



**EDITORIAL**

## Bridging the gaps



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### Introduction

By the year 2020, the international eye care community hopes to have eliminated avoidable blindness as a public health problem. The global partnership, VISION 2020: The Right to Sight, has provided a focus for all concerned (from international policy makers to village level health workers), identified five priority eye conditions, and clarified the key components to achieve this purpose.<sup>1,2</sup> However, as Daniel Etya'ale, co-ordinator for VISION 2020 in Africa points out, there is still a big gap between what needs to be done and what is being done and he estimates that currently hardly 20 per cent of the current needs in Africa are being met. On a more optimistic note, there has been a move towards closer and more functional partnerships between professional groups, governments, NGOs and industry.

### What are the gaps?

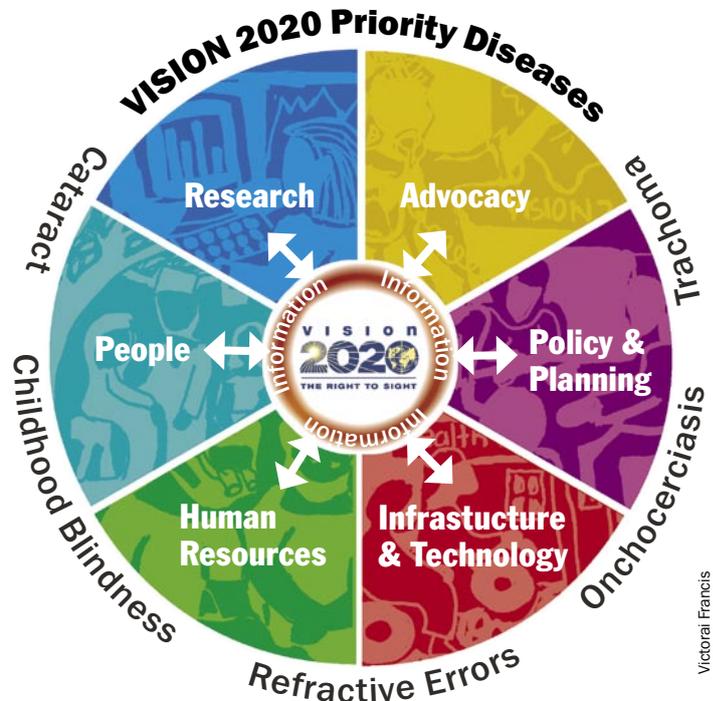
Experience has taught us that medicines, techniques and skills do not on their own solve the health problems of all: applying relevant solutions is the challenge. There is a gap between what we know and what we need to know (the knowledge gap), between health problems and solutions (the research gap), and between evidence-based solutions and what health workers actually do (the 'know-do' gap). Inadequate infrastructure and technology result in service gaps. Human resource gaps need to be filled with trained people working efficiently together. Communication gaps, gender gaps and wealth gaps create a distance between eye care providers and people, the intended beneficiaries. Relevant to all of these gaps is information, depicted in the illustration (Figure 1) as a flow feeding into, and drawing from, each component, provided appropriate 'bridges' are built.

This issue of *Community Eye Health Journal* aims to create 'gap awareness' amongst our readers.

Richard Wormald's article identifies knowledge and research gaps in ophthalmology and suggests ways to bridge them.

In an interview with Allen Foster, Daniel Etya'ale describes his work in bridging the gap between the international VISION 2020 agenda and VISION 2020 action plans in Africa, demonstrating the importance of advocacy and planning.

Hannah Faal's article approaches the human resource gap in two ways: organising available eye care workers to reach into the district through a system of 'vertical teams'; and strengthening the



**Fig. 1. Domains where gaps to achieving VISION 2020 might occur**

performance of a team through recognition of their functional roles (the job they are trained to do) and their team roles (their personal qualities and skills which contribute to the running of the team).

Sally Hartley's article reminds us that professionals have much to learn from the people they serve, and examines how communication can facilitate this.

Sam Powdrill's article, the last in our 'Technology for VISION 2020' series, is a fitting example of bridging the technology gap with guidance on how to repair surgical instruments, especially when working in remote areas.

How to bridge the health information gap is a hotly debated topic. New communication technologies promise quick and easy information transfer but threaten to widen the gap between the technology haves and have-nots, the so-called 'digital divide'. We need to find ways to provide information to eye care providers working in diverse circumstances, from resource-poor rural settings, to centres with access to computers and high-speed internet. In her article, Sally Parsley, E-communications Manager at ICEH resources, describes how to use the internet to access free eye health publications and global discussion forums, while at the same time pointing out that we need a combined approach, using print and new technologies, to reach eye care workers around the world.

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The journal is produced in collaboration with the World Health Organization



Volume 17 | Issue No. 51 | October 2004

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Community Eye Health Journal is published four times a year and **sent free to developing country applicants**. Please send details of your name, occupation and postal address to *Community Eye Health Journal*, at the address above. Subscription rates for applicants elsewhere: one year UK£28/US\$45; two years UK£50/US\$80. Send credit card details or an international cheque/banker's order made payable to London School of Hygiene and Tropical Medicine to the address above.

Website: Back issues are available at [www.jceh.co.uk](http://www.jceh.co.uk). Content can be downloaded in both HTML and PDF formats.

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ISSN 0953-6833

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## What can we learn from the broader health field?

There is much to be learnt from experiences in bridging the gap in the broader health field. The knowledge gap is not unique to eye problems. The Global Forum on Health Research suggests a 10/90 gap, whereby less than 10 per cent of research is concerned with the health problems that account for 90 per cent of global disease.<sup>3</sup> Where research does create relevant knowledge, the 'know-do' gap threatens to prevent its application. *The World Report on Knowledge for Better Health*, due to be launched at the World Summit on Health Research in November 2004, aims to promote ways to overcome the 'know-do' gap.<sup>4</sup>

Public policy scholars have examined the transfer of policies from international to country level. Ogden, Walt and Lush, for example, suggest that internationally driven policies, while raising the profile of an issue through branding and marketing, such as DOTS (Directly Observed Treatment, Short-course) for Tuberculosis control, may simplify approaches to 'one-size-fits-all', and inhibit locally appropriate programmes.<sup>5</sup> There is up till now no evidence that this has happened with the VISION 2020 initiative, possibly because the collaborative approach, and the system of VISION 2020 workshops, takes national and district level realities into account so that plans are locally relevant and applicable.

The approach of reaching right into the community through a link of health workers has been successfully demonstrated in other health areas. One illustrative success story comes from the Gadchiroli district in India where SEARCH (Society for Education, Action, and Research in Community Health) trains village level workers to apply a package of low-cost low-technology interventions for the care of mothers and newborn babies. Research into the effectiveness of this approach showed an almost 50 per cent reduction in neonatal mortality among isolated, rural villagers.<sup>6</sup>

Participatory approaches which involve stakeholders in all stages of service development build bridges between professionals and people. Successful projects have documented their experiences, providing useful models for eye care providers.

What have we learnt about bridging the information gap? A recent article in *The Lancet* claims that "there is little if any evidence that the majority of health professionals, especially those working in primary health care, are any better informed than they were ten years ago"<sup>7</sup> and suggests that the 10/90 research gap mentioned earlier,<sup>3</sup> may well be a 1/99 gap when it comes to health information. The authors draw out crucial lessons from the past. They suggest that 'pull' is better than 'push' and that producers of information should find out what people want, rather than 'pushing' information out to them. Those producing eye health information from an international base face the challenge of finding out what eye health workers in specific locations need

to know, the communication medium that best suits them, and to what extent materials can be developed or adapted locally.

We have also learnt that the participation of end-users helps information transfer. At the high-tech end of the spectrum this might involve enhancing the flow of information within and between countries (such as *HIF-Net* at WHO<sup>8</sup>) or, as a low-tech activity, involving users in the production of educational materials (such as *The Healthy Eyes Activity Book*<sup>9</sup>).

We have seen the success of 'Entertainment-Education' in applying mass entertainment and popular culture to health promotion. Its usefulness to eye health has been demonstrated in trachoma control programmes in Ghana, Tanzania, Ethiopia, Nepal and Niger where National Trachoma Control Programmes combined the talents of the BBC World Service Trust and local health communicators and artists in an International Trachoma Initiative (ITI) funded strategy which combines radio, community media such as dramas, video and print materials.<sup>10</sup>

## Conclusion

A common theme in this issue is that VISION 2020 has provided the impetus for a 'paradigm shift' or a change in the way of thinking about providing eye care services: thinking about population care rather than individual patient care; acting as a team rather than a skilled individual; recognising the importance of local knowledge; adopting an evidence-based approach to practising eye care; and communicating information in multiple ways for different audiences. It is timely for the eye health community not only to be mindful of the gaps to achieving the aims of VISION 2020, but also to cross the divide between disciplines, and learn from the rich body of experience acquired in 'bridging the gap' in other areas of human endeavour.

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# The policy-practice gap: supporting national VISION 2020 action plans

John Buchan



## An interview with Daniel Etya'ale

Co-ordinator for VISION 2020 in Africa, Programme for the Prevention of Blindness, World Health Organization (WHO), 20 Avenue Appia 1211, Geneva 27 Switzerland. Conducted by Allen Foster, International Centre for Eye Health, London School of Hygiene and Tropical Medicine, London.

### Dr Etya'ale, can you tell us what your work involves?

My job is to help countries in Africa develop and implement their national VISION 2020 action plans. This involves visiting countries and speaking with government and non-government agencies so that a well co-ordinated set of activities can be agreed.

