

SYMPOSIUM REPORT

International Symposium on
Collaboration with Traditional Healers
for Prevention of Blindness in Africa
Blantyre, Malawi
September 10-12, 1997

Traditional healers are an integral and important part of most cultures and will remain so. They are respected members of their communities and live and work in the most rural areas. They are the most commonly consulted and most accessible primary health care providers in all African communities.

Eye care programmes have been effective at the district hospital level in many countries. However, there has been limited success in expanding activities beyond this level and in overcoming many of the barriers, precluding cataract surgery uptake by rural communities.

Collaboration with traditional healers in Zimbabwe and Malawi has been successful, with an increase in the cataract surgery uptake and a decrease in the incidence of blinding corneal ulcers due to harmful traditional eye medicines.

Eye care programmes could increase accessibility of services to rural communities by including traditional healers, following appropriate reorientation, in the network of primary eye care providers in the locality. Traditional healers are interested in collaborating with eye care workers. There is now a clear imperative for collaboration. This should be based on mutual trust and respect between the two disciplines as both should complement each other to the benefit of the patient.

Recommendations

1. Collaboration should focus on improving the capacity of traditional healers to assist their patients, on referral, on counselling patients and their families, and on decreasing harmful traditional practices.
2. There is great variation in traditional healer practice. Approaches to collaborative blindness prevention programmes, therefore, must reflect local conditions.
3. A clear understanding of traditional eye care practices is necessary prior to the development of collaborative activities and training.
4. Such collaborative activities should be consistent with Ministry of Health policy and guidelines.
5. Ministries of Health are encouraged to set policy and guidelines, and establish

and regulate traditional healer associations. To protect the public, regulations concerning advertisements and service outcome should apply to all health providers whether they are traditional healers, couchers or biomedical personnel.

6. If a Ministry of Health allows the use of pharmaceuticals by traditional healers, consideration should be given to sustainability and possible adverse effects of combining pharmaceuticals and traditional eye medicines.
7. Collaborative activities should be patient focused, community based, culturally appropriate, and sustainable.
8. Training programmes for healers should be participatory in nature, reflecting the unique role healers have in their communities; the proposed manual should be adapted as necessary.
9. Collaborating eye care programmes should only be established where there are adequate training, support, referral, and feedback capacities.
10. Couching remains a significant cause of visual loss and blindness; the provision of affordable, accessible, high quality modern cataract surgery, with good visual outcome, would reduce this practice.
11. Operational research is needed to clarify the best approaches to collaborative interventions.

Organizing Institutions:

**BC Centre for Epidemiologic & International Ophthalmology
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(Dr Moses Chirambo MD)**

The International Symposium on Collaboration with Traditional Healers for the Prevention of Blindness, held in Blantyre, Malawi from September 10-12, 1997 was supported by the Task Force of the Partnership Committee of Non-Governmental Organizations collaborating with the World Health Organization Programme for the Prevention of Blindness. Symposium participants included eye care professionals from Africa, North America, Europe, and Asia as well as traditional eye healers from Zimbabwe and Malawi. The organisers and participants would like to thank the NGO Task Force and WHO as well as the International Eye Foundation/Malawi for their support of the Symposium.

STERILIZATION OF SURGICAL INSTRUMENTS

Dear Sir

May I mention another method of disinfection not listed in your recent article (Issue No. 19, 1996), which I have used in eye camps in Pakistan. This is the use of steam without an autoclave. One uses a deep sterilizer only partly filled with water, with trays of eye instruments suspended in a rack above the water level. We have used either bottled gas or electricity for heating; I prefer the former in the absence of mains electricity as one can then provide for the lighting with a much smaller generator. Small instruments soon heat up in the steam above the closed sterilizer, and are given at least five minutes. There are several advantages: the steam is largely free of any impurities in the water; the instruments may dry more quickly than after boiling; and there does not appear to be any problem from blunting. Some surgeons and eye theatre nurses will question the efficacy of the method, and demand a longer exposure to steam, but I have not met infection definitely attributable to the method. I would be interested to hear of the experience of others.

Dr Ralph Heaton
**15 Glenway, Bognor Regis
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Comment

The steaming method [that is without pressure] is, a popular and relatively effective method of disinfection in developing countries. Please note - it does not sterilize.

It is important to:

1. Maintain the level and boiling point of the water.
2. Ensure the water is at boiling point before placing the instruments in the steamer - 'heating up' is not sufficient!
3. Steam the instruments for a minimum of 10 minutes and preferably 20.
4. Cover the receptacle.

The questionable access of steam to the lumens of instruments is a serious concern. The steaming method is sometimes chosen only in an attempt to avoid blunting of instruments. There is no other direct benefit of steaming. Rather, adding 2% soda to the water in the boiling method is advised.

References

1. Brouwer MR, Hardus, PLL. Sterilization of ophthalmological instruments. *Tropical Doctor* 1988; 18: 174-6.
2. Hughes RA. Sterilization of Instruments in Isolated Hospitals. *Tropical Doctor* 1982; 12: 87.

References to steaming without pressure would be welcomed. Despite an extensive literature search none have been traced. We welcome correspondence from our readers regarding experience and opinion in this area.

Dear Sir

The article 'Sterilization and Disinfection' in Vol 9, Issue No. 19, 1996, is very useful and informative.

In 'Chemical Methods' acetone is not discussed. Has it become obsolete or is there any other reason?

Dr Kapal Mit Singh
Chandigarh
India

Comment

Acetone has been a popular antiseptic/disinfectant used by ophthalmic personnel, particularly in developing countries.

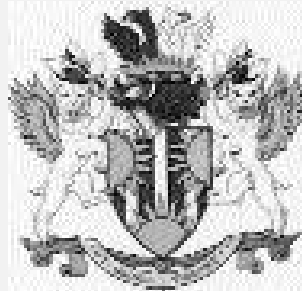
The authors chose not to include it in the Journal article because a literature search on the agent was inconclusive, with such conflicting opinions that it was believed to be unhelpful in an article designed to give clear guidelines. Current texts do not list it as a recommended chemical disinfectant.

The disadvantages of using acetone are that it evaporates rapidly; it is a safety hazard because it is highly inflammable and it does not destroy fungi and spores.

References

- 1 Drews RC. *Ann Ophthalmol* 1977; 9: 781-4.
- 2 Agarwal V, Sharma S. *Indian J Ophthalmol* 1993; 41(1): 20-2.

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STANDARD LIST OF MEDICINES, EQUIPMENT, INSTRUMENTS AND OPTICAL SUPPLIES FOR DISTRICT LEVEL EYE CARE SERVICES

The Task Force of the Partnership Committee (a group of international non-governmental organisations concerned with prevention of blindness) has produced a Standard List of Medicines, Equipment, Instruments and Optical Supplies appropriate for the delivery of eye care services in developing countries.

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