The Royal Australian and New Zealand College of Ophthalmologists

# Contributing to International Ophthalmology Development

| | | | |
|---|---|---|---|
| **Approved by:** Board | | **Last review:** | 08/2016 |
| **Approval date**: | | **Version:** | 1.1 |

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 and Scope

To outline good practice guidelines by which a RANZCO Fellow can assess their contribution to international ophthalmology activities.

## 2. Contribution to International Ophthalmology Development Activities

Australian and New Zealand ophthalmologists, in a manner appropriate to their times, have a long record of considerable contribution to improving vision and eye health in developing countries. Traditionally, much of this has been provided through volunteer clinical interventions organised by individuals, religious groups and charities, and been limited to performing cataract and other surgery. However, latterly, coordinated by nongovernment development organisations in partnership with indigenous government and organisations, participation in integrated activities for the professional development of local eye care workers has become increasingly common.

This change in practice reflects a shift in philosophy. The charity model has been replaced by that of a "development approach". The move has been from doing activities for or on recipients in developing countries, to creating recipient capacity, choice and independence from long-term development.

### 2.1 Development Approach

RANZCO acknowledges both the Australian[1] and New Zealand[2] Agencies for International Aid's aims to support sustainable development in order to improve the situation of people living in developing countries. Both Australia and New Zealand are signatories to the Paris Declaration on Aid Effectiveness[3] and to the Accra Agenda for Action[3] which commit donors, partner governments and multilateral development organisations to undertake actions to accelerate progress towards the goals of improved aid effectiveness via reducing poverty and inequality, increasing growth, building capacity and accelerating achievement of the United Nations' Millennium Development Goals[4].

For health care, development often includes moving away from limited isolated clinical activities. However, there remains a place for specific specialist localised clinical needs-based interventions in some circumstances, particularly in small remote populations as occur, for example, in some Pacific island countries.

For eye care development projects in particular, the challenge is to bring together an amalgam of specialised skills and knowledge towards tailored and targeted inputs, to achieve desired sustainable outcomes. The specialised skills and knowledge involved needs to include:

- clinical activity, directed by evidence appropriate to low-resource settings, and performed to acceptable standards;
- human resource development;
- other resource identification and mobilisation;
- stakeholder negotiation and agreement;
- improved health policy and legislation;
- appropriate and sustained financing;
- effective ongoing advocacy; and:
- informed, transparent, accountable project planning, implementation, monitoring and evaluation.
- Furthermore, those involved in ophthalmic development activities should be aware that other development issues may affect their activities, including gender equality, child protection, human rights, and disability inclusiveness.

With its own literature, conferences and fulltime practitioners, the subspecialty of "International Ophthalmology" encompasses all of this and more, including: epidemiology; operational research to inform activities and systems; health promotion; disease prevention and control; population health; and integration of services, both primary and tertiary and all tiers into effective health systems.

### 2.2 Motivation for Involvement

In the past, for the individual ophthalmologist, the motivation for involvement in developing country activities has frequently arisen from recognition of personal privilege, a desire "to make a difference", and a wish for professional change and challenge, often at a time of mid and later career financial security. In the expectation of "doing good", any intervention has been accepted as "better than none". Sadly, this has repeatedly been shown not to be the case. Although the ophthalmologist may emerge with a sense of contribution and accomplishment, the following activities are examples of poor international development practices that should be avoided:

- activities that disrupt and distort local services
- creating unrequited patient expectations
- poor surgical and other outcomes unrecognised and untreated
- creating an increased and inappropriate workload for insufficiently trained local practitioners
- gifted out-of-date inappropriate medications and out-of-date unrepairable equipment

Motivations for occasional involvement in international ophthalmology activities remain as valid and strong today as previously. And, by taking an interest in and responsibility for eye health in any and all jurisdictions, acting beyond national borders, and ensuring a human right (being enjoyment of good health and wellbeing, with freedom from disability), practitioners fulfil the moral and professional imperatives of being an ophthalmologist[5].