### What training did you have to prepare for this work?

Good question! The simple answer is not one, but a series of training and work experiences. In fact, my whole personal and professional life seems to have prepared me for my current job.

After training as an eye specialist, I worked as a director of the largest mission hospital in Cameroon where, over ten years, I developed an eye care service at the community and district hospital levels. I further expanded this work to the Southern Province and also began to advise an international non-governmental organisation (INGO) on its medical work in other parts of Cameroon and neighbouring Central African countries. This increased my interest in public health ophthalmology and led to a one-year training at the International Centre for Eye Health (ICEH) in London where I obtained a Masters in Community Eye Health. After this I was asked to co-ordinate the onchocerciasis control activities of a consortium of 11 INGOs, which meant being based at WHO in Geneva and working closely with national ministries of health and the African Programme for Onchocerciasis Control (APOC) after its creation in 1995. This led to my current appointment as VISION 2020 Co-ordinator for Africa.

### Where are you based now and how is your work supported?

I am based in WHO Geneva in the Programme

for the Prevention of Blindness. My work is jointly supported by WHO and a group of NGOs.

### When you go to a country for the first time what do you do?

Before going I read as much as I can about the country, its health and its eye care systems, its public health successes (if any) and its major constraints. Then I prepare a summary of the information using a standard database which we have developed at WHO. Afterwards, I prepare a list of the people I would like to meet and some of the key questions needing answers or further clarification. I then contact the national WHO office and arrange my visit through them. Whenever possible I will ask to see the Minister of Health realising that, in most cases, I will only have 10-15 minutes to 'sell' VISION 2020 and seek a broader and more substantial support of the programme by his department.

### What do you speak to the Minister of Health about?

Most health ministries in Africa must compete with other ministries to secure funds for health care in the country. Also, most have many competing needs for those limited funds - malaria, HIV/AIDS, TB, immunisation programmes, hospital services, and staff salaries, to mention only a few. Against these 'public health giants', eye care and blindness prevention are hardly a natural winner. In my discussions with the Minister I will therefore try and emphasise the following points:

- the aim of the VISION 2020 programme – why reducing blindness is important, socially, economically, financially and ultimately politically
- what the international community can provide in the way of help
- what is required from the Ministry of Health and its local partners

- the importance of well planned and highly coordinated activities by all stakeholders
- the importance of a committed and highly qualified national co-ordinator or programme manager.

### Who are the other people you try to meet?

I try to meet the senior ophthalmologists particularly those who advise the government and those involved in training centres. I will also try to see the country representatives of the international NGOs and any local NGOs or religious authorities involved in eye care. The idea is to meet all those who are involved in policy decisions or planning eye care services to learn what they do and how they do it, and to explain the concept of VISION 2020. If there is still some little time left, I will try to visit a VISION 2020 related project, to see real people (the blind, the visually impaired and those who work very hard, sometimes under harsh circumstances), and to be reminded that it is for them that VISION 2020 has been established. This is a real lifeline for me.

### After this first visit what follows?

The first visit allows an understanding of 'where' the country is in terms of eye care and blindness prevention. Do they have a committee? Is there a plan? How recent? Does it address all the VISION 2020 concerns? Has a national co-ordinator been appointed? How well developed are the human resources and infrastructure? What is the estimated cataract surgical rate (a crude but simple and useful indicator of eye care provision)?

The next step will then be a VISION 2020 workshop. This may have several purposes. If there has been little eye care planning so far, the workshop will concentrate on advocacy and the participants will be the influential people involved in decision-making. The aim will be to reassess the need for eye care in the country (magnitude and causes of blindness) and explain the concept, priorities and partners involved in VISION 2020. If the country is already committed to VISION 2020, then the purpose will be to develop a comprehensive national action plan for VISION 2020. Such a workshop will involve Ministry of Health officials from both central and regional levels, eye care professionals, training institutions and NGOs. If there is already a plan then the workshop will aim at district level ophthalmologists, nurses and programme managers and discuss implementation of VISION 2020 at the district level.

### What are the outcomes you look for from the workshops?

First of all, agreement on the size of the blindness problem, the priority areas of

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work in the country, and the need to work together to fight the problem. Second, development, acceptance and ownership of an agreed national action plan; and third the clearest definition possible of the roles of the various stakeholders and eye care providers within the country at all levels of programme implementation.

**What positive changes have you seen in Africa over the last three years?**

First and foremost, a real enthusiasm for VISION 2020 when this has been presented to the ministries of health and eye care professionals – the response so far has been more than we had anticipated. Second, a better understanding of the causes, magnitude and distribution of blindness and available services in each country and within country in each region. We believe that we now have sufficient information for most countries with which to safely plan VISION 2020 programmes and activities. Third, and most encouraging, a coming together of the various parties (governments, NGOs and professional groups) to work together under the mandate of VISION 2020. This move towards closer and more functional partnership in eye care is probably the single most important development over the last three to five years. The problem of blindness is so enormous that no single agency can solve it alone – we must do our utmost to respect each other and work together if we are to reduce the number of people still becoming unnecessarily blind in Africa.

**What are the major challenges facing VISION 2020 in Africa in the next three years?**

There is still such a big gap between what needs to be done and what is done. Currently we hardly meet 20 per cent of current needs and much of that service provision is largely dependant on NGOs. Also, the use of existing resources – people, equipment, infrastructure and money – is still largely inefficient; and there is definitely a need for new resources, both in terms of finances and human resource development. For reasons of sustainability and despite their limited resources, African governments should be the major eye care service providers in the long-term. Therefore, a challenge for NGOs and other partner agencies is to assist governments in ways that will not only expand and accelerate current activities, but also, and more importantly, lead to the creation of functioning, nationwide and effective eye care services. Eye care has the potential to be financially self-sustaining because, for example, of the need and sale of spectacles for presbyopia and other refractive errors. So the major challenges for the next three years are availability and use of resources, and partnership between governments, WHO, NGOs and other interested parties and the eye care professionals.

*For useful resources, please see page 47.*



**HUMAN RESOURCES**

# Reaching into the district: strengthening the eye care team



**Hannah Faal**

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**From individual patient care to population care**

VISION 2020: The Right to Sight has provided a vision and a common goal for eye care programmes. It has provided the paradigm shift, or change in the way of thinking, from individual patient care to population care, a shift from each person doing a job or task, to a group working to eliminate avoidable blindness. Such a common goal needs a team approach.

The VISION 2020 approach proposes that activities should be planned and implemented for a defined population and geographical coverage and promotes the concept of a manageable unit of a population of 500,000 to one million, termed a VISION 2020 delivery unit. Recommendations on targets for services and resources required have been made as unit ratios of the delivery unit, for example two to four ophthalmologists, four to ten ophthalmic nurses per delivery unit. This implies that there is a team responsible for the eye health of the population of a VISION 2020 delivery unit.

**The concept of teamwork**

The term **team** is not commonly used by eye care providers who are more familiar with groups of professionals such as ophthalmologists, ophthalmic nurses, optometrists, support staff, management etc. The concept of teams and team building is more familiar to the management culture.

Management has used the team concept and team building whether in the factory or in organisations to achieve efficiency, effectiveness, job satisfaction and a shared vision. Dr Meredith Belbin, one of the world's leading experts on team building, has conducted research into group interactions and concludes that all members of an organisation have a dual role. The first role, the functional one, is obvious: an eye care provider belongs to the team because s/he is an ophthalmologist, ophthalmic nurse, records officer, anaesthetist, hospital administrator or whatever. The second role, the **team role** is defined by Dr Belbin as "a tendency to behave, contribute and inter-relate with others in a particular way". Members of the team vary in their tendencies, some like action-oriented roles, others are best at people-oriented roles, while others perform the thinking roles for the team. Belbin has identified nine Team-Role types. <sup>1,2,3</sup>

**Belbin's Team Roles**

Role	Contributions and Allowable weaknesses
<b>Action-oriented roles</b>	
SHAPER	Challenging, dynamic, thrives on pressure. Has the drive and courage to overcome obstacles. <b>Prono to provocation, offends people's feelings.</b>
IMPLEMENTER	Disciplined, reliable, conservative and efficient. Turns ideas into practical actions. <b>Can be somewhat inflexible. Slow to respond to new possibilities.</b>
COMPLETER / FINISHER	Painstaking, conscientious, orderly, anxious, searches out errors and omissions. Can finalise something that has been started with complete thoroughness. Delivers on time. <b>Inclined to worry unduly. Weak delegator.</b>
<b>People-oriented roles</b>	
CO-ORDINATOR	Mature, confident, a good chairperson. Clarifies goals, promotes decision making, delegates well. <b>Can often be seen as manipulative, off loads personal work.</b>
TEAMWORKER	Co-operative, mild, perceptive and diplomatic. Listens, builds, averts friction. Very good with awkward people and places the group's interests before their own. <b>Can be indecisive in crunch situations.</b>
RESOURCE INVESTIGATOR	Curious, communicative, extrovert, innovative, explores new areas and opportunities. Develops contacts. Requires close involvement with people, skilled in the use of resources and fits easily into management teams. <b>Over-optimistic. Loses interest once initial enthusiasm has passed. Requires challenge, non-finisher.</b>
<b>Thinking roles</b>	
PLANT	Creative, imaginative, unorthodox. Solves difficult problems. <b>Ignores incidentals. Too preoccupied to communicate effectively.</b>
MONITOR / EVALUATOR	Sober, strategic and discerning. Sees all options, judges accurately. <b>Lacks drive and ability to inspire others.</b>
SPECIALIST	Single-minded, self-starting, dedicated. Provides knowledge and skills which are in rare supply. <b>Contributes only on a narrow field. Dwells on technicalities.</b>

The team role is due to one's personality and is not tied to one's profession. One person might combine the technical role of ophthalmic assistant, with the team role of resource investigator, exploring opportunities for increasing community-based services. Another might have the same technical role, but be more of an 'implementer', good at turning ideas for a new service delivery model into practical actions.

