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LIGHT FOR THE WORLD is a European confederation of national development NGOs committed to saving eyesight, improving the quality of life and advocating for the rights of persons with disabilities in underprivileged regions of our world.

Our priority countries are Burkina Faso, Ethiopia, Mozambique, South Sudan, North East India, Pakistan and Bolivia. In addition, we are active in 9 partner countries in Africa, Asia, the Pacific, Latin America and Europe.

LIGHT FOR THE WORLD has been actively involved in Blindness Prevention Programmes in developing countries for over 20 years. We strive to achieve the goals of VISION 2020 in aligning our work to national prevention of blindness strategies. We support comprehensive eye care programmes, trachoma and onchocerciasis control, and human resource development for eye care professionals. Our focus is on removing barriers and creating fully accessible eye health services for local communities, especially for those who are poor or excluded.

In 2011 our programmes reached 1,037,397 people and more than 41,000 cataract surgeries were performed.
Dear Reader,

in sub-Saharan Africa on average there is one ophthalmologist for every 1 million people. Taking unequal distribution and a huge urban bias into account, the picture becomes even gloomier.

In this issue of Vision & Development you will read about the general challenges and a possible way forward for human resource development for eye health at a global level, the need to move beyond training to effectively enhance human resource capacity and the damaging effects caused by the brain drain of health specialists from Africa.

Ophthalmologists and the private sector can do much to support the development of a sufficient and effective eye health workforce. Funding scholarships and training programmes, providing equipment and supplies, and passing on technical skills and expertise are all important steps towards improving access to eye health for people living in poverty in developing countries.

LIGHT FOR THE WORLD is supporting the training of eye health workers at all levels, a few such initiatives from East Africa, Burkina Faso and Northeast India are highlighted in this issue: We currently provide scholarships for 23 residents at the University of Nairobi, the KCMC in Moshi/Tanzania and the IOTA in Mali. It is a long-term investment that pays off, as experience of the pioneering work at the University of Nairobi shows. The postgraduate training for ophthalmologists was founded in 1978 and over the years, the eye department of Nairobi has become the largest training institution for ophthalmologists in Sub-Saharan Africa. It has trained over 160 ophthalmologists from 12 African countries. Young ophthalmologists, trained in Nairobi, now form the backbone of eye-care programmes in countries like Cameroon, Malawi, Zambia and parts of Uganda and Ethiopia, among others.

Today, health professionals from Kenya, Tanzania, Ethiopia, Burkina Faso, DR Congo, Burundi, Zambia and South Sudan benefit from the LIGHT FOR THE WORLD programme, and in the near future, they will form an important part of the eye health workforce in their own countries.

Yet training alone cannot change the situation. Once graduated, the ophthalmologists need support in settling down and establishing a conducive work environment. Good performance and retention of such staff require close collaboration with the health authorities of the respective countries, attractive employment packages and the availability of necessary equipment and supplies. Last but not least, it is not the ophthalmologists alone who make the difference. A dedicated eye care team is required, effectively combining different skills and responsibilities. LIGHT FOR THE WORLD is therefore not only committed to continue its scholarship programme, but also to provide necessary support after graduation.

We want to thank our partners who have supported us a great deal over the last few years in building up our initiatives in human resource development, and to call on others to partner with us,
Human Resource Development
A Global Challenge and a Way Forward

Dr Babar Qureshi
is a member of the IAPB Human Resource Programme Committee and Senior Medical Advisor to CBM

VISION 2020: The Right to Sight is a global initiative jointly launched by the World Health Organization (WHO), and the International Agency for Prevention of Blindness (IAPB). VISION 2020 aims to eliminate avoidable blindness by the year 2020. The development of sustainable, affordable & equitable comprehensive eye-care systems as an integral part of the national health care systems based on the principles and practices of primary health care is key to achieving this goal. Human resource development (HRD) is an essential component of the VISION 2020 programme and has been recommended as part of all existing and future VISION 2020 action plans. Many attempts have been made to get a handle on the available human resource globally.

In 2006, IAPB’s Human Resource Programme Committee (HRPC) published their findings from the first ever global situational analysis of the HRD in comprehensive eye care. Since then, other institutions have also undertaken studies and the latest one on ophthalmologists by Dr Serge Resnikoff is currently in press.

