Question 2: *What are effective and sustainable mechanisms or processes to integrate local, community, sub-national, national, and regional voices, priorities, and contributions into health system strengthening efforts?*

Integrating Quality Eye Care Services into Primary Health Care to Eliminate Avoidable Blindness

Dr.Ravi Kumar AV, Vijay Kumar, Pratiksha Pal, Sanjib Kumar Jha, Rohan Kumar Jha, Debajyoti Mohapatra, Dr.Jyoti Benawri, Dr. Neeraj Agrawal

Jhpiego India, Essilor India Private Limited

HEALTH SYSTEMS STRENGTHENING ACCELERATOR

Context

Describe the context in which the activity takes place. What is the health problem that you are trying to solve? What health system challenges contribute to this problem? Which voices were engaged in solving this problem before your activity started? Who was missing from the discussion and what was the impact of that absence?

- Globally 2.2 billion people have a vision impairment and in 1 billion of these cases, the vision impairment could have been prevented or has yet to be addressed
- The global financial burden due to visual impairment is around US$ 411 while the estimated cost gap for addressing the unmet need of vision impairment is US$ 25 billion
- India contributes to 20.5% and 21.9% of the world's blind and visually impaired populations respectively with Cataract and Refractive Error constituting more than 80% of the causes

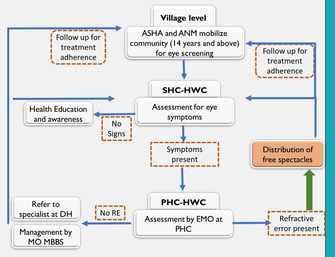
To ensure eye care policies, plans, and packages are built based on the principles of universal health coverage (equity, comprehensiveness, quality and financial protection) WHO recommends three enabling factors for implementing an integrated people-centered eye care

- Improve the delivery of eye care, in particular through primary health care
- Improve health information systems for eye care
- Strengthen the eye care workforce

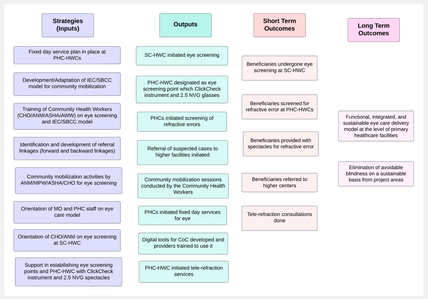
- Government of India (GoI) mandated establishment of Ayushman Bharat Health and Wellness Centers (AB-HWCs) to provide Comprehensive Primary Health Care (CPHC) closer to communities
- Provision of primary eye care is one of the mandatory services to be provided at AB-HWCs
- To revitalize the existing national program on eye care, National Programme for Control of Blindness and Visual Impairment (NPCB&VI), the primary healthcare facilities are being strengthened by adopting the systems-based approach.
- Through this program the free wye care services are limited to secondary and tertiary health centres with a focus on children and elderly populations. This had inadvertently left out economically productive middle-aged population
- USAID India's flagship health system strengthening project, NISHTHA implemented by Jhpiego, is implementing an innovative, integrated people-centered eye care model to deliver quality eye care in partnership with Government and private partners to establish a universal eye care program

Activity Description

- NISHTHA project has the mandate to provide technical assistance to National and State Governments of India to strengthen comprehensive primary healthcare through AB-HWCs
- OneSight EssilorLuxottica Foundation (OSELF) a global leader in the design, manufacture and distribution of ophthalmic lenses, aims to eliminate uncorrected poor vision through primary vision care providers on a sustainable basis. OSELF has deployed primary vison care providers to carry out basic vision test on inclusive business model
- NISHTHA and OSELF partnered with local governments to design, implement and demonstrate a functional and sustainable primary eye care delivery model within the primary care delivery framework
- This model is being implemented in 5 districts across two states of India- Ganjam and Balasore districts in the state of Odisha and Indore, Sehore and Ujjain districts in the state of Madhya Pradesh.
- The primary objectives of this intervention are:
  - Generate awareness among community through focused IEC activities and mobilize them for availing quality primary eye care services at health and wellness centres
  - Enabling three districts of Madhya Pradesh to deliver quality primary eye care services through competent and empowered Eye Mitra Opticians at Primary Health Care –Health Wellness Centers (PHC-HWCs)
  - Creating/strengthening linkages with higher referral centres (sub-district or district hospitals) for effective management of eye care conditions
  - Leveraging technology and available innovative solutions to bring quality eye care services closer to the communities by piloting tele-refraction/ teleophthalmology in three districts of Madhya Pradesh.
- This project is reaching more than 12 million population through 1,000 primary healthcare facilities.



Continuum of Care Pathway for Primary Eye Care



Theory of Change for the Model

Activity Impact

How did this activity strengthen the health system? Which components of the health system did you act on (for example, did you support improvements in financing, cross-sectoral coordination, governance, local ownership, information, human resources, behavior of health system actors, service delivery, or medical products, vaccines, or technologies)? How does this activity contribute to health equity, quality or resource optimization? Be sure to explain the causal pathway by which your engagement of new voices contributed to this impact.

