service delivery.

Conclusion:

Development of the health workforce is the key to effective and high quality service delivery. The significant improvement in the number of people who have had their sight restored as a result of an increased eye care workforce in Nigeria is a testament to this. It must also be added that this was achieved through good advocacy, programme management and committed leadership of the programmes.

Total number of people seen and Surgeries performed from the four states from 2004-2008



1 http://www.who.int/healthsystems/strategy/everybodys_business.pdf

Bridging human resource gaps in the Caribbean

Philip Hand, *Programme Manager: Caribbean and Arvel Grant, CEO, Caribbean Council for the Blind - Eye Care Caribbean*

Refractionist at work in Guyana

When Caribbean Council for the Blind - Eye Care Caribbean (CCB) facilitated the launch of Vision 2020: the Right to Sight in the Caribbean in July 2003, their strategic emphasis immediately focused on human resource development (HRD) in eye health and inclusive services.

An audit of the HRD needs confirmed a major gap at the mid levels of eye health services. CCB noted that, while in the UK and Australia there is about one optometrist to 10,000 people, in the Caribbean the ratio was closer to one optometrist to every 100,000 people.

In order to improve the ratio, CCB began an intense lobby to identify a host government and university in the Caribbean willing to participate in the establishment of a multi level training programme for optometrists and refraction technicians. A university-based training programme was essential if the graduates were to have professional credibility within the Caribbean.

Eventually, the Ministry of Health in Guyana and the University of Guyana proved to be most receptive. After more than five years of intense lobbying and sustained programme development by CCB and Eye Care Guyana, the Ministry of Health now hosts vision centres in nine public hospitals providing refractive and referral services to more than 20,000 clients each year, while the University of Guyana offers an optometry degree programme comprising of a Certificate in Refraction Techniques, an Associate Degree in Optometry and a BSc in Optometry.

CCB and the University of Guyana started a

one year Certificate in Refraction Techniques course in 2005, which helped to demonstrate impact while developing trust and confidence among the partners. This provided a solid foundation for the optometry degree programme and the partners plan to continue working together to establish the Caribbean School of Optometry at the University of Guyana.

At the launch of the optometry degree programme in Guyana on 2nd February 2010, the University of Guyana's Vice Chancellor, Professor Lawrence Carrington, said that 'our satisfaction with the programme in optometry is not derived exclusively from the fact that human sight is a primary attribute of human reality, but because we are convinced that collaboration is an ethic that our university must seek to cultivate, exemplify and to propagate as part of its fulfillment of its mission'.

Partners have worked with the International Centre for Eyecare Education (ICEE) to develop a curriculum that meets international standards, resulting in the Caribbean now having a university-level training programme for optometric personnel which is equivalent to the UK.

Since its inception the Certificate in Refraction Techniques course has produced nine refractionists for Guyana, Jamaica and St. Lucia, with another six currently in training. CCB and Sightsavers will support a further 23 refractionists and 15 optometrists over the next five years. CCB knows that training refractionists and optometrists alone is not enough to ensure service provision to poor and rural communities. In order to support a regional refractive error strategy, CCB and Sightsavers also support initiatives to train spectacle lab technicians, dispensing technicians, maintenance and administrative staff.

Along the way we have learned to think and plan for the long term, and that it is key to fully understand academic structures and course approval mechanisms. It has taken up to five years to establish and approve the optometry degree course and during that time people have come and gone from the process. Having a clear shared vision at the beginning has ensured long term commitment of the institutions involved, rather than over-reliance on individuals. This clarity is again being ensured with plans to establish a School of Optometry as the partners are currently involved in agreeing a memorandum of understanding to guide the process.

Attaining course approval at university level has been complex and required the commitment and understanding of people at high levels within the national and regional partner organisations. They needed to engage with the university's leadership and academic board, clearly present the course, respond to queries and ensure curriculum development and revision corresponded with the university's review and approval mechanisms.

It was also essential to identify advocacy targets and plan an advocacy strategy to suit available resources. Many parties have a stake when it comes to delivering a course at this level, ranging from potential candidates and lecturers to national, regional and international bodies. Knowing when and how to communicate effectively has been vital and keeping communication channels open played a key role – letting discussions stagnate means momentum is lost, ideas dry up and relationships break down.

Sightsavers work in the Caribbean is carried out in partnership with the Caribbean Council for the Blind (CCB) and it member agencies. Sightsavers provides both financial and technical support to HRD programmes.

