Policy on services for cataract

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Acronyms

COs	Country Offices
EFA	Education for All
GRC	Global Resource Centre
HH	Haywards Heath
HMIS	Health Management Information System
HR	Human Resources
HRD	Human Resource Development
IAPB	International Agency for the Prevention of Blindness
INGDOs	International Non Government Development Organisations
IOL	Intraocular lens
LogMAR	Logarithm of Minimum Angle of Resolution (a unit for specifying VA)
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
NGO	Non Government Organisation
QoL	Quality of Life
RAAB	Rapid Assessment of Avoidable Blindness
ROs	Regional Offices
SMT	Senior Management Team
TOR	Terms of Reference
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UPE	Universal Primary education
URE	Uncorrected Refractive Errors
VA	Visual Acuity
VC	Vision Centre
VI	Vision Impairment
V2020	Vision 2020
WCO	World Council of Optometry
WHO	World Health Organization

Executive Summary

Cataract is the commonest cause of visual impairment and blindness worldwide, and services for cataract are the cornerstone of eye care services and a priority of Vision2020 – the Right to Sight [1]. Surgery for cataract is highly cost effective, and good outcomes lead to improved quality of life, visual functioning and economic productivity. Sightsavers works with partners to detect, refer, manage and follow up people with cataract in the countries where it works. This revised policy builds on Sightsavers Strategic Framework 2009 - 2013 and enlarges on the change themes in relation to health, community participation and development. The ultimate aim of Sightsavers change theme in relation to health is that: "Governments will ensure that good quality eye care is available to all people as an integral part of wider health systems". The short to medium term aim is that "Sightsavers will demonstrate approaches to eye care which are scalable, adaptable, cost effective and which strengthen and support the overall health system".

The policy is built on the World Health Organization's (WHO) Health Systems Framework (i.e. the six building blocks, attributes and outcomes), and reflects Sightsavers values, key priority areas and capacity. It provides concrete direction on how the organisation can support the development of safe, high quality services for cataract based on best practice and defined quality standards. The policy on services for cataract also relate to some of Sightsavers' other policies e.g. on partnership and refractive errors.

The policy is based on inputs from Sightsavers personnel throughout the organisation, partner organisations, other external agencies and consumers. Sections 1 to 5 of this document contain background information in relation to cataract; describe how services for cataract fit strategically with the international health agenda; outline the policy statement in relation to the WHO's health systems framework and, finally, outline quality standards under three broad themes. Appendices A to C provide more detail in relation to strategic fit, health system strengthening and the quality standards while Appendix D gives an overview of clinical governance.

Tools for use by Sightsavers, partners and professional bodies to support implementation of this policy are still to be developed and pilot tested. Supporting guidelines will also be developed.

Process of development of the policy

Initiation: The first policy on cataract was produced in 2003. The need to revise the 2003 policy arose on account of 1) Sightsaver's strategic direction and change themes 2) the external environment and global initiatives 3) patient safety and surgical outcomes [2-3] bearing in mind that cataract surgery has risks in terms of poor outcomes for the patient[4], and, as a consequence, harm to the reputation of the organization. Indeed, recent outbreaks of endophthalmitis (intraocular infection) in India led to considerable loss of sight [4]. Population based studies also show that visual outcomes after surgery are not always good [5-6], being particularly poor if surgery is undertaken in surgical camps[7]. All these factors support the need for a policy that encompasses both quality (i.e. clinical governance) as well as the quantity of for services required to meet the need in the population.

Evidence and risk assessment: The policy is based on thorough research and evidence, which entailed commissioning the updating of two Cochrane Systematic reviews. Potential risks and relevant stakeholder policy statements were considered during development of the policy.

Consultation and development: The policy was developed by a task force in consultation with Sightsavers employees, partners and other stakeholders. Consultation was an inclusive process and a broad range of groups reflected on relevant sections and drafts. Adequate time for policy consultation was given and external expert advice was sought.

Distribution / availability: The policy will be distributed to Sightsavers' employees and stakeholders electronically and, if requested, in hard copy. It will also be posted on Iris/intranet.

Monitoring and review: The policy will be monitored for its impact and will be reviewed regularly and when warranted to ensure consistency with best practice and strategic direction. Expert independent feedback will be sought during the review process when necessary.

1. Introduction

Blindness has profound human and economic consequences in all societies due to loss of independence, self esteem and economic productivity [8-9] among those affected and their families[10]. There are also additional costs involved in providing special needs education for children and rehabilitation services for those with irreversible loss of vision. Globally blindness affects approximately 45 million people[11-12], two thirds of whom are women[13]. Cataract is the commonest cause of avoidable blindness (19 million) and the second commonest cause of visual impairment after refractive error. The vast majority of individuals with visual loss due to cataract live in developing countries. The disproportionate magnitude of cataract in developing countries is due to the social determinants of health which are consequences of poverty in its broadest sense i.e. greater exposure to risk factors on one hand and inadequate access to and/or provision and uptake of services on the other[14-17].

