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Manila, Philippines
REPORT

REGIONAL MEETING ON IMPLEMENTING TOWARDS UNIVERSAL EYE HEALTH:

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NOTE

The views expressed in this report are those of the participants in the Regional Meeting on Implementing "Towards Universal Eye Health: A Regional Action Plan for the Western Pacific (2014–2019)" and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Regional Meeting on Implementing "Towards Universal Eye Health: A Regional Action Plan for the Western Pacific (2014–2019) on 4–6 November 2014.
Contents

SUMMARY...........................................................................................................................................5

1. INTRODUCTION...................................................................................................................................7
   1.1 Background...................................................................................................................................7
   1.2 Objectives...................................................................................................................................7
   1.3 Participants...................................................................................................................................8
   1.4 Opening Session.................................................................................................................................8

2. PROCEEDINGS ........................................................................................................................................8
   2.1 Overview of the regional action plan..................................................................................................8
   2.2 National targets and indicators..........................................................................................................8
   2.3 Country presentations on national eye health programmes............................................................9
      2.3.1 Fiji ..............................................................................................................................................9
      2.3.2 Marshall Islands ..........................................................................................................................9
      2.3.3 Kiribati .....................................................................................................................................10
      2.3.4 Solomon Islands ......................................................................................................................10
      2.3.5 Samoa .....................................................................................................................................10
      2.3.6 Cambodia ...............................................................................................................................11
      2.3.7 China .......................................................................................................................................12
      2.3.8 Japan .......................................................................................................................................12
      2.3.9 Lao People’s Democratic Republic ..........................................................................................12
      2.3.10 Malaysia ...............................................................................................................................13
      2.3.11 Philippines ............................................................................................................................13
      2.3.12 Viet Nam ...............................................................................................................................14
      2.3.13 Papua New Guinea ...............................................................................................................14
      2.3.14 Federated States of Micronesia.............................................................................................15
   2.4 International partners and international eye health for advocacy ..................................................15
   2.5 Evidence generated and used to advocate increased political and financial commitment of
       Member States for eye health............................................................................................................16
      2.5.1 Rapid Assessment of Avoidable Blindness (RAAB) in Mongolia............................................16
   2.6 National eye health plans and WHO’s framework for action.........................................................17
      2.6.1 Financing strategies for achieving the regional action plan goals...........................................17
      2.6.2 The Philippine Community Eye Care programme ..................................................................18
      2.6.3 Cataract services – strategies to increase output while strengthening quality assurance .........20
      2.6.4 Uncorrected refractive error services ......................................................................................20
      2.6.5 Low vision and rehabilitation services .....................................................................................22
      2.6.6 Strengthening primary health care services ..........................................................................22
      2.6.7 Diabetic retinopathy services .................................................................................................23
   2.7 Multisectoral engagement and effective partnership for improved eye health strengthened ..........24
      2.7.1 Universal health coverage .......................................................................................................24

3. CONCLUSIONS AND NEXT STEPS ..................................................................................................25

ANNEXES ..............................................................................................................................................29

ANNEX 1: List of participants, temporary adviser, observers and secretariat
ANNEX 2: Programme of activities
ANNEX 3: Photos
SUMMARY

In 2010, WHO estimated that 90 million people in the Western Pacific Region have a visual impairment. More than 10 million people are blind and 80 million people have low vision. Globally, up to 80% of blindness and visual impairment is preventable or treatable. Cost-effective interventions are available for the major causes of avoidable blindness.

The Regional Meeting on Implementing Towards Universal Eye Health: A Regional Action Plan (2014–2019) was held on 4–6 November 2014 in Manila, Philippines. The meeting objectives were:

1) to discuss country situation, priorities and challenges in implementing national action plans for eye health;
2) to identify actions and requirements for monitoring and using national indicators for prevention of avoidable visual impairment (Appendix 1 of the regional action plan); and
3) to identify opportunities for intercountry and regional collaborations to support implementing the regional action plan.

The meeting was attended by 15 country representatives. Representatives concluded the meeting with country-specific next steps for implementation.

The following are the action points and next steps that were identified by each country participants:

Cambodia
• Strengthen primary eye-care services (supported by provincial hospitals) to address backlog and achieve the regional action plan target.

China
• Strengthen primary eye-care services.
• Discussions with Ministry of Health about "universal eye health" to address equity issues, especially in services in rural China.

Fiji
• Service delivery for eye care – strengthening integration into the health system.
• Address gaps in services for refractive error, low vision and rehabilitation.
• Integrate national indicators for eye care within the health information system.

Japan
• Develop a report to advocate to the Ministry of Health, Labour and Welfare on the importance of fundus exams for diabetes patients to prevent blindness, in line with the regional action plan.

Kiribati
• Strengthen primary eye-care services.
• Work with national coordinator for prevention of blindness toward universal eye health.

Lao People's Democratic Republic
• Develop and implement a public health campaign to increase awareness of diabetic retinopathy.
Malaysia
- Implement a national blindness survey, with technical support from WHO.
- Advocate to Ministry of Health to increase capacity to deliver low vision rehabilitation services.
- Discuss with Ministry of Health the low number and misdistribution of eye-care personnel.

Marshall Islands
- Collection of clinical data as evidence for advocacy to the government to support eye health (currently one ophthalmologist and no mid-level personnel).
- Training of eye care to health workers to increase service delivery through referral.

Federated States of Micronesia
- Develop a draft national strategy for eye health with a focus on developing human resources capacity.

Mongolia
- Plans to set up the first low vision centre, including short-term training of staff in Hong Kong SAR (China).

Papua New Guinea
- Advocate to government the need for stronger outreach programmes, diabetic retinopathy programmes and specialty ophthalmology units.
- Plans development of an integrated national low vision care plan.

Philippines
- Pilot testing of the Vision Screening Programme in public schools.
- Development of guidelines on the referral and screening of prematures at risk for retinopathy of prematurity (ROP).
- Philippine National Blindness Survey and Eye Disease Study preliminary report by the last quarter of 2015.
- Scale up the Community Eye Health Project.

Samoa
- Collection of clinical data as evidence for advocacy to the government to support eye health (Currently one ophthalmologist).

Solomon Islands
- Advocate and share the regional action plan among government and partners.
- Plan for a rapid assessment of avoidable blindness.

Viet Nam
- Have the new national action plan endorsed by the government.
- National blindness prevalence survey.
1. INTRODUCTION

The Regional Meeting on Implementing *Towards Universal Eye Health: A Regional Action Plan for the Western Pacific (2014–2019)* was held in Manila, Philippines from 4 to 6 November 2014. The meeting was attended by 15 country representatives, 1 temporary adviser, 13 observers and 4 Secretariat.

1.1 Background

In 2010, WHO estimated that more than 90 million people in the Western Pacific Region have a visual impairment. More than 10 million are blind and the remaining 80 million have low vision. Compared to other WHO regions, the numbers in the Western Pacific are high.

Globally, the main cause of avoidable blindness and visual impairment is cataract and uncorrected refractive error. Three quarters of visual impairment (including blindness) is due to uncorrected refractive error (42%) and unoperated cataract (33%). Cataracts cause 51% of blindness. Globally, up to 80% of blindness and visual impairment is preventable or treatable. Cost-effective interventions are available for cataract (surgery is less than US$150 in most low- and middle-income countries (LMICs) and uncorrected refractive error (spectacles can cost less than US$5 in LMICs.)

In May 2013, the World Health Assembly endorsed *Universal eye health: a global action plan 2014–2019* and agreed to a global target to reduce avoidable blindness by 25% by 2019 from a 2010 baseline (WHA66/11).

In line with the global action plan, *Towards universal eye health: a regional action plan for the Western Pacific (2014–2019)* was endorsed by the Regional Committee for the Western Pacific in October 2013 (WPR/RC64/R7). The regional action plan provides a menu of actions for Member States, WHO and partners that can be adapted to different contexts. The regional action plan also defines indicators to measure progress at the national level.

1.2 Objectives

The meeting objectives were:

1) to discuss country situation, priorities and challenges in implementing national action plans for eye health;

2) to identify actions and requirements for monitoring and using national indicators for prevention of avoidable visual impairment (Appendix 1 of the regional action plan); and

3) to identify opportunities for intercountry and regional collaborations to support implementing the regional action plan.
1.3 Participants

The meeting was attended by 15 national focal points for blindness prevention from Cambodia, China, Fiji, Japan, Kiribati, the Lao People’s Democratic Republic, Malaysia, Marshall Islands, Federated States of Micronesia, Mongolia, Papua New Guinea, the Philippines, Samoa, Solomon Islands and Viet Nam, 1 temporary advisor, 13 observers, and 6 WHO staff. The full list of participants, temporary adviser, observers and secretariat is in Annex 1.

