Integrating New Services into CHW Packages - Lessons from Eye Health

Thu, May 22, 2025 12:44PM • 2:30:02

Speaker 5 55:30
I think we're going to try to go ahead and get started and see if people trickle in and find us in our little location back here, but it looks like we are very much among friends. There's a lot of familiar faces in the room today. So very excited for this. So I think we can definitely really think of this as a conversation among the group. We'll have a few moments to share kind of from some of our ministry partners that are in the room today, who partners and others, but really want to thank you all for being here bright, early, and that you found us back here. I'm Maggie Savage, for those of you that don't know me, I'm the COO of eye Alliance. We do have French to English, English to French, interpretation support this morning. So if you do need that, it'll be captioned at the top up here. But if you'd like to listen, you can download the interpretify app and it will take you to that and you can listen as well. So we do have at least one of our presentations today will be in French from our partner from Cote d'Ivoire. So yeah, I think that's the housekeeping aspects. If you need Wi Fi, the code is over there in pink. Otherwise, I think we can go ahead and get started. So again, I'm Maggie. I'm thrilled to welcome you to the session on integrating the services into community health systems, using I help as an example. But we know that many of those partners that we'll we'll chat with today, have also integrated many other services as well, but really thinking about how we lead this with governments and bring clear vision to communities that have long gone without it,

57:32
I'm going to ask, does anyone

Speaker 2 57:35
still need the interpret fi code before I jump to the next Slide in the room? Great.

57:42
I can click through right? Yeah, we'll

57:49
come back to these.

Speaker 5 57:52
Okay? I wanted to start by introducing you all to Yasa, a community health worker from Margie County in Liberia. We were unfortunately unable to have a CHW voice join us in the room because of scheduling conflicts this morning, so I wanted to tell a little bit of yes story. Yes is one of 1000s adults in Liberia that have received their first pair of eyeglasses through Liberia's pilot community eye health program back in 2021 she was she's a community health worker that was trained on the delivery of

reading glasses and received her glasses during the training from one of her fellow CHWs that was also trained before she had glasses, Jana struggled to read and write. She knew she needed vision care, but had no idea where to go for screening. There was no access in Margie County. When she finally received her glasses, everything changed. She could read again, write and continue to earn her living as a CHW, but even more powerful, she now brings clear vision to so many more in her community for her role as a CHW. I really wish that she could join us here today, but I'm honored to carry her story and the many other CHWs that we've worked with in Liberia and that we will be working with in many of the countries that you'll hear about today, and open the session in her name. So just a quick background on kind of eye Alliance and our work in this space, Liberia is really where the community health worker delivery work for eyeglasses began for eye Alliance, it was one of the very first countries to integrate the delivery of vision screening and reading glasses into its national community health program that is scaling this year. This milestone wasn't just symbolic, it was foundational. It's been a real opportunity to demonstrate what is possible when governments lead the Ministry of Health in Liberia have really championed this work and taken it forward, and you'll learn a little bit about how that's impacted others in the room that will share their story today. But I'm really excited to have this conversation and really think through what happens when we align behind a shared goal of expanding access to the essential services that change lives in immediate and lasting ways. So this morning's discussion will. Focus a bit on vision, how government partners and community health workers are coming together to integrate eye health into national CHW programs. You're going to hear firsthand from leaders in Uganda and Cote d'Ivoire about what that process has looked like for them, and what those enabling policy environments, the reforms that are underway in those countries, and the role that pilots are playing in informing decisions around scale. You'll also hear from a few of our great partners, Last Mile Health the World Health Organization, specs, 2030 program at scale and luala Community Alliance, who are advancing this work alongside government partners and CHWs across Africa. So with that, I'm pleased to introduce Stuart Kiel, who leads the specs 2030 initiative at the World Health Organization and has been instrumental in setting the global agenda on integrated people centered eye care. And so really excited to invite you up here to kind of set the stage for us around why integrating eye health into CHWs is a great priority and proposition.

Speaker 16 1:01:05
Thank you, Maggie. Very great pleasure to be here. And As Maggie mentioned, I am situated just up the road of the World Health Organization in Geneva. I lead the work on vision, and I can one of our key initiatives is the specs initiative. So we'll be exploring that a little bit later, but I wanted to just set the scene. To just set the scene, set the scene to start with. But firstly, wanted to thank eye Alliance and the team for really bringing this COVID together on this important topic of integrating eye health within community health settings. So I think it's good to start with a positive note. Over the last 30 years, there have been significant progress in and significant success in integrating eye health into community health settings. And we just have to think about the significant reduction in the number of children and adults that are blind due to vitamin A deficiency due to infectious causes such as trachoma and also onco sa crisis. These are all very strong community led programs. However, now onto the flip side of that. The challenge now is, as the infectious causes of disease are going down, non communicable eye diseases have risen sharply. And we're talking, of course, about cataract. We're talking about refractive area, diabetic eye disease, and really the list goes on. So the challenge is that we don't just have this huge need, but it's also growing. So we know due to demographic, demographic issues, also lifestyle

issues, these, these eye diseases, are growing to the point where we're not talking about millions, we're not talking about hundreds of millions. We're talking about in the billions, of people in need of eye care. So it's very clear that we something needs to be done, because in low and middle income countries, the majority of services to to meet the need of these people are provided in secondary and tertiary level hospitals, mainly in urban centers. So new strategies are needed. I just wanted to go back to 2019 because this is when who published the first World Report on vision. And there was four key recommendations. I'm not going to go into those now, but one of one of them was to reorientate the model of care, to build a strong primary and community level care. If we want to meet the needs of the population, we need to bring services close to people, and we know that if adequately resourced, the majority of eye problems can be addressed at the community and primary level. So it's very important that we move forward and also this, not only was this recommendation, you know, very strong in the world, report on vision, subsequent resolutions that have been endorsed by member states, also really reinforced this message as well. So to translate the importance now is translating these recommendations into action, and what who has focused on in the last few years is collaborating with hundreds of experts to really come together to develop the technical guidance needed to support countries in implementing these changes. And I wanted to start off with basically the blueprint, a blueprint at who is something called the package of eye care interventions, which basically sets out what interventions should be provided at the different levels of care, and the core interventions that are recommended at the community level of care. There may be more than this, but the three core interventions are vision screening, near and distance vision screening, provision of referral to high levels of care. Of course, where required, there is dispensing and provision of near vision spectacles to correct prep biopia. We know that there's, you know, hundreds of million people, hundreds of millions of people with uncorrected prep biopia. And importantly, which is often forgotten, is the importance of community health in providing very simple but effective education and health promotion so that we can increase awareness and also drive demand for eye care services. So there's a number of other tools that who have developed. I won't go into those now to help turn these into action more practical resources. But I wanted to leave just very briefly in the introduction, a very brief introduction to the specs. 2030, Initiative really recognizing the huge unmet need for care when it comes to refractive error or the need for eyeglasses. Who, who launched this initiative last year really has the mission of supporting countries to create sustainable but also quality, refractive error services and integrating them within primary health care, so not just at the secondary level, primary health care and community settings. A big part of this initiative will be to try to address that huge unmet need for red biopia and the community health sector. And setting really provides the foundation to be able to achieve this. And hopefully I can share a little bit more throughout the morning on that in the panel, but I'll leave it there. And thanks again to I alliance for bringing this group together.

