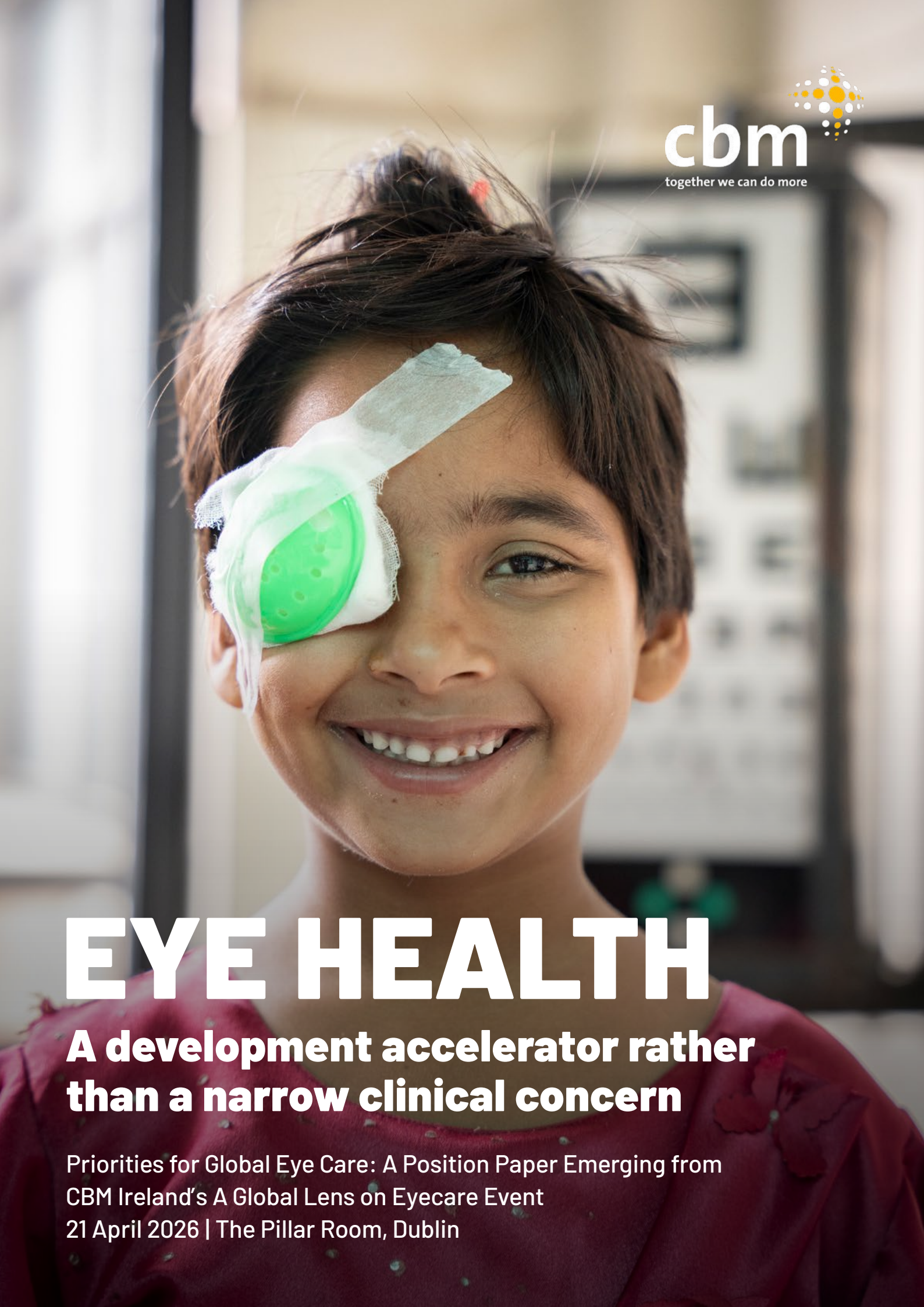

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EYE HEALTH

A development accelerator rather than a narrow clinical concern

Priorities for Global Eye Care: A Position Paper Emerging from CBM Ireland's A Global Lens on Eyecare Event
21 April 2026 | The Pillar Room, Dublin

ABOUT

CBM Ireland is a Christian international non-governmental organisation (INGO) drawing on over 115 years' experience. We work alongside and are accountable to people with disabilities in some of the world's poorest places, fighting poverty and exclusion, transforming lives and building inclusive communities where everyone can enjoy their human rights and achieve their full potential. We are a member of the CBM Global federation and share in the mission, vision and values of the federation.

Our vision is an inclusive world in which all people with disabilities enjoy their human rights and achieve their full potential. We are committed to our mission of fighting to end the cycle of poverty and disability.

CBM's work in inclusive eye health is built on a rights-based, person-centred approach that aims to eliminate avoidable blindness and vision impairment while ensuring equitable access to care—particularly for people with disabilities and those facing systemic exclusion. We strengthen inclusive primary eye care as the foundation for **integrated, people-centred eye health systems**, closely aligned with WHO's Integrated People Centred Eye Care (IPEC) framework.

We support the full **continuum of care**—from community awareness, newborn and childhood screening, and early detection, to referral, specialist services (including cataract surgery, diabetic retinopathy, glaucoma, refractive error correction), and low vision support and rehabilitation. Through our long-standing partnerships with OPDs, Ministries of Health, and global actors, we embed inclusive eye health in national strategies, training systems, and local service delivery.

By linking inclusive eye health, community mental health, and health systems strengthening, CBM Global delivers **holistic programming** that improves individual outcomes and drives systemic change.

A *Global Lens on Eyecare* was inspired by progress achieved using the *Arclight* in our *Preventing Infant Blindness* programme funded by *Electric Aid* and the *Tom Cunningham Trust*. The views expressed in this report are those of CBM Ireland. No endorsement of this paper by the speakers at *A Global Lens* on *Eyecare* or *Coalition2030 Ireland* is to be assumed.

coalition 2030 FOR SUSTAINABLE DEVELOPMENT

This project has been part-funded by Coalition 2030, an alliance of 70+ civil society organisations from the international aid, domestic anti-poverty and equality, environment and trade union sectoral pillars working to ensure that Ireland keeps its promise to achieve the Sustainable Development Goals, both at home and abroad.

EXECUTIVE SUMMARY

Avoidable vision impairment remains one of the most significant and least contested global health failures of the twenty-first century. Despite the fact that the overwhelming majority of vision loss is preventable or treatable, at least one billion people worldwide continue to live with avoidable sight impairment. This burden is not distributed evenly: nine in ten affected individuals live in low- and middle-income countries, and women, children, older people, and persons with disabilities are disproportionately impacted. The persistence of this inequity is not explained by a lack of clinical knowledge or effective interventions, but by systemic failures in investment, health system design, workforce development, governance, and community engagement.

On 21st April 2026, CBM Ireland convened A Global Lens on Eyecare in Dublin, bringing together clinicians, researchers, technologists, policymakers, and global health practitioners from Ireland, the United Kingdom, Africa, and beyond. The event was explicitly designed not only to examine the scale of global eye health need, but to interrogate how known solutions can be delivered equitably and sustainably at scale. Across a diverse set of presentations, a striking consensus emerged: the central challenge in global eye health is no longer innovation or the search for solutions, but implementation within integrated, people-centred systems.

The persistence of this inequity is not explained by a lack of clinical knowledge or effective interventions, but by systemic failures in investment, health system design, workforce development, governance, and community engagement.

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Speakers at *A Global Lens on Eyecare* were **Dr. Kate Coleman** (Ophthalmic Surgeon & Founder of SightTrack), **Dr Andrew Blaikie** (founder of the Arclight Project, University of St Andrews); **Dr. Sirjhun Patel** (Glaucoma Consultant Ophthalmologist, West Suffolk NHS Foundation Trust), **Dr. Gatera Fiston Kitema** (University of Rwanda), **John Sandford Smith** (Emeritus Consultant Ophthalmologist at Leicester Royal Infirmary), **Jaona Lala Iandrinirina** (CBM Global Regional Eye Health Advisor), **Dr. Jonathon Jackson** (Consultant Optometrist and Director of the Northern Ireland Clinical Research Network (NICRN)), **Dr. Ving Fai Chan** (Associate Professor in Global Eye Health at Queen's University Belfast) and **Dr Fatima Hamroush** (Consultant Medical Ophthalmologist & Clinical Director, Drogheda Medical Eye Clinic) as well as **Mr Neale Richmond**, Ireland's Minister of State at the Department of Foreign Affairs and Trade with responsibility for International Development and Diaspora and **Jason Smyth MBE**, six-time Paralympic gold medal winner.

Each of the speakers, with the issue of global eyecare framing their approach to the event, came together individually, but their collective engagements created a framework not dissimilar to the WHO World Report on Vision ambition:

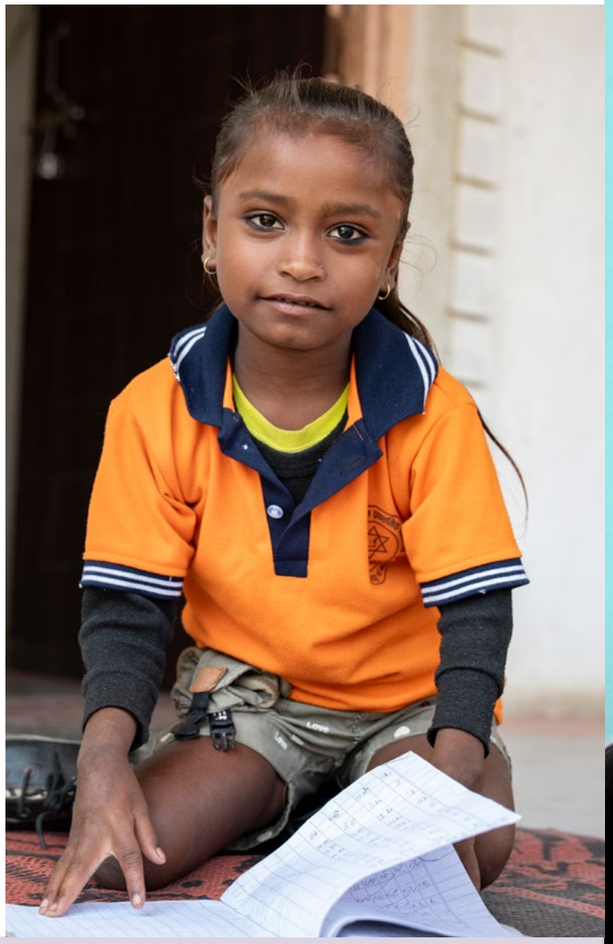
"The World Report on Vision seeks to stimulate action in countries to address these challenges by proposing integrated people-centred eye care (IPEC) as an approach to health system strengthening that builds the foundation for service delivery to address population needs. IPEC refers to eye care services that are managed and delivered to assure a continuum of promotive, preventive, treatment and rehabilitative interventions against the spectrum of eye conditions, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course. IPEC will also contribute to achieving universal health coverage (UHC) and Sustainable Development Goal 3 (SDG3): "Ensure healthy lives and promote well-being for all at all ages"."

It is not a coincidence that their individual efforts converged to create a coherent framework that points towards integrated people centred eyecare as their professional endeavours, some for almost 70 years, have been part of a struggle to address equity and access in eye-health care in economically disadvantaged environments, where the access gap continues to widen as technical and resource development accelerates in economically advantaged areas and stagnates in places that have not seen relative progress.