Spectacles being made in an optical workshop

Human resources for eye health: experience from Bangladesh

Dr Wahidul Islam, *Country Director: Bangladesh*
Md. Rafiqul Islam, *Senior Project Officer: Bangladesh*
Rifat Khan, *Programme Manager: Bangladesh*

Mr. Bulbul, refractionist, examining a patient at Marium Eye Hospital (MEH), Ulipur, Kurigram

Background :

In Bangladesh over 750,000 people are blind, of which 650,000 are blind due to treatable cataract. Eye care services provided by the government continue to remain bleak due to low demand as well as inadequate service delivery, including a lack of infrastructure, equipment, and trained manpower. More than 85% of eye care services, particularly cataract surgeries, are performed by NGOs and the private sector. In 2003, the National Blindness Survey showed that Bangladesh has around 626 ophthalmologists, of which one third do not have any formal micro surgery training to perform cataract surgery. The productivity of the ophthalmologists is also affected by the limited availability of ophthalmic nurses and paramedics.

Programme:

Since 1973, Sightsavers has been working in partnership with local NGOs in Bangladesh to bring eye care services within the reach of the poorest communities. To address the lack of skilled manpower, Sightsavers developed a strategy to provide hands-on training courses for medical doctors and paramedics using in-country training facilities like Chittagong Eye Infirmary Training Complex (CEITC) and Islamia Eye Hospital (IEH). Initially, surgeons were sent to undertake a Micro-Surgery (MS) Training of Trainers Course at Aravind Eye Hospital (AEH), India, but during the mid 90s, AEH gave technical assistance to IEH in developing its own MS training course. Since then, 12-16 ophthalmologists / medical officers successfully complete the course

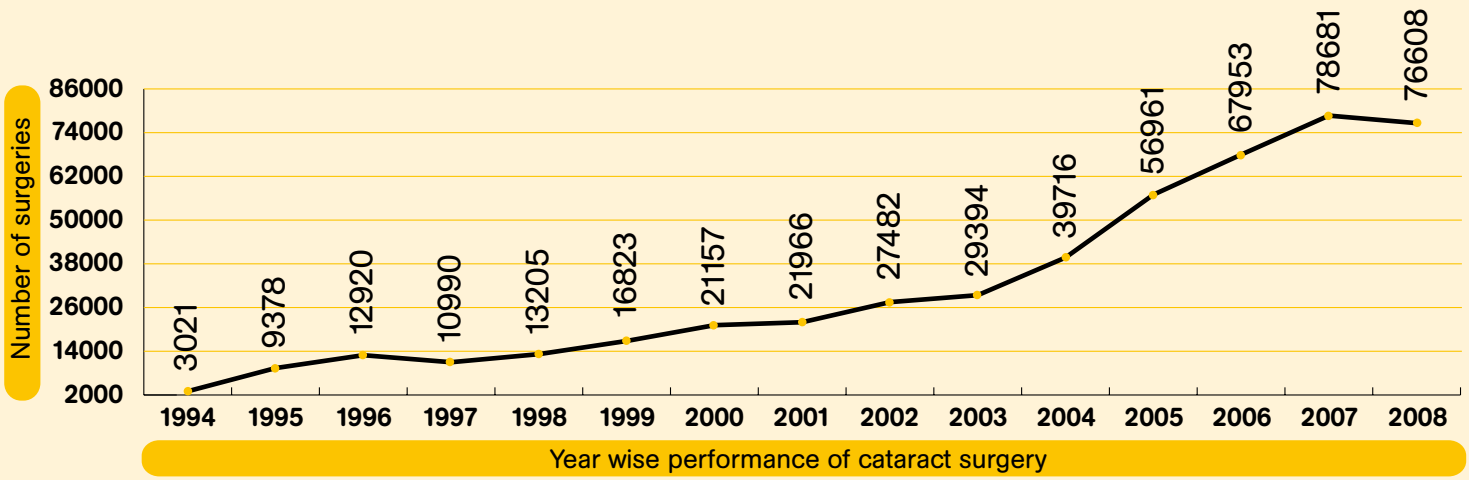
Dr. Habibur Rahman performing surgery at Bangladesh Jatiya Andha Kalyan Samity (BJAKS) Hopistal in Comilla

each year. In 2005, Sightsavers also facilitated introduction of a Small Incision Cataract Surgery (SICS) training course at IEH. Now 99% of IOL surgeries are performed using SICS techniques and the quality of surgery has therefore improved tremendously. All trained surgeons working in Sightsavers supported projects are now able to perform 7-10 SICS surgery in one hour!

In addition, Sightsavers supported a Basic Ophthalmic Training Course for 100 young medical graduates from IEH and the National Institute of Ophthalmology (NIO). More than 40 paramedics received refraction training, and 20 low vision training, from CEITC with support from Sightsavers. To maintain quality, Sightsavers has joined with Aravind Eye Hospital and the National Insitute of Ophthalmology to develop a standard protocol which is being implemented throughout the country.

Future Direction:

Sightsavers will continue to assist its partners, including the government, in building in-country capacity to develop adequate human resources (ophthalmologists and mid level eye care).