Cataract occurs when the normally clear lens of the eye becomes cloudy leading to gradual, progressive loss of vision (usually in both eyes) which can ultimately lead to blindness. Cataracts, which are straightforward to diagnose, are primarily an age related disorder, affecting individuals worldwide, particularly women. Although cataracts cannot be prevented they can be treated by highly cost effective surgery which leads to good visual outcomes [10, 18]. Indeed, there is now a considerable body of high quality evidence from clinical trials and other studies which demonstrates the cost effectiveness of the surgical techniques most frequently used in low and middle income countries (i.e. small incision cataract surgery)[19-20], and that intraocular lens (IOL) implantation dramatically improves visual outcomes [21]. The World Health Organization (WHO) has established standards for visual acuity after cataract surgery [22] and tools for monitoring visual outcomes have been developed [23]. However, evidence from population based surveys indicates that visual acuity outcomes following cataract surgery are not always as good as they might be [5, 7].

Studies have shown that successful cataract surgery can have a dramatic impact on individuals' lives including being able to return to their previous activities including income generation[24] which has an impact on alleviating poverty[25]. Services for cataract, therefore, contribute directly to the achievement of the MDGs[26] as well as improving quality of life[27].

Despite technical advances in the management of cataract, the volume of cataract surgery in low and middle income countries is usually inadequate to control cataract blindness. For example, the cataract surgical rate is less than 500/million/year in many of the countries in sub-Saharan African where Sightsavers works compared with a cataract surgical rate of 7,000/million population in most industrialised countries[28-29]. The low output is due to a combination of factors including weak health systems, insufficient community awareness and participation, poverty, and poor infrastructure and primary health care. These weaknesses are now being addressed through global initiatives and reforms for country ownership, and donor alignment, harmonization and accountability as set out in the 2005 Paris Declaration on Aid Effectiveness which was affirmed in the 2008 Accra Agenda for Action[30].

Control of cataract through the provision of high quality services which are scalable, adaptable, cost effective and responsive to the population remains a priority for Sightsavers. The WHO's health systems framework provides the foundation for Sightsavers policy on services for cataract and the UK's clinical governance agenda provides a framework to reduce risk, promote best practice and so increase the quality of clinical and non-clinical care[31]. Sightsavers strategy also emphasises the need to strengthen eye health within primary health care and the vital importance of promoting community participation.

Note: Sightsavers recognises that the management of cataract in children requires a specialised approach [32] and this will be addressed in a separate document.

2. Strategic fit (Appendix A for more details)

2.1 The international health agenda:

Services for cataract have socio-economic impacts, relate to social development and care of the elderly and link to global declarations and policy frameworks. Underpinning all of these is the Universal Declaration of Human Rights (1948) [33] which establishes the right to the enjoyment of the highest attainable standard of physical and mental health so creating an entitlement for everyone to health care, including services for cataract. Other global initiatives and alliances and their relevance to a policy on services for cataract are listed below.

Contributes towards achieving Millennium Development Goals by restoring sight to the economically active, elderly caretakers and children; MDG 1: Eradicate extreme poverty and hunger. MDG 2: Achieve universal primary education; MDG 3: Promote gender equality and promote empowerment of women; MDG 4: Reduce child mortality and MDG 8 Develop a global partnership for development.

Primary Heath Care reforms: [34] Primary health care provides a mechanism for reaching marginalised groups, so increasing coverage and equity. The integration of primary eyecare into primary health care ensures the early detection and referral of individuals with cataract before they lose independence.

WHO Commission on the Social Determinants of Health. Closing the Gap in a Generation [15]. The "inequitable distribution of power, income, goods, and services, globally and nationally" are major factors which determine the magnitude of blindness due to cataract.

WHO Health Systems framework: [35] The framework for health systems delineated by the WHO underpins the whole of this policy and will be expanded upon throughout the document.

World Health Assembly Resolution WHA/56.26 [36] and WHO/PBL Action Plan for the prevention of avoidable blindness and visual impairment [37]. The 2003 WHO resolution calls on member states to support the Global Initiative for the Elimination of Avoidable Blindness by setting up (by 2005) and implementing national Vision2020 plans (by 2007). A key component of the resolutions is the implementation of national V2020 plans which includes services for cataract.

