Investing in eye health: securing the support of decision-makers

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Introduction

Eye health often receives inadequate resources. Scientific evidence is crucial, but it must be presented in a compelling way if decision-makers in ministries of health are to increase investment to reduce the burden of avoidable blindness and visual impairment. Winning both the hearts and the minds of the people who make investment decisions is critical for obtaining adequate resources. It is important to understand both who influences decision-makers, the potential entry points for engaging with them and the main areas for discussion and potential collaboration. This understanding enables individuals and organizations to engage effectively with policy- and decision-makers in discussing investment in eye health and enables decision-makers to understand the scope and aspirations of partners with an interest in this area.

In 2009, the Sixty-second World Health Assembly endorsed the *Action plan for the prevention of avoidable blindness and visual impairment, 2009–2013* (*1*). The plan highlights the importance of securing the commitment of high-level decision-makers to eye health, and the World Health Organization (WHO) was asked to conduct a political analysis of Member States' experience to determine the best way of securing such support. The methods used to collect these data are shown in Box 1, and the response rates are shown in Box 2. This document presents the results of that work, with experience from low-, low–middle- and upper–middle-income countries (LICs, LMICs and UMICs, respectively) on ways of generating support for eye health and the approaches used to make the commitment a priority.

As ministries of health are invariably the main decision-makers on how and how much to invest in eye health, an assessment was made of the way that domestic and international stakeholders influence ministries of health. The analysis of data from a number of WHO Member States allowed identification of a series of actions that stakeholders should consider for securing the support of decision-makers.

The project design and collection of data from Member States was undertaken by Ivo Kocur in collaboration with WHO regional and country offices. The analysis of data, their interpretation and writing of the paper was done by Piergiuseppe Morone, Eva Camacho Cuena, Ivo Kocur and Nicholas Banatvala. The case studies were provided by Jennifer Gersbeck, Michael Gichangi, Asad Aslam Khan, Van Lansingh, Gullapalli N. Rao and Ravilla D. Thulasiraj. Review and comments were provided by Peter Ackland, Christian Garms, Richard Le Mesurier, Serge Resnikoff, Bruce Spivey, Hugh R. Taylor, the WHO Prevention of Blindness and Deafness team and WHO regional offices.

285 million people have visual impairment: the support of policy-makers to address the burden of impaired vision is essential

Currently, 285 million people in the world have visual impairment. Of these, 246 million have low vision (moderate or severe visual impairment) and 39 million are blind (*2*). The two main causes of visual impairment are uncorrected refractive errors and cataract, and the first cause of blindness is cataract. Definitions and the burden of blindness and visual impairment are given in Annex 1. Most of the causes of blindness are avoidable: globally, 80% of blindness can be prevented, treated or cured (*3*). Visual impairment, including blindness, has significant human and socioeconomic consequences in all societies; the costs of lost productivity and of rehabilitation and education of the blind represent significant economic burdens for the individual, the family and society.

Box 1. Methods

To obtain current information on the prevention of blindness and provision of eye care in Member States in which WHO has a representative, WHO distributed two questionnaires to their ministries of health in 2010 and 2011. One questionnaire was addressed to the national coordinator (or equivalent) for the prevention of blindness, and the second was sent to the ministry of health. Both included questions on how decisions on investing in eye health were made at national level, how the government worked with other stakeholders, and how those stakeholders engaged with each other and with governments to secure the support and commitment of high-level decision-makers in the ministry of health to promote the prevention of blindness and improved eye health.

The questionnaires returned from low- and middle-income Member States were used in the analysis. The countries were grouped as LICs, LMICs and UMICs according to the 2009 World Bank per capita classification of gross national income (*4*).

Respondents were asked to identify the institutions that are involved with the Ministry of Health, in financing, planning and providing eye care services. The roles of stakeholders were grouped into one structural area and two based on activities:

- national committees for the prevention of blindness,
- promoting and raising awareness about eye health to attract investment by ministries of health, and
- planning the delivery of eye care services.

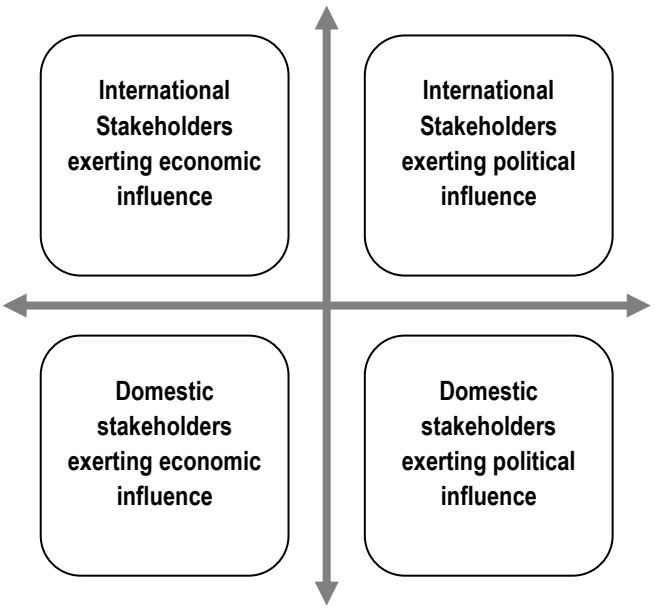
In addition, brief case studies were conducted of the experience of five Member States.

Both domestic and international stakeholders have political and economic influence

In order to improve eye health in communities, ministries of health are often approached by groups and individuals involved in the prevention of visual impairment, including

blindness. Domestic stakeholders, acting at national level, exert 'bottom–up' pressure on national decision-makers, while international stakeholders act predominantly to promote eye health at regional or global level and exert 'top–down' pressure on national authorities.

Figure 1. Stakeholder matrix



Stakeholders may exert predominately economic influence by using their skills, experience and activities to influence the economic rationale for investing in eye health. Other stakeholders exert mainly politically influence, by promoting the political rationale for addressing eye disease. A "stakeholder matrix" (Figure 1) provides a useful framework for understanding these roles. Details of the matrix are given in Annex 2.

Ministries of health play the central role in forming national eye care policy; other stakeholders can influence their decisions

The information obtained from Member States confirmed that ministries of health play the central role in national policy formulation, often supported by ministries of education. Partners engaging with ministries of health on eye health policies could be identified in all four parts of the matrix (Figure 2). In UMICs national professional associations were reported as having the greatest influence on ministries of health, while in LICs and LMICs, WHO and international partners played more prominent roles.

Box 2. Response rates

Responses to one or both questionnaires were received from 82 (57%) of 144 LICs, LMICs and UMICs. The response rates were as follows:

LICs	60%
LMICs	66%
UMICs	44%

Figure 2. Types of stakeholders and other key determinants classified according to the type of influence (economic or political) and the context (international or domestic)

Activities of stakeholders

National committees for the prevention of blindness

National committees for the prevention of blindness include not only ministries of health but also a range of other partners (Table 1).

Table 1. Entities represented on national committees for the prevention of blindness

Entity	Category of country by economic status (%)		
	LIC	LMIC	UMIC
Eye health care professionals (e.g. ophthalmologists, optometrists)	24	26	29

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