



Beyond Good Intentions:

the importance of best practices in international eye care delivery

BY J STAPLE

Blindness is most feared after death and cancer.¹ In the developing world, blindness and visual impairment greatly impact quality of life and ultimately lead to increased mortality. While we do not often think of blindness as a ‘killer disease’, blindness is directly linked to mortality in developing countries. The life expectancy of a blind person is one-third less than that of a sighted peer, and most who are blind die within 10 years.² These numbers are astonishing, and treatment is not just feasible, but should be made available to all. The solution to preventable blindness is manifold and requires an approach focused on best practice principles in public health. Patient barriers to care must be eliminated, eye care must be brought by local eye doctors to patients living in poverty, and local eye care providers must be empowered and supported.

Patient barriers to care are numerous. A recent study found that over two thirds of adults over age 40 in a rural Indian population with low vision secondary to cataracts, glaucoma, and refractive error had

never sought eye care.³ Financial barriers are frequently cited as the greatest hindrance to the uptake of eye care services. However, many other barriers to care exist and need to be eliminated for patients. Many are mired by a fear of doctors, fear of surgery, and fear of treatment. Some patients do not seek care because they believe that blindness is inevitable and without a cure. “Blindness in the elderly is often an expected condition. The main reasons that African patients offered cataract surgery did not proceed were fear of surgery and a belief that blindness was a natural consequence of increasing age, and could not be reversed.”³ Patient barriers to care can be eliminated by fully funding or subsidising care, bringing care to the patients, and providing transportation to the eye clinic for those needing surgery. Additionally, patients and communities should be educated about eye health promotion, surgery, and how to use prescribed medication properly. Unite For Sight, for example, trains local community members to be community eye health workers so that they can help educate the community about eye care and eliminate

fear or misunderstandings about treatment and surgery.

Eye care organisations and programs must be founded on best practice principles in global health. All eye care programs need to be led and managed by local eye care providers, which ensures high quality, comprehensive care over the long-term. Visiting optometrists, ophthalmologists, students, and other volunteers should ensure that they are working under the direction and management of the local eye care providers. Failure to do so can undermine the local doctors, the local health system, and can result in inappropriate or low-quality care without the possibility of follow-up. Those involved with eye care must ensure that they support the ideas and solutions developed by local doctors to help their communities and build local capacity.

Beyond good intentions: the harm of worst practices

Despite good intentions, eye care and global health work that does not follow best practice principles can be wasteful, unethical, and harmful. Worst practices can create

serious public health concerns that introduce new and at times more substantial barriers to patient care, which can reinforce and further perpetuate health disparities and the cycle of poverty. A primary misconception of global health work is the idea that something is better than nothing.

Doctors Rachel Bishop and James Litch, Co-Directors of the Kunde Hospital in Nepal, explain why this philosophy is misguided:

"It is inappropriate arrogance to assume that anything that a Western doctor has to offer his less developed neighbour is progress. These [Western physician] tourists are often working outside their trained specialty or have little concept of how that specialty applies to Nepal. They frequently don't understand local illness presentation, culture, or language. They often offer inappropriate treatment because they think they 'must give something.' The consultations are often one off, with little possibility for follow-up and the local health providers are left to pick up the pieces with no record of the consultation. If an unregistered Nepali doctor on holiday in the United Kingdom offered general medical consultations in a shopping centre there would be a public and professional outcry."⁴

Short-term interventions that fail to work with local health care providers frequently disrupt the local health care system.

"While [Western medical] teams provide temporary but sporadic access to health care, overall, they do not improve long-term access and they may, in fact, undermine existing services. It is unclear whether the short-term projects are treating only individuals who under current circumstances would have absolutely no access to medical care because of an inability to pay for it, or if they are diverting some otherwise paying or potentially paying patients from local practitioners and facilities. Local practitioners who must earn a living in the community cannot compete with the volunteers who donate their services. Furthermore, they cannot provide the same volume of free care over sustained periods and remain financially viable. Because the patient population... has not been closely analysed, it is difficult to assess the precise impact on the local health care delivery system. If these groups actually do compete with local providers, the possibility exists that they could be put out of business, further restricting access to health care."⁵