1.4 Opening Session

Dr Shin Young-soo, WHO Regional Director for the Western Pacific delivered the opening address. He emphasized that each country may have its own approach to achieve the integration of eye-care services. However, it is important to ensure that everyone has access to services – regardless of their age, gender or social position.

Mr Marcus Samo (Federated States of Micronesia), Dr Baasankhuu Jamiyanjav (Mongolia) and Dr Claude Posala (Solomon Islands) were elected as Chairperson, Vice-Chairperson and Rapporteur, respectively.

2. PROCEEDINGS

2.1 Overview of the regional action plan

The regional action plan focuses on the integration of eye diseases control programmes into wider health-care delivery systems and developing more comprehensive eye-care services. Where appropriate, eye health should be included in broader noncommunicable and communicable disease frameworks. The regional action plan centres on universal health coverage (UHC), achieved in eye health through the provision of comprehensive eye-care services integrated into the national health system.

2.2 National targets and indicators

The regional action plan has three objectives. Each objective includes measurable deliverables and indicators endorsed by the World Health Assembly.

Indicators relate to 1) epidemiological data on the prevalence and causes of visual impairment; 2) eye-care human resources – ophthalmologists, optometrists, and allied ophthalmic personnel; and 3) Cataract Surgical Rate (CSR) – the most feasible proxy indicator for the provision of eye-care services.

Data collection from private hospitals and clinics has been a challenge in some countries because of its tax income implications. In Malaysia, data collection is underway in the public system; however, there is resistance from the private sector to provide data on cataract surgeries. Similarly, in Viet Nam and Papua New Guinea, it is difficult to request data of the surgeries and other eye-care services provided by private hospitals and clinics.

In the Philippines, there is a unified registry and information system. An Administrative Order mandates that all hospitals should report the cataract surgeries they conduct, but only 10% do so. To collect data, the Government is requesting from the national health insurance company (PhilHealth) a record of cataract surgeries among its members. Data is also being requested from other stakeholders who are not members of PhilHealth.
Several recommendations on how to resolve the issue on data collection were raised such as counting of intraocular lens (IOL) sales. A recommendation was discussed for legislation in standardizing data collection of eye services from the private sector. However, there are limitations to this idea and the role of WHO. Cataract surgical output data are collected to understand needs and demonstrate progress.

2.3 Country presentations on national eye health programmes

2.3.1 Fiji

In January 2014, a national eye-care coordinator was employed. The National Prevention of blindness Committee was set up in February 2014. The National Eye Care Strategic Plan (NECSP) core group met on 28 October 2014 to review the NECSP 2009–2013 and identify priorities for NECSP 2014–2019 as follows:

- To align the NECSP 2014–2019 with the regional action plan and the Ministry of Health and Medical Services’ strategic plan 2014–2019;
- Human Resources – to give attention to the clinical workforce plan;
- Service delivery – to strengthen integration into the health service delivery system and address gaps in services for refractive error, low vision and rehabilitation;
- Health information system – to integrate the national indicators for eye care;
- Partnerships – streamlining the stakeholders to avoid duplication of services or funding;
- Finance – majority of the finances are still part of the Ministry of Health and Medical Services and is not segregated to different clinical areas; and
- Monitoring and evaluation – to develop a results framework.

One challenge is mapping human resources. Although there are many ophthalmologists, only three are in the public system.

2.3.2 Marshall Islands

The health service is provided by 2 hospitals, 56 health centres, 4 private clinics including two optometric clinics and 1 NGO youth clinic. The eye health system is not functioning due to a lack of:

- implemented policies, plans and programmes for eye health/prevention of blindness or links with nongovernment organizations (NGOs);
- national coordinator or committee for eye health;
- budget allocated specifically for eye health;
- links with other sectors or programmes; and
- eye health is not incorporated into socio-economic or poverty-reduction policy.

The lack of eye health personnel has resulted in a low output of eye-care services. Diabetic-related eye diseases are common. Yet only one ophthalmologist provides clinical services. Although there are two or three general nurses who assist the ophthalmologist during surgery, there are no dedicated mid-level eye-care personnel.

Occasionally, a private optometrist is appointed to the outer islands and the cases are brought to Majuro. Eye service missions are not regularly conducted but have been provided by the Taiwan (China) government, Canvasback Missions and Israel.
2.3.3 Kiribati

The eye health staff includes seven eye nurses: one is training with Pacific Eye Institute (PEI). One ophthalmologist is also training. Eye nurses increased from one in 2010 to eight in 2014. Three nurses are also expected to join in 2015.

The Ministry of Health and Medical Services has a referral committee and most cases of diabetic retinopathy and retinal detachment are referred to Fiji and Australia. Kiribati’s clinic only serves ready-made spectacles.

One success is the development of the National Eye Care Strategic Plan 2015–2018 which was drafted on September 2014. The International Agency for Prevention of Blindness (IAPB) and The Fred Hollows Foundation New Zealand assisted in developing the strategic plan.

Having limited space of the eye clinic, which is only 5x5 meters, is a challenge. Equipment (no camera or laser) and medicines supplies are inadequate. Other challenges in eye health in Kiribati include allocation of eye nurses, funding support and no eye health committee and coordinator.

2.3.4 Solomon Islands

Solomon Islands has a National Eye Care Strategic Plan (NECSP) 2010–2014 with a mission of “Quality Eye Care for All”. This was developed by the National Programme for the Prevention of Blindness and the Ministry of Health and Medical Services, in partnership with WHO and IAPB. The NESCP 2010–2014 focuses on human resources infrastructure and facility and disease control.

Solomon Islands has 6 eye doctors, 38 eye-care nurses of which 3 are diabetic nurses, 1 optical manager and 1 optical technician. The ophthalmic nurses who underwent training at the PEI also assist in the refraction at the National Referral Hospital.

In line with the second component of NECSP 2010–2014, infrastructure and facility, 1 tertiary eye centre has been built, along with the National Eye Care Office and 1 training facility.

As for the third component of NECSP 2010–2014, disease control, diabetic eye services have been integrated into the National Diabetic Centre and dispensed on average 940 spectacles annually. Eye-care health promotion was launched through print ads and TV ads. To map the prevalence of trachoma in Solomon Islands, 21 nurses were trained in trachoma screening. Eye-care services including treatment and surgery are covered by the Government except for spectacles.

2.3.5 Samoa

Eye-care personnel in Samoa are all based in Apia. This includes 1 ophthalmologist, 6 eye-care nurses, 1 full-time optometrists and 1 optical technician. The health centres in other areas do not have eye-care facilities and staff.

Samoa has drafted its National Eye Care Plan (2015–2019). The plan focuses on screening at the primary level, human resource development and retention, procurement of equipment and consumables, funding and resources for eye programmes. The Fred Hollows Foundation New Zealand is assisting Samoa to establish a national eye health coordinator position. This coordinator is expected to periodically consult stakeholders, finalize the NECP 2015–2019 with costing for endorsement, and review, implement, monitor and periodically evaluate the NECP. Samoa has adopted the national indicators of the regional action plan. Rapid assessment of avoidable blindness (RAAB) is expected to be done soon to have data on
prevalence of visual impairment and blindness.

Integration of eye care within the national health systems has been successful with support from partners: Senese Inclusive Education, Clarence Sebastian Foundation, IAPB, The Fred Hollows Foundation New Zealand, PEI and WHO.

One challenge is data collection. Although statistics of cataract surgery are collected, sustainability of eye health financing is also a challenge. Most eye-care services are free-of-charge including treatment, surgery and referral schemes to Australia or New Zealand. Other challenges include personnel shortages and retention of trained eye health personnel.

2.3.6 Cambodia

Based on the RAAB survey conducted in 2007, the blindness rate in Cambodia is 0.38%. The leading cause of blindness is cataract (74.7%). Approximately 333,359 people are living with visual impairment and 57,857 of them are severely visually impaired.

Eye-care human resources in Cambodia are divided into 4 categories: 1) general ophthalmologists who undergo 4-year training at the University of Health Science, supported by Fred Hollows Foundation and Eye Care Foundation since 2007. 2) specialized ophthalmologists who undergo a 2-year programme in Phnom Penh – supported by “Sight for All”. 3) ophthalmic nurses who undergo a 1-year training. 4) refraction nurses who undergo a 3-month or 6-month course which started since 1996. Trainings for the different categories of human resources occur at least once a year.

As of 2013, there are 37 ophthalmologist, 110 ophthalmic nurses and 33 refraction nurses. By 2020, the target human resources numbers are 67, 250 and 73 respectively. The number of eye-care facilities in Cambodia increased from 3 in 1993 to 21 in 2014, and by year 2020 it is expected to have additional facilities in the remote areas.

The estimated annual number of incident cataract cases is about 20,000 and there are 80,000 backlog cases of cataract as of 2014. There are 176 clinics providing refractive error services, 20 of which are government-owned, six are managed by NGOs and 150 are privately owned.

