Community Eye Health

Volume 15 Issue No. 41 2002

AN INTERNATIONAL JOURNAL TO PROMOTE EYE HEALTH WORLDWIDE

SUPPORTING VISION 2020: THE RIGHT TO SIGHT

HOW CAN WE IMPROVE PATIENT CARE?

Gullapalli N Rao MD
L V Prasad Eye Institute
Hyderabad – 500 034
India

Improving patient care has become a priority for all health care providers with the overall objective of achieving a high degree of patient satisfaction. Greater awareness among the public, increasing demand for better care, keener competition, more health care regulation, the rise in medical malpractice litigation, and concern about poor outcomes are factors that contribute to this change.

The quality of patient care is essentially determined by the quality of infrastructure, quality of training, competence of personnel and efficiency of operational systems. The fundamental requirement is the adoption of a system that is 'patient orientated'. Existing problems in health care relate to both medical and non-medical factors and a comprehensive system that improves both aspects must be implemented. Health care systems in developing countries face an even greater challenge since quality and cost recovery must be balanced with equal opportunities in patient care.

Non-medical Aspects

The fact that the patient is the most important person in a medical care system must be recognised by all those who work in the system. This single factor makes a significant difference to the patient care in any hospital. In developing countries financial constraints often lead to compromised quality of care.Thiscanbecorrected by the introduction of management systems that emphasise cost recovery. Our experience shows that a system should first be developed to attract patients who can afford to pay for high quality services and such a system should then be extended to non-paying patients. This system has the advantages of high quality care and good cost recovery. Some of the issues that need to be addressed to improve patient care are listed below.

An Afghan mother and child wait for eye care in Kabul, Afghanistan

Photo: Murray McGavin

1. **Access.** Accessibility and availability of both the hospital and the physician should be assured to all those who require health care.
2. **Waiting.** Waiting times for all services should be minimised. In most developing countries, the high demand for services often makes this a huge problem. Nevertheless, it has to be addressed effectively through continual review of patient responses and other data and using this feedback to make the necessary changes in systems.
3. **Information.** Patient information and instruction about all procedures, both medical and administrative, should be made very clear. Well trained patient counsellors form an effective link between the patient and the hospital staff and make the patient's experience better and the physicians' task much easier.
4. **Administration.** Check-in and check-out procedures should be 'patient friendly'. For example, for in-patients, we have instituted a system of discharging patients in their rooms, eliminating the

Community Eye Health

Volume 15 Issue No. 41 2002

International Centre for Eye Health
Institute of Ophthalmology
University College London
11– 43 Bath Street
London ECIV 9EL

Tel: 00 44 (0)207 608 6909/6910/6923
Fax: 00 44 (0)207 250 3207
E-mail: See box on this page
Web-site: www.jceh.co.uk

World Health Organization Collaborating Centre for Prevention of Blindness

Typeset by
Regent Typesetting, London

Printed by
The Heyford Press Ltd.

On-line edition by
OASIS/Xalt

ISSN 0953-6833

need for the patient or the family to go to another office or counter in the hospital and waiting there for a long time. This has been favourably received by patients.

5. **Communication.** Communicating with the patient and the family about possible delays is a factor that can avoid a lot of frustration and anxiety. The creation of a special 'Patient Care Department' with a full time Administrator has helped our institution significantly and has enhanced our interactions with patients and their families.
6. **Ancillary Services.** Other services such as communication, food, etc. should be accessible both to patients and to attending families.

Medical Aspects

The medical aspects of patient care are much better understood by most health care providers. This is dependent on the quality of medical and technical expertise, and the equipment and quality assurance systems in practice. The following factors contribute to the improvement of patient care.

1. **Trained Personnel.** A well-trained 'Eye Care Team' is critical to providing high quality care with desirable outcomes. Lack of adequate personnel and lack of adequate training facilities for the available personnel are major problems. The temptation to recruit untrained or poorly trained people should be resisted. The number of training programmes must be increased, and the existing programmes must be improved. Making a uniform basic curriculum available for all training institutions/programmes should help bring about standardisation.
2. **Quality Eye Care.** There is significant concern about the outcomes of cataract surgery, and other common surgical procedures. Incorporation of quality assurance systems in every aspect of patient care is critical. For example, adherence to asepsis in the operating rooms will help reduce post-operative morbidity and proper training of oph-

thalmologists in diagnostic techniques will help achieve better control of sight-threatening diseases.

3 **Equipment.** All the necessary equipment must be in place and properly maintained. This is vital to the performance of the medical system and contributes significantly to better results. Eye-care equipment of acceptable standards is now available at reasonable prices, and this must be accompanied by appropriate maintenance systems.

4. **Use of Proper Instruments.** Good quality instruments are now available at lower costs. With the development of proper inventory control systems for a given operation, the costs can be lowered.
5. **Use of Appropriate Medications.** Access to low cost medicines is an absolute necessity for appropriate care.
6. **Use of Newer Technologies.** It is important to continually employ newer technologies that improve the quality of care. Of course, this must be done with reference to cost-efficiencies.

Improvement of patient care is a dynamic process and should be uppermost in the minds of medical care personnel. Development and sustenance of a patient-sensitive system is most critical to achieving this objective. It is important to pay attention to quality in every aspect of patient care, both medical and non-medical.

☆ ☆ ☆

The Patients View: How Can We Improve Patient Care?

Ingrid Cox
RGN KRN COA ENB 176
CCBRT Disability Hospital
PO Box 23310
Dar es Salaam
Tanzania

Introduction

The number of blind people in the world has reached over 50 million. For Vision 2020: The Right to Sight to succeed, there must be a significant increase in those receiving health education and also patients coming for surgery.

In his booklet, 'Breaking Down Barriers', Gert Vaneeste[1] outlines the barriers that patients can face when required to go to hospital and also practical ideas on how to overcome these barriers.

- But how do the patient and the community perceive the care that is offered to them?
- Do they want to receive the care that we feel they should receive?
- Is the care itself a barrier?
- Should we accept that some patients just want to remain as they are without our help?

Pre-operative eye clinic in Sudan

Photo: Ingrid Cox

An Example: Joseph Mwangi

"My backache is getting worse, my eyesight is not good, I find it difficult to help with the digging in the family vegetable plot, I can just about get to the toilet and back with a bit of assistance from my grandchild.

However I am lucky, my family is looking after me; they give me somewhere to sleep, a hot meal every day and in exchange I try to look after their young children by telling them stories. I never went to school so reading is not an issue. I feel secure and safe with my family around me.

The village 'doctor' is also my friend. He comes and sees me from time to time with his lotions and potions but they do not do much for me now, although I still live in hope and believe what he says.

After all, at least I am better off than my other friend who was blind and went to the hospital and returned blind and is now in pain.Noonecanhelphim.Eventhe 'doctor' cannot stop his pain.

I am getting old. We have always known that we are going to get old, weak and blind and now I just enjoy each day as it comes. My parents worked hard to look after me. I did the same for my children. Now I just want to be left in peace, be cared for and relax in this quiet time I now have left."

This is the view of many of our patients who may have low vision or are blind . . .