- Tripartite partnerships, led by NISHTHA, have been established between the OSELF, Jhpiego and Govt. stakeholders to implement the pilot model in five districts
- A for-profit organization (OSELF), a non-profit organization (Jhpiego), and Govt. body agreed to play complementary roles toward realizing the common goal of achieving universal quality eye care.
- While the services were initiated in July-2022 in Odisha, the services were rolled out in June-2023 in Madhya Pradesh

Jhpiego-NISHTHA

- Customization of operational aspects of the project in line with CPHC guidelines in consultation with relevant partners
- Mapping of HWCs and referral hospitals for the intervention
- Community Mobilization through design and development of communication materials
- Joint advocacy for expansion and scale-up after successful demonstration

OSELF

- Mobilization and incentivization of Eye Mitra Optician in the intervention districts of two states
- Funding for the pilot for demonstration of intervention model
- Supply 2.5 NVG spectacles
- Facilitate periodic performance review of pilot project

Govt. Stakeholders

- Overall project oversight and management
- Dissemination of operational aspects of the model to CHC MO I/Cs & BPMs, OAs and other relevant stakeholders
- Ensuring availability of logistics and medicines at HWCs
- Facilitate availability of Space for EMs at the PHC level for Eye Screening
- Periodic review and monitoring of the Project

The updates as of now are-

- Locally relevant IEC/BCC materials have been developed to create awareness of general eye care and community mobilization initiated across more than 9,000 villages in 5 districts
- Close to 120 Eye Mitra Opticians from OSELF were engaged to provide quality primary eye care
- More than 3,000 service providers and frontline health workers have been trained in the provision of quality eye care
- As of now 46,835 people have been screened by EMO and 38,344 of them were found to have refractive error for which the free spectacles were distributed through the model

Evidence

What evidence do you have that the integration of local, community, sub-national, national, and regional voices, priorities, and contributions in this approach was successful? What evidence do you have that this approach led to health or health system impacts? How can you best show what your activity accomplished? How do you know that you met your goals? Is the evidence able to be measured? Graphs or charts may be useful here to show this evidence.

Integration can be observed at 3 different levels

1. At the level of community, the frontline health workers generate awareness and facilitate demand generation with the help of Community Health Officers, thus making this a people-centered care model.
2. The Eye Mitra Opticians are essentially the young under-employed men and women in rural and semi-urban areas to become primary vision care providers. The model has formally engaged EMOs into the public health system to provide the quality care
3. At the sub-national level, each of the parties has invested their expertise and/or resources to complement the Government's mandate of universal health coverage

The health system impacts of this model are ascertained by the following:

- One of the key proposals in the World Report on Vision to address the challenges in eye care is to make an integrated people-centered eye care, embedded in health systems and based on strong primary health care. This model fulfills all criteria required for a successful eye care model.
- From the implementation data it can be observed that, out of the 46,835 people mobilized for screening, more than 80% of people had any eye problems. And out of these persons with any eye problem, close to 70% of people had an uncorrected refractive error. Without this model, close to 38,000 people would not have received quality care and treatment closer to their homes.
- By mobilizing resources (finances, skilled HR, information systems for eye care, and free spectacles), the model has allowed the public health system to divert crucial resources to other priority areas.
- To summarize, this model has presented a high-performing health care that is accountable, affordable, accessible, and reliable and thus resulting in better quality, enhanced equity, and resource optimization

Table-1 summarizes the achievement the model has accomplished during the first 10 months of implementation. The targets were set based on the existing disease statistics in the public health system.

Table-1: Key Outcomes (July'22-May'23)	Target	Achievement
Number of PHC- HWCs with established Eye Screening Points	169	169 (100%)
Number of participating Eye Mitras at designated day a week across PHC-HWCs	73	73 (100%)
Number of beneficiaries screened for eye care services at PHC-HWCs	42,000	46,584 (111%)
Number of people provided with spectacles by Eye Mitras (45% URE)	18,900	26,243 (139%)
Number of beneficiaries referred to higher facilities for accessing eye care services	12,600	11875 (94%)

Facilitators

What aspects of the health system, context, or external partner support helped make this successful? For example, were there existing working groups in place that enabled efficient coordination between stakeholders on this activity? Did you use a tool or knowledge resource from a global partner like WHO or UNICEF to help inform your activity?

A few of the key facilitators for this model are:

- The Govt. of India's mandate to bring a paradigm shift in primary healthcare from segmented and limited to comprehensive primary care, closer to communities, has heralded a new wave of appetite for sustainable innovations and partnerships.
- With the roll-out of operational guidelines for providing expanded range of services at AB-HWCs, there is a heightened requirement for contextualization of national-level operational guidelines into an implementable model that can be integrated to the existing pathway of care. The model implemented by NISHTHA just did the same
- With the ongoing efforts to strengthen the functionality and content of care at HWCs, there was expanded range of drugs, consumables, and diagnostics at HWCs. This has led to better health-seeking behavior among the communities and families at the HWC level
- The Eye Mitra Opticians are local care providers, and by streamlining their skills into the public health system, there was an amplified response from the community to receive care from their own people without any additional

Challenges

What were some problems or challenges that you faced during your activity implementation? Did you expect these challenges or were they unanticipated? How did you respond to these challenges?

Challenges faced	Solutions adopted
Private Sector Involvement: General skepticism on the involvement of the private for-profit sector in the care provision at primary healthcare facilities	Orientation/sensitization of frontline health workers on the model and using community structures to spread the awareness among community
Overshooting of targets: With the evolution of the model and the increased number of people using the services, new patterns in disease statistics original to the geography of implementation were observed. This led to a temporary disturbance in the supply of spectacles	• Ensuring clear communication between the clients and the services providers • Planning in such a way that the resources could be mobilized easily and within short period of time
Information on backward referrals: During the initial periods of the model, there was no scope for frontline health workers to understand the outcomes screening and referrals	A digital platform to complete the loop by linking all three levels- frontline health workers at the community level, service providers at the facility level and specialists at the secondary / tertiary care level

Lessons Learned

What lessons have you learned while you implemented this activity? How will this impact future activities or approaches? What advice would you give to other implementers and health systems actors in other countries that might want to adapt your approach?

USAID FROM THE AMERICAN PEOPLE
RESULTS FOR DEVELOPMENT
HEALTH STRATEGY AND DELIVERY FOUNDATION
ICF
BILL & MELINDA GATES foundation