Dr Belbin also promotes the concept that nobody is perfect but a team can be. A team is capable of sustained and enduring success as it builds up a store of shared experience, information and judgement.

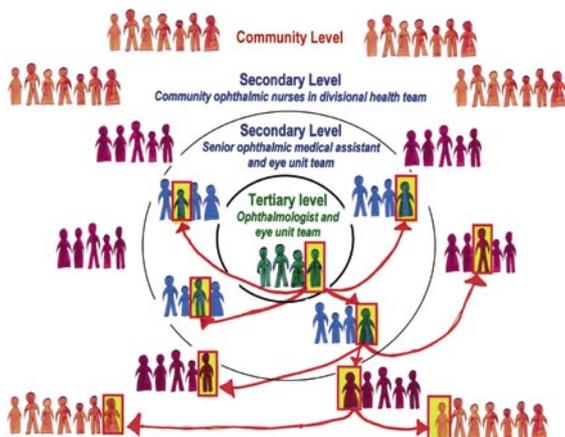


Fig. 1. Horizontal and vertical teams

## 'Horizontal' and 'vertical' teams

In eye care programming to achieve VISION 2020 there may be 'horizontal' and 'vertical' teams. A horizontal team is made up of workers who function within the same health administrative level, e.g. an eye unit, an ophthalmology department. It can be represented by a series of concentric circles with the number of staff increasing in the outer circles.

A vertical team is made up of staff who function at different administrative levels but are responsible for the coverage of a geographical area or a population unit, e.g. eye care providers who work in a health district. These two types of teams will have some members belonging to the vertical as well as a horizontal team (Figure 1). The regional ophthalmologist could belong to the horizontal team in his/her hospital and the district ophthalmic nurse could belong to the district health management team.

## Building a team

A team does not happen by chance but needs to be built. The first stage is the sharing of a vision, a common goal. The next is building the team. The following may be the challenges.

With the horizontal team:

- breaking down professional boxes and recognising the complementary nature of the work of each team member
- acknowledging the inter-dependency of each team member to achieve the shared vision
- defining roles, responsibilities, job descriptions and shared information
- recognising the role and function of sub-teams, e.g., operating theatre team, outpatient team
- ensuring representation/feedback of sub teams in the main team
- resolving potential conflicts of interest and promoting co-operation of members on other teams, e.g., ophthalmic nursing matron and the hospital nursing department.

A vertical team usually has members of the same or similar profession. The main challenge is the long distance team membership. Frequent communication is essential and visits for problem solving, supervision, support, and training are crucial to prevent professional isolation and ensure quality and standards.

## Strategies to achieve a team culture in eye care programmes

**Training** should include the team concept and team building skills, leadership and vision building within a management module.

**Training of teams** rather than individuals, aiming at achieving a goal rather than transferring knowledge and skills to an individual, e.g. a programme wishing to provide paediatric ophthalmic services would train a team made up of an ophthalmologist, anaesthetist, nurse etc. The teamwork will be reinforced by the shared training experience.

**Composition of teams** should include a mix of personnel, e.g. a district eye health horizontal team is made up of one ophthalmologist, four ophthalmic nurses, eight general nurses, one driver, one secretary etc. The district vertical eye health team is made up of one district ophthalmologist and four sub-district senior ophthalmic nurses. The sub-district eye health vertical team is made up of a sub-district senior ophthalmic nurse and the sub-district community ophthalmic nurses.

**Co-opting members into the team** on a short or long-term basis when additional skills are needed.

**Scheduled and regular team meetings** which cover work plans, review targets, successes, failures, unforeseen events, 'post-mortem' reviews of shared events, resolve controversies and reach consensus and planning for the next period. The systematic recording of the minutes of the meeting, and rotating the chairing, help the team stay focused and develop each member of the team.

**Celebrations** of outstanding performance of a particular team member.

**Support group** which would also respect personal privacy.

**Linkage of the horizontal team to the vertical team** to help break down the box which isolates institutional care from population coverage as staff have to function within and between levels of health care and between individual care and population care.

## Management team

In countries where lack of resources is a major problem, the careful management of financial and other material resources can be what keeps a programme alive. A good management structure ensures that human resources are available in quantity, quality and deployment and that they have the infrastructure and technology to deliver services. Belbin's team roles become particularly pertinent in the management team. VISION 2020 – a shared vision – requires teams whose members have a functional as well as a team role to deliver it.

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## CASE STUDY The Gambia National Eye Care Programme

The vision of The Gambia's National Eye Care Programme was to reduce blindness due to cataract. There was a lack of trained human resources and people for training. The vertical team concept used paramedics to deliver cataract surgery and other eye services at each divisional health facility.

The team was responsible for the eye health of a population of 150,000-200,000. Roles, responsibilities and limitations of clinical management of the cadre were defined. They were trained in management skills to enable them to take responsibility for the eye health of the defined population and to lead their sub-district/division eye care teams.

The supervising ophthalmologist met with the team during quarterly visits to provide service, supervision, support, some supplies and training. Best of all was when a joint visit was possible of the ophthalmologist, the programme manager and the equipment technician. Using this concept of vertical and horizontal teams has resulted in achieving a cataract surgical rate of 2000 and integrated eye care services from community to tertiary level in a sub-Saharan African country.



# Bridging the gap between health care professionals and communities

**Sally Hartley**

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## Introduction

Bridging the gap between health care professionals and communities is a difficult task. It involves establishing a culture of community participation and improving the process of communication between the two groups. Effective communication between these groups is not easy. The people concerned often speak different languages, have different levels of education and competence, different priorities in life and generally understand things differently. In addition, the greatest proportion of communication is transmitted non-verbally, through gestures, facial expressions and 'body language'. This is important for two reasons. Firstly, any feelings of pity, superiority, frustration, dismissal or respect, will almost certainly be transmitted through these alternative modes of communication, they carry much more powerful messages than those contained in what is **said**. Secondly, many of these non-verbal messages, with the major exception of speech intonation, are visual and are therefore missed by people who cannot see well enough to pick them up. This combines to give an effective recipe for communication breakdown.

This article will examine the process of communication in terms of **need**, **opportunity** and **means**. It will also examine the potential benefits of improved communication between health care professionals and community members in terms of what health care professionals might learn from the community. It is important to remember that community members include people with visual impairments and their families.



Victoria Francis

**must want to listen.** For this to happen both parties must feel that they will enjoy and benefit in some way from the exchange. Health care workers sometimes feel that it is only what **they** say to the community member or patient that is important. They often spend long hours deciding what this should be. The community member might not be ready to listen because of more pressing problems on his/her mind. In either of these situations effective communication is unlikely to occur. The answers to the following questions are required: "Is there the need by both parties to communicate? If not, why not? How can this be resolved?"

The second pre-requisite for effective communication is providing the **opportunity**. For example, effective communication is unlikely to occur if not enough time is allowed. Is there the opportunity to communicate? Is the health worker too busy? Location is also important, for example, advice concerning private and personal issues given in a frightening environment or a public place, is unlikely to be heard. It must be asked, whether communicating with individuals or groups, is this the best place for this conversation?

The third pre-requisite is the **means**. This refers to the ability and compatibility of the 'tools' of communication, for example, the same language, ability of both parties to listen and or talk, (read or write if this is the means that is being used). The questions that need to be asked are "Do both parties have an effective means of communication? Do they speak the same language,

use the same dialect, understand the same terms? If not, how can this be reconciled?"

So what can be learnt from community members if effective communication is achieved? The evidence indicates that stakeholders i.e. those involved and affected by 'visual impairment' (which, in this article, I use to refer to all degrees of sight limitation from blindness to refractive errors), agree that community members have a potentially positive contribution to make towards improving the quality of life of people with visual impairment. John Hubley<sup>1</sup> and also Muhammod Sabur<sup>2</sup> highlight the importance of community participation in effective eye care. They provide information about **what** community members can do to improve eye care, such as early identification, prompt action in seeking treatment and adhering to advice. They do not focus in detail on **how** this can be achieved. The **how** question is the question that can be answered by listening to perspectives of community members. In other words the health care workers are the 'experts' on answers to the **what** questions, but the communities are the 'experts' on answers to the **how** questions. Obviously it is only by combining this expertise that a true solution can be found, hence the need for community participation in service development. It would seem that if the recommendations of health care professionals are to be put into practice, there is a need to ask, to listen and to act on the expertise of the community members. As a Masai proverb puts it "One head cannot contain all wisdom".



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## Communication

Effective communication is a two-way, turn taking activity, requiring participation from both parties. It is used to share ideas and knowledge, establish identity, give instructions, ask questions and express feelings. It has three pre-requisites.

Firstly, there must be a **need** or desire to communicate. The health care worker must **want** to communicate with community members and the community member

# 'Health care workers are the 'experts' on answers to the *what* questions, but the communities are the 'experts' on answers to the *how* questions'

## What can eye care providers learn from communities?

### Prevention and cure are only part of the story

Listening to community members tells you that prevention and cure of eye disease is only part of the problem. There is global agreement that up to 80 per cent of eye disease is avoidable, i.e. preventable or curable. For example, a recent study of blindness in children in Bangladesh shows 68 per cent is avoidable (32 per cent preventable, 36 per cent treatable).<sup>3</sup> If services concentrate on cure and prevention only, 32 per cent of blind children in Bangladesh are without any support. These children face exclusion from society, health, education and employment and their needs should be addressed alongside any curative programme.

