The Royal Australian and New Zealand College of Ophthalmologists

Guidelines for Clinical Activity in Developing Countries According to Good Development Practice

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The Royal Australian and New Zealand College of Ophthalmologists ACN 000 644 404
94 - 98 Chalmers Street, Surry Hills NSW 2010 Australia
T 61 2 9690 1001 F 61 2 9690 1321 E ranzco@ranzco.edu
ranzco.edu

1. Purpose

To outline good practice for RANZCO Fellows who are involved in clinical activities in developing countries.

2. Background

RANZCO's development approach[1] is modelled on that of both the Australian and New Zealand governments' aid organisations. [2,3] RANZCO supports the concept of sustainable development to improve the situation of people living in developing countries, and accepts the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008),[4] which commit donors, partner governments and multilateral development organisations to undertake actions to accelerate progress towards improved aid effectiveness. RANZCO is committed to contributing to the realisation of the Millennium Development Goals[5] and the related Sustainable Development Goals,[6] particularly those related to achieving good health and wellbeing.

3. Clinical Activity in developing countries

A development approach to public health interventions in developing countries is now widely recognised as more effective than a charity approach.[7,8] This has changed the paradigm for aid contributions made by ophthalmologists based in developed countries.[1,9] Isolated, brief clinical interventions that create no legacy of ongoing care are now understood to be often counter-productive and unacceptable. However, there remains a place for isolated clinical activities in some circumstances, particularly in small remote populations as occur, for example, in some Pacific Island Countries.[10]

When applying current development best practice[11] to eye care, it is recommended that clinical activities performed by external ophthalmologists incorporate clinical teaching of local eye care practitioners. However, care must be taken to ensure such clinical activity does not disrupt and distort local services.[12] Such disruptions may have further implications, including: leaving unrequited patient expectations; producing poor surgical and other outcomes that go unrecognized and untreated; creating an increased and inappropriate workload for insufficiently trained local eye care practitioners; and leaving behind (even with the best of intentions) out-of-date, inappropriate medications and unrepairable equipment.[13]

To maximize the impact of the time and effort invested, ophthalmologists should carefully vet the organisations and projects to which they contribute.[1,14] When that contribution includes clinical activity, ophthalmologists should ensure that any assignment undertaken meets standards of good practice.[1,9,13,14,15,16] As with clinical practice at home, the onus is on the ophthalmologist to strive to provide eye care and outcomes of the highest standard possible.[17] Although not comprehensive and no substitute for experience, Table 1 provides a checklist the ophthalmologist may use to determine if standards are likely to be met.

Table 1: Checklist for the assessment of the clinical content of assignments offered to developed-country ophthalmologists who wish to contribute to international ophthalmology / blindness prevention activities in developing countries

Check item for a clinical assignment:	Comment:
Appropriate practices and standards should be documented and adhered to	At a minimum, all clinical activity should: • Use appropriate[13] well-maintained equipment (in the case of electrical equipment, protected by voltage stabilizers, with standby generators as required) and instruments.[18] • Use appropriate in-date medications and other clinical consumables.[13,15] • Have documented protocols adhered to for: - adequate sterilization of surgical instruments[19] - management of clinic, ward and operating theatre activities[20] - clinical pathways[16] - clinical care[15] (with evidence-based minimum standards[16]) - recording service data - recording and monitoring outcomes[21] - clinical audit[21] - implementation of improvement suggestions arising from review of adverse outcomes - monitoring patient satisfaction • Protect and promote patient well-being • Not discriminate on the basis of ethnicity, age, gender, religion or inability to pay for services[22] • Offer, if appropriate, supervised, in-service, high quality training of local eye care practitioners • Be initiated and developed in such a way that it has fair prospect of continuing at a high standard beyond the duration of the expatriate ophthalmologist's assignment and the project she/he is working for.
If required, an interpreter should be used	An interpreter is essential if the ophthalmologist is not fluent in the local language and communications beyond simple patient instructions (such as "look up") are required. Preferably, the interpreter should have previous experience working in the circumstances prevailing because knowledge of technical terms and their translation is essential. This is especially so for clinical teaching. Otherwise, the ophthalmologist will spend her/his time teaching the interpreter and not health practitioners.

There should be opportunity for appropriate formal debriefing at assignment end	This should involve two-way assessment and comment by and of the organization/project employing the ophthalmologist and the ophthalmologist. Fair appraisal with positive and negative assessments presented in a nonthreatening manner is essential. The aim should be improvement of the organisation and its projects and workers, and of any future contribution the ophthalmologist may make to the same or similar projects. A mutually satisfactory experience of the ophthalmologist's input and outcomes should encourage the organisation and ophthalmologist to commit to recurring contribution by the practitioner. This is likely to be all the more productive and rewarding if that commitment is to the same project. This opens the possibility of the ophthalmologist being a resource and mentor for local practitioners, both between visits and after the project's completion.
Local cultural protocols need to be understood and adhered to, as appropriate.	When planning to practise overseas, the ophthalmologist should broadly familiarise herself/himself with the local cultural context, and any relevant local cultural protocols. Having a basic understanding of such protocols, which govern day-to-day interpersonal interactions, may be key in establishing effective communications with local patients, as well as building rapport and establishing long-term working relationships with local health professionals.

