Cataract surgeon training directors meeting
May 7-10, 2007
Moshi, Tanzania

Summary & Recommendations

Summary

Cataract is the leading cause of blindness in Africa. The elimination of blindness due to cataract involves the provision of a continuum of services of which cataract surgery itself is only a part. Mid-level eye care personnel, including non-ophthalmologist "cataract surgeons", are major contributors to VISION 2020 in Africa. The main function of this cadre is to perform cataract surgery, however they generally are responsible, within the VISION 2020 comprehensive sustainable eye care service concept, for other essential clinical and community eye care duties. Due to shortages and inequitable distribution of ophthalmologists, it is anticipated that in many African countries the (non-ophthalmologist) cataract surgeon cadre will remain essential to achieving VISION 2020 goals.

Cataract surgeon training directors, and other key personnel from 12 countries in Africa met in Moshi, Tanzania to discuss the selection, training, equipping, supervision, and management of cataract surgeons. There is considerable variation in these aspects throughout Africa; nevertheless, there are common elements in training and deployment. The participants reviewed existing programmes and made the following recommendations to strengthen the selection, training, support, and supervision of cataract surgeons to achieve VISION 2020.

Recommendations

National level coordination, planning, and selection
Training institutions should be actively involved in national VISION 2020 plans. The training institutions are encouraged to foster the development of continuing medical education of graduates, assist with the formation of alumni groups to foster continued learning, and network with other training institutions that contribute to the training of the VISION 2020 team.

In every country, a "cataract surgeon" job description should be adopted. Professional recognition and career structures are needed to ensure they remain productive, functioning, and satisfied. Selection (and deployment) criteria should be well defined; engaging all partners, with consideration of priority least served geographical areas.

Training programmes
The facilities (faculty, infrastructure, resources) need to be strengthened and adequately financed to ensure that students receive a high quality education. Specific areas requiring strengthening include improving the teaching skills of training faculty to improve quality, improving the training in both clinical and non-clinical subjects, developing a policy and criteria for accreditation of external training

facilities as well as the main/base training centre, and ensuring that essential diagnostic and treatment equipment, educational material, and additional consumables for trainees are available.

Many curricula are not fully developed or are out-dated and there is a mismatch between these and the expected role of the cataract surgeon (job description), and what is actually taught and assessed. The curricula need to be reviewed to identify gaps; most curricula need to have non-medical topics included, with indicators to measure success and quality of skills of the trainee. Curricula should be regularly evaluated against the aims and developments in a country.

Training programmes should have continuous internal assessment systems and yearly evaluations. Gaps in the assessment of student competencies should be identified and used to re-design assessments, with more emphasis on continuous assessment. Formal assessment of students, mostly clinical in nature, should be expanded to include other areas of skills development. Since self-monitoring by the cataract surgeon using the WHO recommended manual/software should be mandatory, students should start using this during training, along with logbooks / portfolios to continuously assess progress. Guidelines for registration and certification of graduates should be clearly defined.

The training institutions should ensure that the training of the other members of the team to support the surgeon should be carried out at the same time (or just after) as the cataract surgeon.

Support following training

Evidence strongly suggests that support and supervision following training are essential to achieve a high level of productivity, quality, and satisfaction by the cataract surgeon. The cost of establishing the infrastructure (construction, necessary equipment, baseline supplies) for a cataract surgeon to be effective is high; external donors are needed to assist most countries. Attempts should be made to ensure that these are in place prior to the deployment of the cataract surgeon to prevent frustration and maximise on the investment in training. Improving support and supervision can be accomplished through implementation of a national strategy for continuing procurement, supply and maintenance of equipment, instruments, and consumables. Participatory supervision (both technical and managerial) following training should be implemented. This should include monitoring and evaluation of the programme.

Cataract surgeons need to be part of a functioning VISION 2020 team and freed from as many managerial duties as possible. Continuing medical education should be budgeted and planned for.

Africa-wide coordination and research

The last Africa Human Resource Development for Prevention of Blindness meeting was held in 1988. An Africa-wide human resource development meeting to address all aspects of mid-level human resource development in Africa would be helpful. Evidence-based planning for human resources for VISION 2020 in Africa is minimal and research is needed to inform decision-making regarding training, deployment, productivity and satisfaction.