Developing and expanding an eye health workforce in Pakistan

Niaz Ullah Khan, *Country Director: Pakistan*
Munazza Gillani, *Programme Manager: Pakistan*

Fatima, a Lady Health Worker, testing the visual acuity of a family during her routine visit to slums in Gadap Town, Karachi

Abstract:

Availability of trained human resources (HR) is vital for the effective functioning of any health system. The National Eye Health Programme (NEHP) in Pakistan has placed special emphasis on the institutionalisation of human resource development (HRD) to enhance coverage and access. This includes the establishment of training institutes in both the public and non-government sectors; training of ophthalmologists in community eye health; specialised training programmes for allied vision sciences professionals such as optometrists and ophthalmic technicians; and revitalising the eye health component of primary health care through the training of Lady Health Workers in eye health promotion and prevention of eye disease. This strategy has been implemented with full ownership and stewardship by the public sector and has been a successful recipe for scaling up both the training and deployment of eye health professionals within existing health services.

Background:

Pakistan is a diverse country with a population of 165 million people divided into five provinces with two federally administered zones. The first population based national blindness survey, conducted in 1987-1988, showed a prevalence of 1.78%. The second population based national blindness survey, conducted in 2003-2004, revealed

a prevalence of 0.9%. This demonstrated a significant halving of the blind population over a period of 15 years. Presently, it is estimated that there are about 1.5 million people with blindness and nearly four million people who are visually impaired in the country.

The first five years of the NEHP (1994-1998) focused on understanding the need for HRD, the institutional structures, and on developing linkages within and across the region with the assistance of international partners. A pilot phase to train different cadres of eye care teams was run in conjunction with a district comprehensive eye care (DCEC) strategy that invested in strengthening eye health infrastructure and HR capacity for eye health at the district level. The second NEHP (1999–2003) used the learning and experience from the first plan to enhance and scale up institutional development for training in all the provinces in the country and this was linked with a parallel scaling up of DCEC programmes in the country. As part of the third NEHP (2005-2010), subspecialty training has now been added to the range of training programmes to address specialty needs now arising from improved detection and referral of complicated eye conditions.

Programme initiatives and outcomes:

Since the 1990s the national committee for prevention and control of blindness has sensitised and lobbied key policy and decision makers to institutionalise HRD programmes in Pakistan. This included situation analysis and human resource planning in the provinces, together with development of a CEC strategy. Initially, the committee agreed with three critical human resources needs i.e. development of community ophthalmology; development of other eye care personnel like optometrists and ophthalmic technicians, and revitalising the eye health component of primary health care.

Developing community ophthalmology:

With the support of international partners Pakistan Institute of Community Ophthalmology (PICO), Peshawar, initiated a one year masters degree programme in community ophthalmology in 1998.The programme trains ophthalmologists in the areas of public eye health and management, with a specific focus on community health, advocacy and outreach activities. The first batch of community ophthalmologists played a significant role in laying the foundation on which a national eye health programme could be developed. This took the form of comprehensive eye care (CEC) cells in the four provinces and these cells served as the planning and coordination units for the devolving national programme, and provided a leadership role in designing, implementing and monitoring the district CEC programmes and HRD training programmes in their respective provinces. The College of Ophthalmology and Allied Vision Sciences (COAVS) plans to start a Masters in Community Eye Health from 2010.

Developing mid level eye care professionals/personnel:

The situation analysis supported by WHO in 1980 revealed a lack of trained human resources, specifically those providing support to the ophthalmologists working at the tertiary and secondary levels. As a result, there were low outputs and limited outreach services for the communities. The national committee approved a training programme for eye health professionals, initially training ophthalmic technicians for a duration of one year. This was started in 1993-1994 at PICO in Peshawar with the support of Sightsavers. In the second national eye care plan, and based on deliberations and feedback from partners, human resource planning was redefined and organised with a career path requiring a three year course for the students. The process progressed and was implemented in phases, with establishment of institutes for training in each province in Pakistan.

The Pakistan Center for Vision Sciences (PCVS) was established within PICO Peshawar which served as the progenitor for other provincial institutes. A new precedence of public-private partnership (PPP) was set in Punjab through upgrading of the Punjab CEC Cell, firstly to a new Punjab Institute of Preventive Ophthalmology (PIPO) and then to a College of Ophthalmology and Allied Vision Sciences (COAVS). All construction and establishment costs were provided by the provincial government, and other capital costs for infrastructure, equipment and training were provided by Sightsavers, Fred Hollows

Foundation and WHO.

In Sindh province, a new vision sciences centre was set up at Civil Hospital in Karachi through a PPP with Sightsavers. As a result of intense advocacy efforts and using the precedence of demonstration models in the other three provinces, the government of Balochistan province established a training programme for ophthalmic technicians at their multi-purpose training centre in Quetta through PPP with Sightsavers. A leading national non-government organisation, Al-Ibrahim Eye Hospital in Karachi, known as Isra School of Optometry and supported by Sightsavers, also offers a four year course in line with approved national guidelines.

The various institutes thus developed in the country were used to raise the profile of eye health and blindness and, through sustainable production of an eye health workforce, increase the coverage of eye health services, strengthen the human resources for eye health as part of health systems strengthening, and provide the rationale for creation of posts and deployment of trained staff within the public sector.