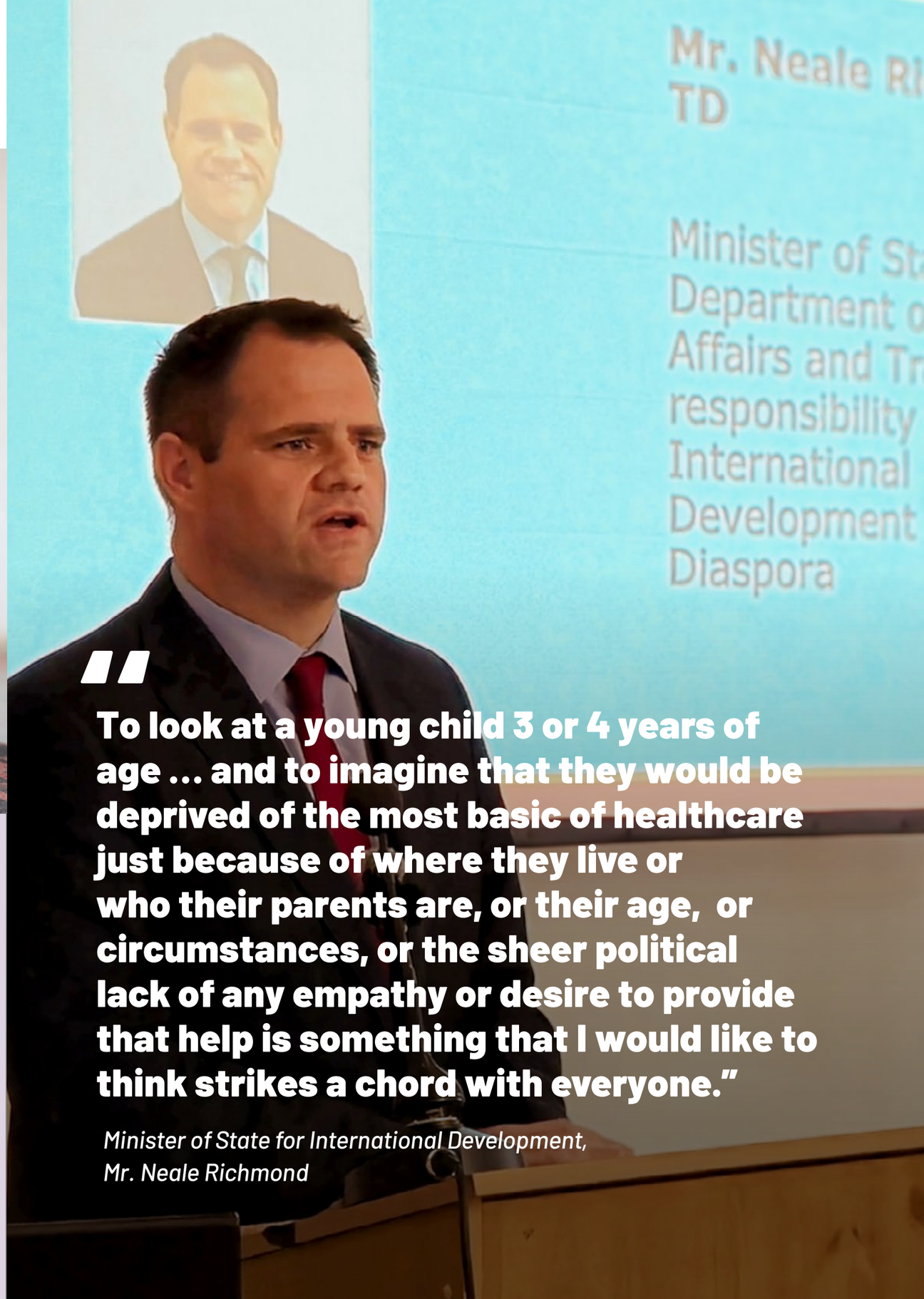
This position paper synthesises the insights generated at the event and situates them within the global policy architecture established by the World Health Organization (WHO), particularly the World Report on Vision (2019) and the framework for Integrated People-Centred Eye Care (IPEC), alongside the International Agency for the Prevention of Blindness (IAPB) 2030 In Sight strategy. It argues that eye health must be understood as a core development and equity issue, inseparable from universal health coverage (UHC), primary health care, and disability-inclusive development.

Drawing on evidence and case studies presented at the event—including large-scale community screening in Madagascar, interprofessional education reform in Rwanda, frugal diagnostic innovation through the Arclight Project, emerging AI-enabled retinal diagnostics, behavioural research on trust and service uptake, and system-level governance perspectives—this paper identifies eight strategic priorities for global eye care and makes recommendations for commitments that are needed at the Global Summit for Eye Health in November 2026. It concludes with stakeholder-specific recommendations for donor governments, national governments, eye health NGOs, and development NGOs more broadly.

On July 23, 2021 the UN Resolution, *"Vision for Everyone: accelerating action to achieve the Sustainable Development Goals"* (A/RES/75/310), was unanimously adopted by 193 nations. It commits the international community to providing eye care for the 1.1 billion people with preventable sight loss by 2030, making eye health part of national agendas to achieve the Sustainable Development Goals (SDGs). The resolution was introduced by Bangladesh, Ireland, and Antigua and Barbuda, and, with the Global Summit for Eye Health planned to take place in Antigua toward the end of 2026, it is timely that this modest event *'A Global Lens on Eyecare'* takes place in Ireland six months in advance of the Global Summit, a time when recommitting to the UN Resolution, and moving beyond mere words, is more important than ever.



The message from Dublin is clear and urgent: the tools to eliminate avoidable blindness already exist. The task now is to align political will, financing, systems design, and community trust to ensure that these tools reach those who need them most.



To look at a young child 3 or 4 years of age … and to imagine that they would be deprived of the most basic of healthcare just because of where they live or who their parents are, or their age, or circumstances, or the sheer political lack of any empathy or desire to provide that help is something that I would like to think strikes a chord with everyone."

Minister of State for International Development, Mr. Neale Richmond

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1 EYE HEALTH AS A GLOBAL DEVELOPMENT AND EQUITY IMPERATIVE

Eye health occupies a unique position within global health and development. Vision underpins education, employment, mobility, independence, and social participation across the life course. Its loss not only diminishes individual capability, but also reinforces cycles of poverty and exclusion at household and community levels. The WHO has repeatedly emphasised that vision impairment is both a cause and a consequence of inequality, with the burden falling most heavily on populations already facing multiple forms of disadvantage.

The World Report on Vision fundamentally reframed eye health by recognising it as an essential component of universal health coverage, rather than a specialist or discretionary service. The report estimated that at least 2.2 billion people live with vision impairment globally, with at least one billion cases preventable or untreated. Out of the 1 billion, there are 43 million people who are blind and a further 295 million living with moderate-to-severe visual impairment.

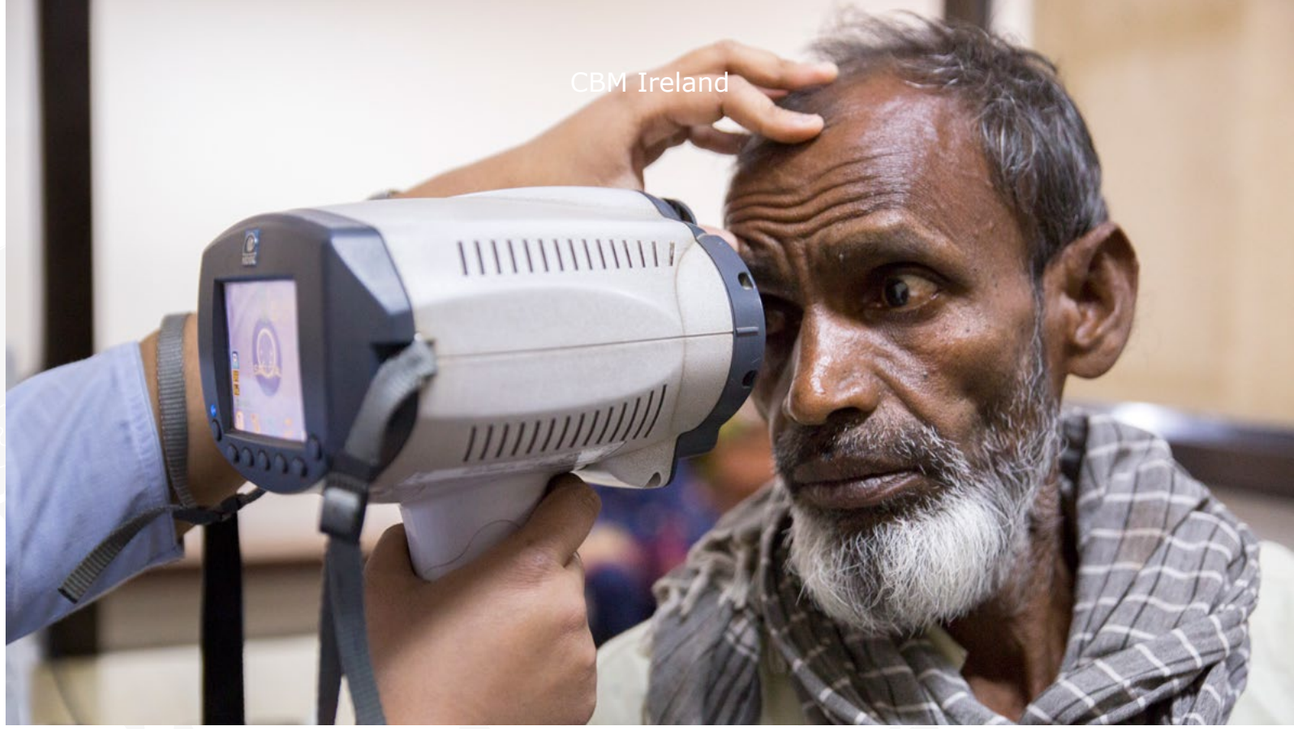
Nine out of ten people with vision loss live in low- and middle-income countries, and 55% are women and girls. The vast majority of these people only need a small intervention, like a pair of reading glasses, to correct their vision.

Crucially, it highlighted that the majority of these cases could be addressed through highly cost-effective interventions, such as refractive correction, cataract surgery, and early detection of chronic eye disease.

The report states:

"Today, millions of people live with vision impairment or blindness that could have been prevented but, unfortunately, was not. While the exact number is unknown, it is estimated that 11.9 million people globally have moderate or severe vision impairment or blindness due to glaucoma, diabetic retinopathy and trachoma that could have been prevented. The estimated costs of preventing the vision impairment in these 11.9 million would have been US$32.1 billion. This represents a significant opportunity missed in preventing the substantial personal and societal burden associated with vision impairment and blindness."

This framing aligns closely with the IAPB's 2030 In Sight strategy, which positions eye health as a development accelerator rather



than a narrow clinical concern. IAPB argues that improving vision contributes directly to multiple Sustainable Development Goals, including education, decent work, reduced inequalities, and economic growth. The evidence presented at A Global Lens On Eyecare strongly reinforced this perspective, demonstrating that eye health outcomes are determined less by clinical sophistication than by the structure and functioning of health systems.

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The economic cost of avoidable sight loss exceeds $400 billion annually, while the human costs—lost education, reduced productivity, diminished independence—are incalculable. Eye health is a foundational development issue.

Vision directly underpins:

- education and learning outcomes
- workforce participation and productivity
- independence and dignity across the life course

More specifically, WHO's World Report on Vision highlights the impact of vision impairment for the individual:

"Studies have consistently established that vision impairment severely impacts quality of life (QoL) among adult populations … have lower rates of workforce participation and productivity and higher rates of depression and anxiety … vision impairment can contribute to social isolation, difficulty walking … compound other challenges such as limited mobility or cognitive decline … people with severe vision impairment experience higher rates of violence and abuse, including bullying and sexual violence …"

- and for society as a whole

"Vision impairment also poses an enormous global financial burden as demonstrated by previous research that has estimated costs of productivity loss. For example, a recent study among nine countries estimated that the annual cost of moderate to severe vision impairment ranged from US$ 0.1 billion in Honduras to as high as US$ 16.5 billion in the United States of America, while annual global costs of productivity losses associated with vision impairment from uncorrected myopia and presbyopia alone were estimated to be US$ 244 billion and US$ 25.4 billion, respectively."

The WHO has established that vision impairment is both a driver and consequence of poverty and inequality. Yet, paradoxically, many of the required interventions are among the most cost-effective in global health.

Eye health remains under-integrated in universal health coverage packages, national development strategies and education and social protection systems. Amongst the many priorities under the Sustainable Development Goals, eye-health is relatively neglected.

2 STRUCTURAL INEQUALITY AND THE LIMITS OF TRADITIONAL EYE CARE MODELS

John Sandford-Smith's opening contribution provided a stark contextual framing for the discussion that followed. By contrasting per capita income levels in high-income countries with those in many African contexts, he illustrated the structural constraints under which eye care systems in low-resource settings must operate. In environments where public health expenditure is extremely limited, models of care that rely heavily on specialist personnel, expensive equipment, and hospital-based delivery are inherently unsustainable and such models are not transferrable from high-income to low-income countries.