Cambodia is aiming for the elimination of blinding trachoma by 2016. The National Trachoma Survey is underway in 24 provinces and the country is implementing the SAFE strategy of WHO. Although active trachoma has declined in the last 10 years, blinding trachoma remains a challenge.

Childhood blindness rate in Cambodia is estimated to be 1.5 per 1000 children. Based on a Blind Schools Survey conducted in 2009, the main causes of childhood blindness are corneal scar, congenital cataract and eye injuries. Annually, 30,000 children are screened for refractive errors in schools.

Based on a hospital-based study in Phnom Penh, 10% of blindness nationally is due to diabetic retinopathy and 3.1% is due to glaucoma.

A Prevention of Blindness Programme has been developed under the Ministry of Health. Other successes include good donor support, availability of treatment protocols, good documentation and human resources development. Blindness prevalence declined from 1.2% in 2000 to 0.38% in 2007. Challenges include the inequitable distribution of human resources and limited eye-care funding from government.
2.3.7 China

Based on the National Epidemiology Survey in 2006, 35% of visual impairment in China is due to cataract. China has a 5-year national plan for prevention of blindness. The current plan focuses on the elimination of avoidable blindness due to trachoma, cataract, retinopathy of prematurity, low vision, myopia and refractive of error. A main strategy is the training of eye-care personnel.

In 2014, China launched an ophthalmic online data collection system. Hospitals enter basic information including the hospital name, number of ophthalmic personnel and details of services conducted.

China has two major health insurance systems: for rural and urban residents. These systems cover more than 95% of residents.

The Ministry of Health will develop a 2016–2020 national action plan. This plan will focus on cataract, diabetic retinopathy, glaucoma, uncorrected refraction error, and how to attain the Vision 2020 strategy. In May 2014, a national prevention of blindness meeting was held. Participants discussed alignment of the national plan with the regional action plan.

2.3.8 Japan

Blindness and visual impairment are not considered a public health problem in Japan. These are not prioritized because they are not life-threatening conditions and the blindness rate in Japan is only 0.15%. There is no specific government programme for eye health.

Eye-care services have been partially integrated into Japan’s health system. Until 2007, fundus examinations were included in the basic health checkups conducted by municipal governments. However, since 2008, with the introduction of a health guidance programme targeting metabolic related syndromes, fundus examinations were excluded from the programme.

The main cause of low vision and blindness for adults in Japan is glaucoma (23.9%). Japan has specialized eye-care services for children including school screening, preschool health checkups and health checkup for 3-year-old children.

The majority of the 12 797 ophthalmologists in Japan are in private practice. Services are of good quality, with good access and low out-of-pocket cost. Challenges include relatively high prevalence of visual impairment due to diabetic retinopathy and low rates of fundus exams. The number of new ophthalmologists is decreasing while the number of older patients at risk of vision loss is increasing.

2.3.9 Lao People's Democratic Republic

There are 17 provincial hospitals with a dedicated eye-care unit. There is one ophthalmology centre in Vientiane. The country has 22 ophthalmologists, 4 basic eye doctors, 6 refractionists and 49 ophthalmic nurses in 17 provinces.

Based on the 2007 RAAB survey, the prevalence of blindness is estimated at 0.5%. The main cause of blindness is cataract (65.3%). Other causes are glaucoma (12.5%), corneal (6.9%), surgical complication (6.9%), Phthisis bulbi (4.2%) and posterior segment disease (4.2%).

Tertiary level eye care is available in the National Ophthalmology Center (NOC). Secondary level eye care is available in the four regional hospitals and 13 provincial hospitals. District hospitals provide some primary level of eye care.
Ophthalmic nurses and residency training started in 1995 and 2002, respectively. The former is a 4-month training which is done twice a year.

Among the successes of eye health are the formation of the National Committee for Eye Health and the drafting of its national 5-year plan for national policy for eye health. The country has also established partnerships with WHO, IAPB and other NGOs and government agencies. Eye-care units in provincial and district hospitals were also developed and with initiatives to screen for diabetic retinopathy in general hospitals in Vientiane and some provincial hospitals.

Priorities include development of a public health campaign to increase awareness of eye health, especially diabetic retinopathy. There is limited access to eye-care services in the most remote areas and the number of eye-care personnel is inadequate at all levels.

2.3.10 Malaysia

The main causes of visual impairment in Malaysia are uncorrected refractive errors (42%) and cataract (33%). The key issues in the prevention of blindness are:

- lack of updated epidemiological data;
- lack of knowledge and/or will within the Ministry to acknowledge visual impairment as a public health problem;
- lack of coordination between eye-care providers;
- minimal Rehabilitation Services within the Ministry of Health;
- low number and misdistribution of eye-care personnel; and
- unequal cataract output due to geographical coverage, infrastructure and lack of human resources.

In January 2011, the Ministry of Health assigned the Prevention of Blindness and Cataract Services Monitoring Committee under the governance of the National Ophthalmic Services Management Committee. This committee plans, implements, monitors and evaluates prevention of blindness programmes. Malaysia has 400 ophthalmologists and 1300 optometrists. The regional action plan has had substantial impact on the eye health system of Malaysia. The Deputy Director General of Public Health agreed to chair the National Council for the Prevention of Blindness. The regional action plan influenced the public health physicians to renew commitment to their involvement in eye care and inspired some optometrists to the forefront of primary eye care.

Among the successes in eye health are the establishment of a Mobile Cataract Screening and Surgery services and Satellite Cataract Surgical Centres and the development of the National Eye Database.

2.3.11 Philippines

The national eye-care programme estimates a more than 40% decrease in the number of people with bilateral blindness from 560,000 in 2012 to 300,000 in 2014. This is mainly due to an increase in cataract surgeries (20%) from around 1087 in 2012 to 1300 in 2014.

As embedded in the revised Administrative Order 2013-0010 or the Revised Guidelines in the Implementation of the Prevention of Blindness Programme, the vision of the Prevention of Blindness Programme Strategy is “All Filipinos enjoy the right to sight by year 2020”.

The programme aims to:
- Provide access to quality eye-care services for all;
- Strengthen partnerships among and with stakeholders to eliminate avoidable blindness in the Philippines;
- Empower communities to take proactive roles in the promotion of eye health and prevention of blindness; and
- Work towards the preservation, restoration and rehabilitation of sight of indigent Filipinos as a strategy in poverty alleviation.

The Philippines has drafted an Administrative Order: Ensuring Access of the Poor to Operative Cataract Services using National Health Insurance Program Packages (Philhealth). Eye-health activities include vision screening and Primary Eye Care (PEC) training modules. The Vision Screening Program was developed in coordination with the Philippine Eye Research Institute (PERI) and is being piloted in some public schools. The Primary Eye Care Training Modules include three levels: program managers, service providers and community health workers.

A Community Eye Health Project was developed to establish the community eye health teams consisting of local chief executive, health personnel, ophthalmologists, optometrists, NGOs and other interested stakeholders. The team is responsible for the implementation of the eye-care programme in their respective localities.

The Clinical Pathway Guidelines and service packages that integrate Lifestyle Related Diseases (LRD) and Visual Health, including diabetic retinopathy, have been finalized and there is a plan to develop guidelines on the referral and screening of premature babies at risk of Retinopathy of Prematurity (ROP).

The Philippine National Blindness Survey and Eye Disease Study which will be conducted by the Philippine Eye Research Institute has been approved and its preliminary report is expected to be released on the last quarter of 2015.

2.3.12 Viet Nam

Based on the 2007 RAAB in the 16 provinces of Viet Nam, the main causes of blindness are cataract (55%) and posterior disease (10.1%).

The eye-care programme is led by the Ministry of Health/National Prevention of Blindness (PB) Committee. Provincial PB committees in all provinces and are headed by their own provincial president or vice-president.

There are about 1600 eye doctors and 2000 eye nurses in Viet Nam, however, the majority of eye doctors (87.4%) practice in the cities and plain areas. Only (12.6%) work in highlands and mountainous areas.

Viet Nam has 21 government and 11 private-owned eye hospitals, 9 eye centers, 80 eye departments in general hospitals, 23 eye departments in social disease prevention center, and 2 eye departments in health care centers.

2.3.13 Papua New Guinea

There is a high prevalence of blindness and visual impairment throughout Papua New Guinea. In a study on patients over the age of 50 years, it was found that 29.2% were visually impaired and 8.9% had functional blindness.

The health facilities are classified according to population coverage, and availability of investigative facilities, medical specialists and consumables and pharmaceuticals. This classification of facilities creates a referral system whereby a case that cannot be effectively
managed by one facility is referred to the next level. Eye care is a National Department of Health function, managed under the Medical Standards Division.