There are a number of common problems when collecting such data:

- problems of agreed definitions of different cadres;
- paucity of data at country levels;
- difficulty of having one focal point; and
- scattered information.

However, despite these challenges sufficient data are now available through WHO, IAPB and ICO to enable the planning of human resources for eye care at country level.

Of all elements in VISION 2020 - The Right to Sight, Human Resource Development has proven to be the most challenging yet the most effective one.

The Challenge

Blindness places an immense socioeconomic burden on the individual, the community and the state at large. Nearly 90% of the burden of blindness and visual impairment is borne by the developing countries of the world. This complex socioeconomic scenario complicates the already compromised economies of these countries. VISION 2020 has emerged as a symbol of hope for millions of those who have been thrown into the ruthless darkness of blindness. Almost a decade has


passed since the launch of VISION 2020 in 1999. Of all of its elements, HRD has proven to be the most challenging yet the most cost-effective.

The last decade has seen tremendous achievements in terms of political commitment, global support and implementation of the VISION 2020 programme at national level in many countries. However, a lot remains to be done, especially in terms of HRD.

The need for HRD is greatest in developing countries. They not only lack the required health workers but also face the dual problem of a non-existing HRD plan and structure. In addition, despite the fact that right from the outset VISION 2020 has recommended the development of eye care teams and not just the cadre of ophthalmologist, the whole range of eye care workers are lacking. Unlike infrastructure and technology, which is relatively easy to buy, human resource needs to be developed, deployed, retained and continuously provided with medical education, and professional and ethical development. In view of the experience that we have gained in HRD for comprehensive eyecare over the past decade it is imperative to identify the challenges that we must face and resolve if we sincerely wish to achieve the goals of VISION 2020.

**The Way Forward**

1. We need to seek continuous, sustained socio-political support for the HRD segment of the VISION 2020 programme, regionally, nationally and within various professional communities concerning eye care personnel. In this context special emphasis needs to be made on understanding the unique needs of the

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developing world and the need for countries with similar needs and socio-economic environments to collaborate with each other. A forum for sharing information and experience of HRD can facilitate structured interaction between these countries. Each country then needs to focus on the development of a national eye care programme with a strong HRD component.

2. We need to focus on the development of eye care teams, including various cadres of eye care workers for different levels of eye care delivery i.e. primary, secondary and tertiary levels. Each level has its own HRD needs and these must be addressed accordingly.

3. We must standardise HRD across all cadres of eye care personnel in terms of curricula; level of skills development; teaching, training and learning methodologies, and the provision of CPD (continuing professional development) and CED (continuing ethical development). Training courses need to focus on community and public health perspectives as well as on planning and management. This could be achieved through the national eye care programmes.

4. Strong emphasis needs to be placed on the ongoing collection of up-to-date data concerning HRD at national level through the national eye care programme. All public health measures regarding blindness prevention need to be based on empirical research and not mere estimation and conjecture. The data from the countries then need to be collated at the regional and global levels.

5. A workshop should be organised by WHO, IAPB and ICO, to establish global definitions for different cadres of HR working in eye care.

6. Data on institutions involved in training and certifying different cadres of eye care workers need to be collected at country level and then collated at regional and global levels.

7. We recommend that National Human Resource Development Task Forces be developed with specific terms of reference including situational analysis, formulation of a strategic plan, implementation, monitoring and evaluation of HRD for comprehensive eye care services.

8. Regional information resource centers networked with similar country-based units/ centers need to be developed for HMIS in eye care. The issue may be dealt with in the framework of VISION 2020 programmes as VISION 2020 regional and local resource centers for information capable of regular updating and circulation of information.

We have already made significant progress since Vision 2020 began.5

Eye care is more fortunate than many other fields of health in terms of what has already been achieved around HRD. But much remains to be done and we have less than a decade to achieve it. Therefore, it is vital to plan strategically for our future HRD needs and to meticulously follow our plans.

Acknowledgements:
I acknowledge the contributions of the Human Resource Programme committee especially Dr Bruce Spivey, Dr Pararajasaegram (Co-Chairs), Dr Suzanne Gilbert the co-ordinator of the committee and Dr Ayesha Abdullah.


Training courses need to focus on community and public health perspectives as well as on planning and management.
International Recruitment of Health Workers

A boost to inequities in health care provision

Liliana Marcos (FPFE) and Mareike Haase (terre des hommes Germany), Advocacy officers for Action for Global Health.