In addition to negatively affecting local public health systems, short-term interventions can also cause significant harm to patients. At times optometric missions focus on prescribing eyeglasses to hundreds of patients during a one



Ghanaian Ophthalmologist Dr James Clarke examining a patient.

to two week trip. These short-term interventions rarely work in partnership with local eye care providers, thereby undermining the local health care system. Furthermore, patients who have cataracts, pterygium, or other curable eye diseases may be given eyeglasses for their operable condition, or told that the surgery that they need cannot be done by the visiting team to restore their sight. If an option for subsidised or free cataract surgery is not provided, the patient is likely to believe that nothing can be done for their eye condition, thereby perpetuating and developing new barriers to care.

"It is... important to recognise that while spectacles provide an easy answer to the need for presbyopic correction, the mere handing out of spectacles without an appropriate eye examination biases against quality eye care for everyone regardless of socioeconomic status, sex, or geographic circumstance. Coupling spectacle distribution to meaningful eye care is an important link in the blindness prevention chain from community to hospital. Random spectacle distribution breaks the chain of patient care and is counterproductive."⁶

To remedy the 'worst practice' of short-term interventions, visiting eye care professionals must work with local ophthalmologists at local eye clinics. The local eye clinic should lead and manage the visiting eye care providers, and they should collectively provide care for patients in remote locations. The local eye care professionals know their region and the local health care system the best. The local providers will need to be available for patient follow-up on a long-term basis, and the clinic should regularly revisit the region. Patients requiring surgery or other advanced care can

be referred to the local provider for free or subsidised eye care. However, 'referring' to local eye doctors will not reduce barriers to care unless transportation, education, and free or low-cost care are provided. Countless patients can be told to go to an eye doctor, but the measured impact depends on the number of patients who actually receive quality care.

Short-term 'surgical safari' missions are an additional concern, and one of the worst offenders. Surgery is too often provided by visiting surgeons without collaboration and direct involvement by local ophthalmologists. Even the most experienced visiting surgeons cannot overcome the risk of complications caused by short-term surgical interventions. When visiting surgeons do not work with their local counterparts, there is no surgeon to provide the vitally important follow-up care or to treat infections. The surgical team may leave and never know if a patient developed a severe infection. If there is no nearby eye care professional, a patient will not be able to access necessary physician care or medication to treat a postoperative complication. In addition to negatively impacting the patients themselves, a poor surgical outcome can lead an entire community or region to fear doctors and surgery.

"The perceived quality of the provided services had a strong influence on uptake. Patients who reported having spoken to someone who had good experiences with the service provider were more likely to avail themselves of the offered cataract surgery. Conversely, patients who had heard negative aspects about the services provider were not inclined to take up services. Virtually everyone had discussed cataract surgery with relatives or friends."⁷

These short-term surgical interventions also undermine the local eye clinics. While a limited number of patients may be able to access free surgical care by visiting ophthalmologists, countless others will not have access to the care. Patients are often turned away and will never seek care or surgery again. Meanwhile, patients tend to view Western visitors as superior, compromising the status of local doctors.⁸ Many decide to wait until another Western doctor visits instead of seeking care by the local ophthalmologist. At times, rich patients receive care by the visiting doctors because, though they can pay for surgical care by the local ophthalmologists, they prefer to receive surgery from the visiting Western doctor who is perceived to be a better health care provider.

Optometrists and ophthalmologists who visit developing countries should focus not on providing care to patients, but instead their aim should be to assist and support local eye doctors to provide daily care to patients living in extreme poverty on a year-long basis. Visiting eye care professionals have an important role to provide professional development opportunities to local eye doctors so that they can continue enhancing their skills. While doctors in countries such as the UK and US have ongoing professional development opportunities (i.e. continuing medical education (CME)), these same annual training opportunities are not available to eye doctors in most developing countries. One-on-one mentoring and training opportunities for the local ophthalmologists and optometrists are the best and most productive ways to provide volunteer service internationally.