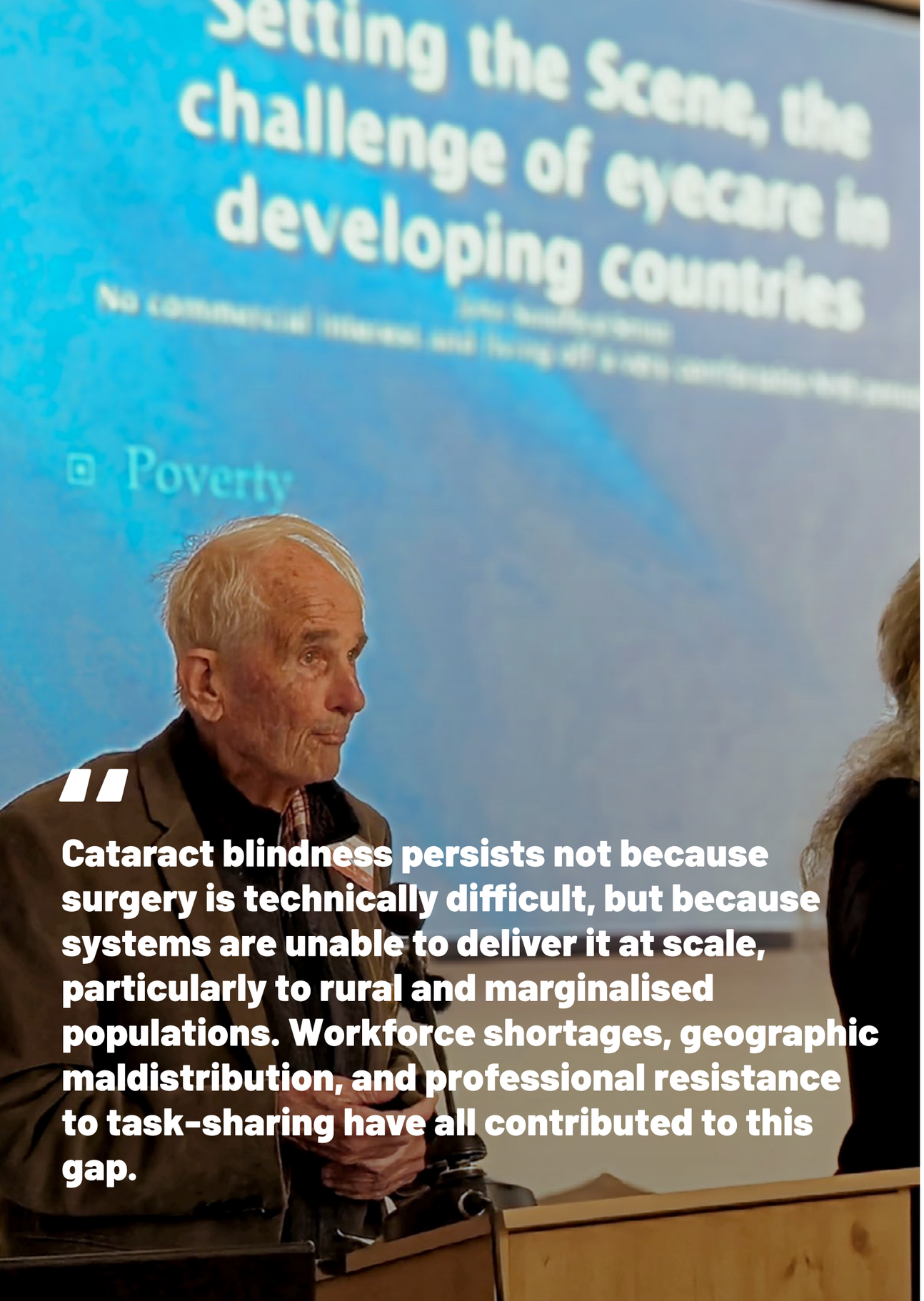
Historical global initiatives such as VISION 2020 achieved notable successes, particularly in addressing infectious causes of blindness. However, Sandford-Smith observed, progress has been far more limited in tackling conditions such as cataract and chronic eye disease. Cataract blindness persists not because surgery is technically difficult, but because systems are unable to deliver it at scale, particularly to rural and marginalised populations. Workforce shortages, geographic maldistribution, and professional resistance to task-sharing have all contributed to this gap.

These observations mirror WHO analyses, which identify inequitable coverage and fragmented service delivery as the principal barriers to progress in eye health. The implication is that future gains will depend less on discovering new treatments, and more on **re-engineering how eye care is embedded within health systems.**

This reflects the UN Resolution, *"Vision for Everyone: accelerating action to achieve the Sustainable Development Goals"* which

"Encourages Member States to put in place an integrated and whole-of-government approach to eye care, building synergies with other development priorities and strengthening their collaboration with academia, research institutions, the scientific community, civil society and the private sector, in order to improve safe and affordable access to eye care services."

PRIMARY EYE CARE AND COMMUNITY-BASED DELIVERY AT SCALE



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A central theme across the event was the foundational role of primary eye care in achieving equitable access. WHO's IPEC framework explicitly identifies primary health care as the most effective platform for delivering preventive, promotive, and early intervention eye care, particularly for underserved populations.

The Madagascar newborn and child eye screening programme presented by CBM Global's Jaona Lala Iandrinirina offers one of the most compelling demonstrations of this principle in practice. Operating in a context of extreme workforce scarcity—Madagascar has 2.5 Ophthalmologists per million population, Ireland has 40, Norway has 68—the programme trained primary health personnel and community health workers to conduct eye screening using the Arclight device. The Madagascar example if typical of the challenges facing low-income countries from a workforce perspective:

Over 80,000 children were screened within 17 months, with a remarkably low false-positive rate, indicating that quality was maintained alongside scale. The screening identified 344 conditions that without cross-disciplinary training using low-cost, easy to use technology (the Arclight) would have gone undetected. These were 344 children that would otherwise have received no treatment, or at best, much delayed treatment. Within this cohort were 15 cases of retinoblastoma as well 200 cases of conjunctivitis whose timely identification should not be underplayed. The WHO World Report on Vision states:

"Eye conditions that can cause vision impairment and blindness – such as cataract, trachoma and refractive error – are, for good reasons, the main focus of prevention and other eye care strategies; nevertheless, the importance of eye conditions that do not typically cause vision impairment – such as dry eye and conjunctivitis – must not be overlooked. These conditions are frequently among the leading reasons for presentation to eye care services all countries."

More importantly, as moderator Dualta Roughneen pointed, while there have been 80,000 children screened under this project in the past 12 months, there remain 4 million more children under five in Madagascar that are not yet accessing basic screening.

This could equate to 750 children with undiagnosed retinoblastoma across the country.

What is particularly significant about the model presented by Mr. Iandrinirina is not only the volume of screening achieved, but the way in which eye care was integrated into existing health system functions. Screening was embedded within immunisation and nutrition services, reducing opportunity costs for families and strengthening continuity of care. Referral pathways linked community-level detection to secondary and tertiary services, ensuring that identified cases received appropriate treatment, including life-saving interventions for conditions such as retinoblastoma.

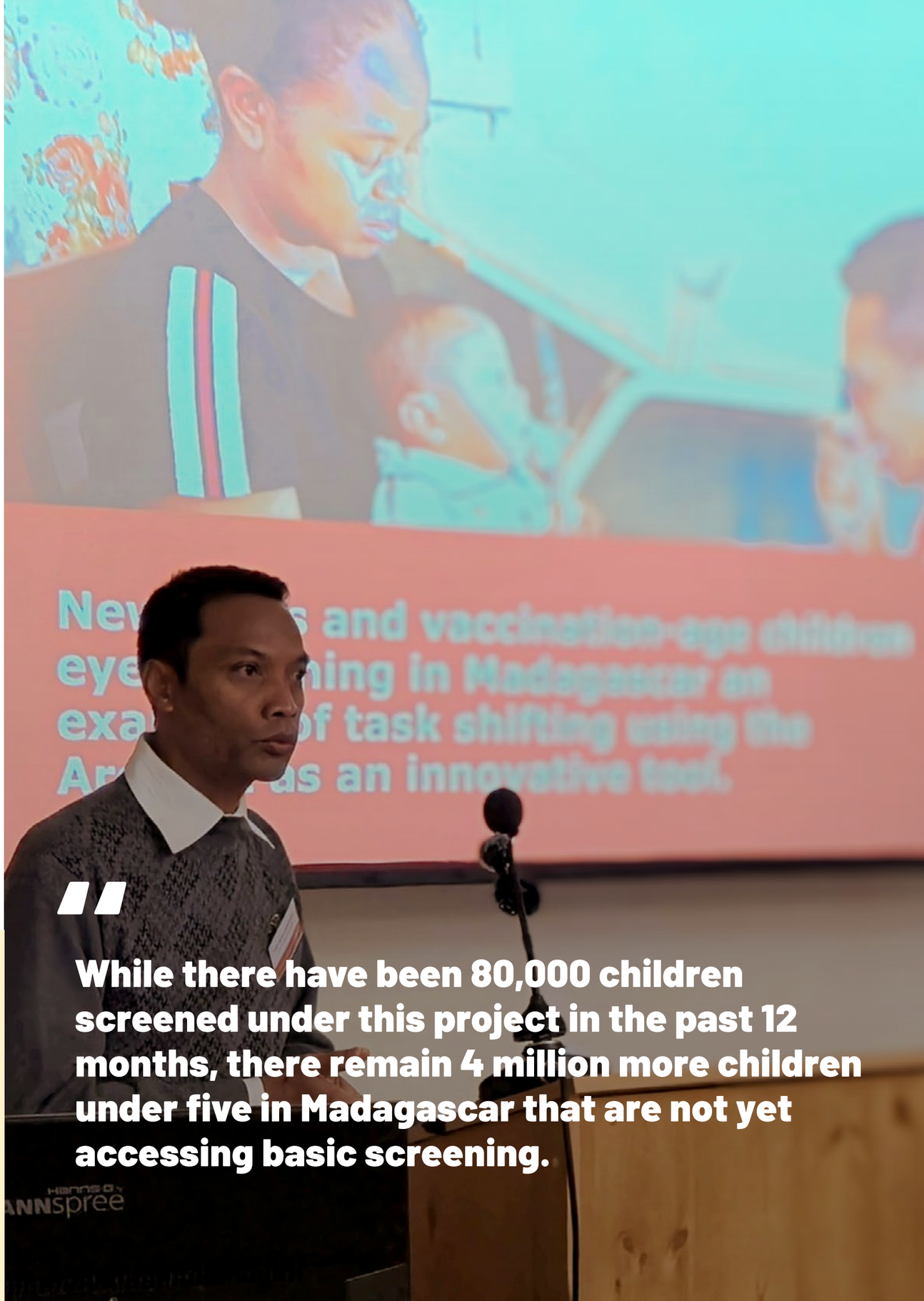
This approach exemplifies the IPEC principle of delivering care *"as close as possible to where people live"*, while maintaining strong system linkages. It also illustrates how eye health can be leveraged as an entry point for broader child health and development interventions.

