1. Editorial

Quarter 1 proved to be exceptionally busy and productive for IAPB Africa as several processes moved forward and we delivered on a couple of outstanding commitments.

We were all delighted with the rapid progress of a new, and exciting, partnership with COECSA and the Health Community of East, Central and Southern Africa (ECSA-HC), which we now anticipate will culminate in presenting Resolutions around the eye health workforce to 9 Ministers of Health in mid-May. We were equally delighted to be awarded a 4 year grant, on behalf of a consortium of members and partners, by Seeing is Believing to strengthen the teaching of Low Vision and Ophthalmic Nursing in 5 countries.

In terms of processes, we delivered on our commitment to finalise the external evaluation of our 10 Year HReH Strategy and this has now been shared with member agencies along with our management response. Secondly, we have now moved into top gear in our work with WHO-Afro to validate the core competencies of the eye health team. We expect this process to be concluded, on schedule, by the end of the year.

We also convened the 3rd advocacy capacity building workshop in Togo, trained key staff in Uganda on the IAPB Africa Data Base and held a two day internal workshop with the IABP Africa chair, co-chairs and Secretariat, as well as our HReH Task Team.

Looking forward, we are now actively planning for the joint ECSA-HC, COECSA, IAPB stakeholders workshop in Nairobi on May 9th and our own Annual Review and Planning Meeting, also in Nairobi from 10-12 May.

Dr. Aaron Magava, Chair, IAPB Africa.
2. IAPB NEWS

2.1 SEEING is BELIEVING

IAPB Africa is delighted to announce the award of a grant from Seeing is Believing to a consortium of members and partners to help address the eye health workforce crisis in Africa. More specifically, at the request of SiB, IAPB developed a single project with 2 key components designed to strengthen the training of Low Vision Practitioners (LVPs) and Ophthalmic Nurses (ONs) in 5 countries in SSA. IAPB Africa will be the contract holder but since we are not an operational agency, all the funding and all the activities will be sub-contracted to a number of member agencies (BHVI, AFCO, Sightsavers, OEU and Addenbrookes Abroad) active in South Africa, Nigeria, Ghana, Botswana and Tanzania: The project starts on 1st April 2017 and will run until June 2020. IAPB will be a net contributor to this project.

2.2 STRATEGIC ADVOCACY ROUND 3

This workshop was the third in the current series of advocacy capacity building which has now reached 14 countries.

To date, 7 countries have succeeded in integrating HReH in HRH and 3 are implementing the integrated plan against a target of 10 countries integrating and 5 countries implementing by 2018.

This workshop differed from previous workshops in that we dropped the idea of training advocacy advisers and brought Directors of HRH directly into the process.

Togo, Benin and Ethiopia were introduced to the strategic advocacy approach while Ghana, Mali, Burkina Faso and Malawi returned for further mentoring. The very good news is that Togo and Benin have both successfully integrated eye health workforce planning into national HRH plans due to earlier efforts in 2015 by WHO to sensitise countries through the WISN planning tool. The table below summarises progress to date.

<table>
<thead>
<tr>
<th>COUNTRIES</th>
<th>Advocacy Group Exists</th>
<th>Current Advocacy Plan</th>
<th>Advocacy Plan Implemented</th>
<th>Integrated HRH Plan</th>
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<th>MoH Funding for Eye Health Workforce</th>
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2.3 THE EAST, CENTRAL AND SOUTHERN AFRICA HEALTH COMMUNITY

Following a steering group meeting (ECSA, IAPB and COECSA) in Arusha at the end of February, and the circulation of the Minutes, planning is now well underway for the full stakeholder’s workshop in Nairobi on 9th May. This workshop will (a) Prepare a Resolution to be presented to 9 Ministers of Health at their annual meeting on 20th May in Geneva and (b) Establish a Standing Eye Health Expert Committee to work with the ECSA-HC and sustain our input into the wider sub-regional health agenda. IAPB is enormously grateful to those member agencies who, when called upon, provided additional resources to make this process possible.