Strengthening the primary health workforce

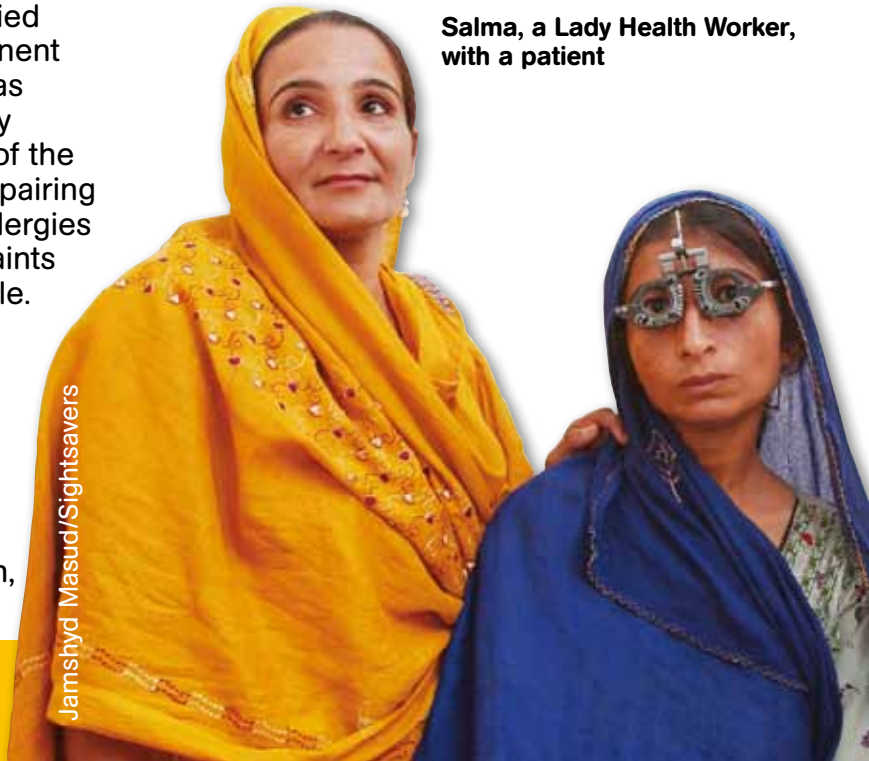
The government of Pakistan launched a National Programme for Family Planning and Primary Health Care in 1993-94. The programme focuses on deployment of Lady Health Workers (LHWs) at the community level for health promotion and disease prevention. A LHW is responsible for a population of about 1,000 people or 125-150 households, and visits each household at least once a month. She is considered as the first line health workforce. The national eye health committee lobbied for strengthening the eye health component of primary health care. This advocacy was supported by research at the community level, which identified that at least 30% of the community suffered from non- vision impairing eye conditions, such as conjunctivitis, allergies etc . The mean frequency of eye complaints was 55 cases per month for 1,000 people. Based on this evidence, eye health training of LHWs was piloted initially at the community level around a basic health unit, then at sub-district level and subsequently at district level. All results clearly demonstrated an increase in uptake of eye care services for surgery at the district level, especially for women, and also a reduction in simple eye infections that could be easily treated at the primary level but were unnecessarily increasing the outpatient load at the district hospitals.

In 2008, a national initiative to train 20,000 LHWs was initiated as a part of existing health structures and now the government of Pakistan is funding the training of 50,000 LHWs in eye health as part of primary health care.

Going to scale

According to Pakistan's national eye health plan, the country needs 215 community ophthalmologists, 2,650 optometrists/ graduates in vision sciences and 3400 ophthalmic technicians/nurses. In addition, 80,000 PHC workers deployed at the community level need orientation in eye health.

Sightsavers facilitated the establishment of four training institutes at the provincial levels and one in the NGO sector to meet the human resource needs for the national eye health programme. These institutes are producing an average of 10 community ophthalmologists, 100 OTs and 80 optometrists/vision graduates each year. So far, 86 community ophthalmologists, 47 optometrists, 10 orthoptists and 440 OTs have been trained in Pakistan. In the national eye health programme 2005-2010, the provinces provided concurrence and commitment for creating the posts needed for the programme. In Punjab, all positions have been approved and created, and the graduates are being placed against those positions. In Sindh and North West Frontier, advocacy efforts are underway with relevant government authorities to create new posts for eye health professionals.



Salma, a Lady Health Worker, with a patient

For the training of LHWs, Sightsavers shifted its approach towards health systems strengthening rather than working as a vertical approach where PHC workers were trained by ophthalmologists. Using this systems strengthening approach, our partners were able to train 32,000 LHWs in Pakistan. The government of Pakistan has scaled this approach up by providing training to the remaining 50,000 LHWs across the country.