Speaker 5 1:05:50
Thank you so much Stuart. So with that and really seeing how some of the things that Stuart just spoke about are playing out in countries, I want to turn to some direct country examples on how governments and partners are integrating this new service of delivery of readers and vision screenings into their community health systems. So I'd like to start with Dr Jimmy Ultraman, who's a senior medical officer from the Community Health Services directing division Directorate at the Ministry of Health of Uganda, and he will share a little bit about Uganda's experience to date on the sort so dr Jimmy, come on up.

Speaker 17 1:06:40
Hi people. Good morning, everybody. Jimmy Bucha ring is my name. I work for the Minister of Health Uganda, in the Division of disability and rehabilitation and Community Health Department. The Ministry of Health and government of Uganda has been implementing eye health significantly for about 1520, years, where I would probably say this program has been entirely supported by a number of partners in our country, given the fact that Uganda does focus on this, focus on on on, on on, diseases Probably are life threatening, so the focus on eye health and other disabling illnesses is quite very limited, and that is why this program of eye health has been strongly supported by my partners. But nonetheless, the support that has really come in from the partners has really awakened the government of Uganda for Ministry of Health, that is actually a burden of eye health conditions, that is actually leading to a number of of our community members getting blind, and that this, this interventions to our partners, has really started to awaken our government to start focusing on on improving The delivery of eye housing, delivery of eye health services, both at facility level and at community level. Interestingly, our country through the existing, you know, police objective policy, existing policies, we have been able now to strengthen both the facility delivery platform and also the community delivery platform through our national health policy, where we strongly, strongly, You know, putting emphasis on the delivery of of generally, community health services. And so this has, really, you know, informed us, you know, that in our country, close to 60% of our population before they reach the community, before they reach the facilities to access health care, the first result to a number of community

1:09:46
alternatives,

Speaker 17 1:09:49
including, you know, additional healers, including mothers that need to give birth, traditional birther tenants and for. For people that have eye conditions have been subjected to a number of, you know, traditional cases would be, you know, use of if someone has an infectious eye condition, then they're exposed to use of urine as a treatment modality at community level, some have been exposed to use of breast milk, especially newborns, those that are about about about a year old, so those have been exposed to use of use of breast milk, cancer treatment, mortality. So us coming in to strengthen community company, we are basically wanting to bridge the gap that has been created because we had not prioritized the delivery of Community Health Services, and so the community had to look for options, and those are some of the existing options. But with existing program, you know, it hasn't been well streamlined over a number of years, but recently, because of the number of strategies that we have developed and standards we are now starting to streamline the delivery of eye health services. Importantly to note is that at community level, we have leverage the existing community program through HIV, TB and Malaria, so that we because the existing structures at village and parish level, where we have community health volunteers who have been trained through the existing, long standing programs of Manila, HR and TB, we've been able to leverage on that existing expertise of these community health workers to try and also integrate community. I mean, community, yes, community health program where we our partners, distinct partners like Chai sex savers now through, most recently, an alliance to make sure that we standardize the training, training materials for all these community health workers to be able to screen screen with an identification of the common eye health conditions, and for those that can be able to benefit what's what I mentioned, those that have caused

by opium can be able to get corrected. Using the ready to click readers, especially for the porter halls and for the those for the other age groups that have any other eye condition, they'll be able to quickly identify and refer to near results facilities, we are definitely using public existing public health facilities since these are more distributed in our country, more than the private sector, and so we are able to identify these plans with regard to the nearest source facility for other assessment by the by the our healthcare system. Yeah. So in a nutshell, that is how our our system is, is designed. But I must say that I think if, if we did have really support members of being there in the game, because so so many yachts, I don't think we will have prioritized this discussion. As the Minister of Health, I want especially to my my friends here in high alliance that the Minister of Health is strongly now prioritizing integrating eye health. And they were very minister and permanent secretary. Were very interested, when we we we have this discussion to the tables of making sure that we are able to to to to distribute an issue eyeglasses at the household level, this is something that hadn't been hadn't reached through their notice, and they were very excited, and asked us to quickly come up with standards that clearly defined the specifications for most all, most of all, the classes, both prescription was. Non prescription. So the government can be able to include this national supply chain systems that plan for procurement and eventual distribution the way we have, or to to issue other devices, particularly the mobility the basic mobility devices. So I am very hopeful and positive that through these discussions, will be able to improve the eye health services, particularly on the on the issuance of both prescription and prescription. Thank you very much.

Speaker 5 1:15:43
Thank you so much, Dr Jimmy. It's been a pleasure to work with Dr Jimmy and his team. One of my colleagues was with them in Uganda when they were developing the guidelines and the trading package for the delivery of readers through the Community Health System, and she reported back that Dr Jimmy is the champion of integration, so if anything wasn't aligned with the systems that were already in place, he quickly called it out. And that's what we get really, really excited about, is thinking about, how are we doing this work through systems integration, rather than creating any sort of new parallel delivery structures with government partners. And so with that, I'm going to turn it over to Dr Kaja Francois from the Ministry of Health in Cote d'Ivoire. She's the director of the Directorate of community health and health promotion, and I'll share a little bit of a story later on of how we met, but in talking about government really seeing this opportunity and and having pulled from government for this work, she's an incredible champion of what is happening in the eye health space, as well as all of the reforms that are going on in Cote d'Ivoire right now around community health more generally. And so I will let her share the story And journey of Cote d'Ivoire. So over to you, Jana,

1:17:40
Vien de la cote,

Speaker 18 1:17:46
one they just began COVID Enough million David Cote a nose

Speaker 19 1:17:58
that in Cote d'Ivoire, he may we have more than 29 million inhabitants in Cote d'Ivoire, and we also have many health establishments, both at the University and primary levels, and we have, right now,

Speaker 19 1:18:22
12,000 1499 community health workers who are active and therefore produce community data integrated into the National Information System. And in relation to this population of community health workers, we have, on average, one community health agency for about 1200 inhabitants. People, and this represents, I mean, an enormous amount of work, because the usual standard, the standard in the documents, is one community health agency for every 500 people. And it must also be said that we have 23% of women in this population of community workers,

1:19:02
Bucha de the difficulty a particular.

Speaker 19 1:19:09
Other things that are also very special for Cote d'Ivoire is that we have more than 60 local ethnic groups. And so who says 60 local ethnic groups talk about a lot of cultural difficulties that embrace each other, and in particular, we are the largest cocoa producer still in the world, and now the third largest coffee producing country in the world. Maybe we've become the third largest producer because the producers have so many eye health problems that they don't sort the coffee efficiently. Well, that was the parenthesis.