WHO World Alliance for Patient Safety. Safe Surgery Saves Live 2008 [3]. In recognition of the high morbidity and mortality associated with surgery, particularly in developing countries, the Alliance has addressed infection and safe surgery, both of which are relevant to cataract surgical services.

World Health Assembly Resolution WHA59.23 and the WHO Global Health Work Force Alliance Kampala declaration [38]. Shortage of health workers is a key constraint to the provision of services for cataract.

2.2 Programmatic linkages within Sightsavers strategy:

Making connections is a key component of Sightsavers' strategic framework. Integration, strengthening and supporting wider health systems are priorities. For services for cataract these include:

- High quality demonstration approaches which are scalable, adaptable and cost effective
- Social inclusion: Community based rehabilitation services contribute to the detection and referral of people who may benefit from services for cataract.
- Community Development: Services for cataract should be designed taking account of the needs in the community, people's perceptions and health seeking behaviour, as well as costs and expectations.

3. Policy statement in relation to health systems framework (Appendix B for more details)

A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health[35]. Sightsavers recognises that the health system framework provides the context and the foundation for its policy on services for cataract. Sightsavers also recognises that the health system building blocks are interdependent and to be effective need to be strengthened to achieve the overall health system framework goals of improved health by level and equity, responsiveness, social and financial risk protection and improved efficiency. Other attributes which Sightsavers recognises are the need to anchor strengthening health systems in community participation and in evidence. In its fullest sense, this policy extends into the concept of the Health for All paradigm originally documented in the Alma Ata Declaration of Primary Health care in 1978.[39]

Sightsavers policy on services for cataract is summarised in the following statement:

3.1 Building Blocks

Service Delivery

1. Sightsavers' preferred approach for the delivery of services for cataract is one which guarantees a continuum of eye care, which includes refractive and low vision service, within the health system framework.
2. Sightsavers will support primary health care reforms including strengthening the eye health component with particular reference to early detection of those with visual loss due to cataract, counseling, and referral
3. Sightsavers does not endorse sporadic surgical cataract camps, nor mobile operating theatres nor case-finding without service.

Eye Health Workforce

4. Sightsavers supports the development, deployment and retention of an appropriately trained and supported general and eye health workforce for the delivery of services for cataract. This includes cataract surgeons, when appropriate and acceptable.

Medicines, Technology and Infrastructure

5. Sightsavers recognises that access to biometry and affordable high quality intraocular lenses (IOLs) which match patients' visual needs are essential for high quality services for cataract.
6. Sightsavers will advocate for the incorporation of IOLs in national drugs lists and duty exemption.
7. Sightsavers supports provision and maintenance of infrastructure, equipment and consumables necessary for cataract services.

Health Information

8. To strengthen health management information systems (NHMIS), Sightsavers promotes the incorporation of appropriate indicators of services for cataract within an eye health information system integrated into the broader NHMIS.
9. The eye health information system should be able to generate data on cataract surgical rate by age and gender.

Health Financing

10. Sightsavers encourages the development of innovative public-private partnerships, social enterprise approaches, health insurance schemes and local financing options, including user fees, which promote access, sustainability and social protection.

Leadership and Governance

11. Sightsavers will contribute to efforts which strengthen capacities for leadership, management and governance at policy, planning, and implementation levels
12. Sightsavers will support services which are accountable to consumers and donors
13. Sightsavers will support and be part of broader coalitions, alliances and consortia for scaling up services.

3.2 Attributes

Quality

- Sightsavers will work with its partners, and professional and regulatory bodies to ensure that clinical governance systems for cataract are in place (e.g. regular audit of outcomes; assessment of patient satisfaction) and quality and safety standards for consumers and providers are adhered to.
- Sightsavers will encourage its partners to provide services in a clean, safe, accessible environment which is responsive to consumers and providers

Access

- Sightsavers will place special emphasis on equity and access for women, persons with disabilities and vulnerable and marginalised groups and support social protection mechanisms.

Coverage

- Sightsavers will advocate for and prioritise development of demonstration approaches which can be taken to scale to enhance coverage.

3.3 Outcome of strengthening health systems

Strengthening of the building blocks and attributes of the health systems framework will lead to the following outcomes:

- Cataract surgical rates which address population needs so leading to a significant reduction in the prevalence of visual impairment and blindness from cataract
- Improved visual function and quality if life which will contribute to achievement of MDGs.
- Efficient use of resources and cost effective services
- Services which are responsive to the cataract visually impaired and communities
- Financial risk protection in which no-one remains visually impaired from cataract because they cannot afford the service, or become impoverished because high user fees.

Sightsavers will support research which provides the evidence base for demonstration approaches and advocacy for scaling up of cataract services in a way which strengthens health systems.