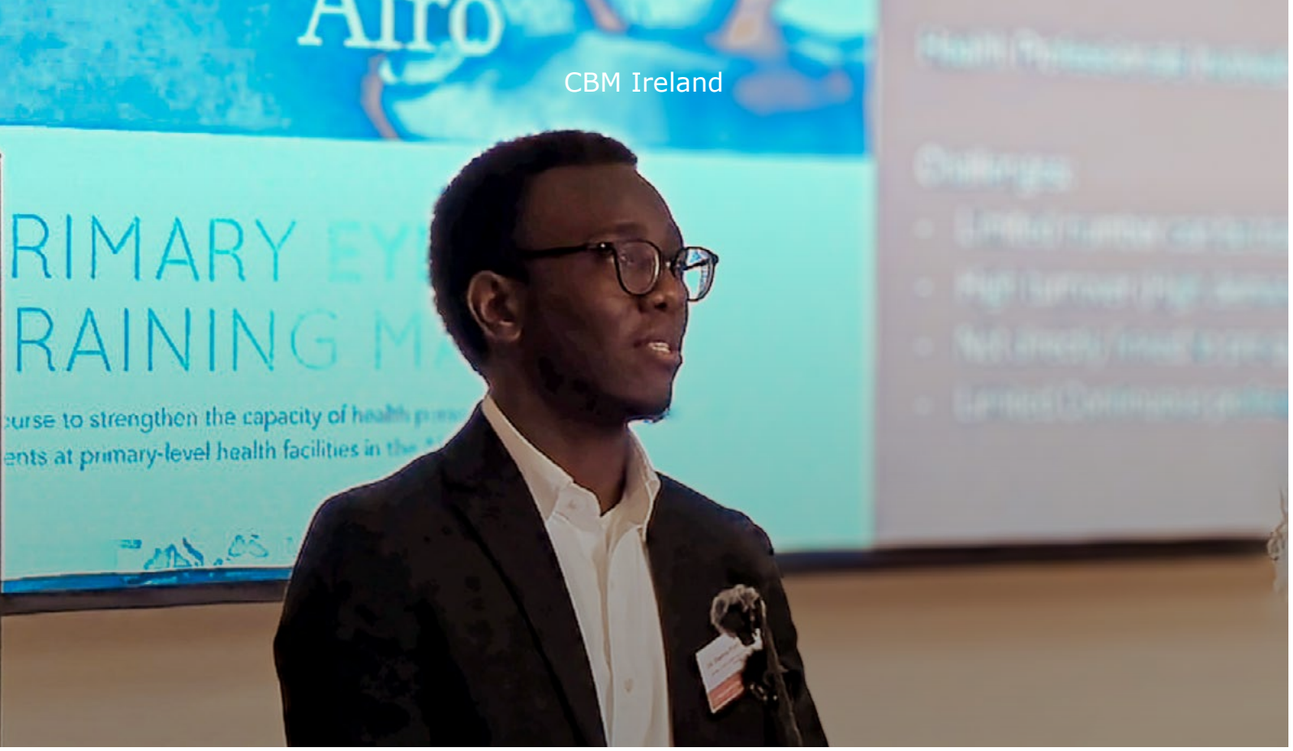
346 Diagnoses from Arclight Screening Programme

Diagnosis	Number	Per 10,000
Allergic Conjunctivitis	153	16
Bacterial Conjunctivitis	137	16
Corneal Disorder	27	2
Retinoblastoma	15	2
Congenital Cataract	7	1
Congenital Glaucoma	4	<1
Ophthalmia Neonatorum	1	<1
False Positive	2	<1

What is Retinoblastoma ?

Retinoblastoma is a kind of eye cancer that starts as a growth of cells in the retina. The retina is the light-sensitive lining on the inside of the eye. The retina is made up of nerve tissue that senses light as it comes in through the front of the eye. The light causes the retina to send signals to the brain. The brain interprets the signals as images. Retinoblastoma happens most often in young children. It's usually diagnosed before age 2. It most often affects one eye. Sometimes it happens in both eyes. For most children, treatment doesn't require removing the eye to get rid of the cancer. The outlook for children diagnosed with retinoblastoma is quite good if it is detected in time.





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WORKFORCE TRANSFORMATION AND INTERPROFESSIONAL EDUCATION

Workforce constraints were repeatedly identified as a critical barrier to scaling eye care, but the event also demonstrated that these constraints can catalyse innovation in training and service delivery. The presentation by Dr. Gatera Fiston Kitema on interprofessional education in Rwanda provided a system-level response to this challenge.

Traditional eye care training models tend to reinforce professional silos, with ophthalmologists, nurses, optometrists, and other cadres trained separately. In overstretched health systems facing rising burdens of chronic disease, such fragmentation undermines efficiency and continuity of care. Drawing on WHO guidance and evidence from interprofessional education

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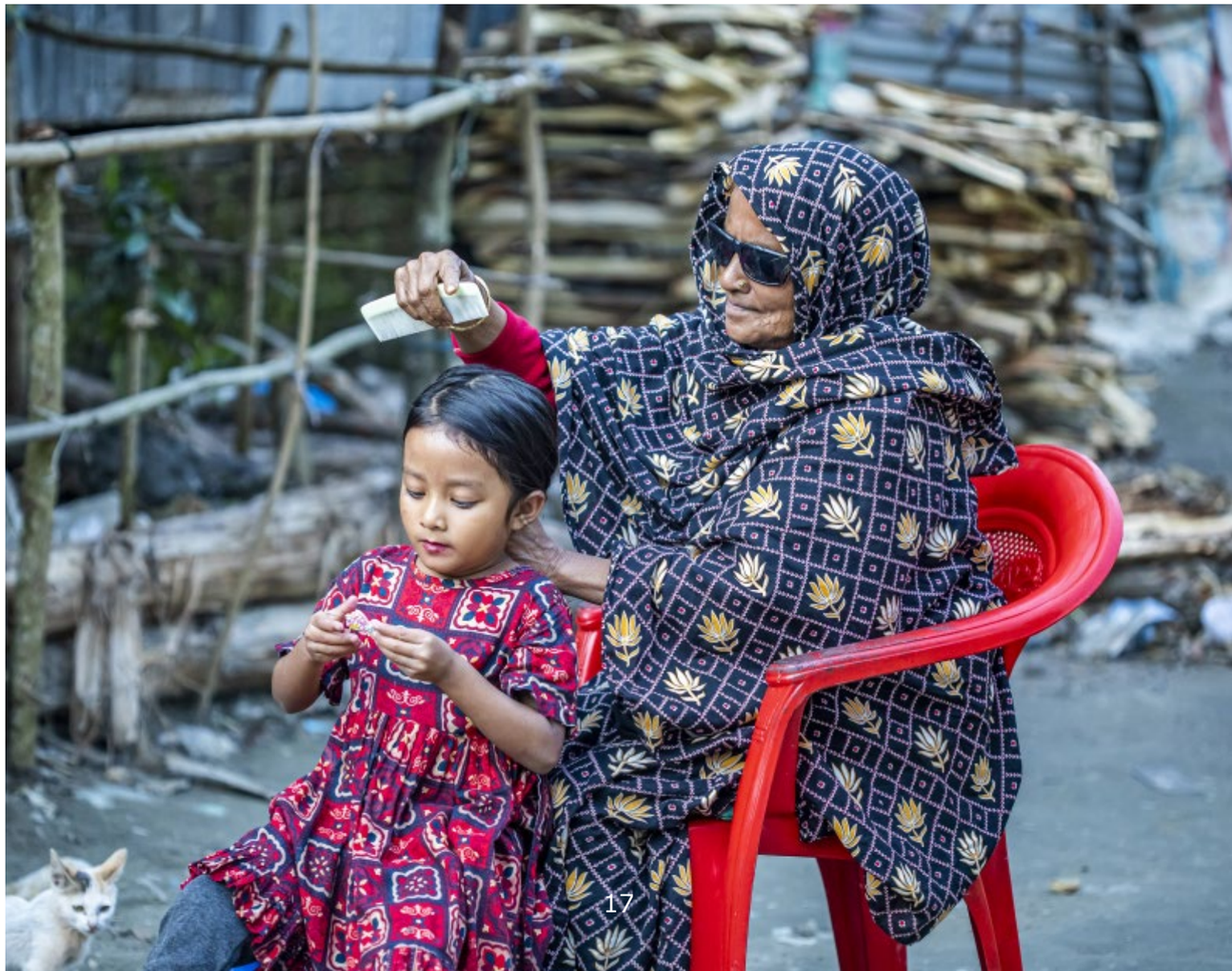
research, the Rwandan IPEHE model brought together students and practitioners from multiple disciplines to train collaboratively in population-oriented eye health.

The results demonstrated not only improvements in technical knowledge and skills, but also measurable changes in collaborative behaviour within clinical practice. This is a critical insight: education influences outcomes not directly, but through its effect on how health workers interact within systems. By aligning training with real-world service delivery needs, interprofessional education strengthens referral pathways, reduces duplication, and improves patient experience.

This approach is directly aligned with WHO's emphasis on team-based primary care and with IAPB's call for workforce models that prioritise collaboration over hierarchy. It also has clear relevance beyond low-income settings, offering lessons for health system reform in Ireland and other high-income countries facing workforce pressures of their own.



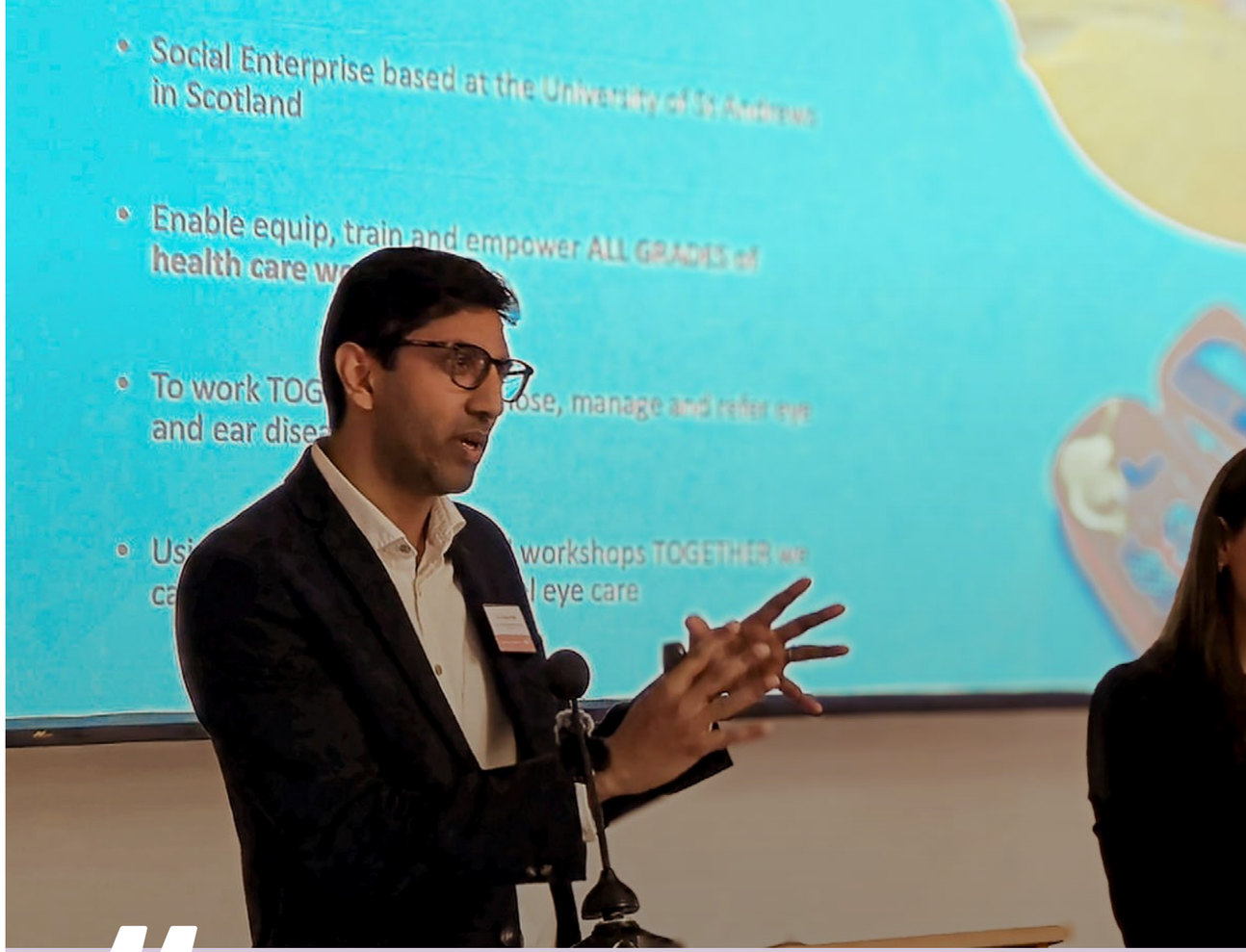
5 DIAGNOSIS, FRUGAL INNOVATION, AND THE ARCLIGHT PARADIGM

Dr. Sirjhun Patel's detailed exploration of glaucoma diagnosis in low-resource settings highlighted how clinical practice must adapt to context. Glaucoma is a leading cause of irreversible blindness globally, yet diagnosis typically depends on technologies that are unavailable in most primary care settings in low-income countries. In such contexts, rigid adherence to high-resource diagnostic protocols effectively excludes large segments of the population from early detection.