Papua New Guinea’s National Eye Plan considers the three areas of Vision 2020 and strategies to collectively improve the vision of its people. To improve eye care, advocacy is needed to the government for stronger outreach programmes, a diabetic retinopathy programmes, specialty ophthalmology units and integration of additional teaching and appropriate low vision aids to the existing training courses. Papua New Guinea has a shortage of eye-care personnel. There are only 9 national ophthalmologists in public practice and 4 are in training. A major focus of the National Eye Plan is the development of human resources.

2.3.14 Federated States of Micronesia

Hospitals eye-care services are recorded in the national health information system. The visiting teams who provide eye care also generate their own reports. There are 2 nurses and 1 ophthalmologist who are training and are expected to be the core starting point for eye health. Most eye-care services are provided by the government. If services are not available, patients are referred abroad for treatment, covered by health insurance (except if diabetes related). The Federated States of Micronesia plans to increase the number of visiting medical teams and engage with other organizations interested in assisting to carry out a prevalence survey.

2.4 International partners and international eye health for advocacy

International partners play a critical role in the prevention of blindness by setting standards and guidelines, support innovations, new technology, new approaches, advocacy and provide funding for programmes and training.

Governments also need to increase funding and leadership to prevent blindness. The purpose of the regional action plan is to ensure that the governments are leading national programmes. The role of partners is complementary.

For effective partnerships, NGOs must be engaged as partners, not only as funders and project managers. Successful partnerships involve inclusive committees, coordination and consultation, national plans, policies and strategies, information sharing, reporting, monitoring systems and data collection.

The regional action plan assigns most responsibility for advocacy to international partners. However, internal advocacy and champions within health ministries and programmes are also important. Good advocacy requires evidence, strategy and partnership (ESP):

Evidence – Evidence is the foundation of advocacy, e.g. RAAB, assessments of eye-care systems, project reviews, experience in other contexts, journal papers, economic analyses and patient figures.

Strategy – Good advocacy requires a basic plan, direction and series of actions, requiring long-term investment. A clear idea of the key issues and required actions from stakeholders are also important.

Partnership – Having a united voice among the partners is fundamental. Advocacy is personal, political and cultural.
2.5 Evidence generated and used to advocate increased political and financial commitment of Member States for eye health.

2.5.1 Rapid Assessment of Avoidable Blindness (RAAB) in Mongolia

The RAAB survey in Mongolia was conducted in 2013 in collaboration with WHO and the Ministry of Health. The survey showed that untreated cataract and uncorrected refractive errors are the major causes of avoidable blindness and low vision in Mongolia. The second main cause of blindness is glaucoma followed by non-trachomatous corneal opacity. At present there is one bilateral cataract blind person for every three operated people. Also, 20,500 people aged 50 and above have uncorrected refractive errors and more than 180,000 people have uncorrected presbyopia.

The survey found a reduction in age-specific prevalence of blindness and low vision, except in the oldest age group (80 years and above). The main barrier to surgery is lack of public awareness of possible treatment. Poor selection and late complications are the major causes of poor visual outcome after cataract surgery. The prevalence of functional low vision is relatively high. Of the operated patients, 94% received an IOL. However, the visual outcome is well below the WHO recommendation. Based on the survey findings, it was recommended to increase the CSR by at least 10% per year to compensate for the demographic trend. This is to be achieved through:

1. Detailed analysis of the current cataract surgical services to identify constraints;
2. Intensified health promotion to inform people of benefits of cataract surgery;
3. Lobbying to raise awareness that treatment of cataract reduces poverty;
4. Intensified early case finding;
5. Increased efficiency in referral system for cataract surgery;
6. Application of high output methods for cataract surgery; and
7. More resources.

The survey report also recommended expanding optic services, glaucoma control and facilities for glaucoma surgery and low vision services, and to improve the visual outcome of cataract surgery through:

1. more detailed pre-operative examinations;
2. analysis of the clinical causes of the relative high proportion of late complications;
3. analysis of current practice to determine power of IOLs;
4. analysis of current surgical practices to reduce surgical complications;
5. routine monitoring of cataract surgical outcome can be helpful in the analysis of the surgical process.

The target of the national strategy for prevention and control of avoidable blindness (2014–2019) is to reduce the prevalence of avoidable visual impairment by 25% from the 2010 baseline.

Challenges include addressing human resource needs; improving quality and quantity of the surgeries and services at all levels; expanding pre-school and school children screening; providing refraction, eye-care examination and spectacles; training staff for early detection and treatment of glaucoma; the development of ophthalmic services to deal with blinding posterior segment diseases; and the lack of a monitoring and evaluating system.
2.6 National eye health plans and WHO's framework for action

2.6.1 Financing strategies for achieving the regional action plan goals

Health financing deals with how resources are collected and spent on health care. The level of spending is often a good measure of the size and strength of a health system. Usually, higher-income countries spend more on eye health than lower-income countries.

How resources are collected and spent depends on health system effectiveness in service delivery, equity and accessibility. Collection and spending can also indicate whether a system is self-sustaining or dependent on outside assistance.

The poorest countries tend to have the smallest amount of health spending but the burden of payment is pushed to the people. This is inequitable as service access depends on capacity to pay.

There are two key challenges in eye-health financing. First is the need to increase the size of the resource pie. Options include traditional sources (domestic government budgets, donors), non-traditional sources (private capital) and non-traditional ways (pooled bids across countries/issues). The global action plan provides evidence of the extent of the problem. The next step in seeking financing is to present eye health as a good investment.

The second challenge is to ensure eye-care services are integrated into insurance systems and that coverage is extended. When integrating eye-care services into national health systems, the critical question is: can people access those services? The key indicator is the surgical coverage rate, which is the extent to which eligible patients are receiving cataract surgeries.

The challenge of moving towards UHC is well explained by WHO's “broadening the box” diagram. With any pool of resources there is choice on how to spend them – covering certain services; covering certain groups of people; and covering the costs. Even in the most high-income countries, health systems are targeted at the most cost effective and necessary services and tend to be targeted at ensuring that the poorest and most vulnerable are protected from health costs.

Eye health is likely to be well suited to innovative and targeted financing interventions. The bulk of untreated blindness is made up of cataracts, which is relatively transactional in nature and not dependent on chronic management. The combination of a prominent private sector and social and economic barriers to eye health mean that there may be opportunities for improved financing arrangements to make a difference.

New innovation is occurring at the enterprise level, with cataract hospitals combining operational efficiencies and innovative pricing structures to ensure that they stay solvent as a business yet also provide fee free treatment to the poor. An expert roundtable meeting on Models of Innovative Financing for Eye Health in Manila in December 2014 will focus on overcoming barriers to better eye-health systems and improving systems, new sources of finance beyond traditional funding and harnessing private sectors.

There are possible frameworks for eye-health financing in the near-term. First is the increase the use of services. Second is the increase in the provision of services which entails increase in productivity and efficiency in the use of resources and improvement in the systems, processes and procedures. In the group activity participants discussed:

- Mongolia has free eye-care services for children but for adults, there is government provided insurance for those who can afford.
• Generally, there is universal health insurance in China but coverage has to improve on outpatient services. There is a lot of interest in investing in eye-health programmes but the sustainability of public policies and training has been problematic. Refusals for care and quality of service delivery are common barriers in the increase of services. The government shows willingness to collaborate with other organizations to improve eye services in China.

• In the Philippines, cataract surgery and other eye surgeries are included in the health insurance system in which 60–80% of the population are covered. Challenges include low capacity to deliver services, misdistribution of eye-care professionals, low number of ophthalmologist in the public services and low awareness of the services. WHO and external partners could assist in the provision of equipment and start-up capital for the medical supplies and medicines.

• Cambodia does not have an insurance system that includes eye health. There is also an issue of misdistribution of eye-care professionals, not having ophthalmologists outside urban centres.

• In the Lao People's Democratic Republic, cataract surgery and other eye surgeries are covered by an insurance system. Low awareness of eye care services, especially in the rural areas, is a barrier to the increase of such services.

• Viet Nam has health insurance for the poor which covers 100% of the cost. For the near-poor there is a minimum of 80% coverage that includes main eye-care services. More than 50% of the population is covered by the insurance system but the target is 90% by 2020. Ophthalmologists, as part of a government programme, are sent to rural areas for one year after graduation. A barrier in the eye-care system is low awareness of services.

• Japan has a full coverage of health insurance. Economic growth and affordability encourage the eye-care system to advance. Prevention of blindness is not considered a public health issue. Thus, political advocacy becomes critical e.g. in regards to diabetic retinopathy. WHO could assist in advocacy to the government in recognizing key areas, such as diabetic retinopathy.

• In Malaysia, only 3–5% of the population is covered by insurance which is purchased privately. Issues include the lack of knowledge about disease and lack of human resources for eye care. Political advocacy is necessary to improve eye health in Malaysia. WHO could assist in advocacy to the government including through supporting documentation and data.