### Humility

Listening to community members tells you that people with visual impairments are often very brave and strong. It tells you that they are people who have thoughts, feelings, ideas and aspirations, just as any other person. It tells you that they have a lot to offer other people with similar eye diseases in terms of emotional support and understanding. It tells you that their families and their communities sometimes reject them and that they often have little choice or control of their lives. Their lives are hard and challenging. It tells you that many community members do not understand their needs.

The process of increasing awareness is usually a humbling experience for health care workers and serves to motivate them to communicate better and with more respect. They begin to consider their 'patients' as whole people and not just walking 'eyes'! Respecting the people as people will result in them respecting and trusting in return, so the advice given to them e.g. bringing people for treatment early, following treatment procedures, changing life styles, and improving their environment, will be better understood and appreciated.

### Advocacy

People with visual impairments have an important role to play in raising the community awareness, in education and advocacy. They are in the unique position of knowing what it is like to be blind and knowing how they themselves have managed to overcome some of the



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challenges they have faced. Their families too have a great deal to offer each other in terms of support and understanding. Who could be better to explain a treatment procedure to another person than someone who has already experienced it?

### The problems faced by people with impairments

The various aspects of disablement that people with visual impairment face are usually similar to those faced by people with other impairments. These include reduced social integration, unequal rights, and lack of access to health, education and employment opportunities. Health care providers can facilitate access to community based rehabil-

itation programmes where these exist, so that they may be more fully included in society.

In conclusion, health care workers can learn much from community members if they learn to listen. This requires a paradigm shift away from perceiving themselves as the only or most important expert, to recognising the importance of local knowledge and performing the more difficult role of facilitator and supporter. This means recognising people with eye problems and their families as the most important community members. It means working in partnership with them and other community members to achieve maximum prevention and adherence to medical treatment. This process of participation is likely to reveal locally based strategies that can change and improve existing services. It is likely to reveal the tremendous strength, bravery, humility and wisdom of people who have learnt to cope with their lack of sight, or the lack of sight of a loved one. They have learnt to come to terms with exclusion from society, discrimination, limited choices, lack of opportunity and independence. They have much to teach us! We need to listen and to learn.

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Mohammad Muhit



# Bridging the gap to evidence-based eye care



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In the first article in this series, I touched on the enormous challenge to make access to information equal for those who need it at the time and place when they need it. Only if this is achieved can we successfully promote an evidence-based approach to health care. The move towards open access publishing is taking us some way to achieving this. However, there are further gaps to be bridged if we are to turn eye care workers into evidence-based practitioners. We can define an evidence-based practitioner as one who combines their individual knowledge and expertise with the best available external clinical evidence from systematic research.

The standard approach to evidence-based health care is:

- 1 Formulating a question
- 2 Looking for evidence, which usually means searching the scientific literature
- 3 Appraising the information, i.e. deciding if it is reliable
- 4 Applying the evidence
- 5 Evaluating the process.

## Formulating a question

The first gap we need to bridge relates to the way that health care providers think about knowledge and information. Asking a question might be difficult for those who have been taught to practice medicine by rote, memorising lists of causes and treatments without ever being taught to ask the question "why?" or "how do you know?" Creating a thirst for knowledge, and encouraging people to practice it, is

the challenge for implementing evidence-based practice in ophthalmology.

An important starting point is to challenge anything new; just because it is new, it does not necessarily follow that it is better. It is almost certainly going to be more expensive so what additional benefit is there to justify the additional cost? But it is almost as important to challenge established practice. Just because we always do things in certain ways does not mean it's the best way of doing it. How many of our readers continue to treat corneal abrasion with antibiotic ointment and a pad? The few trials that have been conducted suggest that padding slows healing and increases discomfort. There is no evidence that padding reduces the risk of secondary infection (though this might be more of a concern in poorer countries with less sanitation or dusty environments from where no such studies have been reported).

## Looking for evidence

Once we have a question, the search for an answer follows, and here lies another gap. As already stated, there are major inequalities in access to and availability of reliable information sources. A major problem is that the holders of information demand payment for access. The amount to pay is rarely adjusted for ability to pay and prices are set by richer economies. Looking for evidence can also be a time consuming process, time which a busy clinician in an overwhelmed and under resourced outpatient clinic will rarely, if ever, have. Those with internet access can run simple searches to find answers. However, of the

evidence available, the average searcher will find only a fraction, which is why services which synthesise and evaluate research, such as *The Cochrane Library*, are valuable.

## Appraising the information

Once we have found sources of information to answer our question, we must appraise it – is this information reliable? The challenge to evidence-based health care is to ensure that information is reliable, of good quality, free from bias and not linked to the personal advantage of any individual or group of individuals. It should be available and accessible to users of information in a form that is interpretable and relevant. It should also be quality controlled. How then is evidence graded? What hierarchies are used for judging the quality of evidence?

Table 1 gives an example of one such hierarchy from the Canadian Task Force on Preventive Health Care. Randomised controlled trials (RCTs) provide the best evidence for the effectiveness of interventions because the control group provides the comparator (which allows us to quantify an estimate of the effectiveness of a treatment) and randomisation prevents bias in selecting who gets treated and who is a control. It also deals with the possibility of baseline dissimilarities between treatment and control groups which may account for the outcome of the trial rather than the intervention; these are termed confounders which may be apparent or hidden. The randomised controlled trial, and especially the systematic review of several random controlled trials, is more likely to inform us than mislead us.

**Table 1. Levels of Evidence – Research Design Rating**

I	Evidence from randomized controlled trial(s)
II-1	Evidence from controlled trial(s) without randomization
II-2	Evidence from cohort or case-control analytic studies, preferably from more than one centre or research group
II-3	Evidence from comparisons between times or places with or without the intervention; dramatic results in uncontrolled experiments could be included here
III	Opinions of respected authorities, based on clinical experience; descriptive studies or reports of expert committees

Source: Canadian Task Force on Preventive Health Care. Available from: [www.ctfphc.org](http://www.ctfphc.org)

# ‘Creating a thirst for knowledge, and providing the tools to access, assess and apply it, is the challenge for implementing evidence-based practice in ophthalmology.’

Human beings are usually rather quick to attribute cause and effect. Traditional methods of healing rely on QED (*Quod est demonstrandum* – as is demonstrated) type evidence. The patient was ill, the doctor treated and the patient recovered. Thus the treatment was effective. We forget that the patient may have got better anyway and that the treatment may have been sham or placebo. Hence it is only RCTs which can properly attribute cause and effect and additionally estimate how powerful the effect of an intervention is; not just does it work, yes or no, but by how much is the probability of an adverse outcome reduced or a benefit increased. One intuitively useful measure of effect which can be derived from trials is the NNT – the number needed to treat for one to benefit. For ocular hypertension, this may be as high as 40.

Other types of study, cohort and case control, often called observational studies, can quantify effect or risk but are more prone to bias and confounding. But the commonest type of medical report in ophthalmology, the case series (where there is no comparator or control group) is not only likely to be biased through selection but also cannot provide an estimate of effect size. It is that very basic sort of evidence, the QED type, which surgeons and eye doctors often seem to think sufficient. Much needs to be done to educate clinicians about the nature and quality of evidence on which we base our practice. It is also necessary to apply quality control to the studies themselves. RCTs vary greatly in quality, and stringent criteria for evaluating the quality of individual studies need to be applied.

## Applying the evidence

One common difficulty in relating existing evidence to the patient in front of you is that your patient may have little in common with the subjects who participated in the trials. This is the external validity of a trial. If the inclusion/exclusion criteria are so tight that only a small sample of the population at risk of the effects of a disease are included, it can be difficult to interpret and apply the evidence. For example, in chronic glaucoma, we only have evidence of the effectiveness of lowering intraocular pressure in ocular hypertensives, people with early manifest glaucoma and normal tension glaucoma because these are the only patient groups included in trials where treatment has been compared to none. And apart from a few African Americans, the patients were all white Europeans. How far can we apply

those findings to the populations of the rest of the world? Another gap occurs for people who are routinely excluded from trials, such as pregnant women and children.

Implementing evidence in practice is difficult to achieve and doctors often only use evidence if it fits with their pre-existing beliefs. One strategy is for agencies to develop evidence-based guidelines. There are numerous examples of guidelines which are not evidence-based since these are much easier to produce. Usually, these are developed using a select group of ‘experts’ whose dominant opinion becomes the basis of recommended practice. This is not evidence-based.

## Evaluating the process

The final step in evidence-based practice is to monitor the effectiveness of interventions in the real world. Trials are clinical experiments conducted in carefully controlled conditions. It is well known that outcomes in trials tend to be better than in ordinary clinics and this is another gap between evidence and practice. Regular monitoring of outcomes is therefore an important part of the evidence base.

Personal audit is an excellent means for surgeons to monitor and improve their practice. Research is ongoing to develop a simple database for use in VISION 2020 programmes globally. Large-scale representative studies of outcomes are important to establish standards which can be used for audit. Several large outcome studies for cataract surgery have been conducted such as those in the USA, UK and Scandinavia. The latter is a large register of cataract surgery in Sweden which allows monitoring of rare but important adverse events such as endophthalmitis and also provides information on effectiveness of prophylactic measures which cannot be detected in trials (since they are never large enough to detect differences in the occurrence of rare events). Registers have been important in establishing the evidence base for corneal transplantation.