3.4 Research and advocacy

Sightsavers will support research which provides the evidence base for demonstration approaches and advocacy for scaling up of cataract services in a way which strengthens health systems.

3. Quality standards (Appendix C for more details)

Quality standards are needed in the following areas

- to prevent harm to patients undergoing cataract surgery as well as to providers of the service
- to promote best practice
- to ensure that services for cataract meet the need in the population.

Specifically:

A. Quality standards for patient and provider safety

- The hospital has and uses a pre-operative check list to reduce risk
- The hospital has and uses an infection control policy
- The hospital has a policy on staff safety and protection

B. Quality standards for best practice

- The hospital has a clearly defined care pathway
- The hospital has a standard protocol for surgery
- The hospital has a system for assessing patients' satisfaction with their non-clinical care

C. Quality standards for programmes

- The programme outputs are based on accurate population based data
- The programme addresses the needs of marginalised groups

- The programme has an effective case detection mechanism in place
- The health facility has a good management information system for cataract
- Health facility has good HR practices in place

Details outlining the data to be collected and means of verification are provided in Appendix C.

Countries need to find out which regulatory bodies are responsible for quality standards in health, and what the national quality standards are.

Sightsavers will work with and support partners and professional bodies to implement and monitor standards so that risk is reduced and to improve the quality of clinical and non-clinical care.

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Appendices

Appendix A: Strategic fit with the international health agenda

Services for cataract have socio-economic impacts, relate to social development and care of the elderly and link to global declarations and policy frameworks. Underpinning all these is the Universal Declaration of Human Rights (1948) [33] which establishes the right to the enjoyment of the highest attainable standard of physical and mental health so creating an entitlement for everyone to health care, including services for cataract. Other global initiatives and alliances and their relevance to a policy on services for cataract are listed below:

The Millennium Development Goals (MDGs) [40] are particularly relevant for cataract:

- *MDG 1 Eradicate extreme poverty and hunger:* Visual impairment and blindness due to cataract are both a cause and consequence of poverty [9, 17, 41]. Restoring sight not only restores quality of life but also helps individuals regain independence, continue to earn a livelihood and contribute to family financial security and social harmony [24-25, 27].
- *MDG 2 Achieve universal primary education:* Restoring sight to elderly family members frees children from caring roles at home so they can attend school.
- *MDG 3 Promote gender equality and promote women empowerment:* Women have a significantly higher incidence of cataract than men and in many regions are less likely to access services. Programmes which target women will promote gender equity
- *MDG 4: Reduce child mortality:* Restoring sight to grandparents and elderly relatives will enable them to fulfill their role as primary carers of children particularly of those orphaned by AIDS.

- *MDG 8: Develop a global partnership for development:* Partnerships between state and non-state actors at country, regional and global level are vital to promote the development and uptake of services for cataract leading to reduction in the burden of visual impairment.

Primary Heath Care reforms: [34]
The integration of primary eyecare into primary health care for early detection and referral of individuals with cataract before they lose independence is of vital importance. Primary eye care also provides a mechanism for reaching marginalised groups, so increasing coverage and equity.

WHO Commission on the Social Determinants of Health. Closing the Gap in a Generation [15].
The Commission's report states the following: "The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life". The commission recommends action based on the following principles: improve daily living conditions, tackle the inequitable distribution and measure and understand the problem. Should these principles be implemented there would be less cataract, and less cataract blindness.

WHO Health Systems framework: [35]
The framework for health services delineated by the WHO underpins the whole of this policy and will be expanded upon throughout the document.

World Health Assembly Resolution WHA/56.26 [36] and WHO/PBL Action Plan for the prevention of avoidable blindness and visual impairment [37]
The 2003 WHO resolution called on member states to support the Global Initiative for the Elimination of Avoidable Blindness by setting up (by 2005) and implementing national Vision2020 plans (by 2007). A key component of all national plans will include services for cataract.

WHO World Alliance for Patient Safety. Safe Surgery Saves Live 2008 [3]
In recognition of the high morbidity and mortality associated with surgery, particularly in developing countries, the Alliance first addressed infection and then safe surgery. A check list was developed for procedures before, during and immediately after surgery and although the concept of a check list is good the generic WHO checklist is not suitable for cataract surgery and needs to be modified.

World Health Assembly Resolution WHA59.23 and the WHO Global Health Work Force Alliance Kampala declaration [38]
The declaration states that "Health workers are the cornerstone and drivers of health systems. The shortage of health workers is unanimously accepted as one of the key constraints to the provision of essential, life-saving interventions…..Health workers are also critical to our preparedness for and response to the global security threats……Without prompt action, the shortage will worsen and health systems will be weakened even further. Addressing the critical shortage of health workers is a high priority for WHO. Member States".