Each year, Europe trains around 173,000 doctors. Africa – a continent which bears 24 per cent of the world’s disease burden – trains just 5,100 doctors. Shockingly, only three per cent of the world’s doctors, nurses and midwives work in Africa. The World Health Organization (WHO) considers that a country is “in crisis” when it has less than 2.3 health professionals per 1,000 people, and that 57 countries face a severe shortage in their healthcare workforce. Guinea, Somalia, Niger and Sierra Leone have less than 0.2 health workers per 1,000 citizens.

The shortage of health workers in developing countries is the result of multiple factors such as difficult working conditions or a lack of training and recruitment systems. But the situation is made far worse by the inequity in the distribution and mobility of health workers. Health workers, like most people, tend to prefer living and working in areas where there are higher standards of living, safety and a good infrastructure are guaranteed. While in Senegal 20 per cent of the country’s population lives in the capital, Dakar, 50 per cent of its physicians work there. That means that the rural areas are under-served and this constitutes a major barrier to health access for all. 80 per cent of rural doctors in South Africa migrated from Zambia and Zimbabwe, since even the rural areas there provide much better living standards than in their home countries.

The inequities in healthcare provision are most apparent when we compare a country as rich as Spain, for example, and somewhere like Haiti. In Spain there are 9.5 health workers per each 1,000 citizens, while in Haiti they have only 0.36 workers to the same ratio of people. Our planet is getting smaller, which is great news because it makes migrating possible between urban and rural areas or even internationally. However, it also impacts on health inequities. Half of Haitian doctors are working in countries that are members of the Organisation for Economic and Co-operation and Development, (OECD) which includes all of the EU member states. International migration and recruitment of health workers from low- to middle- or high-income countries is an important factor in making the equitable provision of health services impossible.

To find the perfect balance between the right of communities to enjoy the highest standard of health, and people to migrate, the International Community agreed in 2010 on a voluntary Global Code of Practice on the International Recruitment of Health Personnel drawn up by WHO. The code tried to establish conditions for a win-win situation through fostering efforts to train enough health workers to address the global shortfall. It also aims to improve working conditions so that less people migrate. When recruiting from abroad, destination countries are asked to uphold agreed ethical and legal norms and embed them in their national policies, but not to stop people from migrating. Migration in itself is not the problem; the problem is that there is a global gap of 4.3 million health workers and, in a free market without regulation and with more demand than supply,
those with more money get access to the best care.

Along with the requirement for the countries to plan their professional needs in advance and train their own workers in a self-sufficient way, the code includes the idea of compensation. The richer country should, through its cooperation with development policies and within partnership agreements, compensate the country of origin by supporting the training of more health workers or strengthening its health system. In this way, and even if it takes time to fully implement the code, poorer countries will not lose out.

The challenge now is to ensure that the voluntary code is implemented by the international community. Our network, Action for Global Health, is advocating for the strengthening of health systems through adequate training of more healthcare workers in the developing world, and for the international community to implement the code. We have published a report, Global Health Workforce Crisis: Challenges for France, Germany, Italy, Spain and the UK, which assesses the performance of European governments against the commitments in the code, with the aim of monitoring and communicating how it is being implemented over time. In the last week of March 2012 our conference in Germany brought together the country’s Ministry of Health, WHO and the People’s Health Movement in Zimbabwe among others, where the German government announced a national authority for the implementation of the code.

Access to health for all is one of the key ways of pulling people, and communities, out of poverty. To find out more about our work, and give us your support, you can go to www.actionforglobalhealth.eu.

Rural areas in developing countries are underserved. Migration is one of the contributing factors. 80 per cent of rural doctors in South Africa migrated from Zambia and Zimbabwe.

Action for Global Health

Action for Global Health is a network of health and development organizations from six European countries and Brussels, advocating for the European Union and its member states to play a stronger role in improving health in development countries. AfGH takes an integrated approach to health and advocates for the right to health for all.
In 2010, sub-Saharan Africa had an estimated 1,200 ophthalmologists. Other eye health personnel included 225 cataract surgeons, 450 optometrists and about 4,000 mid-level eye health workers. While these figures are estimates, they provide clear evidence of the magnitude of the gap to be addressed in an area of 850 million people, with high population growth rates informed.