The Ophthalmic Field Worker

The enthusiastic ophthalmic field worker who wishes to make an impact on the community and reduce the amount of avoidable blindness, may see Joseph Mwangi as a

A person with unilateral cataract in Cambodia

Photo: Ingrid Cox

blind cataract patient, not as an individual with rights and opinions. She can help to improve the quality of his remaining life by offering to him a 'quick' 30 minute operation which will restore his sight. Or perhaps her contribution is improving the sanitation in his village and reducing the amount of trachoma; then taking a few patients with end stage glaucoma for a second opinion to the large hospital a day's journey away, even though she knows not much can be done about their condition.

Our field worker is a carer who has been trained and wants to show that skills and knowledge can improve the lives of those in the community. However, often as field /health workers we impose our values, training and knowledge on our patients and forget that there may be some very good reasons why they do not want to come to the hospital. We find this difficult to accept.

The Blind Patient and Hospital

It is forgotten that for a blind patient to come to hospital is very difficult. Travelling to an unknown city, perhaps never even visited when sighted, is a terrifying experience and more daunting now that he or she is blind. The fears of the city, where to stay, what is going to happen

The Patient's View

After eye surgery in Sudan

Photo: Ingrid Cox

when left alone in this hospital, possibly far outweigh the perceived advantages of restored sight.

The patient has heard that the operation is painful and that you have to suffer with the pain before you get better. They 'take out your eye and put it back in again', but some people never get their eyesight back. Why is that? Am I one of those patients? No one will be able to talk to me as I come from a different tribal region. How am I going to pay for food; where do I sleep or how can I go to the toilet if my grandchild is not there to take me. Will I get home?

Stories, Questions and Comments

Stories travel well in small communities, and are believed more than those of the health worker who proudly brings a person from another village after he had had his sight restored in the big city.

- For many patients the fear of the unknowncannotbeovercome.Ithas been saidthatforeveryunsuccessfuloperation, five good operations have to be done to counter the effect in the community.
- How do you explain Joseph Mwangi's neighbour's trabeculectomy operation compared to Joseph's 'quick' cataract operation?
- It is often held as a guiding light that money is an obstacle to surgery. We know of patients who have walked for days in Southern Sudan to receive treatment at a free eye camp and are incredibly grateful for any care that they can get. But we also know of the patient who is blind and lives right behind the hospital and still does not come for treatment,whether free or not.
- Recently in Tanzania, a well-meaning citizen gave a blind patient money to come to the city for cataract surgery. The patient did indeed come to the city but spent the money on alcohol, returning to his home some weeks later, happy but still blind!

Our expectations and priorities may not be the same as our patients.

Even if Joseph Mwangi did come for surgery and then went home with his sight restored there are still decisions that he would have to make.

Will he put in his eye drops and return for his follow-up appointment? He can see and that is what was promised. What is the need to go through all that travelling, cost and upsetting the family routine again? Regarding spectacles, he cannot read anyway, and he reckons that at his age he is not going to start to learn.

Summary

The patient's view of eye care can be very different to the health worker's view. Neither view is right or wrong. We must recognise and be sensitive to traditional beliefs within communities in which we work and for which we have a genuine concern and sense of responsibility. As health workers we must try and accept that we are to offer the best care to all but also understand that there are sometimes situations when what we have been taught is neither acceptable nor wanted by Joseph Mwangi and others like him. As standards of eye care improve and the past misconceptions of poor eye care diminish, so too will the sharing of unhelpful beliefs and even untruths. This is what we should be working towards – improving and maintaining standards of eye care, and patient care,communicatingclearlyandeffectively with those who look to us for help.

Reference

1 Vaneeste G. *BreakingDownBarriers*. Christoffel Blindenmission, 2001.

After eye surgery in Sudan

Photo: Ingrid Cox

Patients' Perspective: An Important Factor in Assessing Patient Satisfaction

R Muralikrishnan MHM MSc
A K Sivakumar MHM
Lions Aravind Institute of Community Ophthalmology
720 Kuruvikaran Salai
Gandhi Nagar
Madurai 625 020
Tamil Nadu
India

Conventionally, the preparation of a patient satisfaction questionnaire is based on textbooks, one's own perception and similar forms used at other hospitals. This process often reflects the providers' perception of factors influencing satisfaction, perpetuating their shortcomings and not adequately dealing with necessary cultural and social variations.

Methods

Aravind Eye Care System in India, one of the highest volume eye care centres in the world, developed an innovative way of developing an in-patient satisfaction assessment tool. All the 'suggestions and complaints' of in patients registered in a separate suggestion register during the year 1997 were scrutinised and grouped. To confirm that the groupings indeed reflected the patient's expectations and concerns, another survey through interviews was conducted on 50 patients and 50 staff (ophthalmologists, nurses, administrative staff) with the objective of finding out the patients' expectations, concerns and worries.

Findings

The 123 different complaints in the initial study and the results of the supplementary study were used to develop 12 different categories to assess patient satisfaction. These are:

1. Medical care
2. Nursing care
3. Behaviour of staff
4. Clear information
5. Personal attention
6. Responsiveness to complaints & care*
7. Integrity*
8. Physical facilities
9. Supportive services
10. Cleanliness & maintenance
11. Waiting time
12. Charges

* *Derived from the supplementary study*

Action(s) Taken

In order to monitor patient satisfaction objectively, questions were developed in the broad categories, piloted and developed as a standard questionnaire to grade responses on different point scales. Some additional information, such as age, gender and treatment, was also included for better analysis. The questionnaire also used very clear and simple language and was worded to elicit thoughtful responses.

Consequence of Action(s)

This process has helped to develop a standard questionnaire to measure patient satisfaction regularly in our hospital. The expectations are also understood as these change and are incorporated into the questionnaire from time to time. The results are presented to the hospital's Quality Council and during meetings of heads of departments with a view to taking corrective actions. Individual audits are also undertaken on high patient dissatisfaction areas. The impact is that our patients are more satisfied (our regular survey results confirms this) and we experience an average workload increase of 15% every year. The success of our assessment and improvement of patient satisfaction is because we take into account the patients' own views and perspectives.

☆ ☆ ☆

We requested further information regarding the programme at Aravind Eye Hospital, specifically details of the QualityCouncilandthe Questionnaire. These have kindly been sent to us and are included below.

D D Murray McGavin MD FRCOphth
Editor

Aravind Eye Hospital Quality Council

Dr P Namperumalsamy, Director
Chair of the Council
Mr A K Sivakumar, Faculty-LAICO,
Secretary
Dr G Venkataswamy, Chairman
Mr G Srinivasan, Secretary to Trust
Dr G Natchiar, Joint Director
Mr R D Thulasiraj, Executive Director
Dr M Srinivasan, Chief Medical Officer
Dr S Aravind, Administrator
Mr R Meenakshi Sundaram, Community
Outreach Manager
Mr Ganesh Babu, EDP In-charge
Mrs R Alees Mary, Nursing Training
Coordinator

Terms Of Reference

1. Aravind Quality Council is a Management Committee, which will meet once a month, to direct, monitor, and support the Quality Management Programmes in Aravind Eye Hospital, Madurai.
2. The Council will approve Department level Quality Objectives and Performance Standards as they are developed or amended.
3. The Council will review and approve any major changes or re-organisation that is perceived as necessary for the quality improvement process.
4. The Council will review and approve requests for additional support relating to quality improvement. Such requests may include the following:

- Staffing
- Staff developments
- Equipment/instruments
- Space
- Re-organisation or re-structuring

5. The Council will review the impact of the various quality improvement measures.
6. The Council will approve the Quality Manual, which comprises Quality Principles and Quality Improvement Practice in Aravind Eye Hospital, Madurai.