The Arclight Project represents a fundamentally different approach. Rather than attempting to replicate hospital-based diagnostics, it distils the essential components of eye examination—history taking, visual acuity assessment, pupil examination, anterior segment inspection, and optic disc evaluation—into a simplified, teachable framework supported by a low-cost, solar-powered device. Training materials, simulation tools, and mobile-based supports extend the reach of this framework and enable non-specialist health workers to contribute meaningfully to early detection and referral.

Crucially, this is not a compromise on quality, but a re-definition of appropriateness. WHO has repeatedly emphasised that effective health technologies must be affordable, robust, and suited to local conditions. The Arclight ecosystem exemplifies this principle and demonstrates how frugal innovation can act as a system enabler rather than a standalone intervention.

Dr. Patel's presentation focused on the utility of the Arclight in glaucoma detection was supplemented by a pre-recorded intervention from Dr. Andrew Blaikie which outlined the developments in frugal technology by The Arclight Project beyond the Arclight itself but also the Holo binocular indirect ophthalmoscope (BIO) and the Newton Tonometer, as cost effective alternatives to expensive, and often unaffordable and geographically unsuitable alternatives. He noted that the frugal technology is backed up by research and evidence. One particular study concludes *"that the Arclight offers an easy to use, low cost alternative to the traditional direct ophthalmoscope to meet the demands for screening and diagnosis of*



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What is the Arclight ?

A pocket all-in-one ophthalmoscope-loupe-otoscope for the 21st century. No replacing blown bulbs, no worrying if the battery is dead – ideal for low resource countries and also as a backup or training tool. For novices (students, health workers), the occasional user with some familiarity (doctors, nurses), to specialists (ophthalmologists, optometrists).

Key features

- **EASY TO USE** – multiple features. Intuitive operation. View the optic nerve or ear drum first time with no fuss.
- **PORTABLE** – shirt pocket or around the neck. For a detailed view of the anterior segment, eyelids and skin.
- **SOLAR POWER** – charge in a few hours – for a 'normal' day's work or a week of casual use.
- **LED** – precise diagnosis needs outstanding illumination. Low in infra-red and ultra-violet for comfort and safety.
- **USB** – indoors or poor light – plug and go with a modern USB C

The Global Health Team in St Andrews have supported the long-term development of the Arclight through research and helping to train health-care workers in a variety of settings in partnership with CBM and others.

visually impairing eye disorders in low-income and middle-income countries", contributing the World Report on Vision (2019) challenge that 'an important component of UHC for eye care, therefore, is that all people obtain the eye care services they need without risking financial hardship from unaffordable out-of-pocket payments". Developments such as the Arclight technologies through the University of St Andrews responds to the 2021 UN Resolution that

"Recognizes the need to further encourage the transfer of technology from developed countries to developing countries, on mutually agreed terms, to advance access to eye care services and assistive technologies"

and

"Notes the contribution of the private sector, academia and civil society to the promotion of eye health, and encourages the development of public-private partnerships, aligned with national government plans, legislation, contexts and priorities, and national policies and priorities to advance vision for everyone."

DIGITAL INNOVATION, AI, AND THE SHIFT TO PROACTIVE EYE CARE

While frugal technologies address access barriers, emerging digital innovations are reshaping what is possible in early detection. Dr. Kate Coleman's presentation on portable retinal imaging and AI-enabled analysis illustrated a paradigm shift in eye care: for the first time, it is becoming feasible to identify pathology within the eye before symptoms occur, using tools that can be deployed far beyond specialist clinics.

Conditions such as glaucoma and diabetic retinopathy are often referred to as *"silent"* causes of vision loss because substantial damage occurs before individuals are aware of a problem. Dr. Coleman demonstrated how non-mydriatic retinal photography, combined with AI algorithms, allows both clinicians and non-specialists to visualise and interpret changes in the optic nerve and retinal vasculature. Importantly, the same images that can be interpreted by humans can be analysed at scale by AI systems, dramatically expanding screening capacity.

WHO has cautioned that digital health technologies must be embedded within functioning systems to deliver value. Without clear referral pathways, governance frameworks, and safeguards around equity and data use, such innovations risk exacerbating disparities. The discussion at the event therefore emphasised that AI should be seen as an enabler of integrated care, complementing primary eye care and community-based models rather than replacing them.

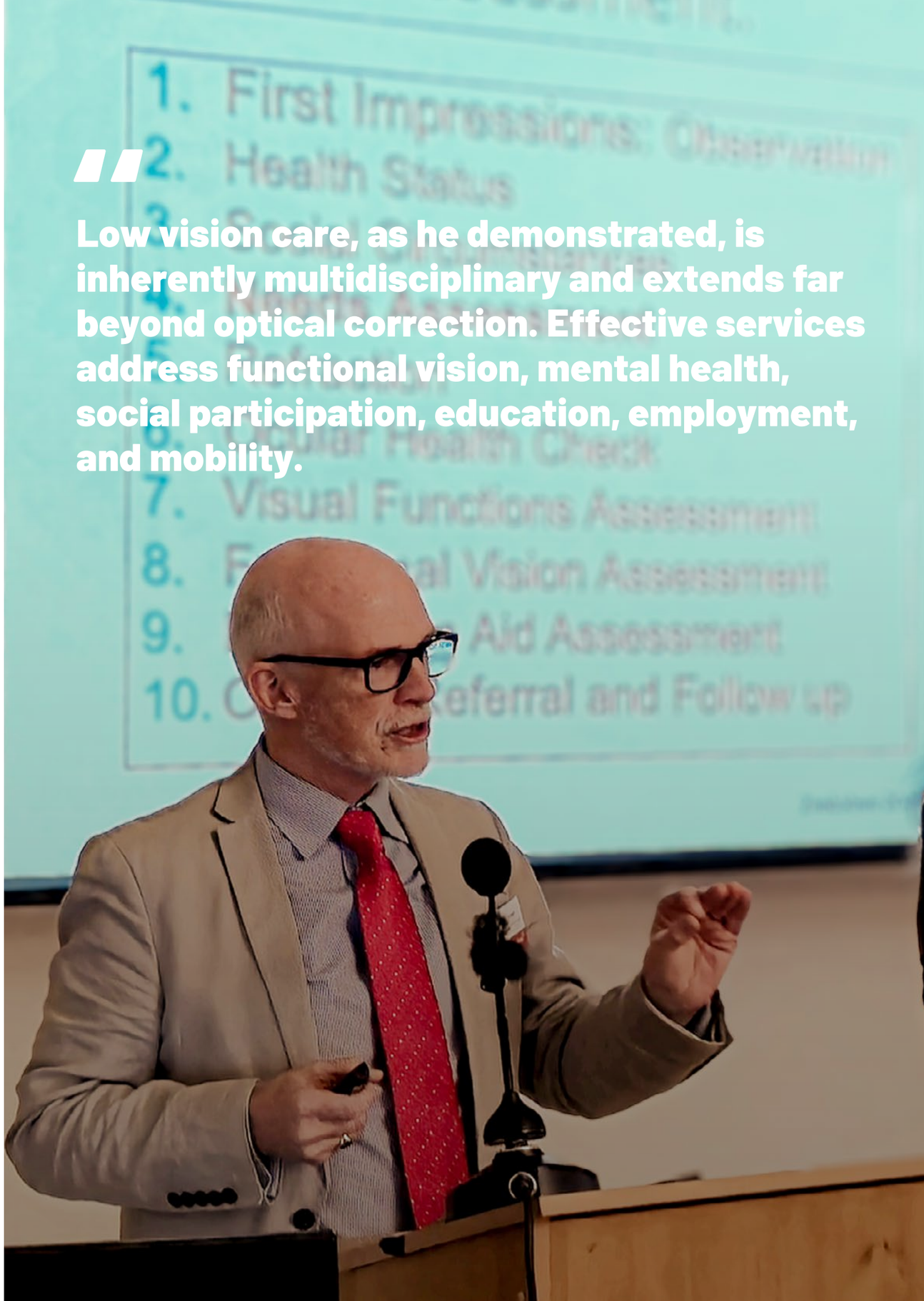
7 LOW VISION, REHABILITATION, AND PERSON-CENTRED CARE

Dr. Jonathan Jackson's contribution shifted the focus from prevention and treatment to the longer-term needs of individuals living with visual impairment. Low vision care, as he demonstrated, is inherently multidisciplinary and extends far beyond optical correction. Effective services address functional vision, mental health, social participation, education, employment, and mobility.

Dr. Jackson's analysis of hub-and-spoke models in Northern Ireland illustrated how specialist expertise can be combined with accessible community delivery to achieve both quality and reach. Importantly, outcomes in low vision care must be measured in terms of quality of life and sustained functional benefit, not simply clinical metrics. This perspective aligns closely with WHO's IPEC framework, which places individuals' lived experience at the centre of care.

For global eye health, this reinforces the need to view rehabilitation and inclusion as integral components of eye care systems, rather than optional add-ons. It also underscores the importance of linking eye health programmes with broader disability-inclusive development initiatives.

Skills transfer has underpinned eye health development between from resource-rich countries to resource poor and should continue as an integral part of an approach to bridging the gap across contexts. A shift from direct implementation of surgery and procedures to training and development has already taken place but remains limited in scope and ad-hoc in the majority of cases. The case for greater structured collaboration between individuals, research and academia, private sector actors, with facilitation between governments by international NGOs remains an area where further gains can be made.



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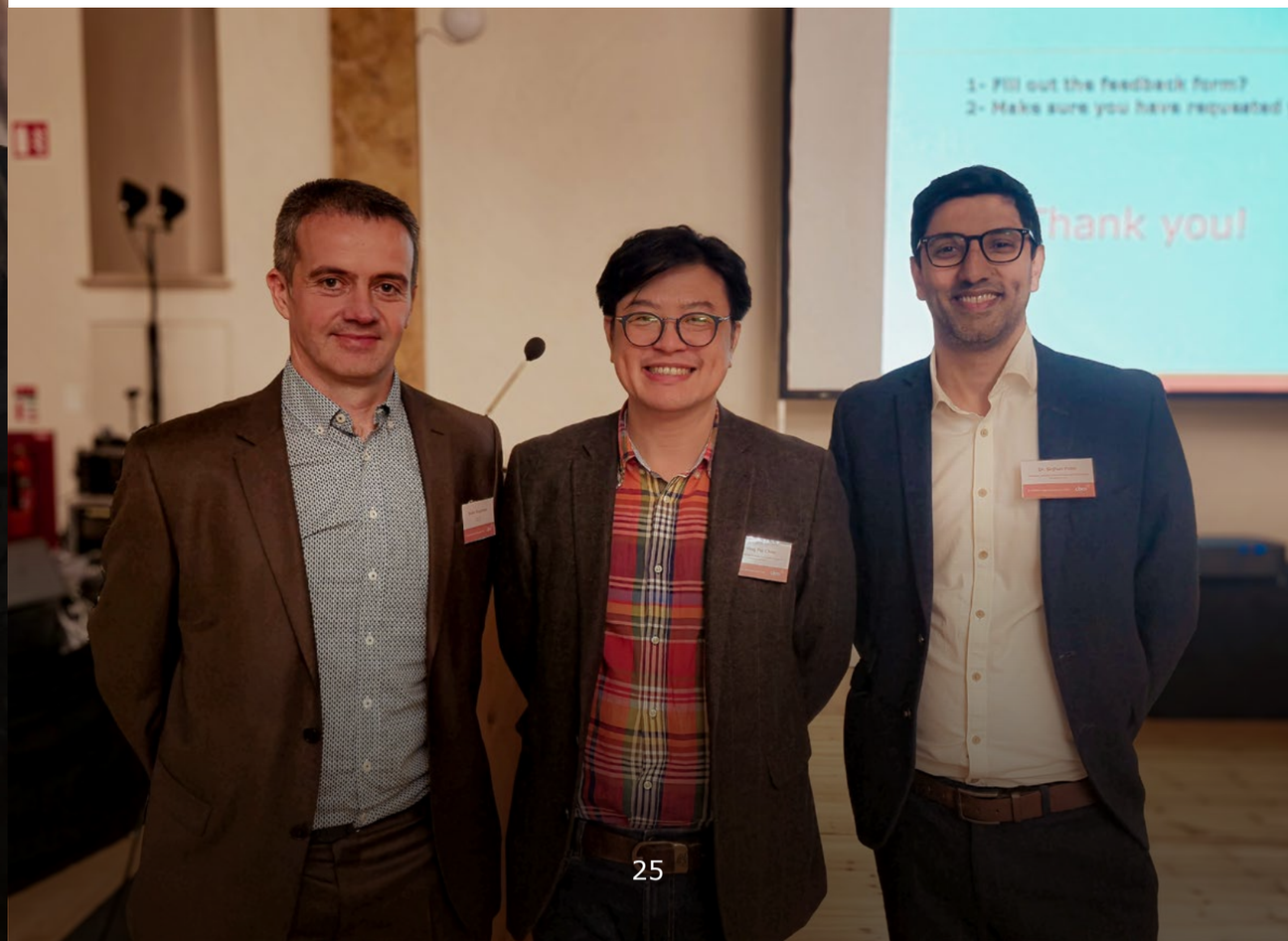
TRUST, CULTURE, AND THE “MEANING GAP” IN SERVICE UPTAKE

One of the most conceptually important contributions came from Dr. Ving Fai Chan, whose work challenges a foundational assumption in global health: that information leads to behaviour change. Drawing on research in Zanzibar, Chan demonstrated that even when screening coverage is high, referral uptake can remain extremely low due to fear, mistrust, and misalignment between clinical logic and lived experience.

