

Teams for better ophthalmology care

The College of Ophthalmology of Eastern, Central and Southern Africa (COECSA) annual scientific congress has been successfully held in the different countries of the Eastern, Central and Southern Africa (ECSA) region over the last 4 years. This year, the annual congress will make its half-decade mark. The Uganda Ophthalmology Society will host it on the 16th - 18th August at the Commonwealth Speke Resort Munyonyo, Kampala, under the theme “*Team Work in Eye Care*”.

With a few years remaining to 2020, the Vision 2020: reducing avoidable blindness target year, there has been tremendous success in fighting avoidable blindness globally. However, the challenge still remains with 39 million people estimated to be blind and 285 million to be visually impaired¹. The usual suspects: cataract, glaucoma, uncorrected refractive error, childhood blindness as well as the emerging threats such as diabetic retinopathy still remain major challenges, particularly in sub Saharan Africa. This year's congress is dedicated to exploring how the different stakeholders of eye care in the region have worked together and/or can begin to work together to re-energise efforts to fight avoidable blindness. It comes on the backdrop of several economic, political and technological changes since the vision 2020 declaration in 1999. These have created challenges such as reduced donor support, which needs to be innovatively and sustainably overcome; as well as opportunities such as low cost technological advances that must be exploited.

There have been several success stories from teams created for better eye care in the ECSA region. This has been noted in establishment of COECSA speciality communities, the LINKS program that has given birth to networks for diabetic retinopathy and retinoblastoma, as well as increased opportunities for collaboration and shared learning among the different stakeholders.

Communities of practise: COECSA has established different communities of practise that bring together different ophthalmologists interested in a particular area and enable them to exchange ideas. Some of these have cascaded into development of regional treatment guidelines. In the planning of this year's congress, we reached out to these different communities to set the agenda of breakout sessions and have conversations around the most pressing issues in their different areas. They will learn from each other and recommend some action points going forward. For example, in the anterior segment session, the key discussion is on how to establish corneal banks in the different ECSA countries using the Ethiopian case study. In the glaucoma session, the key discussion is on stopping glaucoma in Africa. The manager's session will focus on why programs succeed and community eye health will take stock of case studies of successful interventions for public eye health.

Role of non-ophthalmologists: If we are to succeed in our efforts, there is need to not only work together as ophthalmologists but as all stakeholders in eye care. For example, the success of a cataract program comes not only from having the best surgeon, but also from a manager who plans and handles logistics and an ophthalmic clinical officer who screens and does pre-op basics. There also needs to be someone to do biometry, a theatre anaesthetist/nurse to block, a counsellor to advise post op care, a follow-up nurse to ensure follow-up, and an optometrist to ensure best correction. Therefore, this year's congress is dedicated to recognising the role of managers, administrators, allied health and educators in eye care. Unlike the previous congresses, which focused mostly on ophthalmologists, this year's congress will provide special sessions for educators, managers, and allied health workers to exchange views on their individual roles in eye care. Our hope is that this will cascade into establishment of non-ophthalmologist COECSA communities of practise and set a precedent for subsequent congresses.

Integrating to primary health care: A great deal more still needs to be done to maximise human resource for eye care. Although there have been tremendous leaps in training human resource for eye care, with an increase in the number of ophthalmologists, ophthalmic clinical officers, and optometrists, the numbers are still insufficient. For example, in Uganda, the host country, there is only 1 ophthalmologist per million and 5 OCOs per million. These figures fall far too short of the VISION 2020 recommendations of 4 ophthalmologists per million and 10 OCOs per million². One way to address this gap, as we continue to encourage training, is to integrate eye care into primary health care. A number of regional studies show that mid cadre and primary health workers still have insufficient knowledge and skills and knowledge in eye care³⁻⁶. Other studies show that in developing countries, primary health care workers can help reduce the levels of blindness, especially in children^{7,8}. Having front line health workers not well skilled and equipped in eye care has a number of potential problems such as misdiagnosis, mistreatment, delayed referral and eventual poor outcomes. In two separate studies in Tanzania and Kenya, patients who visited lower health care facilities were more likely to present late to eye hospitals^{9,10}. This highlights the fact that all efforts to train and equip primary health care workers in eye health should be encouraged.

Interdisciplinary networks: Diabetic retinopathy is now one of the emerging leading causes of avoidable blindness¹¹. The Vision 2020 LINKS program has tremendously contributed to addressing this by initiating a global DR-Network. This network consists of NCD managers at ministries of health, program administrators, physicians, and ophthalmologists. It has created a

platform of shared learning on the best practise. For example, at a DR-Net review meeting in 2016 on the side-lines of the IAPB congress in Durban, it emerged unanimously that the best practise for screening for DR was if ophthalmologists and physicians began talking. There was overwhelming evidence that ophthalmologists needed to move from their comfort zones in the eye clinics and take the screening to the physicians' diabetic clinics. Most of the institutions in the ECSA region have already adopted this and have set up fundus cameras in the diabetic clinics.

Another network that has been set up through the LINKS program is the retinoblastoma network. Retinoblastoma is one of the leading causes of blindness and mortality¹². Management is more difficult in Africa due to late presentation of the children to the hospitals, lack of well-trained ocular histopathologists, limited treatment options and social complexities. The retinoblastoma network has brought the different players together and linked them to centres of excellence in India and Europe. This will help in creating an enabling environment to find local solutions to this problem.

Teamwork in research: The COECSA congress provides a great opportunity for researchers in the region to share their work. There is enormous potential for researchers in the region to collaborate on large multi-centre projects. This year's congress will have two special sessions on research skills for lecturers and young ophthalmologists with an interest in research. It will also have the launch of the COECSA research repository, a platform that will increase the research output of eye related research in the region¹³.

Unity is our strength and with these partnerships, we will bring this vision into reality.

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