2.4 EXTERNAL EVALUATION OF THE IAPB AFRICA HRcH STRATEGY

Early in February we shared the Summary Report of the External Evaluation and the IAPB Management Response with all member agencies. The full report of the Evaluation is also available to members on request. The next step in the process is to review the recommendations collaboratively during our Annual Meeting, now scheduled for 10-12 May in Nairobi, when members will have the opportunity to comment on the findings and suggest changes that might be necessary to keep us on track.

2.5 IAPB DATABASE UPDATE

With the advent of eye health reporting formats such as the WHO eSurvey for the Catalogue of Eye Health Indicators, the IAPB Vision Atlas and with national level eye health reporting requirements growing, the demand for data to satisfy eye health reporting needs is intensifying. It is clear that the current national Health Management Information Systems (HMIS) do not contain eye health components detailed enough to fulfil the needs of management decision making and reporting. The number and broad range of indicators recorded by the IAPB Database (IADb) make it the most comprehensive repository of eye health data in the HMIS environment.

Following a presentation on the IADb at the IAPB 10GA (Course 23 – Health Management Information Systems (HMIS)) there was interest expressed from several African countries but also from China and Indonesia. The non-African countries both stated that the need for strengthened HMIS had been identified and instead of reinventing the wheel the IADb as a ready-made solution had great appeal. Professional bodies, such as the Ophthalmological Society of South Africa, have also taken the IADb into consideration as a data capturing and reporting solution.

In February 2016 with support from the Brien Holden Vision Institute and Sightsavers International, a workshop was held in Seeta, Uganda, to carry out regional level training of eye healthcare and HMIS focal points. It was attended by representatives from 18 referral and eye health hospitals, 3 government services and 11 NGO’s. Uganda plans to have the IADb up and running down to the provincial level within the coming months.

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INTERNATIONAL COUNCIL OF OPHTHALMOLOGY

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2.6 The IAPB VISION ATLAS: Tracking progress towards the GAP

IAPB’s Vision Atlas, launched as a web based platform at 10GA in Durban brings together two data sets that together make a powerful advocacy tool for strong eye care services for all.

One data set is based on estimates of the burden of blindness and visual impairment made by the Vision Loss Expert Group (VLEG) shows estimates for the burden of blindness and visual impairment - for all ages as well as for adults aged 50 and above.

The second data set is an initial report on the key indicators signed off by all member states in the adoption of the current Global Action Plan and is the first time that this information, at the global level, is publically accessible. All the data is fully searchable and is grouped in three areas:

1. **Human Resources:** The Atlas codes data for the total number and number per million for ophthalmologists, optometrists and allied eye health professionals. While the data on ophthalmologists is fairly robust – due to registration requirements, we were not able to filter out those no longer in practice. Optometry numbers are less certain mainly due to a less formalised registration and varied acceptance. Allied health professionals was the most problematic and least reported, with virtually no accepted understanding about the cadre.

2. **Cataract services:** Cataract Surgical Coverage (CSC) is increasingly recognised as a useful indicator of Universal Health Coverage (UHC), especially in respect of services for older people. We report on surveys from 35 countries which show clear inequities in access to services most starkly by three countries in Africa with a CSC, at <3/60, of less than 50%.

Cataract Surgical Rate (CSR) was easier to collect, of the 100 countries included 18 had a CSR of <500 and a further 24 reporting a CSR of between 501 and 1,000. These levels fall far short of meeting the need of the population.

3. **National Planning and Evidence:** This brings together a range of information – the countries which have conducted population surveys of eye health, system assessments of the strength of eye health services and whether there is a national eye care plan, coordinator and prevention of blindness committee.

We have been impressed by the level of data reported so far and hope that this will continue to build so that the Vision Atlas can become an even more effective tool

The current data should however be read with some care given the limitations of the reporting. If any country data that is missing, incorrect or out of date please email visionatlas@iapb.org. Following validation it will appear in updates. We plan to launch a print version later in 2017 so please send any updates to us by June.
3. WHO NEWS

3.1 WHO-AFRO

With Dr. Minchiotti back in Brazzaville, we held several telecons with HRH colleagues in WHO-Afro and WHO-Geneva to review progress with the validation of the core competencies. Dr. M. Gichangi has been recruited as a consultant to undertake the review of the draft and completed the first review by 8th February. The primary target for this work will be Ministries of Health, with training institutions, professional and regulatory bodies and INGOs as secondary targets. The aim is to improve the quality of training by taking the first step towards competency based training for key members of the eye health team. During Dr. Minchiotti’s absence, a second consultant was recruited to complete the PEC algorithms and training guidelines, which we expect in 2017.