The ultimate aim of the whole process is to ensure zero defects in the services and a high level of patient satisfaction.

Aravind Eye Hospital In-patient Feedback Form

Aravind Eye Hospital is committed to giving high quality medical care and quality service. In order to assess our performance we would like you to take a few minutes to complete this questionnaire.

a) Name: …… b) Age: …… c) Sex: Male / Female

d) M.R. No.: …….. e) Room No: ……..

Please answer all the questions by circling the number you feel to be appropriate. If you would like to add any comments or make suggestions, please use the box at the end.

Excellent = 1 Good = 2 Average = 3 Poor = 4 Don't know = 5

1. Your opinion about doctor(s) and medical care:

Doctors' Competence	**1**	**2**	**3**	**4**	**5**
Doctors' Attitude and Behaviour	**1**	**2**	**3**	**4**	**5**

	Adequate	Inadequate
Listen to my problems		
Time spent by the doctor: explanation about my health and treatment		
Explanation about any specific procedure / treatment		
Daily visit		
Privacy while examining		

2. Your opinion about nurses and nursing care:

Smiling face / polite / friendly	**1**	**2**	**3**	**4**	**5**
Attitude and behaviour	**1**	**2**	**3**	**4**	**5**
Promptness in meeting the needs	**1**	**2**	**3**	**4**	**5**
Explanation of the process of treatment & progress	**1**	**2**	**3**	**4**	**5**
Provision of psychological support/reinforcement	**1**	**2**	**3**	**4**	**5**
Enquiries about food/night rest/discomfort/etc.	**1**	**2**	**3**	**4**	**5**
Provision of health education	**1**	**2**	**3**	**4**	**5**
Medication/treatment in time	**1**	**2**	**3**	**4**	**5**

3. How would you rate the charges and costs of services at Aravind?

❑ High ❑ Reasonable ❑ Low ❑ Don't know

4. How would you rate the attitude and behaviour of ward co-ordinators?

1 2 3 4 5

5. How responsive were all staff to your needs?

1 2 3 4 5

6. How do you rate the level of communication and information you received at Aravind?

1 2 3 4 5

7. How do you rate the general cleanliness of the ward?

1 2 3 4 5

8. How do you rate the catering / food service at Aravind?

1 2 3 4 5

9. How would you rate the facilities at Aravind (refreshments, pharmacy, etc)?

1 2 3 4 5

10. How would you rate the general facilities in the wards (space, furniture, etc.)?

1 2 3 4 5

11. List the areas where you experienced long waiting times:

12. Would you recommend Aravind to friends and /relatives?

❑ Strongly ❑ Hesitantly ❑ Will Not ❑ Don't Know

13. Overall, how would you rate the services offered at Aravind?

1 2 3 4 5

14. Please add any further comments or suggestions you would like to make.

THANK YOU FOR YOUR VALUABLE FEEDBACK!

Patients' Feedback: Follow-up Actions

Suggestions and Grievances	Actions taken
Behaviour of Staff	
• Rude behaviour of certain doctors and nurses	• Concerned staff writes apology letter to the patient (decision by Joint Director and the Nursing Superintendent)
Clear Information	
• Appoint a person in the ward who can speak different languages	• Appointed an in-patient counsellor fluent in 5 languages (Tamil, English, Malayalam, Hindi and Telugu)
• Nurses do not provide sufficient information to patients about the various procedures	• This was addressed in the Quality Service Workshop for Nurses
• Place information boards indicating the length of stay, operation charge, etc	• Information boards are now placed in front of the counselling department
• Health education can be provided using television sets in the wards	• Information cassette on cataract and eye care has been developed and is being played frequently in the wards
Personal Attention and Care	
• Receptionists guiding the patients to the clinics walk very fast leaving the patient behind	• This was addressed in the Quality Service Workshop
Physical Facilities	
• Provide hot water for the patients	• Hot water is now provided to the rooms, but needs improvement
Supportive Services	
• Complaints about quality and quantity of food	• Did a quality audit on catering; a member of the management team checks the quality and quantity randomly every day before serving
• Open a separate telephone booth for local calls	• A separate local call booth established near the cycle stand
Cleanliness and Maintenance	
• Toilets near Room no.10 smell badly	• Frequency of cleaning the toilets has been increased
Waiting Time	
• Explanation should be given to the patients about the long waiting time in the Laser room.	• Sisters are asked to provide an explanation when a patient is made to wait in the Laser room
Charges	
• Provide instruction about the fees to be paid at 'old card' registration	• Boards displayed in the 'new card' & 'old card' registration counters provide information about the consulting fees
Miscellaneous	
• Take some action against the monkey menace	• The monkeys have been caught and taken away

Establishing Lines of Communication

Lucy Roberts BA(Hons)
Project Coordinator
Full View Information Centre
521, Galle Road
Ratmalana, Sri Lanka

In Sri Lanka good eye care is available, but there is no holistic integration of services for people experiencing sight problems, whether curable or not. Many people have to travel for a long time to receive the attention of an ophthalmologist, and although the services are free, the journey itself may be costly. When the patient reaches the ophthalmologist he or she is often awestruck, and asks few questions. The patient may not fully understand the diagnosis or prognosis, and is reluctant to 'waste the doctor's time'.

When the patient can grasp the nature of his or her problem there is some peace of mind. One man took his son for two years to different eye specialists, until one doctor had the time to explain the reason for his son's blindness, that there wasn't a surgical answer, that his son will remain blind. At last the family could stop wondering and start adapting.

The ophthalmologists are busy, and can only take so long explaining complex eye conditions, diseases, operations and treatments.

Findings

Our research has discovered a great number of eye care services, a combination of medical, educational, rehabilitational and social. What is missing is any form of coordination between these services or any awareness amongst anyone of all the services available. Neither is there literature in Tamil or Sinhala about eye conditions, prevention of blindness, what to do if you or a member of your family experiences an eye problem, etc.

Actions Taken

1. Production of a leaflet about the Sight Information Centre, which eye specialists can give to patients and relatives.
2. Establishment of an explanatory service regarding a person's eye condition, and distribution of free leaflets explaining eye conditions and treatments in Sinhala and Tamil.
3. The compilation of a directory of information about the eye units in the hospitals, the educational establishments, the vocational training sites, the social services, and all services related to sight problems and sight preservation.

Consequences of Actions

1. An easy method has been established for health personnel to introduce patients to follow-up services which are already active.
2. Provision of a person who understands and can explain the significance of their eye condition, the reasons for surgery or not, for treatment or not, for sight recovery or not.
3. Beginning lines of communication, giving the patient/client a better experience of eye care services, as well as linking professionals in the field with each other and providing a comprehensive list of services. ❑

Teaching Resources: Be Prepared!

Sue Stevens
RGN RM OND FETC
Nurse Consultant
Journal of Community Eye Health
Ophthalmic Resource Coordinator
International Centre for Eye Health
Institute of Ophthalmology
11-43 Bath Street
London EC1V 9EL

The *Journal of Community Eye Health*, with its theme-orientated approach, attempts to inform readers of current relevant educational materials in each issue. Learning and teaching resources are sought extensively but are they always appropriate and used effectively?

This article completes the series on Teaching Eye Health and will overview:

Thecriteriaforselectingmaterials,advise on accessing teaching resources and suggest strategiesfor continuing education.