Speaker 19 1:19:45
You in Cote d'Ivoire, the prevalence of avoidable visual impairments is estimated at 14.3% at 14.3% with a blindness rate at 3.1% seed. So as you can see, this represents a rate six times higher than the global target set by the WHO, where developing countries like ours, Cote d'Ivoire, and it is also a rate that is one of the highest in West Africa. And I could also say that presbyopia affects people nearly 30.58% of people aged 40 and over. That is to say about 5 million people who are affected by this condition. And so it goes without saying that it affects the quality, the quality of life of these people whose activity is falsely the use of closer vision, closer and so he

Speaker 18 1:20:49
will see the to say, the to say, problem, to say statistic, LA, COVID. So minister as usual, metal plastic program,

Speaker 19 1:21:07
Coke d'Ivoire, through its ministry in charge of Health, has seemed fit to set up a national health and eye health program. And this program, AA has developed a national strategy

Speaker 18 1:21:21
in a post book. This strategy

Speaker 19 1:21:25
was inspired and drawn directly from the National Community Health Strategy, which has a much more cross cutting approach, and therefore the main questions of eye health are discussed and implemented through this national program, and in a very particular way, what I would also like to share, with the

support of a the high Alliance, a pilot project between and started In one of the health districts of Cote d'Ivoire Sean, and this title

1:22:07
security, the

Speaker 19 1:22:11
integration of I care into the minimum activity package of community health workers through the initiation of the management of presbyopia and the establishment of a referral circuit. It's very important to us, because it's good. It's good that we can have data, real data,

Speaker 19 1:22:35
convincing that are stuck to the context of Cote d'Ivoire, so that we can really make proposals at the highest level, for the effective integration at national level, of all aspects of of I health in the package of the activity of the Community Health Agency,

1:22:54
There is

Speaker 19 1:22:55
precisely what is expected of this project. The the which is to be able to really ensure the establishment of a referral network, and, of course, the community management of presbyopia. We will have nearly 355 actors who will be trained in this, in care and screening, and more than 42,000 people will be subjected to this screening

1:23:27
activity.

Speaker 19 1:23:28
Reading glasses will be distributed, and therefore more than 12,000 all this denotes a little bit of the strengthening of activities for the accessibility of care in our communities, we have always thought that I care, especially in our countries, is care of I mean privileged for a certain group of the population, when in reality, it is care that is open to everyone and that all types of people should be able to See access to care, to care i health, and therefore here we are talking about equity and accessibility of care. So as I said earlier,

Speaker 18 1:24:14
forte or difficulty, the difficulty, the idea for us is really

Speaker 19 1:24:21
to identify all the aspects and all the determinants that can help us to effectively delegate tasks to the community health agency, and above all, to deal with the difficulties, the possible difficulties specific to the Ivorian system, to the Ivorian health system through the implementation of this project,

1:24:42
the ineffective enforcement

Speaker 19 1:24:44
of accessibility to eye healthcare will be effective for us. This part to this I will say in this meeting, we are we are we think that at the. End of this match, we will be able to we will be able to discuss the perspectives of how we have done so that the package of the Community Health Agency really integrates care. And we think, indeed that all aspects of awareness, screening, and the ideas conceived, the ideas conceived around the fact that I don't, I don't necessarily have the right or that I don't have the necessary means to have access to care. I health, ie ideas that are deconstructed and that we can really work on it. So thank you.

Speaker 19 1:25:54
Dr Kaja, thank you very much, Dr Kaja, to bring up

Speaker 5 1:26:01
our last kind of country specific example from the deputy program officer of that is not your title anymore. I apologize. Of Last Mile Health so Malika, would you please join us and share a little bit about the work that last mile is doing with the Ministry of Health of Ethiopia to integrate eyeglasses into their non communicable disease module for health extension workers. So I welcome you to the stage.

Speaker 20 1:26:33
Good morning. Great. So yes, I'm Alika. I'm our Deputy Chief program officer at Last Mile Health. Last Mile Health works in partnership with Ministries of Health to design scale and sustain community health programs. We currently work in Liberia, Malawi, Sierra, Leone and Ethiopia, and so we've had the good fortune of partnering with I Alliance in Liberia through long standing partnership, but I'm actually going to talk about Ethiopia today. So as we know, NCDs are the leading cause of death worldwide, and in Ethiopia in particular, this is quite acute, given the remote and rural population. So this is where health, where community health workers come in. And I'm sure folks are familiar with the long standing health extension Worker Program by the Ministry of Health. It's an exemplar program. And over the last few decades, the Ministry of Health has really championed the sustainability of the program through 40,000 health extension workers. Ministry is kind of in, kind of like a phase two how to optimize the health extension Worker Program. And as part of that, it's been really essential to think about how to integrate non communicable disease training. And so as part of NCD training in the blended learning curriculum that the ministry is has been championing. Last Mile Health has has partnered to integrate eye care as part of that. And so this has been particularly impactful because there's quite an unmet need of presbyopia in rural Ethiopia. And so in partnership with the livelihood impacts fund, over the last few years, we have been rolling out a project to improve access to eye care through the community health worker model. So we integrated presbyopia management, management into the community health worker, into community health workers workload by thinking about how we could train through a kind of blended and paper based approach, health extension workers were able to provide education, conduct vision screenings, provide access to reading glasses, make referral for more advanced issues, like glaucoma, cataracts, and generate evidence to support kind of the broader implementation of community based eye care services. And so to date, we've trained over 1200 community health

workers in NCDs, and we'll go into this a bit later in the discussion. But that's inclusive of eye care. To date we have through community, through eye campaigns screen. 53,000 people, and 49% of those have received eyeglasses. There's a lot more work to be done. Of course, only training 1200 health extension workers is like a drop in that in the ocean. But over the next few years, we're excited to partner with the ministry of health. I think, in particular, one thing that was, I think that we really learned is, I think Maggie, you talked a lot about how to, how do we like integrate into government systems, and one part of this is how to make sure that eye care and management of presbyopia is not an isolated. And and one of those things was around connecting eye care to other NCD management. So health extension workers now in Ethiopia, for the first time ever, have been trained in things like blood pressure screening, diabetes screening, and eye care is now part of that. So because of a kind of aging population in Ethiopia, and particularly because the health extension Worker Program is often focused on targeting women and children, that there's a whole other population that has been left out, particularly because of traveling to the health facility actually coming to access services. And so I think integrating presbyopia management eye screening has been a huge linkage to care for a population that has traditionally kind of been left out of the health out of the health extension Worker Program, particularly, I think on the other side of that, it's been really valuable for health extension workers themselves. They've often been seen as only providing services to women and children when actually their scope of work and can and should be so much greater. And so the Ministry of Health is really a champion. How do we how do we build the support tools, the training, the skills, the supervision, to think about NCD management now, particularly with the growing burden of disease in Ethiopia. And so we're really excited to continue that journey. I think it's the big kind of takeaway for us at Last Mile Health is it's it's about eyeglasses, it's about eye care. But it's even bigger than that. It's about how to think about eye care and eyeglasses as a link to a bundle of other services so that we can think about a more integrated package. And I think particularly in the kind of environment we're operating in now, health extension workers, community health workers, are often being leaned on. Even more, more task shifting is happening, particularly from the primary health care level, even to the community level. And so whether you know, whether we can acknowledge it or not, community health workers are always going to be lean on. They're going to be assumed for additional tasks. Communities are always going to come to their CHW and say, I need X, Y and Z, and so rather than, rather than just say yes, that's going to happen. What other kinds of systems, what other kinds of training, what other kinds of supervision can be really filled in in order to ensure that they're able to serve like all of the populations that are likely like but they're likely to serve. I think that's it. We can. We'll talk a little bit more about about NCDs, but we've been really, we've been really, I think, surprised around what we've learned through, through training health extension workers in an eye care and I think we've also been fortunate to have a lot of learnings from other countries who have paved the way.