Through Sightsavers' advocacy work, the government of Pakistan has recognised the HRD programme as a demonstration model that can be replicated and gradually scaled up across the country. The government has now approved another Masters degree in community ophthalmology at COAVS and a graduation course in Vision Sciences in key medical teaching institutes in Pakistan from 2009. In addition to this, in three provinces; Punjab, Sindh and Balochistan, the government has taken over all necessary operational expenditure, whilst Sightsavers has been providing necessary support in the faculty development and standardisation of the courses.

Key learning

- Mapping out of the key stakeholders involved at different levels and tiers is pivotal to identify strategic entry points and collaboration with other programmes. This makes the process cost effective and beneficial with a win-win situation for everyone.
- Making VISION 2020 a reality at the country and regional level is impossible without an appropriate human resource development strategy at different levels and tiers. Provision of equipment and infrastructure is likely to be less useful without availability and functionality of human resources.
- Learning from the processes and initiatives is critical for efficient change management and creativity for sustainable development. Initially, the programme focused on ophthalmologists training the LHWs in eye health. However, from programme evaluations, we learnt that integration of eye health into primary health care and the national health management information system is not possible without the active involvement of and shifting the ownerships to the national programme for primary health care.
- Evidence building and advocacy are pivotal to the success of any human resource development strategy. Encouraging research for evidence and hypothesis assessment provides a foundation for effective lobbying, networking and influencing the decision and policy makers.
- There is considerable benefit to be obtained by undertaking human resource planning for eye health together with the relevant planning section in health ministries and departments. This ensures ownership, institutionalisation and subsequent allocation of resources.
- The needs and approaches have to vary for different tiers and levels of services i.e. ophthalmic technicians at the community level, optometrists at secondary and tertiary levels. These evolve over the period with experience and learning, and every country should decide based on local practices and international learning.
- It is quite challenging to advocate for a wholesale package from an eye care context only. A strategy that demonstrates how human resource planning for eye health is interlinked with the wider health development agenda, and how there is inter-dependence between different sectors and fields, will enable us to bring about a step by step change in health care delivery.
- Partnership development that places the onus of ownership and stewardship in public institutes and provides necessary investment for pilot initiatives is the key to develop demonstration approaches and undertake sustained and consistent advocacy for scaling up human resource development and deployment.

Resources and further reading

Gilbert, C.E et al on behalf of the Pakistan National Eye Survey Study Group, (2008), Poverty and blindness in Pakistan: results from the Pakistan national blindness and visual impairment survey. British Medical Journal, vol 336 No. 7634:29-32

Hussain,A; Awan,H; Khan,M.D.; Prevalence of non-vision-impairing conditions in a village in Chakwal district, Punjab, Pakistan' Ophthalmic Epidemiology; Volume 11, Number 5, December 2004 , pp. 413-426(14)

Khan AA. Charting new frontiers of hope in Pakistan. Community Eye Health J 2007;20(64): 65.

Khan N, Khan AA and Awan HR, Women health workers: improving eye care in Pakistan Community Eye Health J 2009;22(70): 26

An ophthalmic training programme in Zambia

Joseph Munsanje, *Country Director: Zambia*
Precious Julius, *Programme Officer: Zambia*

In Zambia, ophthalmic human resource consultants and specialists were trained abroad until 2006, and 90% of the health institutions had no trained eye personnel. The few specialists were mainly in health institutions on the Copperbelt, Lusaka and towns along the rail line.

In order to address the aims of VISION 2020 and scale up the provision of eye services to all districts by 2020, the Ministry of Health, with partners like Sightsavers, started the training of ophthalmic specialists at clinical officer and registered nurse entry level. This in-service ophthalmic training programme started in July 2006.

Candidates were selected from clinical officers and registered nurses with two years general work experience. The training programme lasts for two years and an advanced diploma is issued on successful completion of the course. Nurses receive recognition as ophthalmic nurses (ONs) and clinical offers as ophthalmic clinical officers (OCOs). The trainees attend a six month practical placement at an established eye hospital/unit, such as Kitwe Central Hospital, Lusaka Eye Hospital, Mwami Mission Hospital or University Teaching Hospital. Newly added practical sites are: Livingstone General Hospital, Ndola Central Hospital, Mansa General Hospital, and St Francis Mission Hospital. Chainama College in association with the School of Medicine, University of Zambia underwrites and confers the Diplomas to graduates.

The course covers the following; anatomy and physiology of the eye, pathology, microbiology, general ophthalmology, ophthalmic surgery, refraction, primary eye health, ophthalmic care (for ophthalmic nurses), clinical ophthalmology (for clinical officers), VISION 2020, health systems research, leadership and management, and eye health promotion.

From July 2006, 25 OCOs were enrolled, eight of which have graduated while 17 are still in training. 23 ONs have been enrolled, seven have graduated and 16 are still in training. After receiving the basic diagnostic eye kit to start providing eye services, the graduates were distributed to various district hospitals where units did not have this equipment. Below is the table showing the graduates distribution.