The same applies to eye care and services for cataract. [Note: see Sightsavers' quality standards and check list for human resource development.]

A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health[35]. Sightsavers recognises that the health system framework provides the context and the foundation for its policy on services for cataract. Sightsavers also recognises that the health system building blocks are interdependent and to be effective need to be strengthened to achieve the overall health system framework goals of improved health by level and equity, responsiveness, social and financial risk protection and improved efficiency. Other attributes which Sightsavers recognises are the need to anchor strengthening health systems in community participation and in evidence. In its fullest sense, this policy extends into the concept of the Health for All paradigm originally documented in the Alma Ata Declaration of Primary Health care in 1978.[39]

Appendix B: Strategic fit with the international health agenda

Health System Building Blocks

1. Service Delivery: Preferred Approaches

Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.

Sightsavers' preferred approach for the delivery of services for cataract is an alignment with the health system, where services for cataract are located within the framework of eye health and are available, accessible and responsive to the population. Factors such as population density, need and access must be considered when developing services, either as part of public services, NGO run programmes or social enterprise models. Services for cataract need to have the capacity to deliver services for both adults and children, in urban and in rural settings. At the primary level, services for cataract must embrace community participation and be integrated within primary health care systems. In situations where vertical approaches are already in place (at any level), rapid horizontal integration into the general health systems should be the goal.

Services for cataract must include case detection, counselling and referral at the primary level, cataract surgery at the district/secondary level, and advanced care (including paediatric cataract surgery) at the tertiary level. It is essential that these levels of service delivery have functional vertical links from primary through to tertiary and vice versa. Horizontal dynamic links with community development are also critical for a successful service delivery mechanism.

Services for cataract have the following steps: case detection and referral, examination with management decisions, pre-operative assessment and counselling, quality surgery, and good post operative care. Proper implementation of all these steps minimises the risk of poor visual outcome for the patients and harm to the reputation of the service provider. Good visual outcome as defined by WHO standards and customer satisfaction are the key factors to achieve improvement in quality of life and both should be considered in developing services for cataract. Sightsavers works with its partners, professional and regulatory bodies to ensure that clinical governance systems are in place and quality and safety standards are met.

Sightsavers does not endorse the following: sporadic cataract surgical camps; case finding without services; personnel who are inadequately trained, supported or supervised as these are not consistent with quality outcomes nor the strengthening of health systems.

2. Health Workforce

A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive, motivated and productive).

The key to a successful service for cataract is well a trained and dedicated eye health team who each have clearly defined job descriptions, with career pathways. The inadequate availability of human resources is one of the major impediments to the provision of services for cataract in the developing world. To maximise the use of limited human resources, all efforts should be made to promote job satisfaction and retention within the public health system, and staff deployed in a manner which ensures access for the most underserved communities.

The primary level of health care is the foundation of any health system and due emphasis needs to be placed on training of health workers and other cadres with the potential for case detection, counselling, referral and eye health education (e.g. community workers).

Ideally, services at district/secondary level should be delivered by an eye health team led by an ophthalmologist working with ophthalmic nurses, ophthalmic clinical officers /ophthalmic/optometric technicians with the necessary competencies, knowledge and attitudes within a comprehensive health team. However, in countries or programmes where ophthalmologists are inadequate in number and/or distribution, a task-shifting strategy to adequately support and supervise cataract surgeons who have the necessary skills and attitude should be adopted.

Sightsavers supports the development of the appropriate human resources by strengthening and/or developing the human resource capacity within the context of defined standards of training, continuous professional development and supported by professional bodies. It will do this by enhancing skills of existing personnel and by supporting the training of new personnel in clinical services and management.

Sightsavers will support formal and structured training of Ophthalmologists, Cataract Surgeons, Ophthalmic Nurses, in recognised and accredited institutions leading to a formal qualification and career path. Furthermore, in the case of primary health workers and community workers, Sightsavers will support training in eye health that is integrated within their existing primary health care training programmes. All personnel who are trained should have an enabling environment and the necessary infrastructure and technology to perform their duties.

Sightsavers will also support continuing professional development for the different cadres of eyecare worker who deliver services for cataract.

3. Medicines, Infrastructure and Technology

A well functioning health system, including its procurement and distribution system, ensures equitable access to essential medical products, vaccines and technologies, of assured quality, safety, efficacy and cost effectiveness and their scientifically sound and cost effective use.

Sightsavers maintains that affordable high quality intraocular lenses (IOLs) are an essential component of services for cataract and supports their incorporation in national policies and regulatory systems.