Speaker 5 1:32:53
You're welcome to pick your seat. So those that we've already heard from feel free to join us up here, and then we're going to add a few additional voices to the conversation. So if Satish, who's the head of Global Programs from at scale, would like to join us, and then also Ken ogendo from luala Community Health, who's the director of Internal Affairs, policy advocacy and partnerships, we will start a nice conversation, and then have time for questions and conversation as well. So I'm going to get us going, but I'm happy to turn it over to the crowd here as well for this. So to start, we'll hear from the folks that we haven't heard from yet. So I'll start Satish with you as the Global Partnership for assistive

technology is really working with governments and implementing implementing partners, can you provide the group with a bit of context on the roles that you've seen, community health community health workers playing and delivering vision and rehab services, and any examples that really stand out to you in the work that those that at scale has been supporting are doing. And you can grab that mic right in front of you and hold the button and it'll turn on there at the bottom.

Speaker 21 1:34:13
Yes, good morning everybody, and thank you for organizing and getting all of us over here. It's been a rainy morning, but the information in in the session so far has been quite exciting. Coming back on community health workers. I mean, we already heard lot of examples of work happening in various countries, but the reality is that, and I think the last speaker said it quite well, they are going to be more Star shifting happening to community health workers. If you want to achieve health for all, primary health care system is one of the approach to make that happen. And the cornerstone for primary health care system are community health workers. And it is and. Is where and we have seen to make vision screening, to make Vision Services, eye care services, a reality, we have to rely on these cornerstones, like the community and workers, some examples, which comes in my mind. For example, in Nigeria, where as part of the regular child immunization program, community health workers who's in the community, and identify which are the parents, which are the committee members, which are the other adults who needs presbyopia services, and do appropriate referral for that. For example, in Bangladesh, through the through the through a program which was implemented by BRAC, as well as the vision spring reading classes for improved livelihood for the community, a lot of work has happened. More than nearly 30 odd 1000 community health workers were trained this and then referral for and then provision of reading glasses, as well as data, as data, when shows from Bangladesh, this actually resulted in reduction of almost 2 million people with regards to vision impairment. If I go further down examples in India, for example, where the community health workers, along with the accredited social healthcare assistance, which is called the ASHA over there, or community extension workers, a lot of work is happening over there with regards to enhancing Eye health education programs in at the community level. So various examples, various work happening with regards to ensuring access to IKEA services at the community level through community health workers. Thank you,

Speaker 5 1:36:55
great. Thank you so much. And and I think building on that, I'll turn to Kenna down there and really thinking about luala and the work that they're doing in support of the Government of Kenya. I know that you guys are often called upon to kind of test the integration of new services, whether it's eye health services, which you've been doing more recently, but I'd love to hear a little bit about kind of your approach to thinking about testing and integrating new services into the CHW package as it's being rolled out and reformed within in Kenya, alongside the government, and how, yeah, you're using those strategies now to look at Vision Services. Yeah,

Speaker 22 1:37:39
thank you. Good morning everyone? So that's a great question, and I would just want to ask us to close our eyes for one minute or one second and think about the impact of going blind or being visually impaired, just to center this conversation to the room. As you close your eyes, you can imagine how tough it can be. So as you open your eyes to listen to what I'm just about to say, we are aware that 1.7

billion people are exposed to presbyopia, and in Kenya, and especially where we work, in County as well, 30% and same to COVID. 30% of our population is exposed to presbyopia, and we have had the misconception that you need to have overly highly specialized care to offer eyeglasses, whereas we know you can actually do this through community health workers, so in partnership with livelihood Impact Fund and The Ministry of Health in Kenya, and that's the county government. We took to test what it would mean to take eyeglasses to the last mile, to the households in Kenya. And we set up a campaign training community health workers, 3000 of them, and we also train their supervisors, who we ideally call them Community Health assistants, and these community health assistants also help to supervise them so that we can add some quality to the work they do. And again, we trained 300 health facility workers so that we can bridge the connection between the community and the health facility. With regards to the eyeglasses distribution in every county, and having done that, our community health workers were able to screen 53,000 people, and interestingly, 95% of those wanted the glasses. And that just goes to show the unmet needs which have in our communities, and that is in rural places in Kenya. So as luala Community Alliance, we have seen it is important for us to partner with the government at the county level so that we can increase the uptake of reading glasses within our country. Interestingly, 92% of those who. Receive those eyeglasses, still say it was very easy to access them. So it is up to us within the global health space to democratize the access of reading glasses through community health workers and the primary health care networks which are involved right now globally, Kenya, right now, is poised to set up primary health care networks, and these networks cover community health units where the community health workers work, and we have been pushing this supply chain and see how that can go forward, so that we can make them accessible at the health facility and access at the CW level. I can show the rest list as we continue. Sounds