Chan introduced the concept of a *“meaning gap”,* arguing that health messages often fail not because they are inaccurate, but because they do not resonate with the cultural, emotional, and social realities of communities. Arts-based interventions—such as storytelling, music, and locally produced media—were shown to improve understanding, reduce fear, and increase trust, leading to measurable improvements in referral adherence.

This insight has profound implications for eye health systems. WHO’s policy frameworks increasingly emphasise community engagement and empowerment, yet these elements are often under-resourced. The evidence presented suggests that investing in trust-building and culturally grounded communication is not ancillary, but essential to achieving impact at scale.



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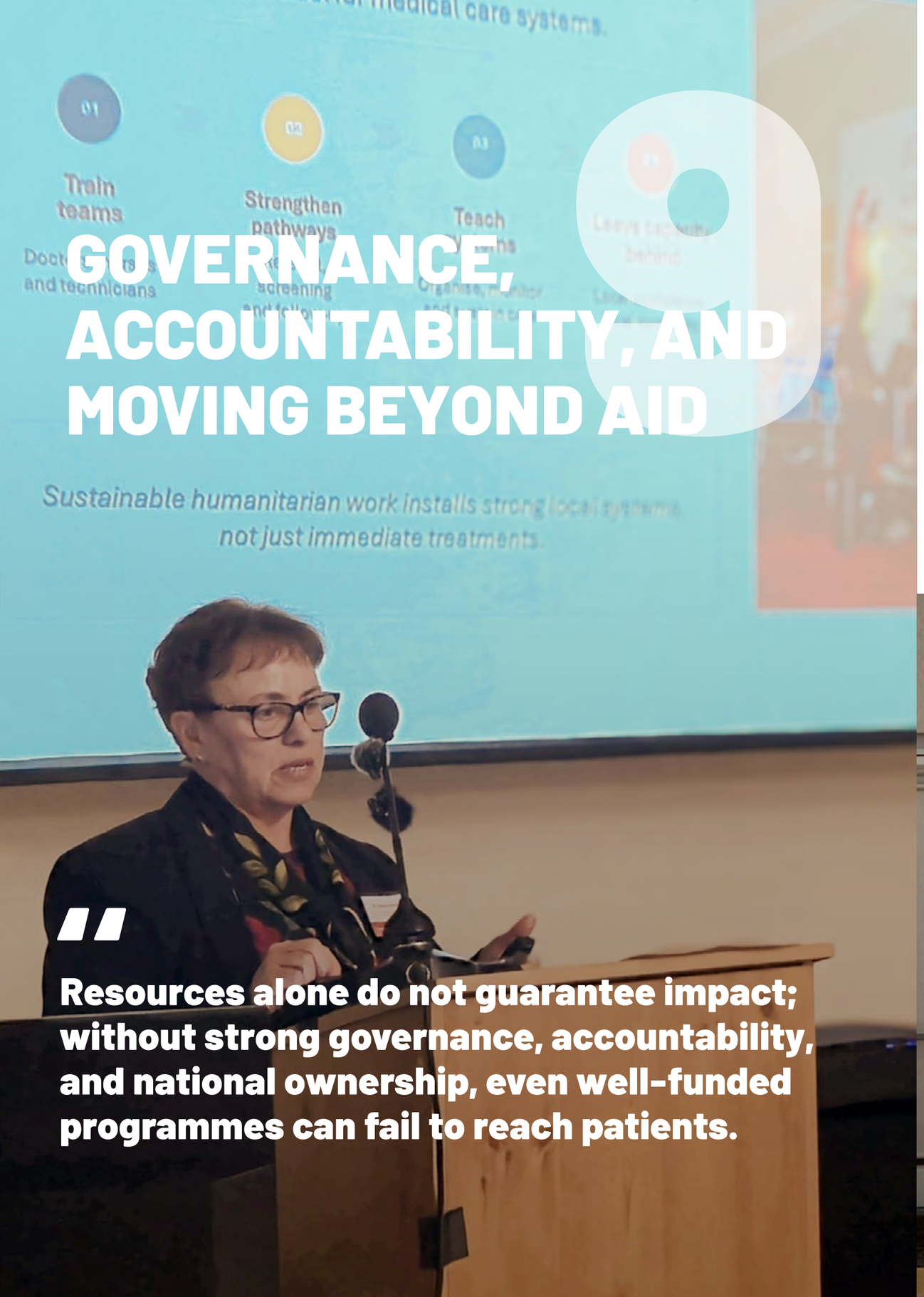
GOVERNANCE, ACCOUNTABILITY, AND MOVING BEYOND AID

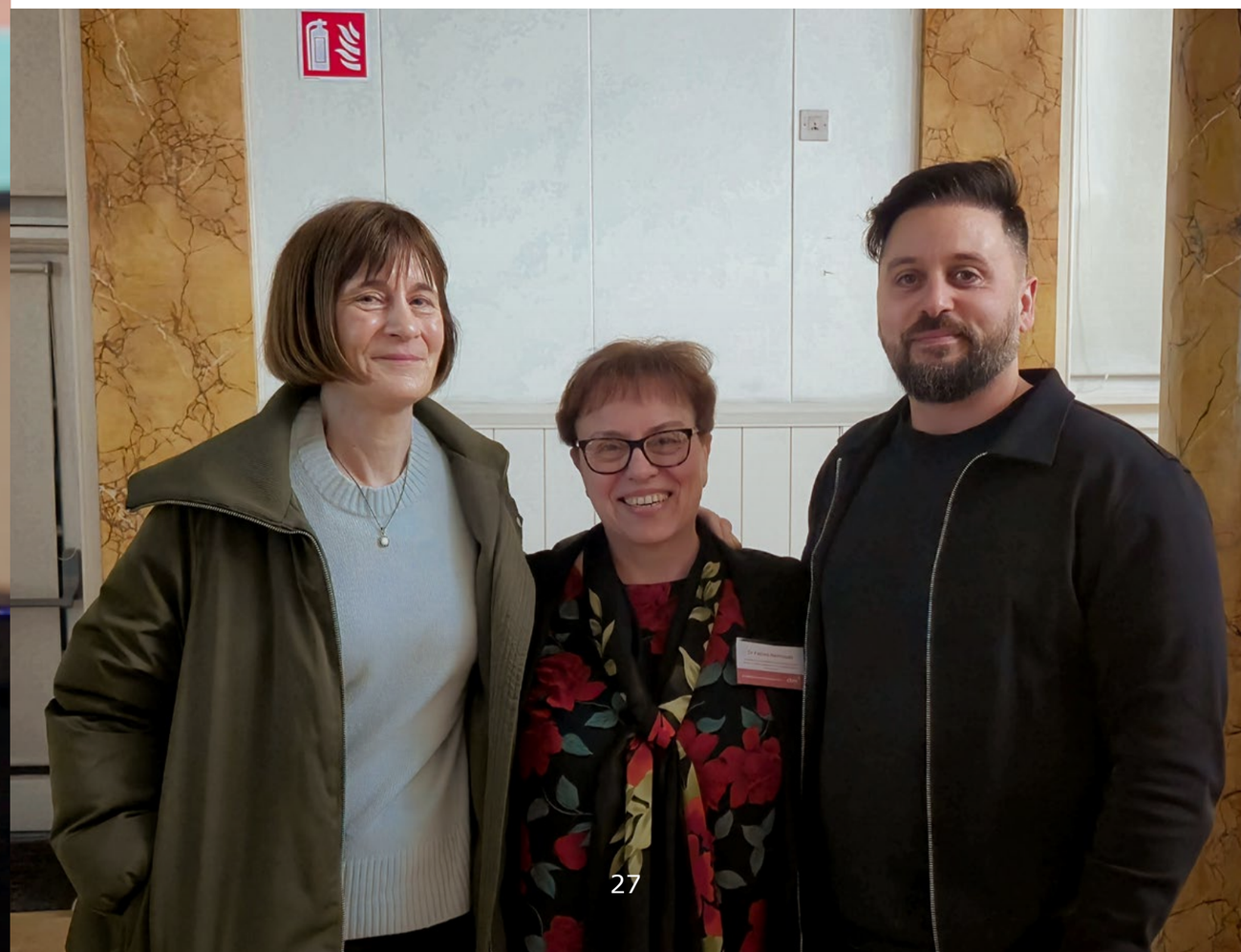
Dr. Fatima Hamroush's contribution provided a critical system-level perspective grounded in experience spanning clinical practice, humanitarian response, and national health leadership. Her central argument was that resources alone do not guarantee impact; without strong governance, accountability, and national ownership, even well-funded programmes can fail to reach patients.

Drawing on examples from fragile and post-conflict settings, Dr. Hamroush illustrated how weak accountability can result in diversion of resources, fragmented delivery, and loss of public trust. In contrast, approaches that focus on capacity building—training teams, strengthening referral pathways, and embedding monitoring systems—create the conditions for sustainable care.

This perspective aligns closely with WHO guidance on health system strengthening and with IAPB's emphasis on moving from project-based delivery to system-wide change. It also resonates strongly with CBM's partnership-based approach, which prioritises long-term institutional strengthening over short-term outputs.