Adverse events can also be monitored by surveillance systems and are in place in many Western countries for collecting information on the adverse effects of drugs. However, few are yet established for surgery, and such information collection is impossible in poorer countries. Global efforts, perhaps VISION 2020, will in time provide the infrastructure for such surveillance.

## Conclusion

Compared to other specialties, ophthalmology has a long way to go in developing its evidence base. I have peer refereed a systematic review for the Cochrane Tobacco and Addiction group which included more than 90 randomised controlled trials for nicotine replacement therapy. In our review on Ivermectin for onchocerciasis, we could find only five relevant studies. This reflects the enormous bias (reflecting the availability of research resources) towards evidence for diseases affecting affluent nations.

But there is also a need for ophthalmologists (like many other surgically dominated specialties) to recognise the importance of evidence beyond QED in informing their practice.



**Treatment for Retinopathy of Prematurity (ROP) is one area of eye care for which the evidence base is well developed. There are four systematic reviews on The Cochrane Library on the subject. The library can be accessed via Hinari for lower income countries at [www.healthInternetwork.org](http://www.healthInternetwork.org)**



# Bridging the eye health information gap through the internet



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## Potential and problems of the internet

The internet connects millions of computers around the world. Once connected, the eye health worker can use internet services to:

- access the most up-to-date information at a fraction of the traditional cost of journal subscription via the new Open Access publishing model
- communicate with colleagues, reducing the sense of professional isolation which comes from geographical separation
- engage in a two way process of communication between health information providers and users
- publish locally appropriate material more easily.

However, if this technology is to play a major part in providing health information, some key problems must be acknowledged and addressed.<sup>1</sup>

A serious concern is with the 'digital divide' – the gap between those with and those without internet access. Only about one in

eight people in the world can connect to the internet and most of these are in high income countries.<sup>2,3</sup> This 'digital divide' is at its most extreme in Africa where it is estimated only one in 70 were able to access the internet<sup>3</sup> and most of those in South Africa.<sup>4</sup>

Some publishers bridge this gap by finding alternative ways to distribute information. The International Centre for Eye Health (ICEH) for example, has adopted an approach to sharing information which combines print and electronic materials and new technology such as the internet, email and CD-ROM to provide information in easily accessible formats and to facilitate local production and adaptation.

We can expect internet access to improve and become more affordable in the future (See Table 1). Potential users should not be put off by a lack of experience – the rest of this article gives help and advice on how to use the internet to access reliable and free eye health information.

**Table 1. Use of the internet throughout the world**

World region	% Population Internet Usage (2004 or latest data)	User Growth (2000-2004)
Africa	1.4 %	183.2 %
Asia	7.1 %	124.4 %
Europe	30.7 %	117.7 %
Middle East	6.5 %	218.7 %
North America	68.6 %	106.3 %
Latin America/Caribbean	9.4 %	180.9 %
Oceania	48.5 %	107.2 %

From Internet World Stats [www.internetworldstats.com/stats.htm](http://www.internetworldstats.com/stats.htm)

## How to find the information you want

First, be clear about what you want to achieve (Table 2).

**Table 2. Different types of health information and how to access it**

What do you want to achieve?	How to find information
Explore a health topic generally or look for some specific health information	<ul style="list-style-type: none"> <li>• Browse health web sites – this can be time consuming</li> <li>• Use a search engine – see 'Tips for searching the web'</li> <li>• Visit information gateway and bibliographic database web sites – these web sites and pages collect links to documents on a specific topic</li> </ul>
Find out about an organisation	<ul style="list-style-type: none"> <li>• Visit its web site</li> <li>• If you don't know the web site address use a search engine</li> </ul>
Keep abreast of current research and practice in the health field	<ul style="list-style-type: none"> <li>• Visit electronic journal web sites</li> <li>• Visit information gateway and bibliographic database web sites</li> <li>• Subscribe to email updates and alert services</li> </ul>
Access free journals on line	<ul style="list-style-type: none"> <li>• Visit Open Access web sites for up-to-date research</li> </ul>
Participate in discussion with a group of others	<ul style="list-style-type: none"> <li>• Subscribe to email lists – read and participate in discussions via email</li> <li>• Visit discussion boards – read and participate in discussions via a web site</li> </ul>
Communicate with colleagues around the world	<ul style="list-style-type: none"> <li>• Use email</li> <li>• Use Instant Messenger computer programs</li> <li>• Visit individuals' web sites</li> </ul>

## Tips for searching the web

Some examples of popular search engines are:

- **Google** [www.google.com](http://www.google.com)
- **Alta Vista** [www.altavista.com](http://www.altavista.com)
- **Yahoo** [www.yahoo.com](http://www.yahoo.com)
- **Dogpile** [www.dogpile.com](http://www.dogpile.com)

Think carefully about how you will enter the search terms you want to use.

- are there alternative spellings?
- which language will you use?
- is the plural term often used as well?
- are there terms with similar meaning?

Use Boolean terms such as:

- **OR**  
Web pages found containing either term will get a higher placing. Note: OR is used by default in many search engines. For example, open-angle OR glaucoma
- **AND / +**  
Web pages found must contain both terms. For example, open-angle AND glaucoma
- **NOT / -**  
Web pages found must not contain the terms preceded by NOT. For example, glaucoma NOT open-angle
- **" "**

Web pages found must contain the exact search term between the quotation marks. For example, "open-angle glaucoma"

Read the help pages provided by many search engines. The symbols used for AND/OR/NOT differ and not all search engines support all the Boolean features.

## Evaluating information

Anyone can publish anything on the internet, and inevitably some of what is published is inaccurate or undesirable. Things to consider include:<sup>5</sup>

- **Author**  
Do you recognise and trust the author's name and affiliation?
- **Publisher**  
Try to assess the publisher's role and authority
- **Point of view or bias**  
Because it is easy to publish on the internet, the variety of points of view and bias will be the widest possible
- **References**  
References allow you to evaluate an author's knowledge
- **Accuracy**  
Can the information be verified?
- **Up-to-Date**  
When was the information published?

## Examples of useful web sites



### WEB SITES AND PAGES FOR EYE HEALTH WORKERS

**VISION 2020: The Right to Sight**

[www.v2020.org](http://www.v2020.org)

**VISION 2020 E-Resource**

[www.laico.org/v2020resource/homepage.htm](http://www.laico.org/v2020resource/homepage.htm)

**WHO (World Health Organization)**

**Prevention of Blindness and Deafness**

[www.who.int/pbd](http://www.who.int/pbd)

**International Centre for Eye Health (ICEH)**

[www.iceh.org.uk](http://www.iceh.org.uk)

**American Academy of Ophthalmology (AAO)**

[www.aaopt.org](http://www.aaopt.org)

**Cochrane Eyes and Vision Group (CEVG)**

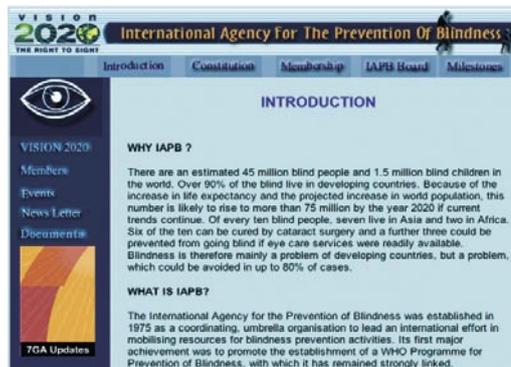
[www.cochraneeyes.org](http://www.cochraneeyes.org)

**EyeText** Ophthalmology image database, study cards and monographs

[www.eyetext.net/index.php](http://www.eyetext.net/index.php)

**INASP Eye Health links**

[www.inasp.info/health/links/eye.html](http://www.inasp.info/health/links/eye.html)



**International Agency for the Prevention of Blindness (IAPB)** [www.iapb.org](http://www.iapb.org)

**OMNI Gateway Ophthalmology links**

<http://omni.ac.uk/text/browse/subject-listing/WW100.html> (low graphics version)

**Task Force Sight and Life**

[www.sightandlife.org](http://www.sightandlife.org)

**VisionConnection (Lighthouse International)**

[www.visionconnection.org](http://www.visionconnection.org)

### OPEN ACCESS WEB SITES FOR FREE UP-TO-DATE RESEARCH

**Archives of Ophthalmology**

<http://archophth.ama-assn.org>

**BioMed** Free access to peer-reviewed biomedical research

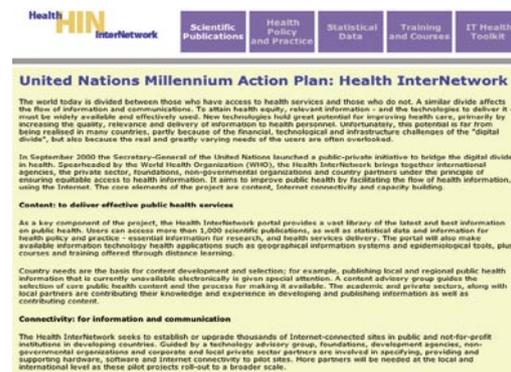
[www.biomedcentral.com](http://www.biomedcentral.com)

**Directory of Open Access Journals (DOAJ)**

[www.doaj.org](http://www.doaj.org)

**FreeMedicalJournals.com**

[www.freemedicaljournals.com](http://www.freemedicaljournals.com)