2.6.2 The Philippine Community Eye Care programme

The Community Eye Health Project in District 4, Nueva Ecija Region III is a comprehensive eye care model providing a package of quality eye-care services at all levels of care. The package includes health education, advocacy and promotion of eye health care with focus on avoidable blindness and establishment of a referral system connecting all health facilities to ensure patients receive quality eye health care at appropriate levels in the health system.

The Community Eye Health Team is composed of Provincial Health Officer (PHO), Provincial Health Office NCD Coordinator, DOH Representative CHD III, NCD Coordinator CHD III, 7 MHOs and 1 CHO, Local Chief Executives, Ophthalmologists and optometrists, Hospital Representatives, NGOs and religious groups. The team will develop systems and
procedures for the integration and provision of services at the community level. Specifically, the team's functions are to:

1. act as the project management group;
2. advocate for local legislation;
3. develop the workplan, collect and analyze data using appropriate monitoring and evaluation tools;
4. conduct programme monitoring and implementation review;
5. document the progress and good practices in the implementation of the project;
6. advocate for LGUs to increase budget allocation and seek external resources from development agencies, private sectors and other partners;
7. advocate for the expansion of PhilHealth membership for the eye care services especially for cataract surgical services;
8. advocate for the prioritization and utilization of corresponding finances for eye care services;
9. draft local ordinance, district or provincial resolution (Sub-Committee on Policy);
10. train health workers and other concerned partners on Primary Eye Care (Sub-Committee on Capability Building); and
11. provide and enhance the local health units and hospitals (Sub-Committee on Service Delivery).

Management of minor eye diseases will be implemented as part of the primary eye care in Barangay Health Stations and Rural Health Units but major eye conditions and other cases requiring specialized care will be referred. The referral system will be integrated within health programmes (e.g. for older people, and diabetes control), using government health facilities, with links as required with private health facilities and hospitals.

There is no comprehensive Provincial Eye Health Program in place in the provinces except for occasional missions and private sector initiatives in selected municipalities. Thus, the project aims to contribute to the Prevention of Blindness Programme goal to reduce the prevalence of bilateral blindness due to all causes. In 2013–2016, the project aims to increase cataract surgery by 10% per year, reduce blindness and visual impairment due to EOR by 15% per year and establish baseline data for childhood blindness and other eye diseases. The outcome indicators of the Philippine Community Eye Care programme are:

1. Eye Health teams functional (regular meetings held and minutes of meeting documented)
2. Eye Care Services in place at the field and hospital facilities
   a. screening and referral
   b. treatment and management
   c. referral system in place
   d. promotion and preventive services in place
3. Local Ordinances on eye health passed and with funding allocation
4. policy developed and local eye health plan developed
5. number of cataract surgeries
6. number of patients seen for EOR
7. number of eye diseases screened, referred and treated
8. number of cataract surgeries with PhilHealth
   Level of awareness of the population on the importance of eye care and services
2.6.3 Cataract services – strategies to increase output while strengthening quality assurance

Cataract is the leading cause of blindness globally even though it is the easiest eye condition to diagnose. Surgery takes a few minutes and high-quality intraocular lenses are available for a few US dollars. Generally, problems with the “cataract service equation” relate to: 1) service delivery; and 2) demand for service. Programmes often concentrate on creating services rather than focusing on demand.

**Service Delivery**

Service delivery problems include unavailability, inaccessibility, unaffordability and poor quality. The Review of Early Cataract Outcomes and Grading (PRECOG) study was in several countries in Asia and Latin America aimed to validate strategies to determine visual outcome after cataract surgery where follow-up is poor. PRECOG data collection included early vision assessment for all patients immediately after the surgery and late vision assessment. Findings suggest that hospitals with good early vision outcomes also have good final outcomes. Only 50% of the patients who underwent cataract surgery returned for follow-up.

By comparing cataract surgical outcomes and complications, PRECOG will allow hospitals to benchmark with other hospitals.

Cataract surgical outcomes are not routinely measured. This may be due to lack of resources, clinicians lacking time or the lack of available systems to record cataract outcomes.

In group discussion, common problems identified in the service delivery are lack of quality of cataract surgery, continuity of supply of consumables, lack of eye-care doctors and lack of professional development. Proposed solutions included regular monitoring of cataract surgeries, training of procurement staff to be able to adhere to standard practices, to choose reliable suppliers with quality products and enhance the skill of the local eye-care professionals.

In terms of service demand, a common problem is the lack of public awareness of available eye-health services. Eye-care programmes should engage in public advocacy to convince the government to promote eye health.

**Demand for Service**

Quality is the most important link between cataract service and demand for that service. However, there are several barriers to demand such as fear, convenience, knowledge and belief.

Education is one option to overcome these barriers. Education is generally a long-term intervention involving many approaches simultaneously. Economic interventions such as free service, conditional cash payments and free medications are other options.

Some countries shared their experience on the demand for cataract services. In the province of Tarlac, Philippines, the community health workers who brought/referred the highest number of patients to the health centers for cataract services are rewarded. In areas which rely only on visiting teams, it was recommended to send someone who is influential like a senior doctor/nurse, to convince the people to undergo cataract surgery. "Word of mouth" is another factor which could also increase the demand for cataract services. Thus, it is important to provide good quality of service over time.

2.6.4 Uncorrected refractive error services

Uncorrected refractive error is a major public health challenge and is linked to unemployment, poverty, limited educational opportunities and reduced quality of life.
Strategies include enhancing human resources and developing more service delivery programmes aligned to VISION 2020 programmes, national and NGO programmes.

Lack of human resources is one of the main reasons for high rates of vision problems. It is necessary to have a steady but substantial increase in the number of eye care personnel trained in refraction and vision correction. The estimated number of optometrists globally is 281,748 but the availability of trained staff varies tremendously from country to country. In some countries, there are approximately 0.1 optometrists per million population while other countries have 600 optometrist per million population.

The Brien Holden Vision Institute has been involved in programmes to help countries identify their needs and to establish optometry school systems. Most of these programmes are based in Africa. In October 2014, the first optometry school in Viet Nam was opened.

Quality educational resources are being developed and compiled from experts around the world to come up with a global optometry platform to support optometry education. The resources are available online and have been translated into various languages.

The first optometry course in Viet Nam was launched in Ho Chi Minh City on 29 October 2014. The courses offered are either short or long term. Short term refraction courses are conducted to meet immediate needs. The project also involves partnerships between eye hospitals, universities and NGOs to develop optometry services to scale. Some students are sent overseas for optometry bachelor and master degrees. Initially, training will be facilitated by foreigners. Over time local trainers can take over.

For people with low or no income, ophthalmic services should be affordable and of acceptable quality (public sector model). Middle class, or the working poor, require services which are affordable, fashionable and of good quality (social enterprise and franchising models). People with higher salaries may request services that are of good quality, acceptably priced, and fashionable (Private sector optometrists).

In terms of service delivery, one model is to have "all in one" vision centers or an eye-care facility that provides a range of eye-care services, including examinations, refraction, supply and dispensing of affordable spectacles, detection of potentially blinding diseases and treatment of minor eye diseases.

Refractive error services need to fit within existing systems. Despite its difficulties, the public health system is the cornerstone of eye-care delivery in many low- and middle-income countries.

In Malaysia a project involving 12 public hospitals at district level – all of which have no ophthalmologist – deployed two or three optometrists to each hospital. The optometrists played a significant role in changing the paradigm at district level including the use of biometry, which increased to 80% in one setting.

In another example in 2010, a spectacle dispensing optical workshop was set up in Solomon Islands. The workshop was integrated into the Ministry of Health and Medical Services in 2012. The main challenge is sustaining the finances of the unit – currently this is not resolved.

Papua New Guinea, together with the Brien Vision Institute, also started a low-cost vision centre in 2008. Initially the nurses were trained to do refractions. The approach was rolled out in two places that eventually became the source of low-cost spectacles to provincial hospitals and health centers. In China, most public hospitals are not allowed to sell spectacles.
2.6.5 Low vision and rehabilitation services

Some people with disabilities may have a greater need for health-care than the general population. People with disabilities may have multiple health conditions and treatment can be more complex, requiring specialist knowledge and skills of health workers.

However, people with disabilities are twice as likely to find health worker skills and facilities to be inadequate, three times more likely to be denied health care and four times more likely to be treated badly in the health care system. A World Report on Disability 2011 also showed that 50% of people with disabilities cannot afford health care.

Rehabilitation Systems in low-income countries in the Western Pacific region tend not to be a priority for governments. There is also inadequate funding often with selective and limited integration into national health insurance schemes. Assistive technologies are often expensive, causing a gap with actual need in the population. Inadequate referrals and continuum of care between services are also considered as challenges in rehabilitation.