To bridge the human resource for health gap sustainably, there is no option but to build up the local workforce, who provide healthcare to the people, starting at the community level. There is, therefore, no doubt that there is an urgent need to dramatically scale up training. In his article ‘Human Resource Development: A Global Challenge and a Way Forward’ (see page 4), Dr Babar Qureshi has highlighted a number of enabling factors to make training initiatives effective: understanding the specific needs of developing countries, South-South exchange, developing eye care teams, standardisation of curricula, adequate methodology, focus on public health perspectives, data collection and interpretation for a strategic approach, and effective monitoring and implementation.

However, even if an eyecare training programme is set up in such an enabling environment and high quality training is offered, its effectiveness to develop a strong human work force for eye health in a country cannot be guaranteed. Experience in all sectors of development co-operation shows that completing the training aspect of development initiatives does not automatically lead to the desired results. The chain of ‘people trained’ to ‘people perform’ to ‘change takes place’ does not automatically happen.

In proper training equipment, consumables and necessary resources to work professionally are made available. Unfortunately this is often not the case at the work places graduates are deployed to. The provision of an adequate tool-set upon graduation partly addresses this situation. But the overall resourcing of training in the work place to which a graduate is sent, also needs to be addressed. This needs to go beyond the individual graduate to the needs of the whole eye care team to be effective. How frustrating must it be for a motivated, newly trained person not to be able to perform, simply because they lack essential tools.

The work environment to which trained people are deployed, can differ significantly from their training work environment. While practical exposure during the training period...
provides some idea, joining an existing eye care team as a full-time junior staff member is a different challenge, especially in small eye care team settings. Coming in and suggesting change is not always a successful or immediately rewarding exercise. Management are not always able to offer a meaningful process of integration into a team and to adjust the work routine accordingly.

Supervision and monitoring frequently stops with the end of training. If deployed into a smaller team without capacity to provide guidance and supervision, graduates lose an important source of reassurance, confidence building, technical competence and continuing professional knowledge. Modern information and communication technology can provide opportunities for long-distance professional tutoring and personal mentoring.

Last but not least, the importance of living conditions and career development should not be underestimated. Salary levels and social benefits are an important aspect of this, as are the living environment and opportunities for future professional development. Investing in long-term professional training needs to pay off.

A conducive environment for family life, decent housing, access to communication technology and good schooling for children may be unrealistic in rural settings, but it may be possible to address some of these factors.

Investment in the professional development of motivated eye health workers by offering support to access continuous medical education and professional exchange, ideally leading to career development opportunities, is key.

Finally, it is important to engage trained eye health staff in areas in which they are qualified. This means carefully considering how to assign new responsibilities. There might also be the need to challenge the human resource management systems, e.g. when further career positions with higher employment benefits are only open to different job profiles. Not every good clinician is also a good manager.

Certainly the extent to which these factors are relevant and drivers for success or failure in deploying and retaining human resources in eye care depends on the environment (rural/urban), the institutional set-up into which a graduate is deployed and on the graduate him/herself. A sound assessment at the time of placement, ideally with relevant stakeholders involved, could help a great deal to focus on the key change factors.

Some of the issues highlighted may already be addressed during the training, by e.g. giving the right exposure to real work environments in low resourced settings, stimulating creative thinking to find solutions in problem based learning settings, promoting collaborative and multi-level interaction, among others.

Others need a strategic approach and a clear commitment from policy makers, training institutions, professional societies and NGOs to invest beyond training, not least for economic reasons, as training without proper follow up and support can be considered a stranded investment.
Improving Vision – Impacting Lives

Eye health workers in communities:
The key to eye care in rural Assam, Northeast India

Johnson Parackal,
Director, Bosco Reach Out

Bosco Reach Out has used its experience of community participation and building on people’s own knowledge and experience to bring the highly successful Community Comprehensive Eye-Care Outreach Programme to the rural villages of Assam.

Implemented in partnership with the Regional Institute of Ophthalmology and supported by LIGHT FOR THE WORLD, this new eye-care programme has already made a remarkable impact because of its strong community participation, human resource management, participatory approach and well-coordinated efforts. As a people’s organisation, Bosco Reach Out (BRO) designed the entire programme around the concept of the community as both a stakeholder and partner. This definitely has paid rich dividends in terms of ownership and commitment from all sections of the community.