In agreement with Sightsavers, who co-fund the focal person, IAPB Africa is now proposing a six month extension to our current MoU as we negotiate a new MoU and Programme of Work from mid-2017 onwards. Preliminary discussions have already taken place with our funding members and it is likely that the theme for the new MoU, while first seeking to complete all on-going activities, will be health system strengthening.

3.2 COMMUNITY-BASED HEALTH WORKERS

WHO guidelines on health policy and system support to optimize community based health worker programmes: In the last few years, there has been growing interest and attention in the potential of various types of community-based health workers (CHWs) in reducing inequities in access to essential health services, particularly in under-served or excluded, vulnerable populations. The WHO Global Strategy on HRH: Workforce 2030 encourages countries to adopt a diverse, sustainable skills mix, harnessing the potential of community-based and mid-level health workers in inter-professional primary care teams. WHO is in the process of developing guidelines to assist national governments, as well as national and international partners, to improve the design, implementation, performance and evaluation of CHW programmes, contributing to the attainment of universal health coverage and the health SDG targets.
3.3 GUIDELINE DEVELOPMENT GROUP

Following the first meeting of the GDG in Geneva in October 2016, the revised planning proposal [http://who.int/hrh/community/CHW_gdlns_IPP_2Dec2016_c_web.pdf?ua=1] for the guidelines was granted final approval by the WHO Guideline Review Committee. WHO has also identified, through a competitive procurement process, a consortium of academic institutions to perform the systematic reviews that will inform the development of the guideline recommendations.

WHO welcomes expressions of interest from individuals and organizations with a relevant capacity and background to serve as members of the Expert Review Group for the guidelines, whose task will be to review and provide feedback on the early drafts of the document. More information on this will be posted on the WHO’s Community-based health workers (CHWs) webpage [http://who.int/hrh/community/en/] in due course.

3.4 GHWA COMPLETES 10 YEAR MANDATE

The Global Health Workforce Alliance completed its ten-year mandate on May 15, 2016 and has transitioned into the Global Health Workforce Network. The Network will operate within WHO as a global mechanism for multi-sectoral collaboration and dialogue on health workforce policies in support of the implementation of the Global Strategy on Human Resources for Health: Workforce 2030 and the recommendations of the High Level Commission on Health Employment and Economic Growth, as flagged up in previous issues of the Newsletter.

3.5 GLOBAL HEALTH WORKFORCE NETWORK

WHO is pleased to announce the launch of the Global Health Workforce Network, as requested by select Member States, building on a proposal by the Board of the Global Health Workforce Alliance. The May 2016 adoption of the Global Strategy on Human Resources for Health: Workforce 2030 and the recommendations of the High-Level Commission on Health Employment and Economic Growth are the foundation for an ambitious, forward-looking health workforce agenda to progress towards universal health coverage and the Sustainable Development Goals.

The Network will operate within WHO as a global mechanism for stakeholder consultation, dialogue and coordination on comprehensive and coherent health workforce policies in support of the implementation of the Global Strategy on Human Resources for Health and the recommendations the Commission.

WHO will shortly appoint a 12 member multi-sectoral Strategic Advisory Committee, to provide strategic advice to the Network. As part of the transition process from the Global Health Workforce Alliance, David Weakliam (from Ireland, and formerly Chair of the GHWA Board), will serve as the chair of the Network for the first two years. Read the Network Terms of Reference pdf, 297kb.