Speaker 5 1:40:46
great. I think one of the threads that we're hearing in the conversation is really how many of these pilots around integration support that the ministries are doing directly or partners are supporting is really about building a contextualized evidence base. And that was really what we saw in Liberia as well when we first started this work, is that the government really had kind of a vision of what services needed to what criteria they needed to meet to be in the new community health assistance service package, and they asked a couple questions of all the interventions. So I'm going to share those questions, and then kind of turn to this group to talk through what they kind of see as some of the priorities within those questions, and where we're seeing evidence bases grow from this. So if we look at each of these examples, they're adding to that evidence base. But the Liberia Ministry of Health, when they started this work back in right before COVID So 2019 really asked, Is the service vital for morbidity and mortality reduction? Is this work being done already, and by whom? What data and evidence exists from global and national context to support integration of the service. Are the required supply chain, commodities and capacity available? I think Ken just touched on this a bit, as did Dr Jimmy in his remarks. And is there funding potential? So how are we thinking about funding community health worker packages overall, and the prioritization of new services as well. So in the one county initial pilot that happened in Liberia, where we saw similar statistics in terms of both need and provision, and we're really excited on the Liberia front to share that we estimate that everyone that had unmet need in Margie County has been met at this point as the pilot wound down, but really through that, it provided the evidence and the impact outcomes for the Ministry of Health to really make a positive assessment under these criteria to include eye screening and reader's provision in the new National package that is

set to roll out later this year. And so I think one of the things that's been really interesting in this work, as we see new governments come on and be really excited and and build off of the the work that has been done by BRAC for years and years and years, is really thinking about, you know, how can we continue to make the case globally and then take that more nationally. So Stuart, I'm going to turn to you and kind of ask, from your perspective, what evidence you know, are you seeing as most important to support government decision making as you have the different conversations through the specs network with with governments, and what are you seeing as requests to fill some of those evidence gaps? Of you as the who and how are you guys doing some of that? Yeah,

Speaker 16 1:43:48
thanks, Maggie. I think, I think as a as a sector, and as a broader sector and partners, I think they we have moved towards, in the last five years, in a positive direction towards generating the appropriate evidence to support the country, country action. And by that, I mean some of the economic evidence that is now being generated is much more tangible evidence than what it was before. So we're moving away from sort of larger global figures. We're now moving towards producing good studies on the economic returns and also at an individual level. What impact can this have on on earning capacity as well by providing sort of simple pair of reading glasses? And we've seen a few examples of this, I think, eye Alliance and recently had published with UNESCO some work on the huge cost benefit ratio of school Eye Health Program Provision of spectacles at community level. We've seen evidence generated on what impact on earning capacity a simple pair of reading glasses can provide in manufacturing and also in agriculture as well. So I think if this evidence is particularly at the country level, it can be used as very strong advocacy to move these programs forward. I think you. Very briefly, where I see the gaps, and actually I draw on a piece of work, large piece of work that we published last year, which was a Cochrane review of all actually supported by ATS scale, the Cochrane review of all refractive error models that have been provided at community and primary level. And actually will surprise that there were about 200 reports published, but only a very small fraction actually evaluated these, these new models effectively. So I think moving forward, we really have to concentrate, when we have these new models, that they are adequately evaluated, so we can make sure that they're evidence based. Moving forward, we can make sure that we can scale appropriately and also publish them so that we can learn across countries as well.

Speaker 5 1:45:46
Excellent. And I think that many in this room are working on that evidence generation and how we think about publishing it right now. And so I'm going to turn to you, Lika, sorry about that, that one of the learnings in Liberia that you also mentioned for Ethiopia that really stood out to us, and we really kind of want to shout from the rooftops with the ministry there, is that the intervention really did allow CHWs to serve this broader population than previously So community leaders, particularly male community leaders in Liberia, and adult women outside of reproductive and maternal kind of roles, and CHWs and the CHW kind of program stakeholders that kind of reported back to us during our evaluation that this, in turn increased CHW motivation and standing in the community. So really, members of the community that didn't necessarily see the value and benefit of CHWs really starting to and so, you know, I think you started this and probably stopped a little bit, knowing I was going to ask you this question, but really curious to hear kind of what evidence has stood out to you or helped kind of further the case, in making that case with the ministry and its partners in Ethiopia?

Speaker 20 1:47:04
Yeah, I was gonna actually piggyback on how you opened the session a bit, which was just like, what were the what were the criteria we looked in in Ethiopia, and it was quite similar in in Liberia, but was, what are some of the factors, or what are some of the signs we're looking for with the Ministry of Health around Can we, can we integrate I health into the health extension Worker Program? And so similarly, we asked kind of five questions. So is, can this fill a need or gap in the country? So we talked about the rising burden of NCDs. And so I think with the Ministry of Health, the discussion was, it's not just eye health, it's not just eye care. How do we integrate this into an existing module for the health extension Worker Program? And NCD certainly became that that kind of entry point. I think another piece was around demand from the community, from the primary health care system. I think we were very fortunate and lucky to have examples from Liberia, from Cote d'Ivoire, from Bangladesh, from many other countries that we knew there would be a demand. We knew there was a gap. We knew that, like if you build it, hopefully they will come. And so I think we we started to see both from feedback from health extension workers, from supervisors that even starting to do eye campaign to go out in the community, do eye screening, do kind of launch days meant that 1000s of people were lining up, and almost could the supply keep up with the demand. So I think that was another really critical point. I think the other piece of the enabling environment for the community health worker, I think we've talked a lot about, you know, are the like, what we might call the S's, are they, you know, the community health workers, being salaried? Are they being skilled? Are they being supervised? Are they being supplied that that is very similar with integrating any new service. We need to ensure that we're not just training the community health worker, but then we're ensuring all the support systems around them actually allow them to deliver the service with, with anything it's it's one thing to train, but then if a patient comes to you and you're actually not able to provide that actual service, you're not able to give that medication, you're not able to give the eyeglasses themselves. I think the it puts the health extension worker, the community health worker, in a vulnerable position. And so we needed to ensure that the supply chain side of that actually could keep up with them being trained and able to provide that screening. And I think the last piece is just around, like the ministry's commitment. So we've talked a lot about pilot projects demonstrations, but the long term vision is to scale, to ensure that these are integrated into national systems. So from the onset, how do we have, like, very open and transparent conversations with the government around like, what recurring costs? What costs can they take on over time? How do we reduce the overall operating costs of integrating eye care into the government's health extension worker program, and what can that look like over five to. 10 years. And so I think a big part of that was also around the training component of it, because the Ministry of Health has already institutionalized blended learning training, being able to integrate that automatically means there are cost savings there. And so even if other parts of the supply chain or supervision are costs that are upfront over the next few years. We we hope that, you know, over the next five or 10 years, as we can hopefully scale in Ethiopia, some of that can reduce. And then the last thing I would just say is we continue to look at other kind of global exemplars within, within presbyopia management, I think because Ethiopia is very much kind of pioneer, or kind of piloting, and now going to dive in. I think we have a lot to learn from other countries like Bangladesh or in India, other places that have scaled

Speaker 5 1:50:49

absolutely and that was you set this up for a very nice transition to my next question for Dr Khaja. When we first met, I met her back at the community health worker symposium that was held in Liberia, where she sat on a panel to discuss the reforms that were happening within Cote d'Ivoire to the community health worker program and package of services, which you heard her speak about a little bit before. But really, you know, one of the things that stood out from that panel was the library and Ministry of Health was also sitting on it, sharing the experience around eye health integration. And Dr Kaja came up to Abby after the event and said, you know, we have eye health as a priority within the package, but we aren't quite sure what specific services will be able to be delivered within that package. And so what can we do about it? And so we've been working together for a bit now to really refine what that service package under eye health could look like. And so I think this, this idea of really leading from the Ministry perspective, and what evidence they need at that that local level to make these decisions is so critical and so dr codger, my question, kind of for you is, what are some of the recommendations that you might have for other ministries as they look to kind of Define this package of services and and what are you kind of most excited to kind of see coming out of the pilot to help kind of think about the prioritization and what is needed for for you to take on this, this work, I think coming back To really being able, from the outset, have those conversations about what what sustainability and need look like, and what the ministry is able to provide for that long term. So I'll turn it to you. Okay?