Distribution of Graduates (2006 intake)

Hospital	OCO	ON
Kitwe Central	1	1
Ronald Ross General hosp		1
Kasama General hosp		1
Mbala General hosp	1	
Kaoma urban Clinic	1	
Lusaka Eye hosp	1	1
Ndola DHMT		1
Solwezi Urban Clinic	1	
Monze Urban Clinic	1	
Sinazongwe, Malima RHC	1	
Mtendere Mission hospital	1	
Choma Gen hospital		1
Kalulushi DHMT		1

Mr Kapeso OCO has done extremely well by setting up the eye services at Mbala General Hospital. Mrs. Ama A. Ado (OCO) and Mrs. Twaambo M Hachinzobolo (ON), both at Kitwe Central Hospital eye unit, and Mr. Mdaniso Mkandawire of Monze are doing well in the already established clinics. The managers and communities have appreciated their contribution to the eye services and following is a closer look at Mr. Mdaniso's work in Monze District of the Southern Province.

Interview: Mr. Mdaniso Mkandawire, Ophthalmic Clinical Officer, Monze District, Zambia


Arthur Kalila/Sightsavers

Introduction

My training experience in ophthalmology at Chainama was exciting and full of discoveries. It expanded my knowledge base in understanding research and community eye health programmes and has also improved the quality of eye care offered to people in Monze where I am working.

From my background knowledge as a clinical officer, I knew that an eye is a specialised organ of the body but little did I know that the eye is in fact highly specialised.

Challenges during training

The programme is in its infancy and facing a number of challenges like inadequate boarding infrastructure for the students, insufficient learning theatres and dependence on external lecturers. However, let me be quick to mention that the knowledge was of high standard because of the calibre of the lecturers involved.

Benefits of the training

I knew of the eye being highly specialised, but it was also interesting to know that some causes of blindness could be prevented, and if they have occurred, can be corrected by some specialised surgeries. I learnt that the most common causes of blindness in Zambia are cataract, trachoma, refractive errors, glaucoma and onchocerciasis. These conditions could be prevented, treated and corrected and this information I have passed on to the community to make them proactive in seeking treatment for any eye conditions.

Apart from creating awareness in the community, I have been treating eye infections and conditions correctly, correcting refractive errors, assisting people who have conditions that are operable and are within my capacity.

I have been able to assist young children to get back to school by divorcing them from guiding their parents and grandparents who are blind due to avoidable blindness. This is done by linking these blind people to eye camps where extra capsular cataract extractions and trabeculectomies are done.

As an individual, the training has exposed me to personalities that I could not access before and consequently linking me to other training opportunities. The training has been fulfilling and satisfying because it opened my career in ophthalmology. I can now pursue a Bachelor of Sciences in optometry though no institution in Zambia is presently offering such training.

Post training problems

Non existence of training programmes or institutions offering courses that provide continuity to career development like cataract surgery, optometry, low vision etc. However, I must mention that Chainama College of Health Sciences in conjunction with Sightsavers and Vision Aid Overseas are in the process of introducing an Optometrist Technicians training programme which will contribute to the treatment of refractive errors and to the achievement of the VISION 2020 objectives.

The major problems after training are none existence of positions in the new establishment, therefore making it very difficult for the students to be appraised and get their monetary benefits in terms of salary. Sightsavers has taken this as an advocacy issue and are pursuing it.

The consortium approach to resource mobilisation and human resource development

Ronnie Graham, *Regional Director: East, Central and Southern Africa*

Background

Recent international development trends require us to move towards the consortium approach to resource mobilisation. These trends include:

- The move towards enhanced coordination of international non-governmental organisations (INGOs), as witnessed by the expansion of sectoral approaches to minimise duplication and optimise resources.
- The growing expectation by funding partners that INGOs must synergise their efforts to reduce transaction costs.
- The view that governments themselves are increasingly unhappy with multiple, uncoordinated INGO activities in their countries.

These three 'drivers', coming from INGOs, donors and governments respectively will increasingly make the consortium approach the norm rather than the exception.

Prioritisation

Conceptualising, creating and managing a multi-agency consortium presents many challenges. It is vital to establish at the outset agreed areas of activity which add value to the development process. It is inadvisable to create a consortium around service delivery given the plethora of approaches which northern INGOs pursue. In the eye care sector alone, INGOs often pursue mutually incompatible approaches based either on outreach strategies or the Primary Health Care (PHC) approach. In such a situation, it is almost impossible to establish common ground. The exception is where there is a universally accepted methodology, such as the SAFE (surgery, antibiotics, facial cleanliness and environmental change) strategy to control trachoma or the use of CDTI (Community-Directed Treatment with Ivermectin) in onchocerciasis programmes. It is far better to focus on development themes where there is a common interest and clear added value such as human resource development (HRD), research, advocacy and, indeed, coordination itself.