The 4th Global Symposium of the GHWN, following on from Kampala (2009), Thailand (2011) and Brazil (2013) is now scheduled for Ireland in Q4 2017. Further details in due course.
4. MEMBER NEWS

4.1 GEMx and COECSA: A SOUTH-SOUTH SUCCESS STORY

The Educational Commission for Foreign Medical Graduates (ECFMG®) has long been committed to improving world health through excellence in medical education. Through GEMx, ECFMG is building partnerships to extend its commitment to those participating in educational exchange in medicine and the health professions, and is working to address the need for greater international health care training in an increasingly globalized world. Creating a forum for exchange of ophthalmic skills, knowledge and resources in Eastern, Central and Southern Africa is one of the core missions of COECSA. COECSA found this commitment within its institutional members as a way forward to foster regional, post-graduate ophthalmology exchanges, a COECSA priority since 2015. COECSA’s goal is being realized in partnership with GEMx, a service of the Educational Commission for Foreign Medical Graduates (ECFMG®).

COECSA and ECFMG entered into a one-year agreement to pilot post-graduate exchanges in ophthalmology through GEMx. Selected post-graduate residents will gain access to opportunities through the GEMx system at any of the five COECSA institutions listed below:

- University Teaching Hospital, Zambia
- Rwanda International Institute of Ophthalmology, Rwanda
- Mbarara University of Science and Technology, Uganda
- University of Nairobi, Kenya
- Lighthouse for Christ Eye Centre, Kenya

Elective opportunities are expected to be offered in the areas of paediatric ophthalmology, strabismus, glaucoma, and surgery, among others. The web-based GEMx system will enable ophthalmology residents to search for and conveniently apply to the published electives in the GEMx system offered by the five institutions. This pilot is expected to launch in April 2017. Furthermore, COECSA and ECFMG will jointly assess the outcomes of this pilot.

Through ECFMG’s Challenge Grants program, COECSA is receiving funding to allocate to institutions to financially support qualifying residents with financial assistance when they go on an elective exchange through GEMx. ECFMG is proud to partner with COECSA in this pilot to support ophthalmology resident exchanges in Southern, Eastern, and Central Africa through GEMx, and to help cultivate sustainable improvements in eye health across these African regions.
4.2 ICEH: OPEN EDUCATION

ICEH have developed 3 open access courses to date (Ophthalmic Epidemiology, Global Blindness: Planning and Managing Eye Care services and Eliminating Trachoma and are working on a DR one this year. They are very keen to promote their courses and have also made the materials on the course free to all and encourage their use and adaptation by others. All the materials can be downloaded and edited by users.

WHAT IS OPEN EDUCATION? Historically, ‘open education’ has involved reducing the barriers to education and making it more accessible by lowering cost and delivery at distance. Our technological age has provided new ways to expand and apply the principles of Open Education through the global sharing of knowledge and ideas on the internet. ICEH is hosting a series of webinars over the next few months to explore some of these ideas and opportunities with eye care educators and organisations. We are delighted to invite you to our inaugural webinar: What is Open Education?

Engage and learn from ICEH’s own:

Allen Foster  
co-Director of ICEH

Daksha Patel  
e-Learning Director

Sally Parsley  
Technical Lead

Want to join in? Please register now at by clicking here. Interested but can’t attend? No problem! Simply register your interest now and we will send you the link to a video recording of the webinar and a downloadable transcript afterwards. Stay informed: Sign up to the ICEH Open Education e-mail list

More information about the ICEH Open Education programme from the website.

4.3 NTD NGDO NETWORK WASHINGTON COMMUNIQUE - NEW FRONTIERS

The BEST Framework concept – Behaviour, Environment, Social inclusion and equity and Treatment and care – developed by the NNN, provides an overarching framework to guide our efforts. It is how we respond to the SDG agenda, and complements existing initiatives. It provides our community with a framework under which the NNN and other stakeholders can collaborate across sectors and agencies to ensure the achievement of multiple NTD interventions within one comprehensive package. It reaffirms our commitment to working through and strengthening existing national systems in support of government and community priorities. The BEST framework requires comprehensive action in areas beyond the traditional remit of NTD programmes, and, by implications, new partnerships and capacities.

As a community, NGOs have a shared vision to reach the most marginalised populations. We recognise that without targeted strategies and interventions, and without a specific emphasis on social inclusion, we will not be able to reach women, people with disabilities, those affected by mental ill health, people in conflict-affected and fragile areas, migratory populations, and out of school children. Reaching these marginalised groups is a priority for the NNN’s current and future work. In the year ahead, the NNN community will redouble its commitments to the broader development agenda and prioritise the development of the BEST framework in consultation.