The WHO Global Disability Action Plan 2014–2021: Better health for all people with disabilities objectives are:
1. to remove barriers and improve access to health services and programmes;
2. to strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation; and
3. to strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services.

To strengthen the rehabilitation and low vision services, it is important:
1. to improve awareness, policy and legislation;
2. to invest in specific service development;
3. to ensure services remain affordable;
4. to invest in workforce training and development;
5. to increase health service and demand; and
6. to ensure a continuums of care, strong referral systems.

2.6.6 Strengthening primary health care services

Primary health care (PHC) is important to all people, independent of social class. It is the backbone of the health system. PHC includes health promotion, health prevention and early detection.

Investing in PHC is highly effective. In 2002, a study compared the cost of complications from diabetes to the investment in the early detection of diabetes in the Pacific Islands. The study showed that a huge expenditure in treatment of complications and almost no investment in health promotion and prevention.

Primary health care is not cheap care, it needs to be funded. Health promotion, health prevention and early detection can reduce economic burdens associated with treatment and lost productivity. The challenge is how to reduce expenditure in secondary care and put that into primary care. One way is to directly distribute new funds to primary care rather than secondary care services. National eye-care programmes may want to prioritize distribution of new funds to strengthen primary eye-care services, rather than further investing in secondary or tertiary care. National governments should monitor closely where donor funds are being invested within national eye-care programmes, encouraging support towards the primary level.
Advocacy to government for support of primary health care services is crucial. Advocacy efforts require evidence, e.g. economic impact assessments. Advocacy towards politicians may include education through the creation of alliances, building of linkages and production of effective materials, such as short videos.

2.6.7 Diabetic retinopathy services

Approximately 370 million people have diabetes. Most (80%) of these people are from LMICs. An estimated 30% of people with diabetes have signs of eye disease and only 10% are treated.

Compared with cataract, diabetic retinopathy is more difficult to diagnose as it requires a trained expert, a slit lamp and magnifying lenses or a fundus camera. Moreover, diabetic retinopathy does not show symptoms at an early stage and in some cases, there is no improvement in vision after multiple treatments.

As with cataract, services for diabetic retinopathy include capacity for service delivery (training and equipment) and sustained demand for service.

The term diabetic retinopathy includes two diseases – the growth of new blood vessels and the edema at the center of vision (DME). The first is relatively easy to diagnose. Treatment involves scattering of laser spots (PRP). The second disease causes the majority of vision loss in diabetic retinopathy and is difficult to diagnose and treat.

In terms of equipment, diabetic retinopathy requires a slit lamp and lenses to diagnose and laser to treat. Sustainability is a challenge for all the centers to be equipped to deliver services appropriately. Although there are new therapies which involve injection directly into the eye, either with chemicals designed to directly block the factors which lead to disease (anti-vascular endothelial growth factor (VEGF)) or steroids, these require repeated treatment, may cause infection, rise in intraocular pressure and are often expensive.

Often, Glaucoma is also found when a person is diagnosed with diabetic retinopathy. Thus, diagnosis and treatment becomes more challenging. This is an issue that has also to be considered when creating programmes for diabetic retinopathy. Treatment for diabetic retinopathy has to be in collaboration with internal medicine. The most effective way to prevent diabetic retinopathy is a control of blood sugar.

Creating demand for diabetic retinopathy services is challenging because the disease has no early symptoms at the point when treatment is most effective. It also needs life-long follow-up and treatment, usually with regular visits. More often, treatment is uncomfortable and does not improve vision in most cases.

In September 2012, Orbis International and Zhongshan Ophthalmic Center (ZOC) conducted a 5-year programme – Comprehensive Rural Eye Services and Training (CREST). CREST aims to create a rural model of comprehensive and fully networked eye care, facilitate comprehensive examination of all patients; train and equip providers to create service, educate patients to create demand, and establish a platform for advocacy and research. CREST includes 10 rural, county-level eye hospitals in Guangdong, China, which are chosen for geographic coverage and ability to perform independent cataract surgery. These hospitals are also linked to ZOC as coordinating/training centre.

CREST is an e-network that includes: electronic medical records for rural partners to track long-term care and ZOC to track exam quality; telemedicine linking ZOC Grading Center to rural hospitals; and automated SMS reminders to track and improve patient compliance.
To build service delivery capacity, CREST conducts training of doctors. Academic instruction is done at ZOC and hands-on training in comprehensive examinations is carried out on the job. There is also training for nurses, refractionists, ZOC trainers and graders. Initially, treatment is done on a laser-equipped van by the ZOC team but recently, 6 out of these 10 centres have bought or have plans to buy their own lasers. The CREST programme develops service demand through patient education using three high-quality videos:

1) Local patients explain the need for and benefit of comprehensive eye exams in local dialect.
2) Diabetic patient discusses with their doctor and family about the need for eye exams.
3) Operated patient explains surgery won’t improve vision, but prevents blindness.

This strategy did not affect patient willingness to accept the eye exam. When the price of the comprehensive examination was reduced, 70% of the patients agreed to be examined. Some hospitals offered free examination – this resulted in 90% of patients undergoing the examination.

Based on the CREST experience in China, for a diabetic retinopathy programme to be successful, it is important to:
1. Provide free comprehensive eye exam needed to detect diabetic retinopathy;
2. Make hospital procurement of cameras to detect diabetic retinopathy sustainable;
3. Reimburse outpatient laser treatment of diabetic retinopathy; and
4. Improve long-term compliance by rewarding patients with free diabetic medications

In the Marshall Islands, a one-stop-shop NCD clinic for diabetic retinopathy was established wherein a patient could be examined by an internist and ophthalmologist within a day. It is available three times a week. The challenge is availability of professional staff.

In Fiji, the eye-health team visits one hospital every week to offer eye examinations. Diabetes control is often poor but the eye professionals continuously educate new patients and those who have successfully undergone the treatment for diabetic retinopathy to become advocates.

In Solomon Islands, experience shows patient uptake to undergo surgery for diabetic retinopathy is a challenge. Commonly, patients who return for follow-up have no improvement or have worsening vision. This is communicated with other patients.

2.7 Multisectoral engagement and effective partnership for improved eye health strengthened

2.7.1 Universal health coverage

Universal health coverage (UHC) is defined as access to good quality needed services, with financial protection and equity. Countries in the Western Pacific Region are at very different stages of development in terms of UHC.

There three dimensions to UHC are:
1) Financial protection – what do people have to pay out-of-pocket?
2) Population – who is covered?
3) Services – which services are covered?

Health systems are dynamic and can be organized in different ways. One challenge in the effective use of health services is how to connect the resources available around the people. An integrated, people-centred health service is ultimately what UHC needs to deliver.
UHC is a journey. The journey begins by making essential medicines and basic services available to all people through public funding. As countries develop economically and the government have more resources to invest, packages of services are expanding and quality is improving. In a more mature and advanced health system, a comprehensive service package is available and maintains and adjusts to meet the increased demand.

In the Western Pacific Region, several countries have shown commitment to UHC:

- Cambodia's Health Strategic Plan, 2008–2015 states to” provide stewardship for the entire health sector and to ensure a supportive environment for increased demand and equitable access to quality health services in order that ALL the peoples of Cambodia are able to achieve the highest level of health.”.
- In the Lao People's Democratic Republic, the Health Sector Reform Framework talks about reaching UHC by 2025.
- Mongolia's Health Sector Strategic Master Plan: 2005–2015 talks about “responsive and equitable, pro-poor, client-centred and quality services”.
- Malaysia's Country Health Plan, 2011–2015 includes universal access to health care as a key result area.
- In the Philippines, UHC Study Group of University of the Philippines talks about “Provision to every Filipino of the highest possible quality of health care that is accessible, efficient, equitably distributed, adequately funded, fairly financed, and appropriately used by an informed and empowered public”.
- Viet Nam's 5-year Health Sector Development Plan (2011–2015) states to: “Continue to develop a health care system towards equity, efficiency and development, improving quality of care, meeting the growing and diverse needs for health care.”

- Pacific island countries such as Fiji, Papua New Guinea and Samoa also express their aspiration for UHC through national health plans, focusing on primary health care for all, high quality health care delivery and health services that enable equal access by all.

The main challenge in UHC is to recognize that the government should drive change as it has a stewardship role of looking after the needs of the society.

3. CONCLUSIONS AND NEXT STEPS

Participants appreciated the mix of in-depth discussion and lectures on specific issues, e.g. primary eye care, eye-care financing, diabetic retinopathy, cataract and lessons learnt from country presentations. The group expressed their desire to work more closely and stay in regular communication via an email group. Participants outlined the next steps by country:

Cambodia
- Strengthen primary eye-care services (supported by provincial hospitals) to address backlog and achieve the regional action plan target.