**Health InterNetwork Access to Research Initiative (HINARI)**

Provides free or very low cost online access to the major journals in biomedical and related social sciences to local, non-profit institutions in developing countries

[www.healthinternetwork.org](http://www.healthinternetwork.org)

**PubMed Central (PMC)** A free digital archive of biomedical and life sciences journal literature

[www.pubmedcentral.nih.gov](http://www.pubmedcentral.nih.gov)

### INFORMATION GATEWAY AND BIBLIOGRAPHIC DATABASE WEB SITES

**African Journals OnLine (AJOL)** Provides access to African published research [www.ajol.info](http://www.ajol.info)

**Bioline** A not-for-profit service providing open access to quality research journals published in developing countries [www.bioline.org.br](http://www.bioline.org.br)

**International Network for the Availability of Scientific Publications (INASP)** Aims to enhance the flow of information within and between countries. [www.inasp.info/index.html](http://www.inasp.info/index.html)

**Latin American and Caribbean Center for Information (BIREME)** Promotes the use of health scientific and technical information in Latin America and the Caribbean. [www.bireme.org](http://www.bireme.org)

**Public Library of Science (PLOS)** Aims to make the world's scientific publications and medical literature freely available to all. [www.publiblibraryofscience.org](http://www.publiblibraryofscience.org)

**PubMed/MEDLINE** Over 14 million citations for biomedical articles. Many are not free to access but there are links to sites providing free full text articles [www.ncbi.nlm.nih.gov/entrez/query.fcgi](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi)

**SOURCE** Information on health and disability, with three databases – Bibliographic, Contacts and Newsletters / Journals [www.asksources.info](http://www.asksources.info)

### EYE RELATED EMAIL LISTS AND DISCUSSION BOARDS

**EyeText Discussion Boards**

[www.eyetext.net/agora/index.php?site=eyetext](http://www.eyetext.net/agora/index.php?site=eyetext)

**VISION 2020 E-Resource Siteforum**

[www.laico.org/v2020resource/homepage.htm](http://www.laico.org/v2020resource/homepage.htm) (click on the 'siteforum' button)

**Trachoma Information Service**

[www.kcco.net](http://www.kcco.net)

These links give full and free access to information unless otherwise stated. An expanded list, with extra links to internet guides, is available on the *Community Eye Health Journal* web site at [www.jceh.co.uk/links.asp](http://www.jceh.co.uk/links.asp) and you can email [admin@jceh.co.uk](mailto:admin@jceh.co.uk) and request it to be emailed to you. Readers are also invited to inform us of useful links.

## Glossary of terms

**Bookmark** – also called Favourite – a way to save in your browser direct links to web sites you want to see again.

**Boolean searches** – a way to improve searches using 'operatives' such as AND, OR, and NOT.

**Browser** – a computer programme that lets you view the World Wide Web. For example, Internet Explorer. Browsing is the act of clicking on a link in one web document and opening another one.

**Discussion Boards** – popular, fun, alternative places for discussion. They are accessed and viewed on the web through a browser.

**Email** – a way to send messages to other internet users.

**Email Lists** – services to which you subscribe to receive and participate in discussions via email.

**Email Alerts** – subscription services which send you emails when web sites have new content.

**Instant Messengers** – computer programs that let you send a message that immediately pops up on an online contact's screen. Two free examples are ICQ and AOL Instant Messenger.

**Hypertext Links** – text, buttons or graphics that, when clicked with a mouse button, open another page.

**Open Access Publishing** – a new model for financing scholarly publication. Instead of users paying to subscribe to a journal, articles are made available electronically for free and the cost is paid by the authors or institutions.

**URL (Uniform Resource Locator)** – a web site address. For example, the URL for the *Community Eye Health Journal* web site is [www.jceh.co.uk](http://www.jceh.co.uk) To visit this web page type the URL into the address bar of the browser.

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All web links were accessed on 24 September 2004.



# Instrument repair for remote eye units

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Many skilled eye surgeons in remote hospitals face the frustration that a simple instrument, once in good working order, is now bent or broken. Many eye units have a box containing instruments needing repair, hidden away in a stock room cupboard, in the hope that someone, someday, will be able to redeem them.

This article gives guidelines on:

- 1 How to assess instruments and identify those that can be repaired locally, those that should be sent to a professional repair service and those that cannot be repaired at all.
- 2 How to make adjustments and carry out basic maintenance and repairs of surgical instruments.

The article will refer primarily to instruments in an extracapsular cataract extraction set.

**Figure 1. Basic repair set (right)**

- 1 light brass hammer
- 2 bending tool
- 3 cotton wool
- 4 600 grit diamond file
- 5 small Arkansas stone
- 6 assorted fine files
- 7 mild abrasive (tooth paste)



Sam Powdrill

## Assessment

### Quality of the instrument

A good quality instrument is worth repairing. Many less expensive instruments have been poorly hardened and will wear quickly, bend or become dull. Considering the time and effort required, these might not be worth repairing.

### Amount of damage

Cracks in the metal, flaking of metal fragments or sharp edges on 'blunt' instruments risk injury to the patient's eye during surgery. If these defects cannot be repaired adequately for patient safety, the instrument should be discarded. Cracks in the hinges of scissors, needle holders, forceps joints and haemostats will continue to cause problems with alignment and cannot be repaired. Sometimes such instruments can be used for spare parts.

### Value of the instrument

If an instrument such as a capsulotomy scissors, one of the most expensive and most delicate of instruments, needs to be adjusted or sharpened, it is worth sending to a reputable repairer. These scissors are

difficult to sharpen and the metal is extremely hard and brittle. Any attempt to bend the instrument can cause irreparable damage.

The following instruments can usually be repaired on site depending on the experience of the repair technician:

- A *dialler* or *muscle hook* is less expensive, it is made of softer metal and can be easily straightened
- A *Westcott's scissors* can usually be adjusted, tightened and sharpened but this needs some skilled attention
- Most micro forceps – *Colibri*, *Hoskins*, tying and toothed forceps – can be realigned. If the teeth are broken it can be repaired but it is difficult. It may be more feasible to remove the teeth and make a tying forceps out of the instrument instead
- With the correct tools, a groove can be re-cut in a *grooved forceps*.

Re-usable knives can be sharpened but it requires some skill to sharpen the point and keep the edge smooth. Preferably, this should be done by a professional repair service.

**'Many skilled eye surgeons in remote hospitals face the frustration that a simple instrument, once in good working order, is now bent or broken'**

## Remember!

- Careful handling while inspecting, adjusting and repairing instruments will avoid injury and reduce damage to the instrument
- Always clean and sterilise surgical instruments before attempting to repair them or before sending to any repair service
- Repair technicians should wear safety goggles to prevent eye injury from minute fragments of metal.

## Maintenance

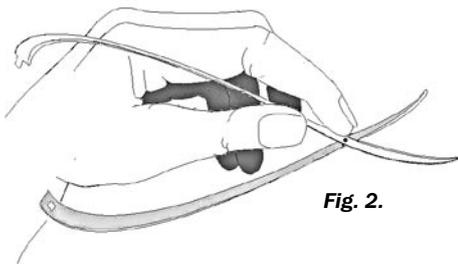


Fig. 2.

### Inspection

First determine what the problem is. It is good practice to try to find only one cause to explain why the instrument is malfunctioning. The operating microscope, when not in use for surgery, can be used to inspect and adjust instruments.

**Look** for bent parts, loose or cracked hinges, scissors or haemostat jaws which do not meet properly or have excessive wear, broken teeth, grooves, rust pitting or shiny areas where there are rubbing points.

**Listen** for clicks in toothed forceps, scissors or hinges.

**Feel** for abrasion, roughness or friction.

**Test** for sharpness. Check surgical blades by piercing a piece of rubber glove stretched over a small container (e.g., a photographic film container). The blade should enter smoothly without a 'pop' or resistance.

Check scissors for sharpness with a few strands of cotton wool. The scissors should cut the strands cleanly without dragging.

While making repairs re-check the instrument periodically in the same manner.

### Cleaning and lubricating the moving parts

Stainless steel instruments will also rust if left wet. This can be reduced by always using distilled or rain water in boilers and autoclaves. Instruments should be dried thoroughly before storing. An instrument may become rusty and the moving parts (e.g., the hinge) will stop working. Commercial rust removal and cleaning solutions are available but soaking in *Coca-Cola* for 30 minutes only is usually effective. Prolonged soaking will damage the instruments. Instruments should be rinsed in distilled water.

A scissors or needle holder with a corroded or stiff joint can be freed up by applying a mild abrasive compound (e.g., ordinary toothpaste), while moving the joint open and shut. Commercial grinding or rubbing compounds are available. A proper lubrication solution should be applied after thoroughly cleaning and drying the instrument.

A Simcoe irrigation/aspiration canula often gets blocked. The blockage is almost always at the tip where the small aspiration port opens. NEVER try to unblock the canula by heating it in a spirit lamp as this will melt the solder and cause a rough canula. Soak it in water first then use a small stainless steel wire alternately from each end of the canula to work the blockage free. This can be done under the microscope or slit lamp to increase visibility.

## Adjustment and Repair

**Alignment.** Check teeth and jaws under the microscope. With a locally made bending tool, and a little practice, many instruments can be repaired easily (see Box 1, Figures 3 & 4). Find the point of greatest misalignment and straighten this first. When bending, choose a slot that fits the instrument well and over-correct slightly because the metal will spring back a little.