Speaker 18 1:52:57
Merci beaucoup. Maggie para por

Speaker 19 1:53:06
and for what I can say about the recommendations, what could we do in the ministry, in the various ministries, so that decisions are made or actions are taken, precisely, that all services are privileged, that there is effective integration. For me, I think it is important that at the level of the ministries, there is this connection between the different sectors. For example, in our country, we have the eye health program,

Speaker 18 1:53:52
but we also have the Community Health Directorate.

Speaker 19 1:53:57
And so there are two or two departments that are in the Ministry of Health and that should work together. So together. So here it's mostly about emphasizing the connection who should be supported there is between the departments, so that there is, I mean, an effort to integrate not only the energies invested, but also the services that are planned, particularly with regard to health and eye health. And I said earlier that the National Strategy for Eye Health is inspired by the National Community Health Strategy. It's not done by chance, but it's precisely so that the

1:54:43
it, there is this

Speaker 19 1:54:45

integration of services in the large package of community health agencies, and that in a concrete way. Since the training, the implementation has made an integrated supervision of all assets. Aspects. The other thing too, what I can recommend is to be able to ensure the prevalences, real prevalences,

Speaker 19 1:55:13
perhaps through studies or evaluations or even rapid surveys to ensure this prevalence, but also to remain focused on the on the definition of services, the definition of services according to priorities context. Because, in fact, everybody, each ministry in each country has a different context, and so if we have through these rapid evaluations, evidence for it,

Speaker 19 1:55:53
moving forward with the definition of the real services to be implemented at the community level, will be much more judicious for these different ministries. Thank you very much. Excellent.

Speaker 5 1:56:04
Thank you. And so similarly, when I met Dr Jimmy back in 220, 23 it was in his office, and it was pretty serendipitous, because we weren't necessarily there to chat community health workers. We were actually discussing some exciting movement on school eye health programming and linking the Ministry of Health with the Ministry of Education on some work that was happening. So I think similarly to what Dr Kaja just said of really finding synergies within either different departments or different ministries to think about where resources were, and it just happened to be kind of right at the time that that Uganda was was defining out what the new Community Health extension worker program would really look like, and and so he quickly said to us, great that you want to do school, eye health, community health workers are going to be assigned to a school. So shouldn't we be training them to both be doing screenings in schools as well as in the community? And really, kind of said we would be a mess if you know this would be a real missed opportunity for us if we didn't take this forward and leverage this for integration into the reform package. And so we were very excited by that we quickly jumped on board with them to think through how best to do this. And so, Dr Jana, I think one of the questions I have for you is, is really, in thinking about, you know, what are, what's the support that partners have been able to provide you, where you've been able to be in the rooms with, you know, the Permanent Secretary and others to really make the case for iheld, as you talked about, kind of in your opening remarks.

Speaker 17 1:57:45
Thank you, Maggie. As opening statement really is that, if it wasn't for the partners that have been, you know, pushing them in the government of Uganda to start prioritizing eye health. I don't think, I don't think we would be here in the first place. In my country, as earlier on mentioned, we're a country that focused on what kills you first, what doesn't kill you we do not prioritize, and that has really, really impacted negatively on the lives of young children, people that earn less than $1 in my country to get blind and the time I got recruited by the Minister of Health and put in disability, I never, you know, thought that I would advocate for persons with disabilities. And when you look at how best can we achieve universal health coverage by leaving no one behind? The first thing I could quickly understand or learn was that no doctor will reach your household. The person that is going to reach your household is a community health worker, and there has been immense work that has been done by partners that have been in my country for some, for some time, particularly sight savers, BRAC Uganda, that have

done Some work in iHeart space. But I must give Sightsavers their flowers, the one of the partners that have tried as much as they can to work with government of Uganda before I actually joined the ministry, and I made sure that when I joined all the partners that. Come into the eye health space. We try as much as possible to make sure that we give them, get, get them aligned to the visions of the of the Ministry of Health, the partners that came and worked, of course, but you know, silent without government of Uganda, and that meant that whatever they were doing somehow did not, you know, target the persons that we tend to reach. And when chai and I Alliance started working with us, I made sure that, you know, we fall in the footsteps of what government is is doing. And I really wanted to thank I Alliance and Chai for accepting to follow what we we we anticipate to achieve in reaching every household, because the Ministry of Health already has existing community health programs that we are leveraging on to integrate high health interventions to reach every household and and I always mention that, yes, you come In with your with support, but there's already existing structures which we can build on, okay, build on, and we see beyond your support, because 1234, years later, you might not be here, but if we we start from the word go to try and leverage on the existing community structures that have already been built by other programs to try and integrate eye health. It is easier for us to start sustainability of these programs, including eye health. So for me again to Airlines for really, really accepting. To walk this journey with the government of Uganda so that we can be able to reach every household, at least in the areas that are highly burdened by eye health conditions. Thank you very much.

Speaker 5 2:02:18
Great. Thank you, and I think that speaks a little bit as well that last statement you just made to also what, you know, Dr Taja was, was talking about of really thinking about, you know, where within the country are we prioritizing based on on data and available evidence within that and so we've had the fortune to work with a number of partners in Uganda, on on school eye health, to really understand where prevalence is, so that, with limited funding at the moment, we can prioritize which regions of the country we would want to move forward with, and the ministry is able to make those decisions effectively and efficiently. And we look forward to doing that similarly around presbyopia in the country too. And so, you know, thinking about data and evidence, Ken, I'm going to turn it over to you to see if you have any reflections on on kind of this topic that we've been discussing as well.

