EDITORIAL

A call to pool our regional resources through conversation, collaboration and collective action

Providing eye care to all who need it wherever they are has continued to be a challenge in our region. Among the challenges cited include on one hand the lack of adequate accessible and appropriate infrastructure and trained personnel to tackle different disease conditions while on the other hand the current cost of those services that are available makes them unobtainable by the poor. As the population we serve grows larger and older in the coming decades these issues will only be exacerbated.

Each country in our region has a diversity of challenges when it comes to delivery of eye care but more importantly each country has unique strengths that others can learn from. One of the ways in which eye health professionals can help to improve the poor state of eye health in Eastern Africa is through regional cooperation and collaboration, leaving out what did not work in the neighbouring country and grasping and building on what works well. Better still we can put together small successes in each country and come up with huge regional success stories.

Let us examine which collective and collaborative actions we can initiate to ensure high quality eye care is available "universally" in our region by addressing critical eye health problems through a regional approach, rather than by individual country action.

Regional Interaction

We often read newspaper headlines such as **"***Members of Ugandan EAC Ministry in Rwanda for bilateral best practices discussions***";** *"Kenyan delegation learns from the Tanzanian experience of mainstreaming environment"*. Let us learn from our politicians and set up regular communication channels to share innovative, comprehensive approaches to address specific eye health issues. An annual scientific congress is not enough. We need more peer exchanges, capacity building workshops, and study tours so that we can share best practices, model policies, and technical expertise to help strengthen our eye programs. We could even develop joint mechanisms to monitor progress towards the elimination of avoidable blindness in our countries. Let us ease cross border movement for patients. Uhuru Kenyatta the President of Kenya in a recent summit in Kampala called for a common East African Community Tourist Visa. Let us take advantage of this and other initiatives such as the East African Community e-identity cards that ease the logistics of cross border travel. Examples exist outside our region -55% of patients undergoing cataract surgery in Nepal come from India. Why should a person from Kirundo in Northern Burundi not travel to Kigali in Rwanda for his surgery rather than taking the much longer journey to Bujumbura? Let us do this in a professional way by setting out a legal framework providing clarity about the rights of patients who seek eye care in another country.

Regional Training Initiatives

We could initiate a program to stimulate contacts and exchanges between existing universities and other training institutions. This program should go hand in hand with programs which promote student mobility and inter-university contacts and cooperation. It would also cover joint appointments, multi-badged degrees, credit transfer arrangements for students, pooling teaching resources, joint professional development activities, and the consolidation of appropriate support functions.

Organizations like The College of Ophthalmologists of Eastern, Central and Sothern African region (COECSA) could develop the open method of coordination in training. This would be voluntary cooperation of the training institutions in the Eastern African member countries. The method uses a series of jointly-agreed tools- objectives, guidelines, indicators, benchmarks and good practices – to improve policies and practice. By using the open method, there would be no official sanctions for those who don't comply but rather, the method's effectiveness would rely on peer pressure and naming and shaming, as no country would want to be seen as the worst in a given policy area.

Let us divide training responsibilities. COECSA countries have a critical shortage of healthcare workers. This in turn translates to an even more acute shortage of medical trainers. Rather than having a proliferation of mediocre poorly resourced training institutions in each country why not divide responsibilities so that different countries are supported to excel say in their area of strength such that we could have an optometry training centre of excellence in Tanzania, a superb residency training in Kenya, corneal subspecialty training in Rwanda, ophthalmic nursing centre of excellence in Mbarara, a Vitreo-Retinal Centre in Tanzania and so on.

Joint Research

Institutions in the COECSA region, whether academic or in service delivery, bring to the table specific competencies and resource capabilities.

Joint scientific and technological cooperation agreements, based on clearly understood mutual benefits would serve to increase the exchange of knowledge and know-how. Multicentre research would involve larger number of participants, different geographic locations, inclusion of a wider range of population groups, and allow comparison of results among centres. These advantages would all increase the generalizability of regional data and help fill in the large gaps in knowledge that exist in our region

Despite the limitations we may have as individual countries in the delivery of eye care we all have the same goals. In unison the resources we have individually can go a longer way and benefit many more. And before we even embark on this as a region we could first learn to communicate, collaborate and act collectively within our own countries.

Wanjiku M, MBChB, MMed, MSc, PhD, FEACO, Consultant Ophthalmologist, Director of Training and Research Rwanda International Institute of Ophthalmology/ Dr Agarwal's Eye Hospital, Kigali, Rwanda
Email: ciku@email.com