### BOX 1

#### How to make your own bending tool

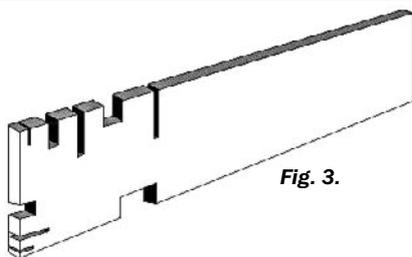


Fig. 3.

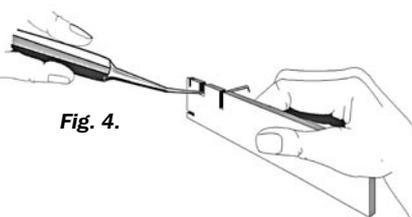


Fig. 4.

The suggested dimensions for a bending tool are one inch wide, five inches long and  $\frac{1}{8}$  to  $\frac{1}{4}$  inch thick. The bending tool should be made from brass or mild steel (Figure 3). The grooves on the tool can vary in width from the thinnest cut that you can make up to about  $\frac{1}{8}$  to  $\frac{1}{4}$  of an inch. Narrow slots are preferable. The slots can be cut with a hacksaw and smoothed or widened with a file (Figure 4).

**Filing or grinding.** Any filing or grinding to remove defects, reshape or restore an instrument should be done only as a last resort. It is important to maintain the original crafted design and shape of the instrument. Filing or grinding removes a lot of metal quickly and can permanently destroy it. Concentrate on removing metal from the flatter surfaces first, and then only small amounts from edges and corners.

**Sharpening.** Scissors and reusable knives require skilled attention. Practice first on old instruments as good instruments can easily be ruined in the hands of a novice.

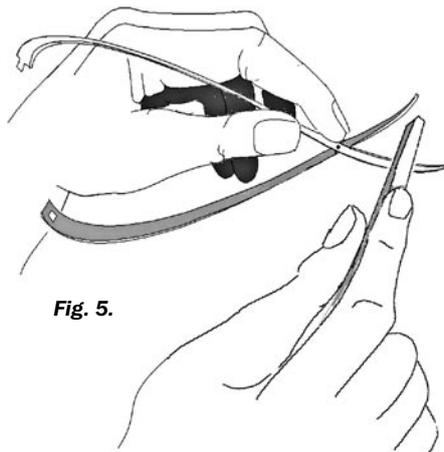


Fig. 5.

- 1 Hold the instrument firmly against a block or table edge
- 2 Always maintain the same sharpening angle with which the instrument was manufactured
- 3 Use a smooth, even movement at the same angle with every stroke of the stone (smooth Arkansas stone 800 – 1200 grit). A more expensive 600 grit diamond file is useful for coarse sharpening and shaping
- 4 Always sharpen in one direction into the cutting edge (Figure 5)
- 5 Hold the blade so that light reflects off the surface being cut and you can see that you are maintaining the same angle on every stroke
- 6 Never sharpen along the inside hollow surface of the blade as this has been hollow machine-ground by the manufacturer.

Note: If you do not have an Arkansas stone, a piece of 1,000 grit wet emery paper can be glued onto a small piece of wood (e.g. a tongue blade) and used instead.

**Tightening.** The hinge on a scissors, needle holder or haemostat may become loose. A good instrument probably has a screw in the hinge but many have a rivet.

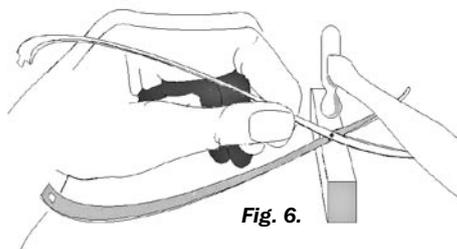


Fig. 6.

- 1 If the screw can be tightened, do this first. Often half of the head of the screw will break off. Then gently knock over the edges of the end of the screw to stop it loosening again.
- 2 If there is a rivet or a screw that will not loosen, tighten the joint by placing the joint flat on a metal surface and gently tapping with a very small hammer (Figure 6).

**Finish.** A smooth shiny finish (surface) resists rust. A smooth dull finish causes less distracting light reflection for the surgeon while operating.

Repair the finish by first using coarser abrasives and then finer and finer abrasives, ending with a polishing compound.

Final sharpening of scissors should be done after polishing is completed. Make sure instruments are thoroughly washed and cleared of all grit before being used again.

Wet emery paper in grit sizes 200, 400, 600, 1,000 is recommended. Always use these with water, a little liquid soap may be added. Many excellent abrasive alternatives are now available from jewellers' supply companies but these are expensive.

For useful resources, please see back page.



## Indirect costs associated with accessing eye care services as a barrier to service use in Ethiopia

Melese M, Alemayehu W, Friedlander E, Courtright P.

**BACKGROUND:** The prevalence of blindness and visual impairment are high in Ethiopia and use of services is limited. Determining the barriers to use of eye care services is critical for planning strategies to prevent blindness.

**METHODS:** A population-based survey of the magnitude and causes of blindness and visual impairment in adults 40 years and older in the Gurage Zone, central Ethiopia was conducted. Among those individuals who had binocular or monocular vision 6/18, an interview to assess use of eye care services and reasons for a failure to use such services was undertaken.

**RESULTS:** Of 850 adults with visual impairment or blindness, 802 were interviewed. Cataract surgery accounted for the primary service currently needed by the blind, followed by trichiasis surgery; service needs were higher for women than for men. Use of services (27.8 per cent of sample) was associated with being male, binocular vision loss, and blindness. The primary reason for a failure to use eye care services were indirect costs (overall, reported by 40 per cent of respondents) associated with accessing the service. There were significant differences between men and women in the reasons for not using the services and between cataract and trichiasis cases but not when comparing binocular vs. monocular conditions, or patients with visual impairment vs. blindness.

**CONCLUSION:** The majority of the causes of visual impairment and blindness are treatable (cataract) or preventable (trachomatous trichiasis). The main barrier for seeking service is related to the indirect medical costs of the service. This suggests that efforts are needed to create mechanisms that 'bridge' communities and eye care facilities. A holistic approach that deals both with the organization of services and the sociocultural factors in communities that affect use is needed. The organization of trichiasis surgery at peripheral health centres and screening programmes which identify and facilitate transport to hospital for cataract patients is one approach. The indirect burden of accessing eye care on the family may be lessened by encouraging patients to have surgery earlier (before they require assistance to reach the hospital), and by improving the efficiency of existing services. Promotion of services must be gender-sensitive, ensuring that specific characteristics of the sociocultural roles of women be considered in order to improve uptake among women. Training and placement of cataract surgeons in rural hospitals would also enhance provision of eye care for the rural population.

Reprinted courtesy of:

Trop Med Int Health. 2004 Mar;9(3):426-31.

## The cost-effectiveness of technology transfer using telemedicine

Johnston K, Kennedy C, Murdoch I, Taylor P and Cook C.

The high burden of disease in developing countries often makes it difficult for health systems in these countries to attain the same level of specialist skills as industrialized countries. Technology transfer is one way to improve specialist skills whilst at the same time reducing the burden of disease. This paper describes the use of tele-ophthalmology, a form of telemedicine, as a mode of technology transfer between the United Kingdom and South Africa. As the burden of eye disease in South Africa is high, the country cannot afford the level of ophthalmic specialization achieved in the UK. The paper estimates the cost-effectiveness of the technology transfer project in terms of a cost per Disability Adjusted Life Year (DALY) averted. We found the technology transfer project to be cost-effective in reducing the burden of eye disease, and that practitioners in South Africa also learned novel procedures that could help future patients and improve cost-effectiveness. Technology transfer using telemedicine is a cost-effective method that richer countries can employ to aid capacity building in the health care systems of poorer countries.

Reprinted courtesy of:

Health Policy and Planning. 2004; 19(5):302-09.

## Reaching the poor with eye services

Experiences from the family practice unit, Manaus County, Brazil

Blindness is often concentrated in poor areas and socially deprived communities, making blindness prevention a social and political challenge. The blindness prevention program at the Family Practice Unit in Manaus County, Brazil, has developed a model to reach patients through the public health system. The approach aims to detect patients in the community and refer them to ophthalmologists based at the clinic. Two ophthalmologists work with family practitioners and community health workers to whom they provide training on how to screen and refer patients. Barriers such as distance, culture, costs, and lack of information are broken down with this approach.

Between the years 2000 and 2003, 15,129 patients were seen at the ophthalmology service of the Family Practice Programme in the city of Manaus. The projection for the year 2004 is 8,640 consultations among the four centers distributed at the north, south, east and west areas of the city. In 2003, 110 diabetic patients sent by family practitioners and community health workers were evaluated, demonstrating the need to improve the screening of diabetic patients in the city. Refractive errors were the reason for consultation in 80 per cent of the patients during 2000-2003. Conjunctivitis, eyelid problems, cataract, and glaucoma were other frequent causes of consultation. Only 6.8 per cent of the patients seen at the unit were referred to the general hospital for further diagnosis and treatment.

Demand for eye care services in this area has increased continuously since the start of this programme. The location of the unit in the community, the focus of the clinic on the poor, and the emphasis on information, seem to have created an efficient and popular service. Brazil has about 50 million people assigned to these Family Practice Units by the Public Health System. If each unit had an ophthalmology service like Manaus, Brazil could make a great impact on prevention of blindness at the community level. The model might also be applicable to other countries.

