Childhood Cataract "Experts" meeting

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Hosted & Coordinated by:
Kilimanjaro Centre for Community Ophthalmology

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Summary

Recent evidence suggests that congenital and developmental cataract is the leading cause of blindness in children in much of Africa. Although data are limited it is likely that the backlog of children needing surgery is around 100 children per million population and the annual incidence is probably around 20 children per million population per year.

WHO recommends that there be one paediatric ophthalmology tertiary centre per 10 million population; few countries of Africa have reached this target. Even in settings with tertiary centres few children present for surgery; those that are brought generally attend too late to achieve the highest quality outcome of surgery. In most settings, boys greatly outnumber boys whereas the incidence is likely to be the same in girls and boys. Virtually all children receiving surgery for cataract in Africa will require long term follow up for spectacle correction and low vision care.

Tertiary facilities in Africa have strengthened the quality of the surgical service provided but have put little effort into promoting early identification and referral or into improving follow up, provision of spectacles, low vision care, or inclusive education. There are two facilities in Africa providing fellowship training in paediatric ophthalmology and one centre providing training in programme management for paediatric ophthalmology tertiary centres.

The Childhood Cataract Experts meeting brought together about ** people from throughout Africa as well as key personnel from Europe and Asia to discuss potential solutions to the problems and to draft a practical manual on best practices for management of childhood cataract in Africa.

Recommendations

1. National Prevention of Blindness Committees are encouraged to identify (existing) paediatric ophthalmology tertiary centres and coordinate with them to define their respective catchment areas. According to WHO guidelines, these catchment areas should cover a population of approximately 10 million.
2. Existing data on childhood cataract from these catchment areas (age, sex, district of residence) should be compiled.
3. It is recommended that, for the purpose of planning and monitoring, a childhood cataract surgical rate (CCSR) be calculated for each VISION 2020 ñdistrictò (population 1-2 million, usually called ñregionsòor ñprovincesòin Africa). This information should be used to identify ñdistrictsòwith low surgical coverage.

4. Evidence suggests that the use of key informants (at the community level) increases identification and referral of children requiring surgery in Asia. Additional research is needed to test this method in Africa with other possible approaches.
5. In many countries there are still many children with cataract admitted to schools for the blind; national policies on admission of children to schools for blind (in particular, ophthalmologic examination prior to admission) are needed.
6. In most programmes that have achieved a significant increase in the number of surgeries in children, it has been necessary to waive surgical fees and to reimburse much of the travel expenses incurred by families to access surgery and follow up. These approaches may need to be adopted in most settings in Africa.
7. Although the exact timing of surgery depends upon the individual characteristics of the child, it is essential that all health care staff considers a ñwhiteò pupil in a child as an emergency and ensure that the child is seen by a paediatric ophthalmologist as soon as possible.
8. It is recommended that all children (in particular, younger children) only be operated on by paediatric ophthalmologists in well-equipped tertiary centres. These centres need to ensure high quality anaesthetic services.
9. Paediatric ophthalmology tertiary centres should have on their staff a ñChildhood Blindness Coordinatorò responsible for counselling of parents (and children), organizing activities for early detection, training health staff, and conducting a tracking system to ensure that children are brought back for follow up, spectacles, and low vision care.
10. Every tertiary centre should have the facilities for the provision of spectacles and a low vision service.
11. Follow up after surgery is essential throughout childhood; strategies shown to be effective (counselling, recording and using cell phones for contact, reimbursement of transport costs, local eye care worker to visit family) should be adopted.
12. Refractive correction is the single most important post-operative service children need and tertiary facilities must have strong optical services.
13. Low vision services and some refractive services (particularly for periodic changes in refractive error) should be decentralized as much as possible; relevant personnel in ñdistrictsò covered by the tertiary centre should be trained in basic service delivery and be accountable for providing these services to children in their areas.
14. Successful low vision service provision requires strong links between the eye care and low vision service, accurate refraction, and near vision assessment. In addition, low vision services should have links with education and rehabilitation. In most settings, special education teachers and rehabilitation workers need training. Eye care providers need to take the lead for initiating and maintaining low vision and educational support.
15. A manual on the clinical and programme management of childhood cataract should be completed and disseminated as soon as possible.

A copy of all of the presentations from this meeting can be obtained from the Kilimanjaro Centre for Community Ophthalmology (pcourtright@kcco.net)