AFRICAN CENTER FOR GLOBAL HEALTH AND SOCIAL TRANSFORMATION  
Building Capacity and Synergies for African Health

5th AFRICAN HEALTH WORKFORCE (HWF) FORUM  
Theme: “Positioning the African HWF for Action to Attain the SDGs”  
Kampala Uganda, 19th to 21st April 2017
4.4 FHF: THE IMPACT OF THE IOL FACTORY IN ERITREA

Since its founding in 1994, The FHF Intraocular Lens Factory in Eritrea has produced more than 2 million intraocular lenses. The Factory plays a critical role in eliminating avoidable blindness in Eritrea which has a blindness prevalence of about 9% of the population, with cataract responsible for 55% of blindness.

The factory has emerged as the “go-to” for the new IOL technology and design. Every year, the demands for IOLs produced by the Intraocular Lens Laboratory shows a significant increase as the field of ophthalmology continues to grow on the African continent.

According to the Factory manager Mengisteab T. Berhan, the Laboratory has received a number of quality and excellence awards from the UK and USA. More than 80% of the lenses produced have been exported to Asian countries, 10% to African countries and 10% to the local market. “I always tell my employees that you never know the lenses we produce will one day be put into our own eyes. So let's produce quality lenses, the only gift we have is this factory,” Mengisteab says.

The factory is now producing rigid and soft lenses and has reached a capacity of producing 200,000 intraocular lenses annually to satisfy the year-to-year growing demands. Despite the technological advances in the factory, many challenges present themselves. Power rationing across the country and has affected the production of the lenses, access to internet and the use of DHL to supply the lens has been very costly since flights to Eritrea are very few.
5. COUNTRY NEWS

5.1 TANZANIA’s digital health road map has government 'in the driver's seat'

Tanzania’s new digital health road map offers a pioneering example of “putting national government in the driver’s seat” and of systems based approaches to e-health, experts say. Tanzanian officials unveiled the investment road map, which outlines a range of digital health interventions for using data to improve health services and outcomes, during the Global Digital Health Forum 2016, held in Virginia. The plan is the culmination of an 18-month project implemented by international NGO PATH with $2 million in funding from the Bill & Melinda Gates Foundation.

The Tanzanian road map is significant, according to digital health experts, because it is unusual to see such a broad, system wide digital health approach and one which is being government-led. The road map calls for an overall investment of approximately $74 million and aims to deliver improvements across five main areas — enhancing health service delivery, strengthening health systems performance, optimizing resource allocation, improving data supply and demand, and connecting and harmonizing data systems.

The Gates Foundation has been so “blown away” by the road map and the government’s leadership on the project that it is negotiating an additional five-year investment of up to $15 million to support components of the proposal, according to Marty Gross, senior program officer. “Fundamentally it’s a different way of doing business because it’s putting national government in the driver’s seat and asking them to tell us what to invest in and how to support their own capacities and systems.”

He also praised the government for getting buy-in from multiple often “fragmented” agencies to produce a “strong technical proposal but which has the mandate to take it forward.” Tanzanian government officials say the road map will transform the health system. “We see the investment road map as a critical component of improving our health system in Tanzania by having better data which will result in better outcomes for Tanzanians.”

5.2 MALAWI: “Wow, it really works!” — Rural Health Worker, Malawi, 2016

Ophthalmoscopes and otoscopes are typically designed for wealthy countries and are complex, heavy, and expensive; their basic designs have remained relatively unchanged for over 100 years. Very few practitioners in low and middle income countries have these essential tools. If they do, they are typically hand-me-downs that don’t work because they need parts that are hard to find or expensive, such as bulbs and batteries. The vast majority of cases of vision and hearing impairment are however found in these countries with least access to diagnostic tools.