2:03:11
Sure. So

Speaker 22 2:03:13
I would like to mention a couple of points that we need to consider. And the first one is integration. And integration should happen at several levels. We need to layer it at the household level, a supervision level and at policy level. At the household level, community health workers move from door to door using people doing ICCM Integrated Community Health, integrated community case management, and as they look at a child or a mother for their needs, and in this case, an elderly person over 3540 years, they should also look at their health and the eyes within that household. So as they look at the child, they also need to go beyond ICCM and mnh and FD and integrate eye health screening at the household level. And so that's one of the things we try to do within the community health worker space in Kenya. And again, integration also needs to go to the supervision levels, because if the supervisors

Do not remind them, then they are likely to forget. And people usually want to concentrate on what is visible. You maybe have malaria fever, but you might forget about esteopia. So the supervisors need to know, as they do their supervision, they need to remember, oh, and community health workers also remember to ask about the eye health or that household and distribute glasses where appropriate. And again, we need to collapse silos at the policy levels, many frameworks and the way many ministries of health are designed, the architecture is such that the ministry the Department of Community Health is on this side, and then the Department of eye health is on this side and there is no intersection. So we need to actively push for integration at that level. Level, and that also means and my next point, we need to build partnerships with the local governments and the national governments in Migori County, where we did the pilot, we had a great relationship with the county level. But now we want to leverage those evidences, bucket them, and take them to the national government so that they can also understand the importance of distributing these eyeglasses. However, my conversations with the national government are also interesting and worth in noting. There is some interesting data within the global health space where some people are thinking that community health workers are over prescribing or under prescribing, and that data needs to be challenged, but we can only challenge that data with more data and evidence. And so it's upon us to create more opportunities to talk about this data and change the mindset of the policy makers at government levels. So that's one of the avenues that I see is important for us. And then lastly, I would like to talk about coalition building in Kenya right now we have the clear vision Coalition, which brings around site servers, CMMB and Lola Alliance. We are keen to join it now that we are into this ice space, and one of the conversations you want to push forward is to see how best can we democratize the access of these glasses, and also talk to the dissenting voices, because you have some healthcare workers who still want to cling to that traditional mindset. So coalition building is emerging as one of the best practices we can do as a sector to see that we improve that. And then lastly, I'll mention that we have this social health insurance in this in Kenya that is providing glasses, ice cream, eye screening for people who are under 18 years, and we would want to expand the benefits package to get to at least 40 years and above, so that you can increase the access of reading glasses. So we have a committee that is sitting down to review the benefits package, and I'm closely working with the head of the i division to see that to where that we we include this conversation there, and also having it on the supply chain. That's the last point. Because if we so, we have this community health units kits, The CW kit does not have the eyeglasses, and we are advocating with them, convincing them that this is just augmenting the services that you are doing, and community health workers are not necessarily taking away your jobs, but augmenting and supplementing what is already happening, so that as they share the glasses in the community. They can also refer for cataracts and other things that I will see within the sector. So it's an ongoing conversation, and we give you an interaction.

Speaker 5 2:07:51
Amazing. Thank you. I think there are a lot of great tidbits in there that I'm actually going to kind of turn to Satish and maybe put some of them as a challenge to you and at scale and and other kind of multi sector partnerships and and funders you know, as as what can kind of you do and in the role that you're playing in this space, to meet some of the things that we've heard on the panel, Some of the things that Ken was just talking about, you know, to really help kind of advance this as part of the global conversation as

Speaker 21 2:08:27
well. Thank you, Maggie. I think we should do all this, and we should support all of the things which has been said, especially with regards to integration of services in the health system and health services keeping community and primary health care at the center. But probably to summarize, I think key roles funders and multi sectoral partners can play in this space is to advocate for policy change. The example which you gave from Liberia is a good example that policy dialog, aligning eye care services with the government priorities and and their strategic plan is is a good way forward. It's not it's a service which is going to be established or initiated in a country and in its own isolated area of work, but aligning that with the country government priorities and commitments, and I think that that's a great example. Promoting supply chain and its optimization, as mentioned by like by fellow panelists, is another good example. How can we ensure that eye care commodities are part of the regular medical supply chain using technology. And I think this is something we have not much touched in the discussion so far. And generally, technology is also seen as replacing workforce. But that's not the reality. Technology is about health. Us. How do we optimize? How do we make our services more efficient? How can we use that services of or use technology in provision of IKEA services? And I think that's another to prioritize. Both I will also add is on capacity building. And lot has been talked about capacity building efforts and how that has resulted in change of service deliveries at the country level. Lastly, supporting efforts on evidence, generation, supporting supporting inter country learning like events like this. I think it's absolutely fabulous. How can country learn from each other? How can we, how can we avoid doing the same mistakes, but how do, how do we learn from those mistakes? Also, how do we learn from the good things happening in other countries? And this and those things needs to be further promoted and, and, and take it forward. Last and final thing. And I think this, this was said earlier, a lot. I think eye care services and vision care services initially did, required that push from stakeholders,

2:11:12
from from all of us,

Speaker 21 2:11:14
and that push model worked well till now to elevate and give the importance of eye care services and vision services and provision of eye glasses, breast pier whatever. But I think now we need to change the narrative, and we need to have a more sort of a full model, where the countries and their health systems are at the center and stakeholders are at the periphery, so that that alignment with the country priorities can happen and not according to stakeholders priorities. So we need to change that narrative from push model to a pull model, where the community health workers and the health systems are at the center and stakeholders are there to support this

Speaker 5 2:11:54
amazing that is a great note to kind of end on in terms of my last question that I'll give each kind of panelist a few 30 seconds or so to kind of share some final thoughts. But I think I'll start down at the end with with Dr Kaja and kind of coming to this, this call for action that Satish just let us in of really centering government and the community, health workforce in this work. Dr codger, what do you see as the greatest driver of success for this integration moving forward,

Speaker 10 2:12:35
on factor the success integration? Decor, you decor le,

Speaker 18 2:12:50
factor de receipts, integration, revenue. Jana, the

Speaker 19 2:12:59
success factors of this integration. The future here, in fact, is me. I am already aligning myself before I put forward my remarks.

Speaker 19 2:13:15
I am in line with the recommendations that colleagues here have been able to make on the issues of funding, integration of services, and also to align with the government's priorities. A very important thing, it's to be able to work on motivation,

Speaker 19 2:13:34
sustainable, local and sustainable of the community actor, a because here we're talking about accessibility, I health care, care that goes to the communities through community health workers. And when we talk about the integration of services, very often we think that we are coming to entrust the work of the Community Health Agency. And who talks about a lot of work also talks about a lot of money in terms of motivation. Even if the motivation is non financial, it is still financially supported. Therefore, of the motive, motivation of the community health worker must be a question that must be really debated in each country, in each ministry, in order to find sources of sustainable funding at the local level who could not interrupt the interventions and remain focused on the priorities of the different countries. The other aspect as well, which is very important, that's what has already been said. It's above all the work between the government and implementing partners. Say. Say Porter, which should be aligned with the government's priorities. And therefore that's enough. It's very important. And when there are these projects, projects, we will say pilot projects in areas, I mean chosen in these countries, it is important that there is a very strong communication about the results, the results obtained, whether it's halfway through or at the end of the project, to encourage governments to take decisions on the issue of eye health, which is also similar to mental health issues, because, as Dr Jimmy said, these are questions when we say it's are infections that do not kill. And so we wait. We wait before getting treatment or at the government level, we wait to make decisions

Speaker 19 2:15:59
more on the question that kills than on the question which are chronic pathologies, therefore, that will be my last point alignment, the connection between the government and the parties is very important for actions to be really well oriented. Thank you. Just

Speaker 5 2:16:18
made around results and that data, the Ministry of Cote four has laid out one of the most comprehensive monitoring and evaluation plans for the pilot that I've seen in a long time. So we're really excited to see what comes out and to be able to share those learnings at the end of the summer. So really quickly, I'm just going to go down the line and ask our panelists in one or two sentences, just

what have you found either most surprising or inspiring in the work thus far to support the integration of vision services into community health? So we'll just Ken, we'll start with you, and we'll go all the way down really quickly to close us out.

