Eye Care in Developing Nations

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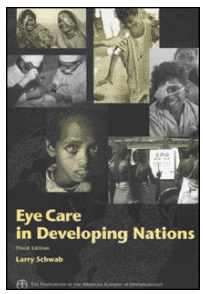
Third Edition 1999



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This third edition of Eye Care in Developing Nations has been eagerly awaited and updates the earlier edition's excellent coverage of eye disease and its management in the less-resourced parts of the world. Written for eye health professionals seeking to serve in developing countries, it is equally suitable for national health care workers, whose first language may not be English, because of its clear and concise delivery.

Dr Schwab responds to the need for affordable, acheivable and appropriate approaches to address the challenge of VISION 2020 —the elimination of avoidable blindness. All the major blinding eye diseases are covered together with relevant guidelines to support clinical practice.

Forthereaderwhoworksinareaslacking easy access to information and materials, the appendices on resource organizations and selected reading will be especially welcomed.

The book has 270 pages and is copiously illustrated with excellent black and white photographs. Thought-provoking, applicable and memorable quotes are added as a preface to each chapter and can only add to this excellent learning resource. The need for compassionate delivery of care to the poorest peoples in the world is addressed in a natural way and makes this publication exceptional for its target readership.

Sue Stevens

Ordering Information

Cost: UK£7/US$13 + £3/$5 (surface) or £5/$9 (airmail) postage.

Payment by banker's orders and cheques drawn on UK£ or US$ bank accounts can be accepted. Please make cheques payable to UNIVERSITY COLLEGE LONDON and send with your order to:

International Resource Centre, ICEH, 11–43 Bath St., London EC1V 9EL. Fax +44 20 7 250 3207; E-mail: eyeresource@ucl.ac.uk

Are We Reaching and Serving the Blind Poor?

Dear Sir

After a career in international banking, I began the study of medicine at age 40 and later established a small family-funded Eye Foundation. I have practised basic surgical ophthalmology in Latin America on a day-to-day basis for the past eleven years. In addition, I have been able to observe and follow the successes and failures of the fifteen projects our Foundation assists in Latin America , Haiti, Africa and Asia.

I am deeply concerned and disturbed by the widespread administrative and organisational failings which lead to unnecessary obstacles being placed in the paths of the blind poor. It appears that we are making enormous technical progress while ignoring the administrative and management skills required to reach the poor more effectively. The following are examples of some of these shortcomings.

1. Failure to 'triage' (priority of need and treatment) arriving patients, thereby focusing our limited resources on the more serious, treatable cases.
2. Turning away the blind due to often trivial and petty bureaucratic policies, e.g., registration cards are not available after 8:00a.m.
3. Insistence on useless laboratory and medical examinations for procedures carried out under local anaesthesia.
4. Cancellation of surgeries, often due to insignificantly raised blood pressure, coughing, anxiety and nervousness, lack of co-operation, etc. Almost all of these cases can be completed uneventfully and safely with the use of minor medications along with a small amount of patience and support.
5. Tying up a surgeon's time and energy with endless, routine clinical examinations.
6. Failing to allocate operating room time, bearing in mind that cataract surgery (and trichiasis procedures in trachoma endemic areas) have greater value and effectiveness in the developing world than all other eye procedures combined.
7. The direct material costs of good quality cataract surgery with IOL are now approximately $15. Ineffective charity programmes routinely charge the poor up to seven or eight times this amount.
8. Keeping uncomplicated post-operative patients more than one to two days, thereby reducing the beds available for new patients.
9. An insistence on large, comfortable US-style hospital beds and accommodation,therebyreducingavailableward space. The blind patient is more than happytospendoneor twonightsunder almost any conditions. His or her real concern and fear is to be sent away untreated due to a lack of available beds.
10. An insistence on unnecessary follow-up. Our own approach in an uncomplicated case is to send the patient who is far from home away with an eye shield and have him return if there is a problem, or if he or she desires to do so. If there is a noticeable loss of vision later, we recommend a return visit for a possible YAG or needle capsulotomy.
11. A frequent lack of empathy and courtesy towards the poor. We don't really have to make an effort to be accommodating if the patient has no other treatment possibilities.

It is worth noting that virtually none of these factors or attitudes are found in such highly effective, superbly organised hospitalsasAravind (India), CBM-Lahan(Nepal) and SEVA-Lumbini (Nepal).

The blind poor make tremendous sacrifices to reach surgical treatment centres. A significant factor in the success of the above three hospitals is found in the confidence and knowledge of the poor that once these sacrifices are made they will not be turned away untreated.

Thank you for the opportunity to express these impressions and concerns.

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