The use of essential and appropriate equipment, instruments, medicines, and consumables in a safe and accessible working environment should enhance quality of care in the context of comprehensive eye care. Sightsavers believes in and promotes the provision of dedicated space for operating theatres which contributes to the quality and efficiency of services for cataract and eye care in general. Sightsavers supports the sourcing of affordable and high-quality equipment, as detailed in the internationally recognised Standard List of Equipment, through local purchase where competitive, or via the Global Procurement Unit in the UK.

4. Health Information

A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.

Almost all countries implement a national health management information system (HMIS) of the data needed by policy makers, health planners and health service users to improve and protect population health as part of health systems.

Sightsavers will promote the integration of an eye health information system within a broader national HMIS including indicators for cataract.

This policy seeks to strengthen national capacities for institutionalising, collecting, synthesising, analysing and applying eye health information for programme development and quality improvement.

5. Health Financing

A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. The system is sustainable, inclusive and fair. It provides incentives for providers and users to be efficient.

The way a health system is financed is a key determinant of population health and well-being. This is particularly true in the poorest countries and communities where the level of spending is still insufficient to ensure equitable access to health services. The strength of a health financing system is its ability to improve health outcomes, provide financial protection, and ensure consumer satisfaction – in an equitable, efficient, and financially sustainable manner.

Sightsavers' policy is to work to strengthen the financing of services for cataract, both on the supply side (services) and the demand side (the uptake of services). Sightsavers is committed to supporting the development and provision of services for cataract which are:

- affordable - low cost, subsidised or free for those who cannot afford to pay for the service
- available - consistent, timely, reliable and predictable supply
- acceptable - to users

Sightsavers supports partners to provide services which are efficient, effective and sustainable. Where income-generating schemes exist they should include all, regardless of ability to pay, and should contribute to the financial sustainability of the service.

This policy encourages programmes to explore development of innovative public-private partnerships, social enterprise approaches, health insurance and local financing options, on the basis of best practice and within the context of strengthening national health services.

6. Leadership and Governance

This involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.

Sightsavers will support the integration of services for cataract as part of eye health into national health policies and plans and supports the development, application and regular review of such policies.
Sightsavers will contribute to capacity building of service providers in leadership and management drawing on tools made available by the WHO and other sources.

Sightsavers will assist national programmes, non-state actors and partners in their quest to go beyond the provision of services to include stewardship in the areas of professional practice and ethics, societal interest and community involvement and ownership, the necessary regulation of prices, and transparency and accountability in services for cataract.

Attributes and outcomes of health systems

Quality and Safety

In support of the World Health Assembly Resolution 55.18 in which WHO urges Member States to pay the attention to patient safety, Sightsavers will support programmes to align with the global principles of patient safety and safe surgery developed by the World Alliance for Patient Safety[2]. Sightsavers will support the development of high quality services for cataract by developing a framework for clinical governance as part of a wider quality assurance system and monitoring and evaluation framework.

Sightsavers will support a culture of quality assurance and patient and provider safety. Sightsavers will work with partners, professional associations and regulatory bodies to incorporate quality and safety in relevant policies, hospital practice guidelines, training curricula and continued professional development. To increase uptake and application of quality and safety practices, Sightsavers will support the wider dissemination of agreed standards.

To improve the quality of non-clinical aspects of care, partners will be encouraged and supported to periodically seek feedback from their patients as well as the population being served on their perceptions on the quality and safety of the services.

Improving access and increasing coverage

Recognizing the need for Primary Health Care reforms, Sightsavers will support interventions that enhance universal coverage. In planning services to achieve equity, access and coverage, it is important that the following are explored: cataract surgical coverage in the catchment population with identification of underserved groups; community understandings and perceptions; health seeking behaviour and willingness to pay. This will promote services that are responsive, appropriate, acceptable and affordable.

In the presence of limited resources, services for cataract will be designed to prioritise the identification and uptake of services by persons who are blind due to cataract in the following priority groups: ,

- Persons who are blind due to cataract. In the provision of services, Sightsavers will work with partners, communities and families to prioritise the identification and uptake of services by persons who are blind or severely visually impaired from cataract, so helping to ensure that no one is left needlessly blind.
- Women: Sightsavers will work with partners to address gender issues in relation to barriers, uptake and demand for services.
- Other marginalised groups: Sightsavers will support partners to ensure that physical and attitudinal environments are accessible to people with disabilities, the elderly and people shunned by society such as those with leprosy.

To enhance coverage, Sightsavers will advocate for and prioritise development of demonstration approaches which can be taken to scale.

Social Protection

Sightsavers believes that no persons should be denied an essential service due to their lack of resource and will, therefore, strengthen existing and support new social protection mechanisms.