China
- Strengthen primary eye-care services.
- Discussions with Ministry of Health about "universal eye health" to address equity issues, especially in services in rural China.
Fiji
- Service delivery for eye care – strengthening integration into the health system.
- Address gaps in services for refractive error, low vision and rehabilitation.
- Integrate national indicators for eye care within the health information system.

Japan
- Develop a report to advocate to the Ministry of Health, Labour and Welfare on the importance of fundus exams for diabetes patients to prevent blindness, in line with the regional action plan.

Kiribati
- Strengthen primary eye-care services.
- Work with national coordinator for prevention of blindness toward universal eye health.

Lao People's Democratic Republic
- Develop and implement a public health campaign to increase awareness of diabetic retinopathy.

Malaysia
- Implement a national blindness survey, with technical support from WHO.
- Advocate to Ministry of Health to increase capacity to deliver low vision rehabilitation services.
- Discuss with Ministry of Health the low number and misdistribution of eye-care personnel.

Marshall Islands
- Collection of clinical data as evidence for advocacy to the government to support eye health (currently one ophthalmologist and no mid-level personnel).
- Training of eye care to health workers to increase service delivery through referral

Federated States of Micronesia
- Develop a draft national strategy for eye health with a focus on developing human resources capacity.

Mongolia
- Plans to set up the first low vision centre, including short-term training of staff in Hong Kong SAR (China).

Papua New Guinea
- Advocate to government the need for stronger outreach programmes, diabetic retinopathy programmes and specialty ophthalmology units.
- Plans development of an integrated national low vision care plan.

Philippines
- Pilot testing of the Vision Screening Program in public schools.
- Development of guidelines on the referral and screening of prematures at Risk for retinopathy of prematurity (ROP).
- Philippine National Blindness Survey and Eye Disease Study preliminary report by the last quarter of 2015.
- Scale up the Community Eye Health Project.
Samoa
- Collection of clinical data as evidence for advocacy to the government to support eye health (Currently one ophthalmologist).

Solomon Islands
- Advocate and share the regional action plan among government and partners.
- Plan for a rapid assessment of avoidable blindness.

Viet Nam
- Have the new national action plan endorsed by the government.
- National blindness prevalence survey.
ANNEX 1

LIST OF PARTICIPANTS, TEMPORARY ADVISER, REPRESENTATIVES/OBSERVERS AND SECRETARIAT

1. PARTICIPANTS

Dr DO Seiha, National Coordinator for Prevention of Blindness, Khmner Soviet Friendship Hospital, 121 Street 110, Sk Watphnom, Phnom Penh, Cambodia, Tel. No.: +855 12 840796 E-mail: doseiha@gmail.com

Dr HU Ailian, Director, Office for National Committee for Prevention of Blindness, Beijing Tongren Hospital, No. 1 Dong Jiao Min Xiang, Beijing 100730, China, Tel. No.: +86-010-58265923, E-mail: halzxf@sina.com

Dr Luisa Cikamatana RAUTO, Medical Superintendent, Lautoka Hospital, P.O. Box 65 Lautoka, Suva, Fiji, Tel. No.: +679 6626449, E-mail: lcikamatana@health.gov.fj

Dr Yoshimune HIRATSUKA, Chief Senior Researcher, National Institute of Public Health Ikegami, Ota-ku, Tokyo, Japan, Tel. No.: 81-48-458-6338, E-mail: yoshi-h@tkf.att.ne.jp

Ms Raebwebwe TAOABA, Medical Assistant, Ministry of Health and Medical Services P.O. Box 268, Tarawa, Kiribati, Tel. No.: 686 28760, E-mail: raebwebwetaoaba1971@gmail.com

Dr Khamphoua SOUTHISOMBATH, Director, National Ophthalmology Center Ministry of Health, Vientiane, Laos, Tel. No.: +856 20 55601720, E-mail: southi1961@gmail.com

Dr Elias Bin HUSSEIN, Head of Ophthalmology Services, Department of Ophthalmology Hospital Selayang, Lebuhraya Selayang-Kepong, Selangor, Malaysia, Tel. No.: +603 6126 3333 ext.4133; E-mail: elias@selayanghospital.gov.my

Dr Jose Marcelino TAÑA, Ophthalmologist, Ministry of Health PO Box 3063, Majuro, Marshall Islands, Tel. No.: 693 4557841, E-mail: drjmtana@yahoo.com

Mr Marcus SAMO, Assistant Secretary for Health, Department of HESA, P.O. Box PS 70 Palikir, Federated States of Micronesia, Tel. No.: +691 320 2619, E-mail: msamo@fsmhealth.fm

Professor Baasankhuu JAMIYANJAV, Chief Government Ophthalmologist Ministry of Health, Ulaanbaatar 15160, Mongolia, Tel. No.: 976-9911-3255 E-mail: jb_opth@magicnet.mn

Dr Simon MELENGAS, Chief Ophthalmologist, Port Moresby General Hospital National Capital District, Port Moresby, Papua New Guinea, Tel. No.: +675 324 8200 E-mail: melengassimon@gmail.com

Dr Rosario Sylvia UY, Medical Specialist II, Department of Health San Lazaro Compound, Rizal Avenue, Manila, Philippines, Tel. No.: 711-7846 E-mail: herb_ross@yahoo.com
Annex 1

Dr Mauinuuese IMO, Head of Eye Unit, Eye Clinic, National Health Services
Apia, Samoa, Tel. No.: 21212 ext. 729, E-mail: maul@nhs.gov.ws

Dr Claude POSALA, Head of Eye Department and Division, Ministry of Health and Medical Services, P.O. Box 349, Honiara, Solomon Islands, Tel. No.: +677 23600 Ext 230
Email: cposala@gmail.com

Dr CUNG Hong Son, Vice Director, National Institute of Ophthalmology
85 Ba Trieu Street, Hanoi, Viet Nam, Tel. No.: 091 3514588, E-mail: cunghongson@yahoo.com

2. TEMPORARY ADVISER

Dr Nathan CONGDON, Senior Advisor, Orbis International North Asia, Oriental Plaza Business Center No. 39, Guangzhou, China, Tel. No.: +86 20 13925056342
E-mail: ncongdon1@gmail.com

3. REPRESENTATIVES/OBSERVERS

Ms Tricia KEYS, Programme Manager, Asia Pacific, Rupert Myers Building
University of New South Wales, New South Wales 2052, Australia, Tel. No.: +61411320572
E-mail: T.Keys@brienholdenvision.org

Dr Manfred MÖRCHEN, Regional Advisor for Inclusive Eye Health
Nibelungenstraße 124, 64625 Bensheim, Germany, E-mail: m-moerchen@hotmail.com

Mr Lachlan McDONALD, Senior Health Economist, 52 Barry Street Carlton
Victoria 3053, Australia, Tel. No.: +61 408390090, E-mail: lmcdonald@hollows.org

Ms Maria Remedios SUPLIDO, Programme Manager (Philippines), East Avenue Medical Center, Quezon City, Philippines, Tel. No.: (63) 917 860 9250, E-mail: msuplido@hollows.org

Dr PHUC Huynh Tan, Associate Director for East Asia, Sacombank Building, Hai Chau Dist.
Da Nang City, Viet Nam, Tel. No.: 845113832999, E-mail: phuyn@hollows.org

Mr Tae Young KWON, Team Manager of Asia, International Development Department
Heart to Heart Foundation, 149-16 Garak 2-Dong, Song pa-Gu, Seoul, Republic of Korea
Tel. No.: +82-(0)70-8145-7932, E-mail: kty@heart-heart.org

Mr Damian FACCIOLO, Regional Program Manager, 52 Barry Street Carlton
Victoria 3053, Australia, Tel. No.: +61 3 8330 8181, E-mail: dfacciolo@iapb.org

Dr Richard LE MESURIER, Regional Chairman, Western Pacific Region
52 Barry Street Carlton, Victoria 3053, Australia, Tel. No.: +61 38330 8102
E-mail: rtlemes@gmail.com
Annex 1

Mr Stephen ALCANTARA, Coordinator, South East Asia and the Islands
Department of Health, Manila, Philippines, Tel. No. (+632) 781-8618
E-mail: salacantara@iapb.org

Ms Ellen VILLATE, Eye Care Officer, Department of Health, Manila
Philippines, Tel. No.: 781-8618, E-mail: villate@yahoo.com

Dr Evelyn AMBROSIO, Low Vision Specialist, Department of Health, Manila
Philippines, Tel. No.: 725-6649, E-mail: belambrosio@g.mail.com

Dr Leo CUBILLAN, Director, Taft Avenue, Manila, Philippines, Tel. No.: 524-7119
E-mail: lcubillan@upm.edu.ph