Early approaches in Sightsavers

Sightsavers has been pursuing government funding for many years and has generated significant experience in accessing such support from the European Union (EU) in particular in Bangladesh, Pakistan, Mali and Malawi. More recently, Sightsavers has been able to generate support from the United States Agency for International Development (USAID), Irish Aid and, to a lesser extent, the Department for International Development (DfID). We can therefore claim a degree of experience and expertise in planning and delivering on large donor funded programmes.

More recently the consortium approach has been pursued in a number of countries and contexts. These efforts included joint Sightsavers-CBM-Fred Hollows Foundation (FHF) programming in Pakistan; joint funding for national prevalence surveys in Pakistan and Nigeria, an (unsuccessful) service delivery consortium in Bangladesh and joint Sightsavers-CBM-International Centre for Eyecare Education (ICEE) support for rapid assessments of refractive error in the East, Central and Southern Africa (ECSA) region, culminating in consortium funding for a new regional School of Optometry in Malawi.

Successful or not, what characterised these initial attempts to work together was a reliance on internal agency resources and a high degree of self-discipline and commitment to translate concepts into practice. In this respect, the conditionality imposed on agencies by donors provides a useful discipline for meeting deadlines and ensuring accountability. However, for many agencies and individuals working within these agencies, working alone and 'in control' of the assumed development variables still seemed a safer bet for meeting organizational objectives. By 2005, Sightsavers could claim a reasonable level of expertise in a) accessing donor support for programmes and b) more limited success in developing the consortium approach.

The consortia approach and donor funding

The expansion of multi-agency approaches, combining the consortia approach with donor funding applications, often in multi-country settings, only really started in 2006 with a growing appreciation of the need for increased coordination amongst agencies at the programme level if the ambitious development goals of the 21st century – the Millennium Development Goals (MDGs), Education For All (EFA) and VISION 2020 - were to be achieved. In Sightsavers, this was allied with the expansion of the Programme Funding Unit (now the Government Relations and Policy Evidence team) and, in a more technical sense, the capacity to manage more complicated contracts.

The first successful example of this approach was the formation of a consortium comprising Sightsavers, CBM, the African Medical and Research Foundation (AMREF) and the Ministry of Health to seek EU funding for the control of trachoma in Kenya. This was quickly followed by a major HRD initiative in East Africa when Sightsavers, Operation Eyesight Universal (OEU), Light for the World and the Eastern Africa College of Ophthalmology (EACO) came together to apply for EU funding to expand the training of ophthalmologists in Kenya, Uganda and Tanzania. Shortly afterwards, Sightsavers and WaterAid successfully combined to secure EU funding for an expansion of trachoma control in Mali.

Around the same time a new coalition of eye care agencies in Mozambique came together to submit ambitious (but sadly unsuccessful) proposals to both the EU and the Champalimaud Foundation. More recently, a larger coalition of agencies; Sightsavers, Light for the World, HelpAge International, Fred Hollows Foundation and the International Agency for the Prevention of Blindness (IAPB), united to submit a successful proposal to the EU for the scaling up of mid level eye care training in Malawi, Mozambique and Zimbabwe. Sightsavers and the Caribbean Council for the Blind also succeeded in securing EU support for a multi-country proposal designed to build organisational capacity in the Caribbean. Further, even more ambitious, proposals are in the planning stage and include a second mid-level training initiative in East Africa.

Learning points and recommendations

Our recent success with multi-country consortia has produced several learning points.

- Donor agencies respond positively to the coordination of INGO activity. Indeed, their support can be interpreted as confirmation that we are increasingly aligning our change themes with broader development agendas.
- More remains to be done to create new consortia at country level, applying to the local delegations of the major funding partners.
- Directors should work to underwrite existing commitments, whether programme or management costs, in funding applications.
- We must broaden our consortium approach to engage with other, non-traditional, development partners. This is widely seen as a positive progression out of the ‘blindness box’.
- We must include government in our planning; they are our key implementing partners, and donors themselves prioritise support to government through sectoral approaches and budget support.
- We should be aware of the effect of the global economic crisis on the INGO sector and use the challenge of financial constraint to optimise coordination.

We have only started this journey of coordinating our work with that of other mainstream development agencies and funders. The starting point in regions and countries which have not yet embarked on this journey may well be the strengthening of coordination with other eye care agencies as a precursor to broader sectoral coalitions in health and education. Our current pre-occupation with eye care must now be extended so that we lead the process in a similar way in the education and disability sectors.

The coordination of NGO activity and the transition from vertical NGO programming and narrow vertical thinking towards an engagement with mainstream development is here to stay. One possible new direction is the extent to which we can promote the idea of donor consortia to match the ambitions of the implementing agencies. Sightsavers, with many years of experience in different countries and different sectors, is well positioned to lead this transition in the 21st century.

