period. Compared with non-trauma cases, trauma cases were more likely to be male (odds ratio (OR): 4.2, 95% confidence interval (95% CI): 3.2, 5.4), non-residents (OR: 6.2, 95% CI: 3.7, 10.5), younger than 40 years of age (OR: 3.2, 95% CI: 2.7, 4.1) and less likely to require follow-up or hospital admission (OR: 0.2, 95% CI: 0.2, 0.3). The three most common types of injuries were superficial foreign body (58.2%), corneal abrasion (24.9%) and blunt trauma (12.6%), while open globe injury occurred in only 17 cases (2%). Comparison with a 10% random sample of all cases seen in the previous 9 months (n = 284) revealed no significant time variation in the types of injuries (p = 0.63). Work-related injuries accounted for 590 (71.4%) cases, where grinding, cutting metal and drilling were the specific activities in more than 90% of the cases. In appropriate settings, only 21.7% of patients with work-related injuries used EPD; 43.7% were provided with EPD, but did not use them at the time of injury; and the remaining 34.6% reported that EPD were not provided.

Conclusions – Ocular trauma at the emergency service level in Singapore involved mainly young non-resident men, were work-related and associated with well-defined activities, and were generally minor. The low prevalence of EPD use reinforces the need for a review of the design and implementation of occupational eye safety programmes, especially among non-resident workers.

Published courtesy of :
Eye 2001; **15**: 75-81

Letters to the Editor

Assessment of Learning Versus Competence

Dear Editor

Dr Prozesky has expertly described why and how learning should be assessed (*J Comm Eye Health* 2001; **14**: 27-28). It should be emphasised that assessing competence in a workplace situation follows the same designs although this assessment is often summative and based on the principles of evidence. In assessing competence, one is concerned with whether the evidence collected (through observation, MCQ, checklists, or oral examination) is current, authentic and sufficient to declare a candidate competent in performing a specific task. That is when the use of OSPE/OSCE is very helpful for the purpose of assessment because it is possible to assess in a given scenario the knowledge, the skills and the attitude of candidates. Historical evidence (reports, testimonials, work history) is also considered in the assessment of competence but its value is limited by its authenticity which can be questionable. As teachers move from didactic to problem-based learning methodology, the assessment of competence becomes a critical issue. Assessment skills will then become not only necessary but also a specialised area with qualified assessors, moderators and verifiers working alongside teachers or trainers as partners. This is the system that is already implemented to some extent in countries including UK, Australia, Singapore and the United States, to name but a few.

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Cataract Surgery

Dear Editor

I did not know that there was room for arguments on whether or not to do ICCE. I thought that all efforts are towards IOL after lens extraction, preferably by the ECCE method. Sadly, in those regions where no surgeon exists to do ECCE with IOL or he/she exists but there is no relevant equipment, ICCE may be performed.

I will restrict myself to the Africa that I know and have worked in – East, West and Central. In all these regions, I have found that there exists a backlog of unoperated cataracts (according to surveys and epidemiological projections)) but there are no (or insignificant) surgery waiting lists in eye departments. The pressure is not on surgery time but community awareness and mobilisation campaigns to increase cataract surgery uptake. Backlog or no backlog, Africa or Asia, I would rather take 15 minutes on ECCE with PC IOL than 3 minutes on ICCE with no implant (and no sutures).

With proper distribution of existing resources within countries in our region - human resources and equipment - every patient needing and willing to have cataract surgery should have lens extraction with IOL inserted.

To increase cataract surgery uptake we need to demonstrate improved quality of service. In my catchment area we used to get resistance to surgery because nearly every elder could name somebody who was blinded by cataract surgery - over a decade ago! Today, nearly every other patient who comes for cataract surgery is on recommendation of our former, satisfied cataract patient. There was a change from ICCE to ECCE with PC IOL. Cataract surgical uptake is increasing by about 20% every year.

I agree with my old friend and ICEH classmate, Dr Mmbaga, that some vast regions still do not have microscopes or surgeons trained in ECCE with IOL and that ICCE may therefore be a good solution. But we must sing the song how inappropriate the technique is and how the relevant local NGOs and Ministries of Health must make acquisition of the very affordable equipment a top priority.

Internally, within the countries, we should retrain ICCE surgeons in ECCE with PC IOL technique.

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COMMUNITY EYE HEALTH COURSES

ProfessorGordonJohnson. InMarch,2002 Professor Johnson will retire after 15years service at the International Centre for Eye Health, London. We shall allgreatly miss his good and wise leadership.

Community Eye Health Courses. There are no plans to continue Courses in Community Eye Health (CEH) at the Institute of Ophthalmology beyond August 2002. There are, however, plans for a proposed, new Community Eye Health Course in London, beginning inSeptember 2002.

Dr Allen Foster. Dr Foster, who is based at the London School of Hygiene and Tropical Medicine, is currently conducting short, one week Courses in Community Eye Health for the Vision 2020 programme. These short Courses are now taking place in 12 Centres around the world.

Dr Foster should be contacted for information relating to both the new, planned CEH Course in London and the Courses in Centres abroad.

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