Unite For Sight: investing in local eye clinics to provide high quality care to the world's poorest people

With Unite For Sight's investments of human and financial resources, local eye clinics are able to eliminate patient barriers to care by fully funding surgeries, bringing eye care services to the patients, providing transportation to the eye clinic for surgery as needed, and educating communities about blindness elimination. The eye care services are comprehensive, including exams by local ophthalmic nurses, optometrists, and ophthalmologists, diagnosis and care for all treatable conditions, promotion, and prevention. This full range of services is delivered year-round. All of these eye care programs are locally led and managed by the local ophthalmologists. Unite For Sight's role is to cultivate and invest in the talent of local ophthalmologist leaders who have the determination and skill to create successful social enterprises that serve the world's poorest people. In Accra, Ghana, for example, Unite For Sight works with Crystal Eye Clinic, which is directed by Ghanaian Ophthalmologist Dr James Clarke. Unite For Sight has provided grants to the clinic to purchase three outreach

vehicles and to hire four full-time ophthalmic outreach staff and three full-time drivers. The clinic has also hired and trained 24 community eye health workers who work daily in their villages. Villagers with low levels of formal education are trained by Dr Clarke to become competent in screening, education, and referring and assisting patients to the monthly ophthalmic outreach team visits that come to their villages. Collectively with visiting Unite For Sight Global Impact Fellows, the local team of village staff and eye clinic staff provides eye care to Ghana's poorest people in the southern region. Unite For Sight's support has enabled Crystal Eye Clinic to more than triple its number of annual surgeries, and 86% of the surgeries are now provided to patients living in extreme poverty. Unite For Sight now provides support for more than 2,000 surgeries provided by Crystal Eye Clinic each year.

Unite For Sight recognises that the eye clinics are businesses that contribute to economic growth and job creation while providing health care services. In addition to providing charitable care, the local clinics must utilise market-driven approaches to achieve long-term success and impact. Unite For Sight requires its partner eye clinics to operate as a business because relying solely on charitable contributions and grants does not enable a clinic to be sustainable or locally competitive. Muhammed Yunus, 2006 Nobel Laureate, explains, "When we want to help the poor, we usually offer them charity. Most often we use charity to avoid recognising the problem and finding a solution for it... Charity is no solution to poverty. Charity only perpetuates poverty by taking the initiative away from the poor. Charity allows us to go ahead with our own lives without worrying about those of the poor. It appeases our consciences."⁹ While the clinic's business continues as an enterprise independent of Unite For Sight's supported outreach programs, the eye clinic's sustainable business model concurrently provides eye care to its paying patients. Having this strong base of independence and sustainability comes from good business practice, which is why Unite For Sight partners exclusively with existing, sustainable eye clinics that also provide care to paying patients.

The role of volunteers

Unite For Sight's visiting optometrist and ophthalmologist volunteers apply their skills and training to provide eye care to patients alongside the local eye doctors. Optometrists share knowledge and skills with local optometrists and ophthalmic nurses, while ophthalmologists provide surgical training and skills transfer to local ophthalmologists.

In addition to Unite For Sight's focus on building local capacity by developing and enhancing the capacity and effectiveness of eye clinics, therefore training the next generation of global health leaders. Unite For

Sight's Global Impact Fellows receive hands-on, structured training in global health while rendering valuable service. Through online training courses in Unite For Sight's Global Health University, the Global Impact Fellows are introduced to best practices in global health, international development, social entrepreneurship, community eye health, cultural competency, and volunteer ethics and professionalism, among other important topics. Upon arriving abroad, the Global Impact Fellows are integrated into the eye clinics' daily outreaches that bring high quality eye care to the doorsteps of patients living in extreme poverty. The Global Impact Fellows are also encouraged to participate in Entrepreneurial Volunteering and the Global Impact Lab, optional Unite For Sight programs for fellows interested in social entrepreneurship and global health research. The Global Impact Fellows—many of whom are students and young professionals—are receiving the opportunity, training, and tools to drive change and to become new leaders in global health who fully grasp the importance of best practices and social entrepreneurship to create innovative models for change. **EN**

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Further reading

Unite For Sight's Global Health University (www.uniteforsight.org/global-health-university) provides comprehensive resources about the best practices discussed in this article and further delineates effective health care delivery in low-resource settings.



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