Outcomes

The outcome of cataract surgery to an individual is the final measure of the quality of the service provided. In recognition of this, Sightsavers will support partners to develop a culture of monitoring cataract surgical outcomes by surgeons using standardised monitoring software[23]. Clinicians will be encouraged to regularly review the visual outcomes of their own surgeries, learn from the results and improve the quality of their outcomes. Sightsavers will work with our partners towards achieving or exceeding the WHO standards for visual outcomes[22].

Sightsavers will work with professional bodies and training institutions to ensure the measurement and monitoring of surgical outcomes is a part of the training curriculum and culture. Sightsavers will:

- Support training and continuing professional development so that all members of the team have necessary knowledge, skills and attitudes.
- Encourage the development of high quality infrastructure, and support the provision of high quality equipment and consumables necessary for good visual outcomes in cataract surgery
- Work with partners to ensure that IOLs of the correct power are used on all patients
- Encourage our partners to periodically seek feedback from patients and the population being served on their perceptions on the quality of the service.

Sightsavers will encourage and support operational research to demonstrate the impact of cataract surgery on peoples' lives.

Responsiveness

The community are the ultimate focus of any health intervention and in recognition of this Sightsavers will work with partners to ensure that the infrastructure used in services for cataract is sensitive to cultural norms and practices. Communities will be encouraged to take ownership of their own eye health by developing and monitoring services. Initiatives which increase the uptake and sustainability of services through community initiatives such as self-help groups will be encouraged.

Sightsavers will support the inclusion of eye health, including services, for cataract into community development e.g. literacy programmes, local councils and integration into community structures.

Improved efficiency

In order to achieve best outcomes within a well organised health system, it is important that the resources are used effectively. Sightsavers will work with partners to strengthen the health management systems to ensure maximum efficiency of financial and human resources and support the provision of appropriate high quality and safe infrastructure, technology and consumables.

Sightsavers will encourage the use of operative techniques which enhance productivity and ensure quality outcomes for patients, such as biometry and small incision cataract surgery.

Sightsavers encourages learning from effective and efficient approaches and the dissemination of best practice. Sightsavers will support the setting up and evaluation of alternative approaches in different settings.

Appendix C. Quality standards

For clinical services

The following is not an exhaustive list, but represents the quality standards needed to prevent harm to the patient undergoing cataract surgery, promote high quality outcomes and reduce the risk of harm to service providers.

Countries should find out what their national quality standards are.

Quality standards for patient and provider safety

Quality standard	Check list to be completed by professionals	Verification	Response
The hospital has and uses a pre-operative check list to reduce risk	• Informed consent is taken on all surgical cases • The eye for surgery is clearly marked and the patient confirms the eye to be operated • Blood pressure and blood glucose status are checked before listing for surgery	• MedR • Observation[2] • MedR	• Yes, partial, no • Yes, partial, no • Yes, partial, no
The hospital has and uses an infection control policy[1]	• The hospital has an infection control policy that complies with international standards http://www.searo.who.int/LinkFiles/Publications_PracticalguidelinSEAROpub-41.pdf • Staff know about this policy • Staff are implementing the infection control policy • Detailed protocols are in place and displayed for scrubbing up • Detailed protocols are in place for sterilization of instruments	• Document • Interview • Reports; observation • Observation • Observation	• Yes, no • Yes, partial, no • Yes, partial, no
The hospital has a policy on staff safety and protection	• Protocols and procedures are in place for the disposal of items potentially contaminated with infections such as HIV (e.g. needles) and has a policy on needle stick injuries that comply with international standards http://www.who.int/occupational_health/activities/pnitoolkit/en/ • Staff know about the policy and procedures	• Document • Interview	• Yes, partial, no • Yes, partial, no

MedR = medical records

[1]An infection control policy should include the following:
- Design of the operating theatre complex
- Patient flow within the operating complex
- Sterilization procedures and technology
- Infection control in the ward and outpatient department