Selection Criteria

• Context and Relevance

Choosing material because someone has recommended it as 'a really good resource' does not ensure it will be effective.

It is important to consider:

- ***WHO** the users will be*

Are they health workers, professionals, Ministry of Health officials, schoolteachers, or patients? Are the materials needed for eye care education for those working at primary, secondary or tertiary level?

- ***WHERE** the materials will be used*

Will it be in a lecture hall, classroom, community room?

- ***WHAT** facilities will be available*

Will there be suitable seating arrangements, a projector, flipcharts, computer, videotape player, good lighting, blackout blinds?

- ***HOW** the materials will be used*

Will the teaching method used be didactic, interactive, group work, project assignments?

• Format

Many formats are now available. Photographs, slides, overhead transparencies and videotapes are useful visual aids to complement didactic teaching or written text. The subject may, however, be more conducive to real situation teaching, conveying the experience of the teacher by means of demonstration, practice, and supervision in the clinical area. Posters are very popular for teaching purposes but care must be taken to display them in appropriate places – stairways can prove unsafe and nervous patients will not appreciate clinical or pathology pictures in a waiting area!

Where teaching materials are for use with ophthalmic patients, e.g., patient information leaflets for health education and promotion, it is vital to ensure these are available in accessible formats, e.g., large print. Audiotapes are particularly appropriate for reinforcing verbal information given to ophthalmic patients.

There are many advantages and disadvantages to consider when choosing formats - see Table 1.[1]

• Cost

Cost may be an important constraint. In an attempt to be helpful and meet the needs of users, suppliers will sometimes offer surplus, out of date materials, free of charge. Such availability is often sought. This must be a guarded practice – free materials are not always appropriate to the actual requirements. Many commercially produced teaching materials, e.g., posters, booklets and videos, are now available from pharmaceutical and equipment companies. Offered free of charge, they attract users with limited financial resources. The content will often, understandably, reflect the sophisticated materials they produce and may even carry advertisements which may result in inappropriate messages in certain situations. It is for this very reason that the *Journal of Community Eye Health* avoids indiscriminate advertising.

• Accuracy

Teaching materials, if they are to achieve their aims, must be up-to-date, applicable and cover the required scope of the subject. Health practice is ever changing and this is reflected in the rate at which medical textbooks appear in new editions.

• Language and Culture

Teaching resources, first and foremost, need to be understood. Availability in the local language makes any learning resource more attractive and valuable and increases its demand. Sadly, most materials are available in English only. Where English is not the user's first language but is the language used or encouraged in the workplace or educational institution, it is important to ensure that materials are produced in plain English. Applying a 'Gobbledygook Test' – see Box 1 – will help decide if the text contains plain English before purchasing in bulk, e.g., books for a whole class.[1]

Teaching material content should avoid stereotyping of target groups but at the same time needs to be culturally appropriate and reflect local practice, conditions, available health services and the values and concerns of users.

Accessing Teaching Resources

• Ordering from a supplier

It should not be assumed, when placing an order, that the supplier will know exactly what material is needed! It is wise first to ask a supplier to provide a publications list on which can be indicated the title and quantity required. Ideally, when placing an order without the facility of a printed order form, the following details will help the supplier to provide the correct publication:

- Full title of publication
- Author(s) name(s)
- Edition

Box 1: Gobbledygook Test

- Count a 100 word sample
- Count the number of complete sentences in the sample
- Count the total number of words in the complete sentences
- Divide the number of words by the number of sentences. This gives the average sentence length
- Count the number of words with three or more syllables in the 100 words. This gives the percentage of long words in the sample. Numbers and symbols are counted as short words; hyphenated words are counted as two words; a syllable, for the purposes of the test, is a vowel sound. So, 'advised' is two syllables and 'applying' is three
- Add the average sentence length to the percentage of long words to give the test score: the higher the score , the lower the 'readability'

It is usual to do this three times to three different samples, one from the beginning of the text, one from the middle and one from near the end. These scores can then be added and divided by three to give the average score

This test is based on R.Gunning's FOG (Frequency of Gobbledygook) formula and was adapted by the Plain English Campaign.

Table 1: Learning Resources – Uses, Advantages & Disadvantages

FORMAT	USES AND ADVANTAGES	DISADVANTAGES
Video	Shows real situations. Demonstrates skills, attitudes and behaviour (good and bad!). Can be stopped to allow discussion. Self-teaching.	Screen must be large enough for the size of audience. Equipment may be expensive or unreliable and should be transportable. May need room blackout.
Slides	Can convey complex information e.g., bar graphs, pathology. Uses large screen – good for lecture halls. Easily transportable. Teacher can be selective and flexible in choice of image and message. Often supplied with supporting text.	Equipment not so easily transportable as the slides. May need room blackout.
Overhead transparencies	Cheap and easy to produce. Overlays can build up information. Flexible – useful for any size of audience. Equipment available in transportable size and reasonably priced.	Spare bulbs should always be available. Teacher can obstruct view. Written information must be large enough to be read by all the audience. May need room blackout.
CD ROM	Interactive. Sophisticated and complex text. Easily transportable.	Expensive. Requires expensive equipment.
Internet	Up to date information. Free availability of many materials – can be downloaded.	Prohibitively expensive equipment and connection charges in some countries. Potential for information overload. Skills needed to access only appropriate material.
Textbook	Familiar and trusted reference tool. May reflect specific course content. Durable.	Individual user only. Expensive to buy and deliver in bulk.
Booklets Leaflets Handouts	Home-made versions can be produced cheaply. A good handout will reinforce important points of a topic.	Teacher sometimes tempted to photocopy full articles to act as a handout, which are not applicable. Commercially produced items can be expensive and contain advertisements. Usually produced in bulk – can be wasteful.
Posters Charts Displays	Raise awareness. Conveys information on other sources – contact details, etc. Home-made versions can be produced cheaply.	Can be difficult to transport. Needs lamination. Written information must be large enough to be seen at a distance. Need to be changed frequently. Commercially produced version may contain advertisements.

- ISBN (international standard book number).
- Price
- Publisher
- Date and place of publication.

It is important the purchaser and supplier agree the amount and method of payment beforehand. Full name and address must be included in the purchase order. Ordering via the Internet will require advance payment by credit card. Some suppliers only deliver to a physical address, not a post office box.

A *Directory of Teaching and Information Resources for Blindness Prevention and Rehabilitation* is available from the International Resource Centre, ICEH. This publication lists some 20 organisations which supply teaching materials on many topics, at varying levels and in selected formats and languages.[2]

Basic Guidelines for Producing Teaching Materials

Many excellent teaching materials are 'home-made', unpublished and unavailable through a supplier. Remember - this does *not* make them inferior! Indeed, materials produced specifically for local use are often more effective. When producing materials, whatever the situation,the following guidelines are recommended:[1]

- Consider the educational background of your users
- Test materials on a sample of users and modify the material accordingly. It is unwise to assume that users will find your initial efforts helpful
- Use plain English or local language(s) in the active tense
- Keep the message brief, to the point and avoid irrelevant material
- Emphasise key messages using bold, appropriate size and style fonts and colour
- Use pictures when the message can be conveyed in this way but make sure this approach is field tested to check for misunderstandings
- Apply the Gobbledygook Test to your own materials too! (see Box 1)
- Use words that reflect the reality of the situation – e.g., don't use the word 'ophthalmologist' if none work on the project. Inclusive language will help to avoid offence and feelings of inadequacy.