The programme included training for teachers, village leaders and volunteers from the neighbourhood. Many of the teachers who received training went on to play significant roles in raising awareness of eye health among the children and in checking their vision. Any children identified as having vision issues were referred to doctors visiting from the Regional Institute of Ophthalmology (RIO). The village leaders and volunteers helped to ensure the smooth running of the outreach by organising people, acting as translators between doctors and patients, and also by helping to check people’s vision.

RIO did an admirable task in screening large numbers of people who came to the outreach camps. The doctors and paramedical staff also trained all of the volunteers, school teachers, community leaders and social workers. To date, more than 1,000 patients have benefited from surgery and many more have received proper treatment from the programme who would otherwise have been unable to afford it. During 2011, over 12,300 people had received treatment after attending the outreach camps.

Bosco Reach Out clearly demonstrates the effectiveness of partnership working between doctors, social workers, NGO partners, teachers, community leaders and volunteers. The participatory nature of the programme also proved to be a great strength. This programme has truly caught the imagination of people in the rural areas of Assam and has ensured that they will see a much brighter future.

Bosco Reach Out

Bosco Reach-Out (BRO) as the name itself suggests tries to ‘reach out’ to the most deprived sections of society in the remote northeastern parts of India. BRO is the social action wing of the Don Bosco province of Guwahati, which operates in the four states of Assam, Meghalaya, Mizoram and Tripura. Since its inception in 1983, it has immersed itself fully in developmental activities in the region leading to social transformation and economic empowerment of the masses. As a pioneering NGO, it has spearheaded people’s movements by initiating self help groups (SHGs), female empowerment and community development programmes. It has also initiated various health programmes.
African Ophthalmologists on the Rise

LIGHT FOR THE WORLD scholarships

The lack of qualified local eye health staff is one of the main barriers to achieving the goals of VISION2020 – The Right to Sight. Scholarships for medical doctors to specialise as ophthalmologists have proven to be an effective way to address this shortage.

Dr Remezo Philbert, one of the residents in ophthalmology, currently supported with a LIGHT FOR THE WORLD scholarship explains that: “As a clinical medical doctor, I have had many instances whereby people came to my office suffering from ophthalmological problems. I have been obliged to refer all of these people to specialists but the majority have no way of paying for such medical care. Burundi has very few specialists and few of those requiring treatment can access them. This lack of specialists in my country has motivated me to specialise in ophthalmology and to get the clinical skills I need to help them.”

Dr Charles Umesumbu Shaku from the Democratic Republic of Congo discusses his own similar experience and the need for Ministries of Health to increase the availability of scholarships, in the interview overleaf. Unfortunately even those medical doctors in sub-Saharan Africa that do want to train in ophthalmology do not have access to the necessary residency training. LIGHT FOR THE WORLD currently provides scholarships for 23 residents at the University of Nairobi, the KCMC in Moshi/Tanzania and the IOTA in Mali. It is a long-term investment that pays off, as experience of the pioneering work at the University of Nairobi has shown. Founded in 1978 by Professor Volker Klauss under an official collaboration between the University of Nairobi and the University of Munich, the postgraduate training for ophthalmologists was supported by the German Academic Exchange Service (DAAD). Over the years, the eye department of Nairobi has transformed into the largest training institution for ophthalmologists in sub-Saharan Africa. It has trained over 160 ophthalmologists from 12 African countries. Young ophthalmologists, trained in Nairobi, now form the backbone of eye-care programs in countries including Cameroon, Malawi, Zambia, Uganda and Ethiopia.

Today, health professionals from Kenya, Tanzania, Burkina Faso, DR Congo, Burundi and Zambia are benefiting from the LIGHT FOR THE WORLD programme. In the very near future they will go on to become an important part of the eye health workforce in their own countries.

Training alone however cannot yet change the situation. Once graduated, the ophthalmologists need support in settling down and establishing a supportive and productive work environment. Good performance and retention of such staff require close collaboration with the health authorities of the respective countries, attractive employment packages and the availability of necessary equipment and supplies. Last but not least, it is not the ophthalmologists alone who make the difference. A dedicated eye care team is required, effectively combining different skills and responsibilities. LIGHT FOR THE WORLD is therefore not only committed to continue its scholarship programme, but also to provide necessary support after graduation.