> **Resources alone do not guarantee impact; without strong governance, accountability, and national ownership, even well-funded programmes can fail to reach patients.**



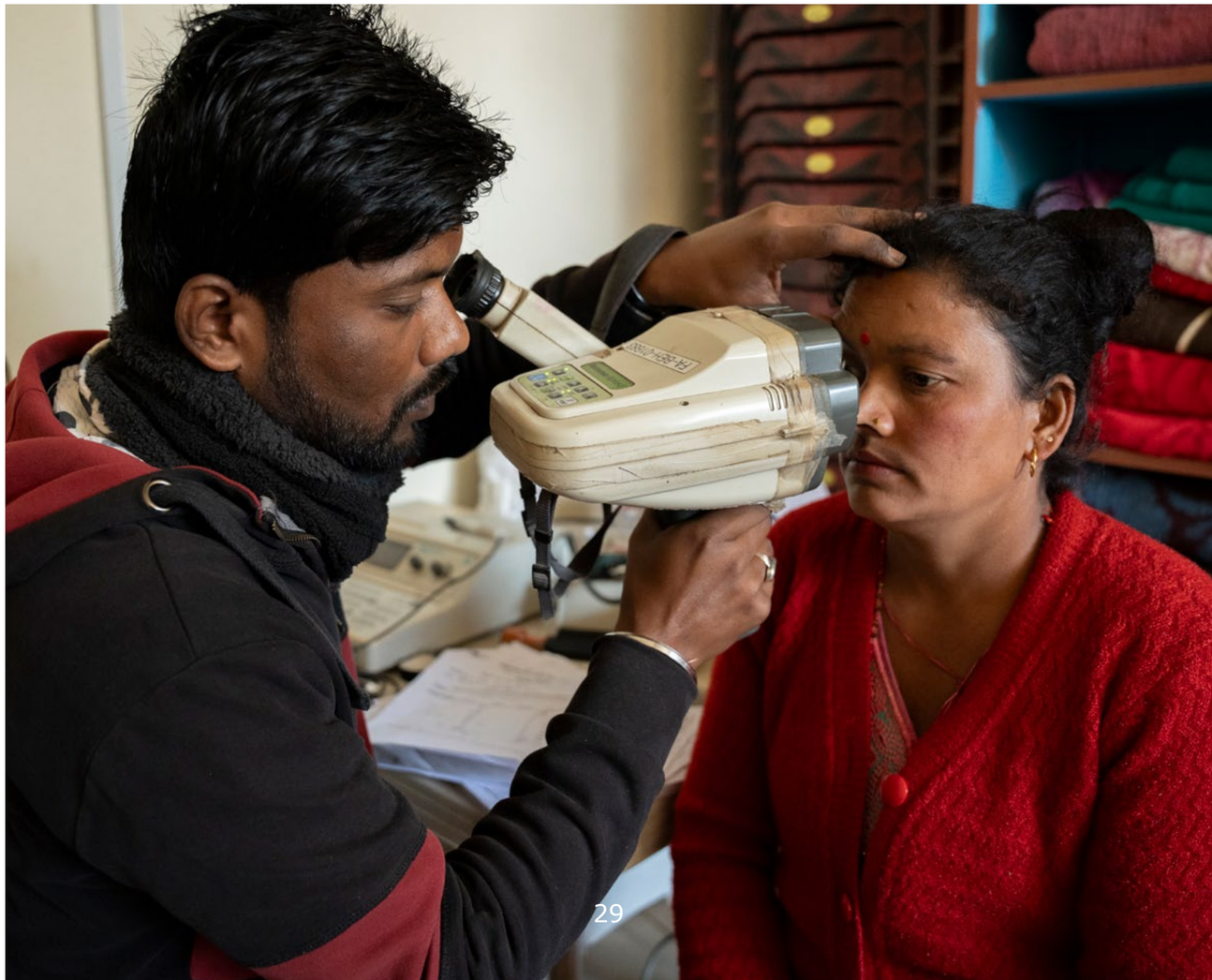
10 STRATEGIC PRIORITIES FOR GLOBAL EYE CARE

Synthesising the evidence and insights from the event, eight strategic priorities emerge. These fit within the IAPB 2030 In Sight strategy which demands that now is the time to **elevate** vision as a fundamental, economic, social and development issue, to **integrate** eye health in wider health care systems and **activate** consumer demand and market change.

- First, eye care must be fully integrated into universal health coverage, with essential services included in national benefit packages and financed through sustainable mechanisms, as recommended by the WHO World Report on Vision.
- Second, primary eye care should be scaled as the foundation of equitable access, with eye health embedded within primary health systems and linked to strong referral pathways, in line with the IPEC framework.
- Third, workforce models must be transformed through task-sharing and interprofessional education, ensuring that collaboration rather than hierarchy defines service delivery.
- Fourth, investment in frugal and appropriate technologies, such as the Arclight, should be prioritised to expand diagnostic capacity in low-resource settings facilitating access that is affordable and responsive to demand at the community level.
- Fifth, early detection of chronic and *"silent"* eye disease should become a central pillar of strategy, leveraging digital tools and AI within integrated systems.
- Sixth, rehabilitation and low vision services must be recognised as essential components of eye care, supporting quality of life and social participation.
- Seventh, community engagement and trust-building must be embedded within programme design, addressing the meaning gap that undermines service uptake, activating consumer demand.
- Eighth, governance, accountability, and national ownership must underpin all efforts, shifting from aid-dependent models to resilient, locally led systems.

More generally, five years from the UN Resolution **75/310 Vision for Everyone: accelerating action to achieve the Sustainable Development Goals** it is urgent that resources and funding necessary to prevent avoidable blindness, the burden of which rests most heavily on low and middle income countries, are committed in November 2026 at the Global Summit for Eye Health. The case for investment is clear. As per the IAPB:

"Eye health services in low- and middle-income countries (LMICs) lag far behind wealthier nations. That is where 90% of people living with avoidable sight loss are based, and where the productivity gains are greatest. [IAPB] findings show that every $1 invested in eye health in LMICs yields $28 in returns. A $7.1 billion investment in six priority areas – from community screenings and eye exams to access to reading and prescription glasses, and scaling up cataract surgery – could unlock a $199 billion boost to productivity in just five years (2026–2030)."



11 STAKEHOLDER-SPECIFIC RECOMMENDATIONS

What becomes clear through the presentations delivered at 'A Global Lens in Eyecare' is that the solutions already exist to democratise access to eye-health. They are not expensive solutions. The future of eye-health should be directed towards accelerating access to innovations that are changing the potential for eye-health transformation globally. What is needed are the financial resources and the political will to put them into play along with connecting the network of stakeholders to optimise resources. Minimal training requirements are needed to accelerate access, screening and diagnosis using new technologies. Selective Laser Trabeculoplasty (SLT) for glaucoma and laser treatment for diabetic retinopathy – along with other solutions - could be delivered by technicians in low-resource settings. The Arclight is an affordable low-cost screening tool requiring minimal training. AI will be increasingly used for diagnostics. Smartphone retinal cameras are a portable, cost-effective device that can now capture high-quality images of the retina, functioning as a low-cost alternative to traditional fundus cameras for telemedicine and screenings. Telemedicine and internet connectivity with the omnipresence of smartphones will allow for real-time diagnosis remotely and trans-continentally. Systems-based solutions are needed but it should be clear that the know-how and technology already exist to make this possible. This is why eye-health offers the opportunity to be a development accelerator rather than being considered a narrow clinical concern any longer.

For donor governments, the priority ought to be to align funding with system strengthening rather than vertical projects, support integration of eye care within UHC, and invest in scalable, evidence-based models.

For national governments, the focus should be on developing and implementing national eye health strategies aligned with WHO and IAPB frameworks, strengthening primary care, and investing in workforce development but taking advantage of new technologies to accelerate practice.

For international eye health NGOs, there is a responsibility to align programmes with

national systems, prioritise capacity building, and contribute to evidence generation and learning.

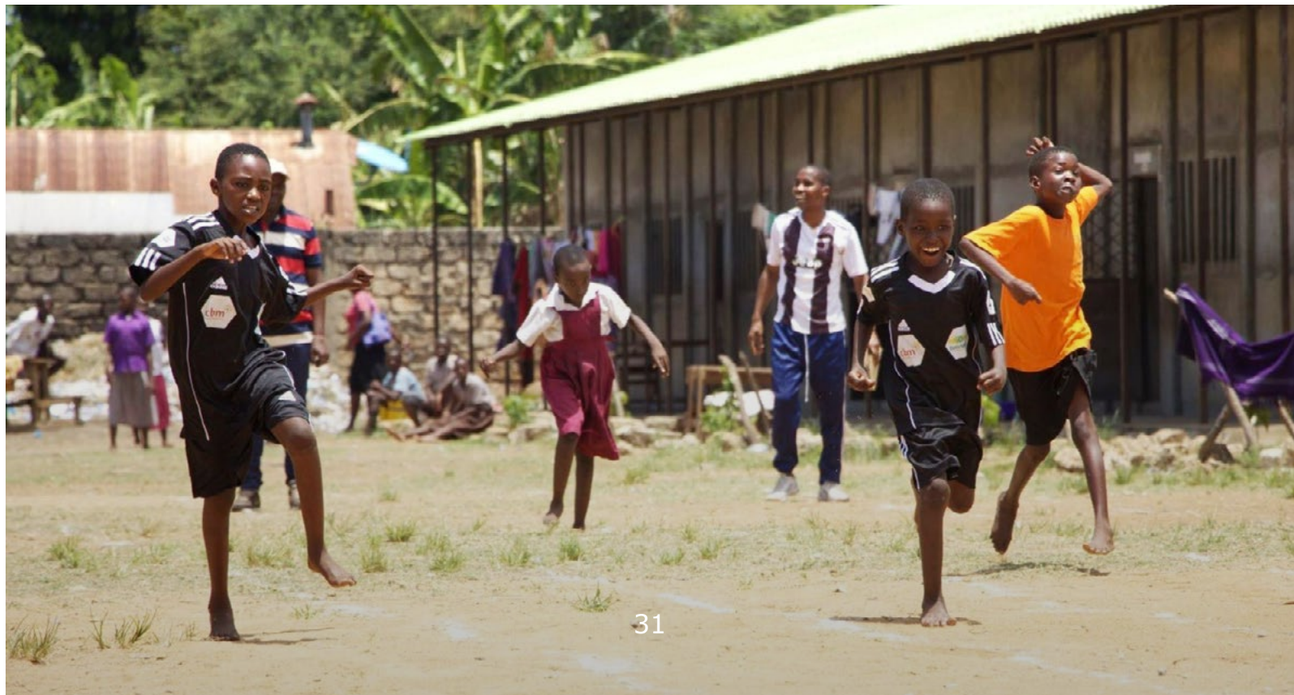
For development NGOs more broadly, eye health should be recognised as a cross-cutting enabler of education, livelihoods, and inclusion, and integrated accordingly.

More specifically, recommendations point towards commitments required at the Global Summit for Eye Health in November 2026.

DONOR GOVERNMENTS

Donors should prioritise long-term system strengthening over fragmented project delivery. Commitments should focus on predictable financing, alignment with national plans, and catalytic investments.

1. Ensure health ODA portfolios include integrated eye care with explicit inclusion of eye health within UHC financing frameworks.
2. Provide multi-year (minimum 5-year) funding agreements aligned with national eye health strategies in priority LMICs, ensuring predictability and continuity of services.
3. Allocate dedicated funding windows for primary eye care integration, to embed eye screening within primary health platforms (e.g. maternal and child health).
4. Finance scale-up of proven high-impact interventions (e.g. cataract surgery, refractive services, community screening using frugal technologies such as the Arclight) to make eye-health care accessible to underserved populations.



NATIONAL GOVERNMENTS

National governments, particularly in economically disadvantaged contexts struggle with resource constraints and competing priorities to a much greater degree than donor governments. Nonetheless, eyecare needs to be considered as a public health priority as recognised in the 2021 UN Resolution:

"Member States are urged, taking into account their national circumstances and priorities, inter alia, to take action to implement the recommendations contained in the World Health Organization World Report on Vision, including to make eye care an integral part of universal health coverage and to implement integrated people-centred eye care in health systems across the spectrum of promotive, preventive, curative and rehabilitative services"

National Governments are urged to:

1. Develop or update a national eye health strategy aligned with WHO IPEC and IAPB 2030 In Sight frameworks with clear targets, financing plans, and accountability mechanisms.
2. Integrate essential eye care services into national UHC benefit packages for basic services (refraction, cataract surgery, screening).
3. Expand primary eye care capacity by training at least 1 primary health worker per 5,000 population in basic eye screening and referral.
4. Increase the national eye health workforce density by 25%, with a focus on equitable rural distribution and task-sharing models.
5. Establish nationwide referral and data systems, ensuring that 90% of detected cases from community screening are traceable through referral pathways by 2028 with culturally specific communications with meaning.

INTERNATIONAL EYE HEALTH NGOS

Eye health NGOs must transition toward system-aligned, capacity-building roles that strengthen sustainable national delivery.

1. Align country programmes with national eye health strategies and Ministry of Health plans.
2. Invest programme budgets in capacity building (training, systems strengthening, workforce development) rather than solely direct service delivery.
3. Support scale-up of integrated community-based models and affordable technologies.
4. Embed community engagement strategies in all programmes in target populations through trust-building interventions by 2028.

DEVELOPMENT NGOS

Development NGOs should recognise eye health as a cross-cutting enabler and integrate it across sectors.