You will need to consider who will write the draft, who will edit it, where you can field test it, what it will cost to produce and if it will involve desk top publishing, a designer, illustrator, translator and printer? This will apply to whatever format you aim to provide.

Strategies for Continuing Education

Resource Centres

Core teaching materials must be accessible to learners. Increasing health information is potentially the most cost-effective measure for improving health care in developing countries.[3] Any project or teaching centre can set up a 'resource centre'. The International Resource Centre at the International Centre for Eye Health in London started life as a shelf in the Journal editor's office! It is advisable to keep learning materials in a central point with someone responsible for their cataloguing, allocation and safekeeping.[4]

In September 2000, the International Resource Centre, London, with the support of Sight Savers International and Christian Blind Mission International, launched a new project providing Regional Resource Centres for Africa, Asia and Latin America. Eighteen months on, five new centres have now been established in India,

Pakistan, South Africa, Colombia and Tanzania. These now aim to help meet the educational and information needs within their regions (see Box 2).

Human Resources

The Oxford English Dictionary defines the word 'resource' as "the means of supplying a want or a need".
Information technology, the newest development contributing to health communication, can now link health workers and makes available to them a wide range of resources. Most sites are 'read only' but some are interactive with some health libraries providing 'touch screen' facilities. But our best means of meeting learning needs undoubtedly remains the *human* resource.

Participants on training courses can be supported following a local, national or international course by means of peer networking and the organisation of 'alumni' meetings. Delegate lists at conferences are a useful way of facilitating follow-up and for providing relevant resource information. The sharing of information with like-minded colleagues, even at a distance, is made easier through the ever-increasing use of electronic newsletters.

As individuals, we all can contribute, in some measure, to learning and information by sharing our own knowledge and experiences, however limited, with those who seek to make Vision 2020: the Right to Sight, a reality.

Box 2: Regional Resource Centre Contact Details

Hope Mlotshwa
Email: hope@sancb.org.za
Motswedi Information Centre
SABPB/SANCB, PO Box 11149
Hatfield, Pretoria 0011
South Africa

Clarena Vasquez Cantillo
Email: colaris@foscal.com.co
COLARIS
Fundacion Oftalmologica de Santander
Apartado Aereo 3128, Urbanizacion el Bosque
Autopista a Floridablanca, Bucaramanga
Colombia

Dr Aliya Qadir Khan
Email: rlrc@pes.comsats.net.pk
Regional Learning Resource Centre
Pakistan Institute of Community Ophthalmology
P O Box 125, Peshawar
Pakistan

Sameera Khundmiri
Email: icareresourcecentre@yahoo.com
International Centre for the Advancement of Rural Eye Care
LVPEI, Post Bag No. 1
Kismatpur BO, Rajendranagar PO
Hyderabad - 500 030, Andhra Pradesh
India

Saraweki Mbelwa
Email: riso@kcmc.ac.tz
Ophthalmic Resource Centre for East Africa
Kilimanjaro Centre for Community Ophthalmology
KCMC
P O Box 3010, Moshi
Tanzania

References

1 Ewles L, Simnett I. *Promoting Health – A Practical Guide,* 4th Edition. Baillière Tindall, 1998.
2 Stevens S. *Teaching Resources for Blindness Prevention and Rehabilitation.* International Centre for Eye Health, London, 2000.
3 Pakenham-Walsh N, et al. Meeting the Information Needs of Health Workers in Developing Countries. *BMJ* 1997; **314:** 90–91.
4 Giggey S. *Rural Community Resource Centres – A Guide for Developing Countries.* Macmillan, 1988.

Acknowledgements

Dr Daksha Patel, Courses Convenor, ICEH has kindly reviewed this article.

☆ ☆ ☆

Ocular Manifestations Of Child Abuse

Harjinder S Chana MD
Ophthalmic Consultant
Norwegain Association of the Blind
P O Box 1250
Mutare, Zimbabwe
Professor Volker Klauss MD
Department of Tropical Ophthalmology
University of Munich
Germany

Introduction

An old lady takes a grandchild, out of concern and compassion, to a traditional healer for advice and prevention of cataract, a condition the child is likely to develop sixty years later. A 'concoction' of various herbs is prepared and prescribed which subsequently leads to bilateral total damage of the corneae, a disruptive 'keratomalacia-like' reaction. A helpless child, victim of traditional and social practices, enters into a life of almost 50 blind and hopeless years.

Fig. 1: Panophthalmitis after 'treatment' with a herbal twig

Photo: Harjinder Chana

It is partly the increased, multifactorial, infant and young child morbidity and mortality that led to the United Nations Convention on the Rights of the Child. This calls for special care and protection of children because of their vulnerability. It states that all countries shall ensure good health for children and protect them from neglect and all forms of exploitation.

In developing countries, children may account for 40-50% of the total population. Yet, they are conspiculously neglected when national eye health and rehabilitation programmes are planned. Most strategies are aimed at the adult group.

Fig. 2: Burns in a 9-day old child

Photo: Harjinder Chana

The Challenge

The challenge lies in a better understanding of the immense eye problems affecting the under-served and vulnerable paediatric group in developing countries and in devising comprehensive national programmes to deal with these problems. It is estimated that childhood blindness causes 90 million blind years (number blind x length of life).

Improved media reporting in recent years has exposed some of the neglect and abuse children are subject to in many societies. However, more information is needed, in particular from Africa. In high-income countries, it is recognised that factors such as broken families, social dysfunction, depression and unemployment play a major role, for instance, in child battering (physical assault of children).

In developing countries, poverty, social and cultural beliefs and taboos and exposure to traditional practices predispose the vulnerable paediatric group to abuse. In many middle- or high-income countries, there is now emergency guidance and advice. Helplines are available whereby children can call for help in the event of abuse. This is still not the case in most low-income countries.

Fig. 3: Victim of a landmine

Photo: Harjinder Chana

The authors wish to highlight a group of children who, due to well-meant but harmful traditional practices in combination with neglect and sometimes outright abuse, present with ophthalmic manifestations. There is generally a high incidence of eye diseases in children which means that children are particularly at risk of harmful traditional and cultural therapeutic practices.

The leading causes of visual insult in children include:

- **Traditional Eye Medicines**

Traditional healers instill herbal concoctions into the eyes for trivial complaints. A herbal twig implanted under the eyelid in a child with mild allergic conjunctivitis led to fulminating panophthalmitis (Figure 1). Herbal ocular 'medicines' are responsible for an estimated 8-10% of corneal blindness in Africa. This permanent damage is the result of herbs with a very high pH or the introduction of micro-organisms that can lead to suppurative keratitis and endophthalmitis. Extract of lemon peels are used for serious eye infections, whereas juice from tomato leaves is used for milder conditions.