Speaker 22 2:16:57
Yeah, thank you. I think for me, what stands out is the way eyeglasses are available everywhere in the shopping malls, but the health system finds it a bit difficult to allow hard workers to just give it, and when you train them, they are actually better capacitated to support you than going to over the counter and buy your sunglasses. So I would urge all of us to invest in the training and the capacity building of community health workers in can you have a special senses module, and also see how we can integrate eyeblas, not just on one module, but have it across the board, like I had an NCD solid, integrated and, you know, integrating it everywhere, and lastly, leveraging AI and electronic community health information systems so that we can build in workflows that make the community health worker screen and help them to refer where appropriate and share the glasses where appropriate. Thank you.

Speaker 17 2:18:00
Thank you very much for me. What really stands out in terms of integration is that, by my immediate supervisors, I think, have about four of them, and all of them have eyeglasses. Use eyeglasses, sorry. And when we try to talk about provision of eye classes, they get surprised as it's not a priority. So often time I keep asking them to take them off and try to read without them, and they get shocked that they actually can't see without them. So when we advocated for inclusion of eyeglasses into the national essential healthcare package, that was the opening statement was we used, and my primary secretary was quickly to tell me, now, go and develop those guidelines, and I want to, I want to confirm that we are at the tail end of having our assistive priority list getting finalized at Uganda, and then we will use that to advocate for provision of spectacles, both of prescription and prescription. Having said that, finally, is that there is, I'm sure, most of the countries, especially African countries, now we, we have some have already developed the integrity service packages for the community health workers. And what is common down here is that all of us have a community health worker. We have an integrated service package. The biggest challenge now is health financing. The health financing is. What brings about the silent programming as you're mentioning, everybody comes with their money and says, My money is meant for A, not B, my money is made for malaria, not eye health, but that money is going to the community health worker. I just learned this this morning from my friend, Doctor Anil. I think we need the common we know that at the end of the day, whether it is malaria, money, HIV, money, TB money, is targeting the community health worker at community. So what we need to do is, how can we pull the money that is made for this committee of whatever program, put it in one basket and use it as we talk of integration? Integration should not be limited to the service package integration. What drives integration is actually funding. How can we start the discussion of having this fund make sure that it targets the entire integrated service package for this house, for this community extension, a community health extension worker that is entering the household to deliver that integrated service service package using those limited resources. So for me, that would be my closing remark, that we start having these discussions for anybody that is bringing resources to support community health work, how we put this money in one basket. And when I am coming with HIV, I have to take the entire package, not just HIV, okay, very basic package. So thank you very much.

Speaker 21 2:21:55
I think two quick points, one for me, what stands out is the is the whole notion of trust which the community health workforce and the primary health care system have at the community level. I think that still needs to be further explored in terms of enhancing services makes a huge difference the life of that individual who needs services, or the family member, if the community health worker says, Have you gone for your services? Are you wearing your glasses? Are you going? Are you ready for your next appointment? And that makes a huge difference. And that trust which that community health force has in the community, to be further used, and we have seen the power of that trust in many health settings. That's one aspect. And the second aspect, I think, is which is also mentioned in various inputs, is, how do we ensure that we all not only talk about services, but we also talk about ecosystem, the whole ecosystem which surrounds those services and make those services possible, be it policy, be it financing, be it overall workforce training and how it can be spread them, not only for existing workforce, but also the workforce was going to come out in the future, the whole information management system related to so this ecosystem is sometime In our quest to have more services and numbers, and we are also responsible in that as donors and development partners in this process, we miss out the ecosystem aspect of this work, and that needs to be equally sanitized.

Speaker 16 2:23:37
Thank you, Maggie. So just a couple of very quick reflections from me, I think, drawing on what Satish said before about the moving away from the push model to more towards the pull model, I think we're in an interesting transition period at the moment where, with a small push, we are getting very strong country demand for support, to support government led eye care services. So that's been evident with the specs initiative we only launched one year ago. There's already 717, countries that have come forward to who to request support to to integrate refractive error services with within health systems. So what we are doing and making sure that we do from the outset, is ensure that all relevant programs and sectors are around the table when we plan for specs, initiatives in countries, aging community, health, education sector, labor sector. So that's one important thing, and I think we're in that transition period. I think also secondly, if we think about innovation, I think we don't just need to think about technology, but we also need to think about innovative models. And I just wanted to highlight who is not, not generally known for its innovation. But one thing we have done is signed a recent agreement with the Universal Postal Union, and are currently working with the government entity in India, the India post, to actually look at implementing vision screening provision of readers through infrastructure, postal infrastructure in countries which has really great. Potential to reach a huge number of people.

Speaker 20 2:25:05
I'll be very quick. Maybe a call to action that's been said already is, how do we just de verticalize eye care and eye health? And I think there are ways, through school, eye health programs, through ICCM, through non communicable disease. Just, I hope, and I think all of us have a certain responsibility to figure out how it's not just about, I care about HIV care, just integrated primary care, and so just, I think holding that value and that truth as as we work to build these kind of resilient primary health care systems is just a general call to action. I think what's inspiring is, even a few years ago, I think the like the dialog was, do we need community health can can they? Can they be trained? Can they, can they effectively supervise? Can they do X, Y and Z service? And that's no longer the question. I think it's, are we overburdening community health workers? Now, how can we, how can we further utilize

Speaker 10 2:26:01
them? Are we Japan's could say some news on trying to socialization? The sante communite, no, the vou model theory, party de la technology actually how we can equip them and support them with the tools they need, and I think

Speaker 20 2:26:21
in particular with eye care. Um, where I think maybe Traditionally, it may be seen as a more kind of vertical service, service delivery model. I'm really inspired by the fact that the conversation is actually about how to integrate that into our overall service package. And I think that just speaks to probably all of the different partners and advocates in the room who have done all the hard work at the policy level, at the kind of government level, at the community level, to actually create that demand.

Speaker 5 2:26:49
Amazing. Thank you so much. I have been a terrible timekeeper as the moderator of this panel, so I would request that if you have any questions, we have pastries and coffee out here, and that we address those one on one with with panelists, or, you know, carry the conversation on from there. If that is okay with everyone. But I really want to thank you all for being here. I want to thank our panelists for sharing their insights. And I'm just really excited about about this future. I think, as many said here, it's not it's no longer an if, it's a when. And really seeing the demand and the centering of governments in this work and the government led nature Of it is just really Exciting. So Thank you. Applause.