Health professionals from Kenya, Tanzania, Burkina Faso, DR Congo, Burundi and Zambia are benefitting from LIGHT FOR THE WORLD scholarships.
What motivated you to get involved in ophthalmology?

My region of Maniema in the DR Congo had never had a permanent ophthalmologist. People had often little choice but to travel to other regions or abroad for even simple procedures. So, two years after qualifying from medical school I started my training to become a cataract surgeon at the Ophthalmic Training Centre for Central Africa based in Kinshasa.

You were working as a cataract surgeon DRC. Why did you decide to enter the residency programme in Uganda?

After five years of hard work and 2,000 cataract surgeries I realised that there were still many underserved areas of eye health: objective refraction, cataract surgery in children, squint management, proper management of glaucoma, evaluation of children with impaired vision and others. I am also interested in the area of research and in expanding my language skills. So I decided to expand my knowledge of eye health and, chose MUST in Uganda due to its excellent reputation and its proximity to my family, who remained in DRC.

You have participated in an exchange programme with University Eye Clinics in Austria and Belgium. Would you recommend such exchange programmes?

Yes, I would absolutely recommend such programmes. It was a real learning opportunity and allowed me to reconcile theory with practice, to see how ophthalmology is practiced in Western countries and to study diagnosis methods and treatments. I spent three weeks in the glaucoma clinic of the University Eye Clinic in Vienna. At the Hanusch-Krankenhaus I watched posterior vitrectomy with membranes peeling and phacoemulsification surgeries. My last week in Europe was in Belgium where I spent 3 amazing days attending 25 talks, 1 clinical course and 4 wet labs at the annual congress of Belgian ophthalmologists.

What are your plans after you complete your studies?

I will return to my family in Maniema where 4,000,000 people are awaiting eye care. If I get the necessary resources and support, I will apply all that I have learned to develop ophthalmic services in the region. I will initiate a community based research study on childhood blindness and visual impairment and will organise ocular surgery for children with the help of visiting paediatric ophthalmologists. I will continue with my project of screening for visual impairment in schools and providing glasses. I will also continue to support the development of human resources in Maniema: increasing the number of ophthalmic clinical officers, ophthalmic assistants, and ophthalmic theatre nurses. And of course I would also like to challenge some young doctors to train as cataract surgeons and ophthalmologists.

On your return what do you envisage as a supporting environment?

I've learnt many procedures that I would like to apply in my daily work. So I will need reinforced infrastructures and an improved building as well as essential equipment. It will be necessary to think about how to support the treatment delivered to poor and outreach will play an important part in ensuring eyecare for all. I would like my staff and I to get further training and continuous professional development.

If you were minister of health, what would you change in the area of human resources for health?

1) Increase the availability of masters in medicine scholarship for doctors; 2) support medical schools and encourage the training of more doctors to satisfy the demand and reduce the doctor: patient ratio; 3) advocate for more 'on-the-ground' primary health workers and less 'city' specialists; 4) introduce on-the-job training for health workers; 5) give a better remuneration package to health workers to combat brain drain; 6) equip hospitals with more technical and maintenance staff; and 7) increase the retirement age.
In December 2011, LIGHT FOR THE WORLD organised surgical training for ophthalmologists in Burkina Faso, West Africa. MTS-THE WETLAB COMPANY, an Austrian company specialising in organising wet-labs worldwide, supported this training by providing staff and equipment. These wet-labs allowed for different surgical techniques to be practised on pig-eyes under realistic surgical conditions.

The training took place between 12–16 December at the Centre Hospitalier Universitaire YALGADO in Ouagadougou, the capital of Burkina Faso, and was the first wet-lab workshop to be held in an African country. Thirteen ophthalmologists from Burkina Faso participated free of charge.

The goal of the workshop was training on small incision cataract surgery (SICS) and trabeculectomy (TE). SICS allows extracapsular cataract surgery (ECCE) with a smaller incision without sutures. Therefore, this type of surgery is less traumatic, is quicker and produces better results than ECCE (in terms of surgically induced astigmatism).

After theoretical introduction to the SICS technique through lectures by Dr Karl Rigal, Austrian Ophthalmologist and member of the Board of LFTW and Dr Jérôme Sanou from the Centre Ophtalmique in Zorgho, Burkina Faso (COZ – an eye clinic supported by LIGHT FOR THE WORLD), the technique was demonstrated by live surgery. This was made possible through ten microscopes, equipped with monitors, which allowed the trainers to observe every step of the surgeries conducted by the trainees.