Ms Arminia MOJICA, Deputy Executive Director, 4th Floor, Coti Building, 623 Edsa Cubao
Quezon City, Philippines, Tel. No.: 63-2-726-3021 to 24, E-mail: amy@blind.org.ph

4. SECRETARIAT

Dr Susan MERCADO, Director, Division of NCD and Health through the Life-Course
WHO Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines
Tel. No.: (632) 528 9980, Fax No.: (632) 521 1036, E-mail: mercados@wpro.who.int

Dr Andreas MUELLER, Technical Lead (Responsible Officer), Blindness Prevention and
Control, Disabilities and Rehabilitation, WHO Regional Office for the Western Pacific
P.O. Box 2932, 1000 Manila, Philippines, Tel. No.: (632) 528 9885, Fax No.: (632) 521 1036
E-mail: muellera@wpro.who.int

Ms Pauline KLEINITZ, Technical Lead, Disabilities and Rehabilitation, WHO Regional Office
for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines, Tel. No.: (632) 528 9865
Fax No.: (632) 521 1036, E-mail: kleinitzp@wpro.who.int

Dr Ivo KOCUR, Medical Officer, Prevention of Blindness and Deafness
World Health Organization, Avenue Appia 20, 1211 Geneva 27, Switzerland
Tel No.: +41 22 79 11435, Fax no.: +41 22 791 0746, E-mail: kocuri@who.int
# PROGRAMME OF ACTIVITIES

## Tuesday, 4 November 2014

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30-09:00</td>
<td>Registration</td>
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<tr>
<td>09:00-09:30</td>
<td>Welcome remarks</td>
<td>Dr Andreas Mueller, Technical Lead, Blindness Prevention and Control, WHO/WPRO</td>
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<tr>
<td></td>
<td>Opening address</td>
<td>Dr Shin Young-soo, Regional Director, WHO/WPRO</td>
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<tr>
<td></td>
<td>Self-introduction of participants, election of Chairperson and Vice-Chairperson</td>
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<tr>
<td>09:30-10:15</td>
<td>Group photo and coffee</td>
<td>Dr Andreas Mueller, Technical Lead, Blindness Prevention and Control, WHO/WPRO</td>
</tr>
<tr>
<td>10:15-10:30</td>
<td>Overview of the meeting objectives</td>
<td>Dr Andreas Mueller, Technical Lead, Blindness Prevention and Control, WHO/WPRO</td>
</tr>
<tr>
<td>10:30-10:45</td>
<td>Overview of the regional action plan</td>
<td>Dr Andreas Mueller, Technical Lead, Blindness Prevention and Control, WHO/WPRO</td>
</tr>
<tr>
<td>10:45-11:15</td>
<td>National targets and indicators: Country Reporting and discussion</td>
<td>Dr Ivo Kocur, Medical Officer, Prevention of Blindness and Deafness WHO/HQ</td>
</tr>
<tr>
<td>11:15-12:00</td>
<td>International partners in support of Universal Eye Health – an update</td>
<td>- Mr Damian Facciolo, International Agency for Prevention of Blindness, WPR</td>
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<tr>
<td></td>
<td></td>
<td>- International Partners</td>
</tr>
<tr>
<td>12:00-13:00</td>
<td>Lunch break</td>
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</tr>
<tr>
<td>13:00-15:00</td>
<td>Successes and challenges of national eye health programmes, discussion</td>
<td>Country presentations by Cambodia, China, Japan, the Lao PDR, Malaysia, Mongolia, Papua New Guinea, the Philippines, Solomon Islands and Viet Nam</td>
</tr>
<tr>
<td>15:00-15:30</td>
<td>Mobility break</td>
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</tr>
<tr>
<td>15:30-16:30</td>
<td>Successes and challenges of national eye health programmes, discussion; continued</td>
<td>Country presentations by Fiji, Kiribati, the Marshall Islands, the Federated States of Micronesia and Samoa</td>
</tr>
<tr>
<td>17:30-19:00</td>
<td>Welcome reception</td>
<td>All</td>
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</table>

## Wednesday, 5 November 2014

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:45-09:15</td>
<td>Recap of Day 1</td>
<td>Dr Andreas Mueller, Technical Lead, Blindness Prevention and Control, WHO/WPRO</td>
</tr>
<tr>
<td>09:15-10:00</td>
<td>International partners in support of Universal Eye Health – an update; Advocacy for eye health</td>
<td>- Mr Damian Facciolo, Program Manager, International Agency for the Prevention of Blindness, WPR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Dr Huynh Tan Phuc, Associate Director-East Asia, The Fred Hollows Foundation</td>
</tr>
<tr>
<td>10:00-10:30</td>
<td>Eye health surveys – WHO recommendations and current capacity in WPR</td>
<td>- Dr Andreas Mueller, Technical Lead, Blindness Prevention and Control, WHO/WPRO</td>
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<tr>
<td></td>
<td></td>
<td>- Dr Ivo Kocur, Medical Officer, Prevention of Blindness and Deafness WHO/HQ</td>
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<td></td>
<td></td>
<td>- Dr Baasankhuu Jamiyanjav, Chief Government Ophthalmologist, MoH, Mongolia</td>
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</tbody>
</table>

**Objective 1: Evidence**
### Annex 2

<table>
<thead>
<tr>
<th>Time</th>
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</tr>
</thead>
<tbody>
<tr>
<td>10:30-10:45</td>
<td><strong>Mobility break</strong></td>
<td></td>
</tr>
<tr>
<td>10:45-12:00</td>
<td>Financial coverage of eye care services</td>
<td>Dr Lachlan McDonald, Health Economist, Fred Hollows Foundation, Australia</td>
</tr>
<tr>
<td>12:00-14:00</td>
<td><strong>Lunch break</strong></td>
<td>Site visit to University of the Philippines Manila, Department of Ophthalmology</td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>The Philippines Community Eye Care programme</td>
<td>Dr Rosario Uy, Department of Health, Philippines</td>
</tr>
</tbody>
</table>
| 14:15-15:45   | Cataract services – strategies to increase output while strengthening    | - Dr Nathan Congdon, Department of Preventive Ophthalmology, Zhongshan Ophthalmic Center Guangzhou, China  
|               | quality assurance                                                        | - Dr Richard LeMesurier, Chair, International Agency for the Prevention of Blindness, WPR, Australia |
| 15:45-16:00   | **Mobility break**                                                       |                                                                                                |
| 16:00-17:00   | Cataract services; continued                                              |                                                                                                |

Dinner hosted by the International Agency for the Prevention of Blindness

**Thursday, 6 November 2014**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:45-09:00</td>
<td>Recap of Day 1</td>
<td>Dr Andreas Mueller, Technical Lead, Blindness Prevention and Control, WHO/WPRO</td>
</tr>
<tr>
<td></td>
<td><strong>Objective 2: Policies, Plans and Programmes, continued</strong></td>
<td></td>
</tr>
<tr>
<td>09:00-10:15</td>
<td>Uncorrected refractive error services – models and strategies for</td>
<td>Ms Tricia Keys, Programs Manager, Asia Pacific, Brien Holden Vision Institute, Sydney, Australia</td>
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<tr>
<td></td>
<td>integration in the health system, discussion</td>
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<tr>
<td>10:15-10:45</td>
<td><strong>Mobility break</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 10:45-12:00   | Low vision and rehabilitation services – good practice, continuum of    | - Ms Arminia O. Mojica, Deputy Executive Director and Low Vision Service Supervisor, Resources for the Blind, Inc., Philippines  
|               | care and resources in the region, discussion                             | - Ms Pauline Kleinitz, Technical Lead, DAR/DNH/WHO/WPRO                                         |
| 12:00-13:00   | **Lunch break**                                                          |                                                                                                |
| 13:00-14:15   | Diabetic retinopathy services – strategies for stronger systems and     | - Dr Nathan Congdon, Department of Preventive Ophthalmology, Zhongshan Ophthalmic Center Guangzhou, China  
|               | new developments, discussion                                              | - Dr Richard LeMesurier, Chair, IAPB WPR, Australia                                               |
| 14:15-15:00   | **Strengthening primary health care services**                          | - Dr Laura Hawken, Technical Officer, HSD/DHS/WHO/WPRO                                          |
| 15:00-15:30   | **Mobility break**                                                       |                                                                                                |
| 15:30-16:00   | Universal Health Coverage (UHC) - The eye care sector as part of the    | Dr Vivian Lin, Director, DHS/WHO/WPRO                                                            |
|               | health system                                                            |                                                                                                |
| 16:00-16:30   | Working closely as a region to achieve the global target – next steps   | Dr Andreas Mueller, Technical Lead, Blindness Prevention and Control, WHO/WPRO                   |
| 16:30-16:45   | **Closing**                                                              | Dr Susy Mercado, Director, DNH/WHO/WPRO                                                           |
Annex 3
Annex 3
Annex 3