4. References

1. RANZCO (2016). *Contributing to International Ophthalmology Development*. Available at: https://ranzco.edu/about-ranzco/our-organisation/policies
2. Australian Department of Foreign Affairs and Trade (2014). *Australian aid: promoting prosperity, reducing poverty, enhancing stability.* Available at: http://dfat.gov.au/about-us/publications/Documents/australian-aid-development-policy.pdf (Accessed: 07 June 2016).
3. New Zealand Foreign Affairs & Trade Aid Programme (2015*). New Zealand Aid Programme Strategic Plan 2015 - 19.* Available at: https://www.mfat.govt.nz/assets/_securedfiles/Aid-Prog-docs/New-Zealand-Aid-Programme-Strategic-Plan-2015-19.pdf (Accessed: 2 June 2016).
4. Organisation for Economic Co-operation and Development (2005/2008). *The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.* Available at: http://www.oecd.org/dac/effectiveness/34428351.pdf (Accessed: 2 June 2016).
5. United Nations. *Millennium development goals.* Available at:

http://www.un.org/millenniumgoals/ (Accessed: 30 June 2016).
6. United Nations. *Sustainable Development Goals.* Available at: http://www.un.org/sustainabledevelopment/sustainable-development-goals/ (Accessed: 9 August 2016).
7. Fowler, A. (1997) *Striking a Balance : A Guide to Enhancing the Effectiveness of Non-Governmental Organisations in International Development*: Routledge,.
8. Ruger, J. P. (2015) 'Ethics of Development Assistance for Health', *Hastings Center Report,* 45(3), pp. 23-26.
9. Lewallen, S. (ed.) (2010) *Before you go: information for ophthalmologists volunteering in developing countries*. San Francisco, CA: The Foundation of the American Academy of Ophthalmology: Committee on International Ophthalmology.
10. Golnik, K., Mayorga, E., Spivey, B., Ritch, R. and Gauthier, T.-M. (2012) 'International Council of Ophthalmology: Refocusing Ophthalmic Education in the Asia-Pacific Region and Beyond', *The Asia-Pacific Journal of Ophthalmology,* 1(5), pp. 255-258.
11. Ramalingam, B., Laric, M. and Primrose, J. (2014) *From Best Practice to Best Fit: Understanding and navigating wicked problems in international development*: Oxfam. Available at: http://oxfamblogs.org/fp2p/wp-content/uploads/2014/05/BestPracticetoBestFitWorkingPaper_DraftforComments_May2014.pdf (Accessed: 5 June 2016).
12. Pahau, D. and Brian, G. (2009) 'Free cataract surgery may undermine local services in developing countries', *Clinical & Experimental Ophthalmology,* 37(5), pp. 532-533.
13. RANZCO (2016) *Guidelines for Donation of Equipment and Consumables* Sydney, NSW: RANZCO. Available at: https://ranzco.edu/about-ranzco/our-organisation/policies
14. RANZCO (2016) *Guidelines for Teaching in Developing Countries According to Good Development Practice*. Available at: https://ranzco.edu/about-ranzco/our-organisation/policies
15. Brian, G., Ramke, J., Szetu, J., Le Mesurier, R., Moran, D. and Du Toit, R. (2006) 'Towards standards of outcome quality: a protocol for the surgical treatment of cataract in developing countries', *Clinical & Experimental Ophthalmology,* 34(4), pp. 383-387.
16. International Council of Ophthalmology (2014) *ICO Guidelines for Diabetic Eye Care*. Available at: http://www.icoph.org/downloads/ICOGuidelinesforDiabeticEyeCare.pdf (Accessed: 2 June 2016).
17. RANZCO (2014) *RANZCO Professional Code of Conduct*. Available at: https://ranzco.edu/about-ranzco/our-organisation/policies (Accessed: 5 June 2016).
18. Srinivasan, V. and Thulasiraj, R. D. (2003) *Ophthalmic instruments and equipment: a handbook on care and maintenance.* 2nd edn. Madurai, India: Adavind Eye Hospital & Postgraduate Institute of Ophthalmology; Lions Aravind Institute of Community Ophthalmology.
19. The Royal College of Ophthalmologists (2012) *Ophthalmic Instrument Decontamination*. Available at: https://www.rcophth.ac.uk/wp-content/uploads/2014/12/2012_PROF_174_Ophthalmic-Instrument-Decontamination.pdf (Accessed: 6 June 2016).
20. Cox, I. and Stevens, S. (2002) *Ophthalmic Operating Theatre Practice: A Manual for Developing Countries.* London: International Centre for Eye Health.
21. Limburg, H. (2002) 'Monitoring Cataract Surgical Outcomes: Methods and Tools', *Community Eye Health,* 15(44), pp. 51-53

22. International Council of Ophthalmology Ethics Committee (2006) *An Ethical Code For Ophthalmologists: Ethical Principles and Professional Standards* San Francisco, California, USA: International Council of Ophthalmology. Available at: http://www.icoph.org/dynamic/attachments/resources/icoethicalcode.pdf (Accessed: 2 June 2016).

5. Record of amendments to this document

Page	Details of Amendment	Date amended
Entire document	Created	12/05/2012
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