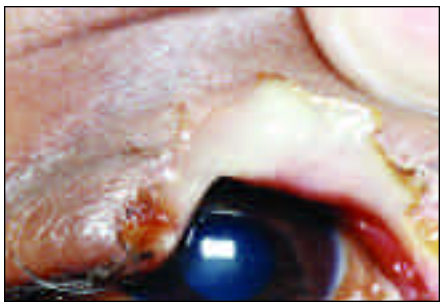


Fig. 4: Victim of a rape-case: human bite of upper lid

Photo: Harjinder Chana

The most common eye diseases treated in children are allergies, conjunctivitis and trachoma. In the case of trachoma, one healer in Kenya used the rough leaf of *cordiasinesis* torubonthetarsalconjunctiva until it bled. Another chewed the leaves of *boscia coreacea*, and the juice obtained along with the saliva was applied to the conjunctival sac, a procedure causing irritation, pain and possibly chemical burns. Also observed were cases of gonococcal conjunctivitis among children and these

followed instillation by the traditional healer of his own infected urine into the eyes of children presenting with trivial ocular complaints.

- **Aftermath of Drought and Famine**

Children are the most vulnerable group during droughts and famine. Inadequate nutrition and poor hygiene due to lack of water cause varying degrees of malnutrition and diseases that lead to blindness.

In some communities, already with depleted food supplies, it is customary for adults and children to share a meal around a common plate. The adults reach for the food first and children struggle to reach the plate.

- **Ocular Injuries and Burns**

A nine-day old child of an overburdened and overworked mother, living in a small crowded place, was left by the mother near a kerosine cooking pot. The stove toppled

Fig. 5: Gonococcal conjunctivitis in a 14-months old child

Photo: Harjinder Chana

giving the child extensive burns (Figure 2). A number of these cases are accidents in the home such as burns, falls with injury, or even suffocation.

- **Socio-cultural Attitudes**

Many mothers and children, through no fault of their own, are forced to live in over-crowded, unhealthy environments and under marginalised conditions that greatly contribute to trachoma, the second leading cause of blindness in Africa.

- **Ethnic Conflicts and Wars**

Thousands of children are maimed and mutilated in wars and by landmines. A case presented here exemplifies the plight of these children due to man-made disasters and catastrophes (Figure 3).

- **Sexually-related Abuse**

Sexual abuse of children, aged 10-15 years, in low-income countries may be more widespread than is generally thought.

Fig. 6: HIV+ herpes zoster ophthalmicus. A mother supports a child

Photo: Harjinder Chana

In rare instances, such abuse may lead to traumatic eye conditions with serious long-term psychological and physical consequences for the child. A case presented here with a human bite in a 12 years old girl rape victim (Figure 4).

- **Gonococcal Conjunctivitis**

Gonococcal conjunctivitis of the newborn is still a major problem in many countries. We would like to document a 14 months old child with frank gonococcal conjunctivitis (Figure 5) contracted from an infected mother. Sexually transmitted disease and now HIV/AIDS are the scourge of our times. A mother infected withherpes zoster ophthalmicus carries a child (Figure 6).

- **Social Structures: Women's Rights**

A husband is often the only person in a household who gives consent or decides if a child can receive hospital treatment, be it surgical or medical, emergency or otherwise. Often the husband is not readily available. Advanced cases of infected perforations or inoperable retinoblastoma (Figure 7) pose a challenge to the attending ophthalmologist. This may result from experimentation with traditional medicines and later the father may refuse to give his consent for surgical treatment. Parents desperately wanting a male child, deliberately pushed this teenage daughter into a fire (Figure 8).

Fig. 7: Advanced retinoblastoma

Photo: Harjinder Chana

- **Squint and Amblyopia**

Very rarely have the eye health planners concentrated their strategies on conditions like squint with resultant amblyopia, refractive errors and dyslexia. These condition can lead to major visual impairment, mostly unnoticed by parents and teachers.

Children with such eye problems are scorned and even expelled from school for no fault of their own - by teachers who do not understand the experience and the disability of these children. Sight is precious and essential in the development of the child.

Conclusions

We feel that clear and definite steps should be taken in some developing countries to establish an awareness about the Rights of

The gender issue: burns

Photo: Harjinder Chana

the Children and to protect them from the negative effects of cultural, traditional and social practices.

The education system is the developing world's broadest channel for the dissemination of health information, health attitudes and practices. Teachers and leaders can play a major role in promoting the health of children and protecting one of our most essential organs - the eyes.

Greater emphasis must be given to the issue of integrating the traditional healers into primary eye care systems. These first-line providers of health are easily accessible and acceptable to the rural populations and can make a vital contribution at community level in rural areas.

***Re-produced with permission from *NU Health Care Journal*, Sweden 1/97 Volume 11.**

☆ ☆ ☆

An Outreach Eye Care Programme, Zambia

Ian Yeung BA MBBChir
Downing College
University of Cambridge
Cambridge CB2 1DQ, UK

Boateng Wiafe MD MSc
Ophthalmologist
Lusaka Adventist Eye Hospital
PO Box 31309, Lusaka
Zambia

Introduction

Based in Lusaka, Zambia, the clinic mainly visits areas around the capital. But the outreach programme ventures further into rural areas.

The mobile clinic is publicised in advance and people from the surrounding area congregate to be screened. Suitable patients (usually mature cataracts) are then transported to the eye camp. These are local hospitals, where a visiting ophthalmologist and a team will stay for a few days. The operations are then performed and the patients transported home free of charge.

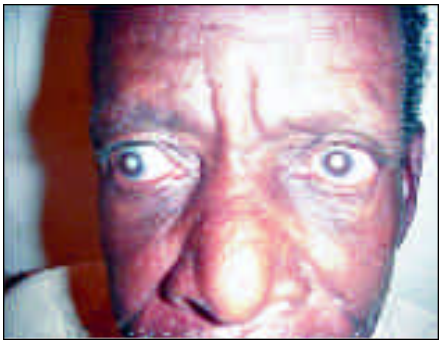
Zambia has unique geographical problems. It has one of the lowest population densities worldwide. Thus it is hard to justify building extensive ophthalmic services across the country.

The mobility of the outreach programme aims to solve these problems. Free transport is provided, thus minimising costs to US $5 per patient. If they cannot afford this, the cost can be reduced to US $3.50 and even US $ 1.70!

Following the team through 4 villages, 126 patients were interviewed and examined.

The following were investigated:

- Demographics of presenting patients
- Ophthalmic conditions encountered
- Patients' visual acuities
- Barriers that prevented patients from seeking eye services earlier.