The simplified design has considerably lower production costs, and the Arclight is now available to low income users through the standard list of the International Agency for Prevention of Blindness at a fraction of the cost of traditional devices. The development of this device has created a piece of disruptive technology that has the potential to transform care in low and middle income countries.
5.3 NIGERIA: Early detection can prevent blindness from Glaucoma

Nigeria Health Watch 🌘

This week (March 12 – 18, 2017) is World Glaucoma Week, and this year’s theme is BIG; Beat Invisible Glaucoma. Our Thought Leadership Series Piece this week is by Consultant Ophthalmologist, Dr. Fatima Kyari. She explains the danger of the silent and gradual blindness caused by glaucoma, and lays out ways in which we can all help improve awareness and services for glaucoma prevention and care.

Dr. Kyari is the Co-Chair for the International Agency for the Prevention of Blindness (IAPB), West Africa.

**It is critical to improve glaucoma care services in Nigeria**

An important first step towards achieving this is institutional strengthening through better training of eye care teams for surgical skills and care, and making medicines and equipment available in tertiary and secondary centres for optimal glaucoma care, thereby increasing clinical treatment options. There are three potential treatment options all aimed at lowering the eye pressure of the glaucoma patient:

1. Medical treatment – a life-long use of eye drops, the most effective being prostaglandin analogues (e.g. latanoprost) and beta-blockers (e.g. timolol).
2. Surgical – the commonest being trabeculectomy, which creates a channel for drainage of aqueous to reduce the pressure within the eye.
3. Laser treatment – works by either reducing the production of aqueous or by increasing the drainage channel of aqueous to lower the pressure within the eye.

Read more about Dr. Kyari’s work [here](#), [here](#) and [here](#). Summary article courtesy Nigeria Health Watch.

IAPB TV: Click on the link for the channel you would like to view

- **Channel 1.** [New glaucoma therapies offer multiple methods of action](#)
- **Channel 2.** [NTA national talk show on glaucoma week](#)
- **Channel 3.** [The role of private nurse training institutions in Kenya](#)
6. HEALTH

6.1 INTRAHEALTH

Below are extracts of an article in the Huffington Post, by Pape Gaye, President and CEO of IntraHealth International. *There is a crisis in our global health workforce. A looming shortage of 18 million skilled workers stands between us and the promise of universal health coverage - and the economies it could help stimulate. But how do we recruit more smart, capable workers to this field around the world? How do we make the most of the health workers we have? And how can countries build the fit-for-purpose workforces they need to foster healthy, productive populations, which are a must for economic growth. These problems are too big for the public sector alone. I spend every day thinking about these questions and looking for answers in the countries where IntraHealth International works*.

He suggests 5 prime areas for investors:

1. Better use of data on health worker needs and availability
2. Stronger education and training institutions for aspiring health workers
3. Focusing on primary health care
4. Tap into the diaspora, not only during emergencies but also through short-term assignments
5. Create policies that pave the way for private sector collaboration.

6.2 THE LANCET PLANETARY HEALTH

Is a new online-only, open access title in The Lancet’s growing family of specialty journals. Building on the foundation of The Rockefeller–Lancet Commission on planetary health, this monthly journal is committed to publishing high-quality original Research Articles, Editorials, Comments, and Correspondence that contribute to defining and advancing planetary health worldwide.

Planetary health has been defined as the health of the human civilisation and the state of the natural systems on which it depends. To explain this idea in simple terms we need to think of humanity as one of the key driving forces of global environmental change. We live on a planet that is shaped by the activity of human beings. We have benefited from the exploitation of the natural resources of the environment and this has allowed us to develop, flourish, and to improve our health. But, we have now gone beyond a sustainable limit. The planet we live in is in grave danger. Species are under pressure. The environmental changes to the climate, the water, the land, and ecosystems are challenging life on the Earth with serious implications for our health and wellbeing. The way we think about the planet needs to be revised, and with it the approach we take to interact with it.'