As glaucoma is a main cause of blindness – especially in a West African country like Burkina Faso – and is now a focus of the VISION 2020 programme, the second goal of this wet-lab was the training of trabeculectomies for glaucoma.

This was done in the same way as the training for SICS – theoretical lectures followed by live, supervised surgery.

Wet-labs are an important part of ophthalmological training in different types of ophthalmic surgeries in Austria. The experience in Burkina Faso shows that workshops like this are also useful in the training of ophthalmologists in African countries. Trainees can gain confidence in ocular surgery techniques before carrying it out on real patients.

The five-day workshop received excellent feedback from participants. Many felt that they had gained confidence in performing the surgeries themselves. This is another important step towards improving the general quality of cataract surgery and in providing glaucoma surgery for patients in Burkina Faso.

By organising wet-labs for groups of ophthalmologists under the supervision of experienced surgeons there is a real chance to not only gain skills and learn, but to have discussions and exchange experiences. Shortly following up such wet-lab training with supervised surgeries on patients should be considered.
CROMA Executive Directors Personally Deliver IOL Donation to Ethiopia

For over ten years, the international pharmaceutical company CROMA has donated viscoelastic lotion and intraocular lenses to LIGHT FOR THE WORLD. CROMA’s donations have made thousands of sight-restoring cataract operations possible in developing countries.

In November 2011, Andreas Prinz and Martin Prinz, CROMA’s executive directors visited blindness prevention projects in Ethiopia, bringing a donation of 1,400 antibiotic eye ointments that will be used to treat various kinds of inflammations. The CROMA executive directors had come because they wanted to see for themselves the need on the ground. Andreas’ and Martin’s journey first took them to the Ethiopian metropolis of Addis Ababa to pick up the LIGHT FOR THE WORLD project manager, before heading south together to visit the eye clinic in Ziway. The eye clinic, which is supported by LIGHT FOR THE WORLD and run by local partner ‘Grarbet Tehadiso Mahber’, provides medical eye treatment to thousands of people from a huge catchment area.

“We are really impressed by all that has been achieved here”, commented Andreas Prinz.

Arriving in Arsingelle

After handing over some of the eye ointment to Dr. David from the eye unit in Ziway, they travelled on to the village of Arsingelle to join an ‘eye care outreach’ programme. Mobile eye care teams regularly travel to rural areas to provide ophthalmic services to people who are unable to make the long journey to the eye unit.

During the outreach programme, which was overrun by people seeking help for their eye problems, the two Prinz brothers met 16-year-old Demetu Gobe and her little sister Tarikwa. Tarikwa had trachoma, a very painful disease which causes the eyelashes to turn inwards and little by little scrape and damage the cornea like thousands of sand grains in the eye. Two months ago Tarikwa had eye lid surgery without which she would have gone blind. Now she was back for a check up and it was also time for Demetu to be examined. Unfortu-nately she too had developed trachoma. Eye nurse Gezachew Abebe did not waste a second and Demetu received surgery on-site. Nurse Abebe knows the operation off pat and during an outreach often operates on 30-40 people a day.

The next stop for the Prinz brothers was the LIGHT FOR THE WORLD supported eye clinic in Butajira, 80 miles south of Addis Ababa. Senior ophthalmologist Dr. Fitsum was delighted to receive some of the antibiotic eye ointments: “Great thanks to CROMA for this donation. The eye ointment is most useful and important for treating our patients”. During their stay at the Butajira eye clinic the CROMA executive directors met with 27-time grandfather Hambamo Dinbore. Hambamo had been blind for over five months and Dr. Fitsum quickly diagnosed cataract. Hambamo was operated on the same day and the very next day he sang “Liramamo, liramamo”, which means “I am happy” as his bandages were removed and he could once more see.

Andreas and Martin Prinz were both touched and reinvigorated by their personal visit to see LIGHT FOR THE WORLD’s work on the ground: “The project visit was an incredible experience. It was great to see the difference we can make for the people here in Ethiopia. Everyone should play a part in making our world a better one.”
If you are interested in an earlier issue of VISION & DEVELOPMENT, please email upsa@light-for-the-world.org to order or download from http://www.light-for-the-world.org/vision.html