Paulo Roberto de Magalhães Silva

Programa Médico da Família (SEMSA), Manaus, AM/Brazil, Rua 05, Casa 48 conjunto Vila Municipal – Adrianópolis Manaus – AM Brazil CEP: 69 057 730.  
email: luz@horizon.com.br

## Preventing broomstick eye injuries in children in Accra, Ghana

Brooms, made from palm branches, have been associated with eye injuries in Ghana. We determined the epidemiology of broomstick eye injuries in Korle-Bu Teaching Hospital in Ghana.

Patients with broomstick eye injuries attending the Eye Clinic over 12 months were recruited after informed consent. In addition to clinical examination, information was collected by questionnaire, in-depth interviews, and passive participant observation to find out about the circumstances peculiar to the injury and access to eye care. This gave us clues to preventive measures.

We treated ten children and one adult. All the children were under 12 years of age, 80 per cent were males, 90 per cent were pupils, and 90 per cent were injured while walking back home from school. Injury occurred while the children were playing a game of shooting a piece of broomstick at each other using a rubber band as a sling. Half the injuries were cornea or scleral perforations that resulted in monocular blindness, usually from complicated cataract, and/or endophthalmitis.

We took advantage of a local national VISION 2020 workshop to discuss a public health approach to the problem. Plans to deal with the issue aim at educating children, teachers, parents and the general public on the dangers of rubber bands and broomsticks in the hands of children, and to promote the proper disposal of any items which could injure eyes. As devices children use for play change, we will also stress the general point about care of eyes. Communication strategies include discussion on eye injuries on television, and talks to children's clubs.

V.A. Essuman and C.T. Ntim-Amponsah

Ophthalmology Unit, Department of Surgery, University of Ghana Medical School, P.O. Box gp 4236, Accra, Ghana. Email: cnamponsah@hotmail.com



**Communicating Health**  
An action guide to health education and promotion

Second Edition 2004  
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The book explores the role of communication in improving people's health. It provides practical guidelines on achieving effective communication in a wide range of settings. First published in 1993, the second edition takes into account recent developments and it has a web link for supplementary information on case studies, links to relevant sites and resources.

See [www.communicatinghealth.com](http://www.communicatinghealth.com)



**Partners in Planning**  
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2001  
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A guide to planning social development programmes, particularly in the fields of health and education. It combines theories of participation with practical advice and activities to support partnerships between professionals and potential beneficiaries of programmes.

Both books available from Teaching Aids at Low Cost (TALC) P.O. Box 49, St. Albans, Herts AL1 5TX, UK. Email: [info@talcuk.org](mailto:info@talcuk.org) Website: [www.talcuk.org](http://www.talcuk.org)

**ADDITIONAL USEFUL RESOURCES**



**Resources for policy to planning**

From Daniel Etya'ale interview, pages 35/36  
VISION 2020: The Right to Sight. Developing an action plan CD-ROM. Version 2. A detailed guide to the advocacy, design, planning, implementation and monitoring of VISION 2020 action plans with more than 250 supporting documents on all aspects of blindness included. A vital resource for national governments, professional organisations, NGOs, eye care managers and other implementers of eye care programmes.

Distribution by IAPB, LV Prasad Eye Institute, LV Prasad Marg, Banjara Hills, Hyderabad 500 034, India. Email: [IAPB@lvpei.org](mailto:IAPB@lvpei.org)

Also available from: [www.v2020.org](http://www.v2020.org)

**Resources for instrument care and repair**

From instrument repair, pages 44/45

- 1 Scan Optics. Manuals. Available at: [www.scanoptics.com.au/pdf/manuals](http://www.scanoptics.com.au/pdf/manuals) 32 Stirling Street, Thebarton, Adelaide SA 5031, Australia. Fax: 61 8 8234 9417 Email: [info@scanoptics.co.au](mailto:info@scanoptics.co.au)
- 2 Cox I and Stevens S. Care of ophthalmic surgical instruments. Community Eye Health Journal. 2000; Vol.13, Issue 35: 40-1.
- 3 Cox I and Stevens S. Poster: Care of ophthalmic surgical instruments. Community Eye Health Journal. 2003 Vol.16, Issue 48: 56-7.
- 4 Cox I, Stevens S. Ophthalmic operating theatre practice – a manual for developing countries. London: ICEH; 2002.

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Business School, University College, Chester, UK.

**EYE CONTACT – DEVELOPING INTERNATIONAL CO-OPERATION**

Please apply for further information / submit 500 word abstracts to:  
Dr Dorothy Field, 38 Dunford Road, Parkstone, Poole, Dorset BH12 2DN, UK.  
Email: [essyp@aol.com](mailto:essyp@aol.com)



**Royal College of Ophthalmologists**

17 Cornwall Terrace, Regent's Park, London NW1 4QE, UK

**EXAMINATION CALENDAR 2004/5 (UK & OVERSEAS)**

**UK EXAMINATION DATES**

Examination	Applications and Fees Due	Essay and/or MCQ Papers	Clinicals/Orals/OSES†/OSCES†
<b>Part 1 MRCOphth</b>	29 November 2004	24-25 January 2005	None
	28 February 2005	25-26 April 2005	None
	15 August 2005	10-11 October 2005	None
<b>Part 2 MRCOphth</b>	13 December 2004	7 February 2005	7-11 February 2005 (Dundee)
	11 Apr 2005	6 June 2005	6-10 June 2005 (Brighton)
	12 September 2005	7 November 2005	7-11 November 2005 (Manchester)
<b>Part 3 MRCOphth*</b>	10 January 2005	7 March 2005	7-11 March 2005 (Newcastle)
	18 July 2005	12 September 2005	12-16 September (Southampton)
<b>Diploma in Ophthalmology (DRCOphth)</b>	25 April 2005	20 June 2005	20-22 June 2005 (Oxford)
	29 September 2005	21 November 2005	21-23 November 2005 (London)

\*This examination has changed since September 2003: please contact the Examinations Department for further details

**INDIA EXAMINATION DATES: Aravind Eye Hospital, Madurai, Tamil Nadu, South India**

Provided a minimum of six candidates are booked to sit, the Parts 1, 2 and 3 Membership Examinations are scheduled to be held on the following dates

Examination	Applications and Fees Due	Essay and/or MCQ Papers	Clinicals/Orals/OSES†/OSCES†
<b>Part 1 MRCOphth</b>	28 February 2005	25-26 April 2005	None
<b>Part 1 MRCOphth</b>	15 August 2005	10-11 October 2005	None
<b>Part 2 MRCOphth</b>	15 August 2005	12 October 2005	12-13 October 2005
<b>Part 3 MRCOphth</b>	15 August 2005	13 October 2005	13-14 October 2005

\* Any changes in any of the above dates will be posted on the website and within application packs. †Objective Structured Examination and Objective Structured Clinical Examination.

Applications packs can be obtained from: Examinations Department at the above address

Tel: 00 44 (0) 20 7935 0702 (X 212, 211, 210) Fax: 00 44 (0) 20 7487 4674 Email: [exams@rcophth.ac.uk](mailto:exams@rcophth.ac.uk)

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**LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE**

**Department of Infectious & Tropical Diseases**  
**Diploma in Community Eye Health**

**21 February - 27 May 2005**

This three-month qualification is aimed at people who want to know more about the major blinding eye diseases and the VISION 2020 initiative. It is especially suitable for eye care professionals including ophthalmologists, optometrists, ophthalmic assistants and nurses, and project managers who want to receive training in Community Eye Health, but cannot be away from their place of work for one year. The course consists of three main components: Controlling Blinding Eye Diseases in the five weeks before Easter; Planning a VISION 2020 Programme in the five weeks after Easter and a written strategy document to be researched and written during the Easter break. We recommend that applicants have a qualification in health sciences and, preferably, are attached to an organisation involved in community eye care. The taught element of this course will also be attended by the MSc students in Community Eye Health.

**Course Fees: £5,250**  
**Recommended living costs: £3,300**

**Application forms are available from The Registry, 50 Bedford Square, London WC1B 3DP, UK.**  
**Telephone: +44 (0)20 7299 4646,**  
**Fax: +44 (0)20 7323 0638,**  
**E-mail: registry@lshtm.ac.uk**  
**Website: www.lshtm.ac.uk/courses**  
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**Reader survey**

Many thanks to all our readers who returned their questionnaires so promptly. We are hoping to receive even more returns, and look forward to acting on your suggestions. The results of the prize draw will be announced in the next issue.

**IAPB 7th General Assembly**

The General Assembly of International Agency for the Prevention of Blindness (IAPB) is held every four years, providing a forum for sharing ideas, expertise, and experiences in prevention of blindness around the world. The Seventh General Assembly, held in Dubai from September 20 - 24, 2004, was on the theme "Partnership in VISION 2020". We look forward to reporting more on this stimulating and enriching event.

**Submissions to Exchange**

*Community Eye Health Journal* invites readers to exchange views and experiences. In the Exchange section we include letters to the editor and short reports about prevention of blindness activities, achievements and lessons from different countries. Examples of reports considered for publication include outstanding achievements of eye care programmes, interesting insights from eye care work, and summaries of research projects. Reports will normally be between 200 – 300 words, but submissions of up to 500 words will be considered. Please send your contributions to The Editor at the address on page 34, or email [victoria.francis@lshtm.ac.uk](mailto:victoria.francis@lshtm.ac.uk) mentioning Exchange in your title.



**Next issue**

The next issue of the *Community Eye Health Journal* will be on the theme 'What's New in Trachoma Control?' Articles include:

- Progress towards elimination of blinding trachoma
- What's new in azithromycin?
- What's new in trichiasis surgery?
- Promoting trachoma control in the community
- Key lessons from the National Trachoma Control Programme, Morocco