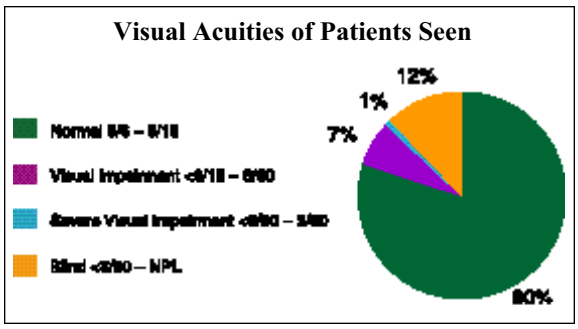
Hypermature cataracts

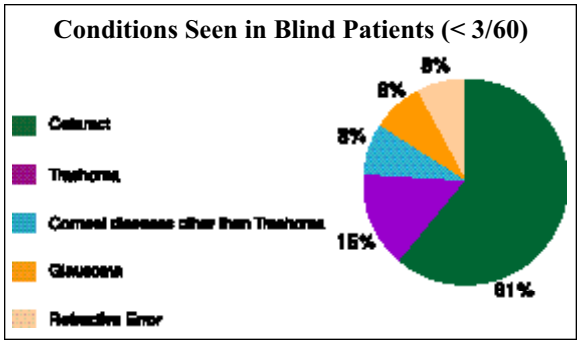
Photo: Boateng Wiafe

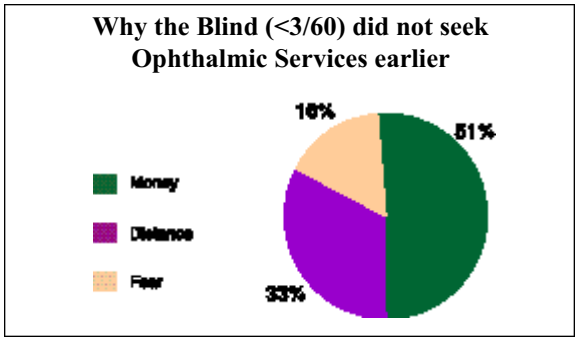
Results

Eye Conditions Seen in Four Villages: 126 Patients

	Men (%)	Women	(%) Children (%)
Refractive Error	39	35	10
Cataract	29	21	0
Conjunctivitis	8	7	29
Trachoma	4	19	14
Glaucoma	2	2	5
Xerophthalmia	2	0	14
Corneal Ulcer/Scar	2	5	5
Others	14	12	24







Discussion

A substantial proportion of patients, 12%, were blind. Sixty-one percent of these were due to cataracts, which correlate well with figures in the literature.[1] A small proportion, 8% of blind patients, was due to corneal diseases other than trachoma. This includes injury, xeropthalmia, use of traditional eye preparations, keratitis due to untreated infections, and many others.

Men and women presented in almost equal numbers, 43% and 38% respectively. One major difference between the sexes was that women were moreaffectedbytrachomathan men, 19% compared to 4%. This corresponds with the well-known observation that *Chlamydia trachomatis* is spread mostly between mothers and their children due to poor hygiene.[1]

Children mostly suffered fromconjunctivitis(29%).This could be reduced with increased awareness about face washing. Xerophthalmia was lessof a problemthanexpected. Only 14% of children were affected compared to a previous 1994 UNICEF estimate of 25-50%.[2] This suggests that the recent government campaign of vitamin A supplementation for children under-5 is working effectively.

Refractive errors were the commonest presenting complaint for adults (39% of men and 35% of women). As most spectacles in Zambia are second-hand, donations should be encouraged.

Distanceand moneywerethemainbarriers that prevented the blind from seeking specialist help earlier (33% and 51%). This corresponds well with known statistics for the developing world in the literature: 48% for money and 44.8% due to logistics in Nepalese patients.[3] As the outreach programme is mobile, this tackles the distance issue while free transport and discounted costs should overcome the financial barrier.

Fear was the third barrier at 16%. The study in Nepal also found fear to be next after money and distance at 33%.[3] This apprehension could be due to lack of awareness, culture, beliefs or uncertainty

over surgical outcome. Improved education and publicity showing cataract patients with restored vision, should hopefully overcome this.

Recommendations

Mobile eye programmes should be integrated into existing primary health care programmes at district hospitals.

Community health workers, traditional healers and schoolteachers should be given basictraininginrecognisingeyeconditions.

Community awareness about the prevention of blindness should be raised. For example, it could be included on the teaching syllabus of primary and secondary schools.

References

1 Sandford-Smith J. *Eye Diseases in Hot Climates 3rd edition.* Butterworth-Heinemann, 1997, 106–120, 187–189.
2 *Zambia Social Indicators.* UNICEF 1994.
3 Snellingen T et al. Socioeconomic barriers to cataract surgery in Nepal: the South Asian cataract management study. *Br J Ophthalmol* 1998; **82**(12): 1424–1428.
4 Vaidyanathan K et al. Changing trends in barriers to cataract surgery in India. *Bull WHO* 1999; **77**(2): 104–109.
5 Fletcher AE et al. Low uptake of eye services in rural India: a challenge for programs of blindness prevention. *Arch Ophthalmol* 1999; **117**(10): 1393–1399.
6 Johnson JG et al. Barriers to the uptake of cataract surgery. *Tropical Doctor* 1998; **28**(4): 218–220.
7 Courtright P et al. Barriers to acceptance of cataract surgery among patients presenting to district hospitals in rural Malawi. *Tropical and Geographical Medicine* 1995; **47**(1): 15–18.

Letters

THE GLAUCOMAS

Dear Editor

The several articles on adult glaucoma that appear in the *Journal of Community Eye Health* 2001; **14:**33-52 are especially well done and much appreciated. Recent epidemiological studies combined with advances in instrumentation will undoubtedly combine to make it possible to detect more individuals in developing countries who have glaucoma. Mention is made of referral to tertiary care centres for definitive diagnosis and appropriate treatment. This affords me the opportunity to call attention to a major barrier to appropriate glaucoma care in many developing countries – the relatively low level of glaucoma knowledge in teaching institutions and tertiary care centres.

During the past 8 years I have conducted 2-week glaucoma workshops at 26 training centres in 23 developing countries scattered throughout most areas of the world. Based on this experience I am comfortable in making the generalisation that most ophthalmologists in the so-called tertiary care centres in the majority of developing countries do not have the clinical skills necessary to accurately differentiate the various causes of glaucoma. The diagnosis of glaucoma continues to be made on the basis of elevated IOP. PACG is diagnosed on the basis of the signs and symptoms of the acute variety. A serious problem is the lack of gonioscopy skills resulting in the rare performance of this most important examinationcomponent.Theresultisfrequent misdiagnosis and inappropriate treatment. Visual fields are either not done or are usually unreliable. Secondary glaucoma is not recognised as such and often treated inappropriately.

The ophthalmologists that I have encountered are bright, usually hard working and highly motivated to learn. They suffer from poor basic training even though the duration of the residency training is often longer than in the developed countries. Glaucoma is a very complex and challenging condition. At the beginning of the workshop there is invariably a low level of confidence especially in diagnostic skills. It is satisfying to see what only 2 weeks of concentrated teaching can accomplish. The participants return to their respective teaching institutions with a fresh outlook and confident enthusiasm in seeing glaucoma patients and an eagerness to teach others.

In summary, it is exciting that new and better screening techniques are becoming available but this begs the question of who will do the final diagnosis and treatment in the tertiary referral centres. A subcommittee of the American Academy of Ophthalmology is compiling a list of training centres in developing countries; the number is now over 200 and still growing. I hope that the preceding comments will stimulate more teaching effort in updating the clinical skills of those who are receiving glaucoma referrals from the primary and secondary allied health personnel in the field. Books, journals and occasional lectures by visiting experts are helpful but not enough. Whatisespeciallyneededisintensive, basic and practical 'hands-on' clinical training, including gonioscopy, by volunteers from the developed countries or by well-trained ophthalmologists from the developing countries.

James E Standefer MD
10080 Hadley Ave North
White Bear Lake, MN 55110-1203
USA

Dear Editor

I have followed with interest the very favourable responses to John Sanford-Smith's earlier appeal for a reappraisal in selected circumstances of ICCE with the newer 'open loop' ACIOL's.

We have used hundreds of ACIOL's in Guatemala over the past ten years - both the classic 4point Kelmann and more recently the 'Omnifit' 12.8mm 3point Kelmann (Aurolab A5528). This is in large part due to the very high incidence of pseudoexfoliation among the Mayan population. We have noticed no more postoperative problems than with PCIOL's.