Developing an eye health workforce – learning from our programmes

Dr. Haroon Awan, *Director, Programme Innovations and Technical Cooperation*

Introduction

Health inequities and service utilisation inequalities are two inter-related factors that are seriously prone to poverty forces. Studies have demonstrated that human resources for health (HRH) density is correlated with infant, under five and maternal mortality. The higher the HRH density, the lower the mortality rates.

It has become increasingly evident that the same correlation applies to blindness, visual impairment and ocular morbidity. In countries and situations where an eye health workforce has been developed and deployed systematically, there has been a marked reduction in prevalence rates.

The preceding chapters describe and discuss the approaches that have been employed in a variety of geographic settings and stakeholder relationships. This chapter attempts to glean from the various case studies the nuggets for our organisational learning that may also prove useful to other professionals, organisations and agencies involved in health workforce development.

1. Ensure planning for human resources for eye health is systematic and institutionalised

Oftentimes, national health programmes plan for service delivery and improving health outcomes without adequate planning for the recruitment, training, deployment and post-training support of an appropriate health workforce. This may be due to economic constraints and insufficient needs assessment of the type and quantity of workforce needed, where they will be trained and how they will be deployed and supported in their work. A thorough situation and policy analysis with stakeholder mapping is required to identify need and potential gaps, and to highlight existing opportunities. This approach also assists in identifying strategic entry points that facilitate training options and prevents wasteful duplication.

Ministries of Health develop long range plans for its human resource needs and use these for estimating allocation of resources as part of health development plans. It therefore follows that engagement with the HRH planning teams in the Ministries of Health is a vital imperative to ensure that training programmes for eye health professionals supported by international partners are aligned with and incorporated in 10 year scale up plans for national health workforce development.

2. Develop and strengthen the institutional base for training

Even though the capital investments may vary depending on whether it is an existing training centre or a new one, the operational requirements for production of a sustainable eye health workforce will essentially be the same. These include standardisation of structured training programmes and curriculae, accreditation of training institutes by professional and regulatory bodies, capacity development of existing faculty and training of master trainers for a new faculty, and academic appointments with commensurate deployment.

Furthermore, training programmes benefit greatly from periodic review by technical experts to ensure quality. It is important that while designing training programmes, production is linked with both eye health needs and market absorption capacity. New training programmes that are developed as part of HRH planning can be used through effective advocacy for creation of posts and deployment opportunities. Oftentimes, a critical mass of health professionals for a new cadre is required before post creation takes place.

3. Utilise the synergy of the existing health workforce

The existing health workforce has a key role to play in expanding the coverage of eye health services. This is particularly true of primary health care workers and community based health personnel. As more and more national health programmes and initiatives recognise the need for and advantage of utilising frontline health workers for its programme objectives,

there is an ever increasing burden imposed on the time available for these health care workers to support other health initiatives.

It is unlikely that primary eye care training on its own in our health programmes is going to be sufficient to invite wide scale acceptance of eye health for integration in mainstream primary health care initiatives. Our eye health workforce programmes would benefit greatly from engaging with the primary health care reform process in the respective countries. This would imply that our engagement in this process would need to be at each of the four reforms – service delivery, public policy, leadership and universal coverage.

4. Document and diffuse good practices from our programmes

Investing in HRH is as much about strengthening training infrastructure as it is about policy change. Policy makers and health planners need evidence to support changes in government policy. Furthermore, policy change involves a prolonged process of concept agreement, piloting various approaches, evaluations of pilots, expanding these to demonstration projects, further evaluations and documentation before consideration for policy revision.

While many strides have been made in developing innovative approaches, diffusion of good practice has been limited. Health systems research for HRH is vital to ensure that an evidence base exists for advocating for policy change. Research, documentation and diffusion need to be part and parcel of the training programmes we support and ensure that they address key policy questions relating to scaling up HRH and retaining health workers.

5. Plan for viability from the outset

One of the key investments that Sightsavers has made through a consortium approach in Africa and South Asia is in strengthening existing training institutes and developing new ones, especially in the public sector. This approach has the added advantage of bringing other stakeholders on board to support a national or regional strategy to develop human resources needed for eye health.

Conditional co-financing is one element of sustainability and can play a vital role in setting up training programmes. In fact, it often acts as a catalyst to boost training capacities and may be required for a number of years to ensure institutionalisation. However, since this support is for a finite period, long term strategies for sustainability need to be designed and phased-in incrementally. It is therefore essential that other aspects of viability be incorporated into programme support for training Institutions. These include sustaining knowledge through local faculty development, improving policies and practices that support staff retention and institutional growth and development, and an in-built system of resource pooling for operational costs to ensure continuity of the training programmes.

Conclusion

Partnerships between state and non-state actors can readily raise the profile of eye health amongst other health priorities, demonstrate cost effectiveness of the approaches that strengthen existing systems and structures, and provide evidence based, scalable and replicable models to Ministries of Health. This collaboration can result in the sustainable production and effective deployment of a well trained eye health workforce based on an investment in development and scale-up plans for human resources for health.

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