1. Integrate basic eye health screening or referral into core programme areas (e.g. education, livelihoods, disability inclusion).
2. Ensure inclusive education programmes include vision screening and access to corrective services for children.
3. Facilitate access to assistive products (e.g. glasses) for identified programme participants.
4. Invest in staff capacity building, ensuring programme staff in health, education, and livelihoods sectors are trained in basic eye health awareness and referral pathways.

UN ORGANISATIONS

UN agencies play a critical role in standard setting, coordination, and technical leadership.

Recommendations to UN agencies include:

- Integration of eye care indicators into all national health information systems that the UN and multilateral funders are supporting.
- Provision of technical support to governments to implement IPEC frameworks.
- Strengthening regional collaboration platforms for eye health policy and planning, recognising shared contextual constraints.
- Inclusion of eye health in broader Universal Health Care and disability strategies.

Additional stakeholders who have a role to play in eye health planning can adapt their priorities and practices to contribute to a world where avoidable blindness is eliminated.

Philanthropic Organisations are well-positioned to support innovation and scale where public financing is constrained.

Recommendations include:

- Investment in scaling frugal technologies such as Arclight and portable retinal imaging, catalysing and demonstrating proof-of-concepts at a country level.
- Funding implementation research to evaluate and adapt scalable models.
- Catalytic funding for early-stage digital health and AI screening initiatives and

supporting approaches that make these accessible in resource-constrained settings.

- Support for cross-country learning and replication of successful programmes.

Private Sector Actors play a critical role in innovation, product development, and service delivery and have the opportunity to adapt their business models to contribute to social development in low-resource settings.

Recommendations include:

- Development and scaling of affordable diagnostic, pharmaceutical, and assistive technologies for low-resource settings.
- Partnerships with governments to support supply chains and distribution systems, transferring skills and processes from the private to the public sphere.
- Investment in digital health and AI-enabled screening platforms aligned with public health systems, costed appropriately to resource constrained settings.
- Pricing models that ensure accessibility and equity, even through subsidisation recognising ability to pay in different settings.
- Include in Corporate Social Responsibility mechanisms for skills transfers, training schemes and knowledge sharing across contexts.

Research Institutions are essential for evidence generation, evaluation, and innovation.

Recommendations include:

- Conducting population-level eye health surveys to support policy planning.
- Evaluating implementation and cost-effectiveness of scalable models.
- Collaborating with governments and NGOs to translate research into policy and evidence-based models.
- Facilitate knowledge, research and skills transfers across countries and institutions.

Professional Associations have a critical role in workforce development, regulation, and standards.

Recommendations include:

- Supporting expanded scopes of practice aligned with task-sharing approaches.
- Developing and delivering interprofessional education programmes.
- Establishing clinical guidelines aligned with WHO standards.
- Advocating for workforce expansion and equitable distribution, as well as mechanisms for skills transfers and cross-country collaboration amongst eye-health professionals.

CONCLUSION

The elimination of avoidable blindness is no longer a technical challenge, but a political and systemic one. The tools exist. The evidence is clear. The remaining task is to organise health systems, financing, and communities around what is already known to work. The imperative now is implementation—**everywhere, for everyone, and at scale.**

In advance of the **Global Summit for Eye Health** in Antigua & Barbuda in November 2026, A Global Lens on Eyecare is advocating for **SMART, measurable, system-strengthening commitments** supported by the necessary funding to support investment accelerators in bridging the gap to accessible, inclusive, eyecare for all.

The evidence presented at the Global Lens on Eyecare event and reflected in this policy brief leads to a clear conclusion consistent with WHO and IAPB frameworks:

Avoidable blindness persists not because solutions are unavailable, but because they are not delivered equitably at scale.

The Global Summit for Eye Health presents a unique opportunity to translate this understanding into tangible commitments. By aligning stakeholders around integrated systems, sustainable financing, workforce transformation, artificial intelligence, mobile technologies and community-centred approaches, the global community can move decisively toward the elimination of avoidable vision impairment.

The imperative is no longer to identify solutions, but to implement them—systematically, sustainably, and universally with the financial commitments necessary to make this possible.

Having co-sponsored the 2021 UN Resolution **75/310 *"Vision for Everyone: accelerating action to achieve the Sustainable Development Goals"***, with Antigua and others, there is an appropriate follow-on role for Ireland to take the lead 5 years later at the Global Summit for Eye Health in Antigua in demonstrating clear and unambiguous commitments to eye-health care in its international development assistance.

The 2021 resolution asks for international financial institutions and donors to provide targeted finances, especially to support developing countries in tackling preventable sight loss. H.E. Ambassador Aubrey Webson, Permanent Representative of Antigua and Barbuda to the United Nations and founding co-chair of the UN Friends of Vision group said in 2021.

"An eye test for a child can be the difference between inclusion and exclusion; A pair of prescription glasses, the difference between access to information and seeking a livelihood and not. Corrective eye treatment, the difference between improved sight and total loss of sight. The gift of sight for the 1.1 billion people living with preventable sight loss is within reach if we ensure world leaders deliver on this moment."

That statement remains as true today as it did in 2021. The opportunities and the technologies are accelerating. The need for financing remains.

ANNEX: A GLOBAL LENS ON EYECARE OVERVIEW

21st April ’26 The Pillar Room, Dublin

CBM Ireland is a registered charity in Ireland, working on disability and eye-health as part of the CBM Global federation, across Africa and Asia. Charity Regulatory Authority No: 20050405 CHY No: 14987. We receive funding from the Irish government (Irish Aid) and the EU, as well as having independently audited accounts annually, compliance with the Charities Regulator Code of Governance and Triple Lock approved by the Charities Institute of Ireland. We are also in full compliance with our requirements under Revenue. More can be found about us at www.cbm.ie

Welcome from Dualta Roughneen, CEO, CBM Ireland

Opening Remarks from **Mr. Neale Richmond TD**, Minister of State at the Department of Foreign Affairs and Trade with responsibility for International Development and Diaspora

Dr. John Sandford-Smith is an emeritus Consultant Ophthalmologist at Leicester Royal Infirmary. He is a widely-respected expert on eye diseases and has been extensively involved in teaching, training and voluntary work. In 2007, he received an MBE for services to blind people in developing countries.

Setting the Scene, the challenge of eyecare in developing countries

Dr. Tunde Peto, Professor of Clinical Ophthalmology at QUB, Clinical Lead of the Northern Ireland Diabetic Retinopathy (DR) Screening Programme

From local to global eyecare: diabetes Due to a family bereavement, Dr Peto was unable to present.

Dr. Sirjhun Patel, Glaucoma Consultant Ophthalmologist, West Suffolk NHS Foundation Trust.

Detecting Glaucoma in Low-Resource Settings: Drawing on work with The Arclight Project

Dr. Jonathon Jackson, Consultant Optometrist and Director of the Northern Ireland Clinical Research Network (NICRN)

Low Vision training in a multidisciplinary context - applications for Ireland and abroad

Dr. Andrew Blaikie, Consultant Ophthalmologist NHS Fife, Senior Lecturer University of St Andrews

The Arclight Project: Frugal Tech that Saves Sight

Mr. Jaona Lala Iandrinirina, Regional Eye-Health Advisor, CBM Global

Newborn eye screening in Madagascar by community health workers

Dr. Gatera Fiston Kitema, Lecturer in Global Ophthalmology at the University of Rwanda

Rethinking teaching eyecare- lessons from Rwanda and relevance for Ireland

Dr. Ving Fai Chan, Associate Professor in Global Eye Health at Queen’s University Belfast

Arts, Culture, and Child Eye Health: improve referral adherence, community engagement, and trust in eye-health services

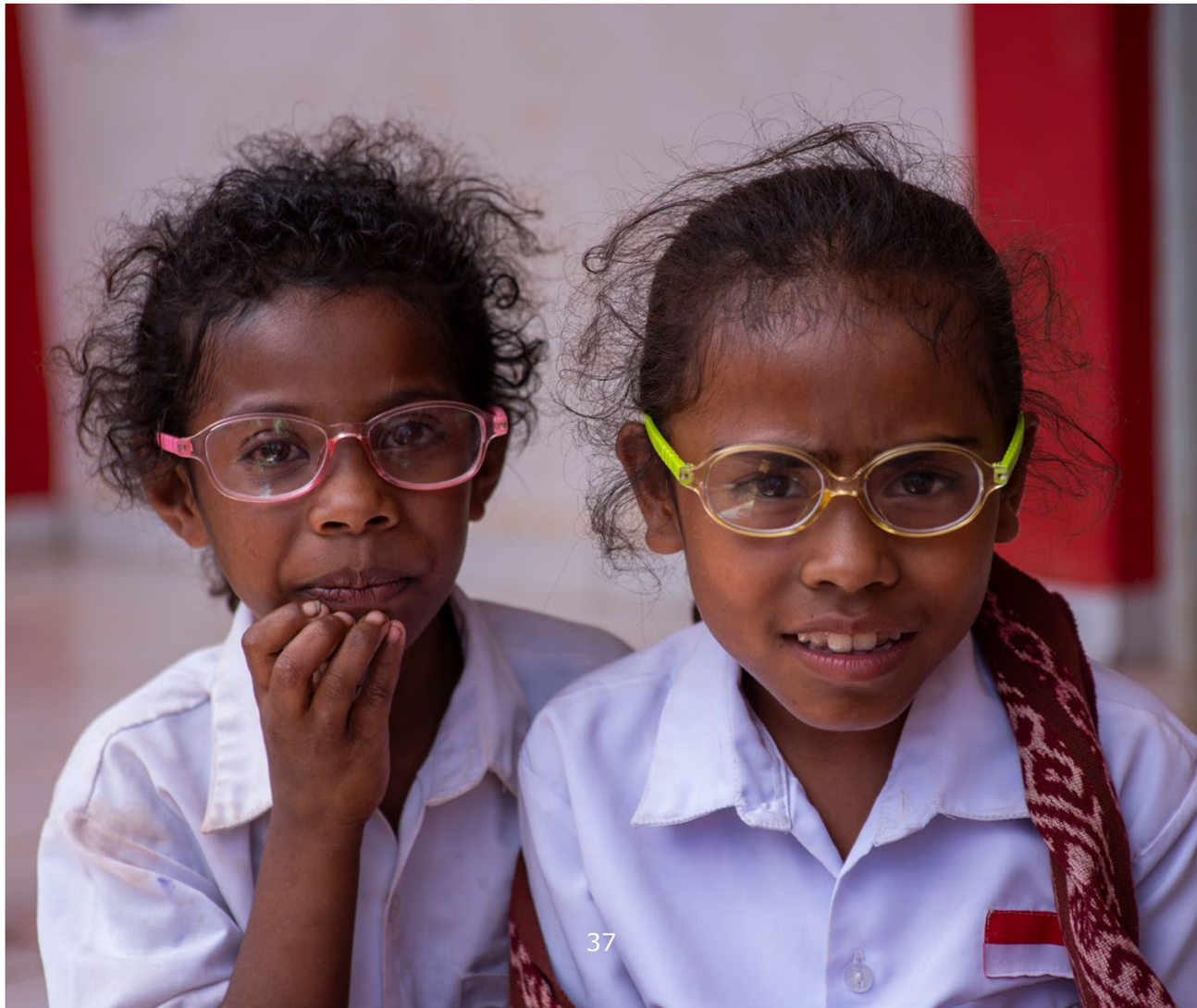
Dr. Kate Coleman, RRCOphth Consultant Oculoplastic Surgeon, Blackrock Clinic, Dublin and founder of iKey

Catching the Silent Thief of Sight at last... SightTrack

Dr Fatima Hamroush, Consultant Medical Ophthalmologist & Clinical Director, Drogheda Medical Eye Clinic, specialist in neuro-ophthalmology and glaucoma care and former Libyan Minister of Health

Beyond Aid: Building Accountable and Sustainable Eye Care Systems

Mr. Jason Smyth is Ireland’s most decorated Irish Paralympic Athlete. Diagnosed with Stargardt’s disease, a condition that severely limits his vision, Jason has won six Paralympic Games golds. His incredible achievements earned him the title of *“Fastest Paralympian on the Planet.”*



Committed to improving the quality of life of people with disabilities and those at risk of disability, in low-income regions of the world.

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