[2]Observation of technology and techniques

Quality standards for best practice

Quality standard	Check list to be completed by professionals	Verification	Response
The hospital has a clearly defined care pathway	• Care pathway flow chart is available at all service points • Care pathway is followed by the eyecare team	• Document; observation • Observation	• Yes/No • Yes; partial; No
The hospital has a standard protocol for surgery	1 A standard written protocol is in place 2 The protocol covers all clinically important areas 3 Surgery is only undertaken by a well trained, competent surgeon or trainees under supervision 4 All cataract patients have a pre-operative slit lamp examination 5 All cataract patients have biometry 6 IOLs of the correct power are inserted 7 Bilateral surgery is not performed at the same sitting except under exceptional circumstances. 8 Postoperative slit lamp examination is done by a trained, competent member of the eyecare team 9 Post operative visual acuities are routinely monitored 10 Post operative refraction and correction are performed for distance and near 11 Interventions are provided (maybe by referral) for visually significant posterior capsule opacification	1. Document; 2. Document; 3. MedR; observation 4. MedR; observation 5. MedR; observation[2] 6. Observation[2] 7. MedR; observation[2] 8. MedR; observation[2] 9. MedR; observation[2] 10. MedR; observation[2] 11. MedR	1. Yes/No 2. Yes; partial; No 3. Yes/No 4. Yes/ No 5. Yes; partial; No 6. Yes; partial; No 7. Yes/No 8. Yes; partial; No 9. Yes / No 10. Yes; partial; No 11. Yes; partial; No
The hospital has a system for assessing patients' satisfaction with their non-clinical care	• The hospital has a policy to ensure patients views are incorporated in decision making about non-clinical aspects of care • Procedures are regularly implemented and actions taken	• Document • Document; records; observation	•

Quality standards for programmes for cataract

The following standards represent best practice in terms of programmes for cataract, which should be rooted in the needs of the population

Quality standards for programmes

Quality standard	Check list to be completed by professionals	Verification	Response
The programme outputs are based on accurate population based data	• The programme has an estimate of the cataract caseload in its catchment population based on surveys/RAABs	• Review of documents	• Yes, partial, no
The programme addresses the needs of marginalised groups	• There is an estimate of the number of marginalised persons who are cataract blind in the catchment population e.g. women, persons with disabilities, ultra poor, nomadic, post conflict states, internally displaced persons • Mechanisms are in place to ensure that marginalised persons are not denied services	• Review of HMIS • Interview	• Yes, partial, no • Yes, partial, no
The programme has an effective case detection mechanism in place	• There is a referral of persons with cataract from the eye health component of primary health care	• Interview • Review of HMIS	• Yes, partial, no • Yes, partial, no
The health facility has a good management information system for cataract	• Cataract surgery as part of the eye health information management is included in the health facility MIS • Patient surgical records are available and updated and contain relevant information	• Review of HMIS • Medical records	• Yes, partial, no • Yes, partial, no
Health facility has good HR practices in place	• Job descriptions, with a clear description of roles and responsibilities, are in place for all members of the team	• Review of documents	• Yes, partial, no • Yes, partial, no

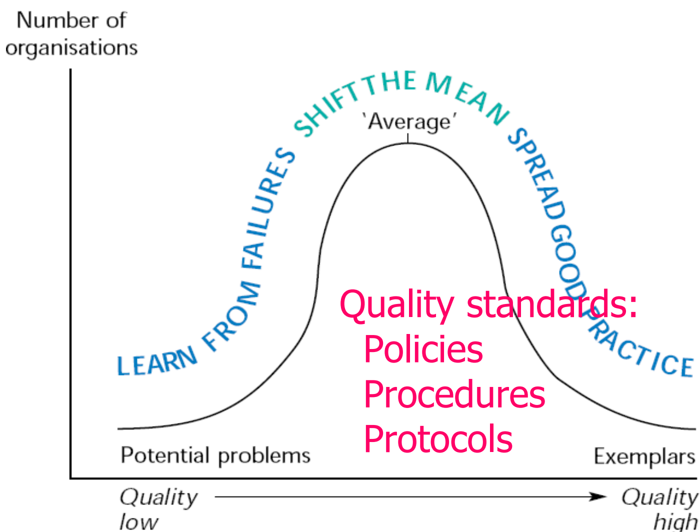
Appendix D: Summary of clinical governance

Source: Scally and Donaldson 1998 [42]

Clinical governance is the term used to describe a systematic approach to maintaining and improving the quality of patient care within a health system.

Clinical governance comprises the systems and procedures that are put in place to improve quality across organizations. The three main ways in which quality can be improved (see diagram below) are by:

1. learning from failure
2. spreading good practice and
3. “shifting the mean” towards the right i.e. towards high quality by applying best practice by the use of evidence based quality standards which comprise policies, procedures and protocols.



Implementing clinical governance requires good leaderships and management; a no-blame culture; good team working and a willingness to change.

Appendix E. Tools for implementing policy.

To be developed:

- Patient level
- Service delivery
- Population level
- Community participation

Check list for use by Country Offices

Check list for use by partners

<u>Additional documents to accompany policy document:</u>

Operational Guidelines
? Modify Document Produced By Venu?

Technical papers on:

- Preventing and treating occupational exposure to HIV
- Biometry

Technical paper on Clinical Governance