As our patients are poor and often from isolated mountainous areas, I have the feeling we may not be seeing the long range effects of posterior capsule opacification. Our clinic has a YAG laser but few understand its purpose or are able to return to take advantage of it. In the occasional case of operating on one eye with ICCE/ACIOL and the other with ECCE/PCIOL, I have been surprised to see how quickly the patient reports subjectively clearer vision following the former procedure – even though tested visual acuity may at the time be the same.

We routinely use the above ACIOLS after vitreous loss with often just a scissors vitrectomy. Again, we see few complications. Not to use an intraocular lens in the case of vitreous loss is virtually to ensure a 100% complication rate.

John Cheatham MD
Obras Sociales del Hermano Pedro
Antigua, Guatemala

A Study of Patients Attending for Eye Surgery at a Rural Hospital in the Republic of Benin

Andrew R Potter
MRCOphth DTM&H

Over a 14-week period from 27 June–4 October 2000 all patients discharged from our eye unit after surgery were asked to complete a verbally administered questionnaire.

The St Jean de Dieu Hospital is situated 15 km north of Parakou, the major town in northern Benin (pop. 100,000+). The eye unit is staffed by one expatriate surgeon, three national nurses and one clerk.

One hundred and fifty-six questionnaires were completed. The age range of patients was from 2-90 years. Ninety-nine (63.5%) were over 65 years. Ninety-two were male, 64 were female (male:female 1.4:1)

Distance Travelled and Means of Transport

- 14% travelled less than 20 km
- 20% travelled 20-100 km
- 66% travelled over 100 km.

The means of transport used were:

- Car taxi (communal) 72%
- Motorbike taxi 10%
- Train 6.7%
- Personal/family car 5%
- Family motorbike 4.5%
- Other car 1.9%.

Pathology

Of the 156 patients, 66% were operated for cataract and 16% for glaucoma. Other pathology included pterygium (4) and entropion (3). When asked how many understood their pathology, 60% said they did not.

Occupation

The patients' occupations were: 37% housewives (who usually work just as hard in the fields, as do their husbands); 29% subsistence farmers and 10% cattle herders. Six were children under 15 years (only one of whom attended school) and five patients were officially retired and in receipt of a pension.

Publicity (Table 1)

Cost of Surgery

We asked each patient who had paid the cost of their operation: 42%wereself-financed; 38.5%were paid by patient's children; 9% were paid by a parent and a further 9% by the patient's wider family. The vast majority (98.7%) did not consider the consultation cost (US$2) too expensive. The price of surgery was acceptable to 95.5% (US$28 for cataract surgery with either an implant or aphakic spectacles).

Emotions (Table 2)

On discharge from the hospital, usually 7 days after their operation, 135 (86.5%) said that their vision had improved, 17 (11%) said it was worse. Each patient was asked if they experienced too much pain either during or after the operation. Whilst 131 (84%) did not experience too much pain, 23 (15%) did. Two patients made no comment.

Evaluation (Table 3)

General Comments

Finally, patients were asked for any additional comments. Sixty-seven patients volunteered 80 comments

- Satisfaction (18)
- Wished for a better result (16)
- Thankful to staff (7)
- Need for hospital to be cleaner (4)
- Experienced too much pain (3)
- Will pray for the staff (3)
- Will tell others to come (3)
- Other comments (26).

Note: *The eye service at St Jean de Dieu Hospital is supported by Christian Blind Mission International.*

Published courtesy of:
Tropical Doctor 2002; **32**: 17–19

Table 1: How Patients Knew About the Eye Clinic

How informed?	No. (%)
Another patient	54 (34.5)
Outreach clinic	46 (29.5)
Radio	35 (22.5)
Family	7 (4.5)
Friends	6 (3.8)
Other	8 (5.1)

Table 2: Emotions Experienced by Hospital Patients

Emotions	No. (%)
Confidence in the doctor	27 (17.3)
Fear	26 (16.6)
Uncertainty	24 (15.4)
Confusion	9 (5.8)
Confidence	6
Confidence in God	2
Satisfaction	1

Table 3: Evaluation by Patients of Their Stay in Hospital

	Satisfactory	Fair	Unsatisfactory
Check-in desk	156	0	0
Nurse	153	1	2
Doctor	131	19	6
Consultation	152	1	3
Operation	129	20	6
Post-operative care	152	1	3

7th General Assembly of the International Agency for the Prevention of Blindness

28th September – 3rd October 2003

MANAMA, BAHRAIN

The scientific programme will cover topics related to the theme of the Assembly 'Partnership in VISION 2020' and will include keynote lectures, plenary sessions, workshops, presentations of model projects, free papers and posters. The Assembly is crucial as it will discuss progress made by VISION 2020 to date and discussion of plans for the future.

For further details please contact:

Gullapalli N Rao
Secretary General - IAPB
IAPB Secretariat, L V Prasad Eye Institute
L V Prasad Marg, Banjara Hills
Hyderabad 500 034, INDIA

Tel: +91-40-3545389/3548267 Fax: +91-40-3548271
Email: IAPB@lvpeye.stph.net or agency@lvpeye.stph.net

Vision 2020 Workshop: District-based Plans For Prevention Of Blindness

Moshi, Tanzania

JUNE 10-14, 2002

The Vision 2020 workshop in Moshi will focus on creating a team approach to prevention and treatment of blindness in the region (eastern Africa).

As the overall theme of the upcoming workshop is district/region based planning for Vision 2020, we *strongly* encourage the participation of district/region health planning teams. We define a health planning team as including an eye care professional and one or two district/region health officers (who have authority to plan and implement agreed activities).

Special Workshop on Gender and Blindness. We anticipate holding a one-day workshop (**Monday, June 17**) on the issue of gender and blindness. Plans for thespecialworkshopongenderand blindness are not formalised yet; please let us know if you are interested in attending.

For information regarding the **Vision 2020 Programme** and the **Gender and Blindness Workshop**, please contact:

Paul Courtright DrPH &
Susan Lewallen MD
Kilimanjaro Centre for Community Ophthalmology
Tumaini University
PO Box 2254
Moshi, Tanzania
Email: kcco@kilionline.com

For **Vision 2020 Programme** registration please contact:

Dr Brian Savage
Department of Ophthalmology
Kilimanjaro Christian Medical College
PO Box 545
Moshi, Tanzania
Email (#1): eyedept@kcmc.ac.tz
Email (#2): savs_tz@africaonline.co.tz
Fax: 255-27-2754890

COMMUNITY EYE HEALTH

Visit the *Journal of Community Eye Health* On-Line

TheJournal,includingrecentbackissues,isavailableon-lineat **www.jceh.co.uk**
Articles are available as HTML documents to facilitate ease of downloading.
PDF formats are also available.
We would appreciate your help in making the website as well known as possible, and would welcome your feedback about using the site.
Thank You!

Community Eye Health

supported by

Christian Blind Mission International

Sight Savers International

Conrad N. Hilton Foundation

International Glaucoma Association

Tijssen Foundation
The Netherlands

Dark and Light Blind Care
The Netherlands

Dutch Society for the Prevention of Blindness

The West Foundation

We express our gratitude to

bartiméus
The Netherlands

for their generous support of our recent Journal on
New Issues in Childhood Blindness
J Comm Eye Health 2001; **14**: 53–72