For further information and to register see [here](#)
7. UPCOMING COURSES

Short Courses and Master’s Programmes Royal Tropical Institute (KIT) – registration is open! Amsterdam, The Netherlands, Language: English

1. Master in International Health

This course is a flexible, modular programme that aims to develop the capacity of professionals to work at the interface of international organizations and national health systems. The Netherlands Course in Tropical Medicine and Hygiene is the core course of this master programme. This course can be followed full-time in 1 year or part-time (up to 5 years). Upcoming course start date: 11 September 2017 More information

2. Using Geographic information systems in disease control programs (GIS)

This course gives an introduction to the use of GIS in disease control programmes and provides knowledge and basic skills on how GIS can be used for disease control, focusing on the epidemiological assessment of disease burden and the improvement of programmatic planning and management. Course dates: 19 - 30 June 2017 (Early bird fee) More information

3. Master in Public Health (MPH/ICHD)


From 17 July to 4 August 2017, the Public Health Laboratory “Ivo de Carneri” (PHL-IdC) on Pemba Island, Zanzibar, United Republic of Tanzania, a WHO Collaborating Centre on Neglected Tropical Diseases, will host the course “Facing the Challenges of Global Health”, an Advanced Residential Course on Poverty-Related and Neglected Tropical Diseases (PR&NTD), organized by the Ivo de Carneri Foundation, Milan, Italy, and the PHL-IdC, under the auspices of the Zanzibar Ministry of Health. The Course is addressed to professionals active or interested in public health, with diverse cultural and scientific background and competence.

The Course is a practical opportunity to acquire a solid knowledge and a critical understanding on PR&NTD, thanks to the expertise of an high quality teaching team made of African and European lecturers with first-hand experience in the domain. For more information, please consult the course brochure or visit the website
8. KNOWLEDGE

1. EYE HEALTH


Pawiroredjo & Minderhourd et al. *The Cataract Situation in Suriname: An Effective Intervention Programme To Increase the Cataract Surgical Rate in a Developing Country*, BMJ, 101, 2017


Gedde SJ. *Treatment Outcomes in the Primary Tube vs. Trabeculectomy (PTVT) After 1 Year of Follow-up*. Presented at American Glaucoma Society Annual Meeting; March 2-5, 2017; Coronado, Calif.


2. HEALTH WORKFORCE


Olaniran, Smith et al., *Who is a Community Health Worker? – A Systematic Review of Definitions*, Global Health Action Volume 10, 2017 - Issue 1


3. HEALTH


Kane, Kok et al., *Limits and Opportunities to Community Health Worker Empowerment: A Multi-Country Comparative Study*, Social Science and Medicine, 164, 2016


The Consortium of Universities for Global Health (CUGH) has released a toolkit to support global health education competencies. It is freely available here: [http://cugh.org/resources/2063](http://cugh.org/resources/2063)

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### Featured Resources:


   The World Health Organisation (WHO) has launched a new data portal to track progress towards universal health coverage (UHC) around the world. The portal shows where countries need to improve access to services, and where they need to improve information. The portal features the latest data on access to health services globally and in each of WHO’s 194 Member States, along with information about equity of access. In 2017 WHO will add data on the impact that paying for health services has on household finances.

   About 44% of WHO’s member states report having less than 1 physician per 1000 population. The African Region suffers almost 25% of the global burden of disease but has only 3% of the world’s health workers.
9. WORLD OPTOMETRY DAY, 23RD MARCH

Uncorrected refractive errors (URE) affect people of all ages and ethnic groups and are the main cause of vision impairment. They often result in lost education and employment opportunities, lower productivity and impaired quality of life.

Peter Ackland highlights our Position Papers on readymade, adjustable and recycled spectacles—‘good practice’ recommendations from the IAPB Refractive Error workgroup. You may also be interested in the Low Vision curriculum released by the IAPB Low Vision workgroup.

Hasan Minto, the Director of Programmes at Our Children's Vision and Director of Child Eye health and Low vision Programmes at the Brien Holden Vision Institute points out that eye care, though inexpensive, continues to be inaccessible to those who need it most. The way forward can be by better integrating with existing systems.

World Optometry Day provides the perfect opportunity to highlight 3 important IAPB Position Papers. Click on each image to link to the document on the IAPB website.
### 10. DATA UPDATE: EYE HEALTH WORKFORCE, SEPTEMBER 2016

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<th>Population UN 2014</th>
<th>Ophthalmologists</th>
<th>Cataract Surgeons (Physician and Non-Physician)</th>
<th>AOP</th>
<th>Optometrists, Optom. Technicians, Opticians, Optical Technicians</th>
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