### 2.3 Assessing Possible Assignments

As a general guide: the ophthalmologist should only choose to work in development projects that:

- follow the principles accepted principles of International Development[3, 4]
- are well-run projects managed by experienced, well-resourced, accountable, reputable development organisations that offer personal and professional support; and:
- require clinical ophthalmological knowledge and/or skills as acquired, developed and honed by ophthalmological training and experience.

Then, as ambassador to a developing country for her/his profession and professional bodies, the visiting ophthalmologist must strive to provide eye care and outcomes of the highest standard possible, as done at home.

So, how can the occasional practitioner assess a possible assignment to determine whether it might be a suitable vehicle by which to make a meaningful international ophthalmology contribution? Table 1 provides a checklist. It is no substitute for experience and insight. However, this checklist and familiarity with the American Academy of Ophthalmology publication "Before You Go"6 may assist ophthalmologists to maximise their impact. With this will come increased satisfaction: that of having helped create expectation, opportunity and choice, particularly by and for those most disadvantaged in developing countries and the local practitioners who will continue the ophthalmic care after the visiting ophthalmologists have left.

**Table 1:** Checklist for the assessment of development organisations, their projects and the assignments offered to developed-country ophthalmologists who wish to contribute to international ophthalmology / blindness prevention activities in developing countries

| **A. For the organisation:** | |
|---|---|
| **A.1 Identifies itself as a development organisation with commitment and experience in promoting sustainable eye care.** | This should be reflected in the organisation's mission (vision, purpose, objectives/aims, values) statement.<br><br>Occasionally involvement in emergency ophthalmic aid may be required after a natural or other disaster. Ophthalmologists should choose to work only with organisations with expertise in immediate crisis relief and aftermath care, and that adhere to relevant codes of conduct for such interventions. The principles and practice of emergency aid are different from those of development. However, many of the checklist items are still applicable and should be considered. |

| | |
|---|---|
| **A.2 Identifies itself as a part of the international development sector with commitment to recognized sector good practice.** | In Australia, the organisation should be a member of the Australian Council for International Development (ACFID), or at least a signatory to the Council's Code of Conduct[7]. This Code is essential reading for ophthalmologists considering involvement in international development (and emergency aid). Similar peak bodies and codes exist in other countries. |
| **A.3 Shows evidence of compliance with international development sector good practice** | The ophthalmologist should be satisfied that an organisation being considered demonstrates compliance with internationally accepted donor government requirements. For example, there should be:<br>• A legally constituted, transparent, accountable governance structure;<br>• Active mechanisms by which in-country partners and recipients have input into the organisation and its projects, and that there is accountability to these groups;<br>• Appropriate human resource, financial and other practices and controls;<br>• Accurate reporting of activities and audited finances (usually through an easily accessible annual report);<br>• Concordance between public claims made (particularly with respect to fund raising) and actual activities and outcomes acknowledgement of the cost of fundraising and administration, and that these are in line with sector norms for the activity undertaken;<br>• Non-profit status;<br>• Promotion of gender equality;<br>• Protection of the welfare and interests of children; and:<br>• Clearly defined complaints handling and resolution mechanisms for in-country recipients, partners, governments and workers, and developed-country staff, volunteers and donating and interested/informed public. |
| **A.4 Identifies itself as a part of the international ophthalmology/ prevention of blindness sector with commitment to recognized sector objectives and practices.** | The organisation should be a member of the International Agency for the Prevention of Blindness (IAPB)[8]. This international peak body, in partnership with the World Health Organisation, is responsible for a campaign to eradicate preventable blindness: "Vision 2020—The Right to Sight"[9]. Familiarity with Vision 2020 is essential for ophthalmologists considering involvement in international development. Alternatively, the organisation may be a member of a developed country Vision 2020 international eye care committee or developing country Vision 2020 coordinating committee. To confirm, contact your local Vision 2020 branch. |

| | |
|---|---|
| **A.5 Shows evidence of engagement with international ophthalmology / prevention of blindness sector, and contribution to improvement and coordination of sector activity** | The organisation's employees and volunteers should attend IAPB and Vision 2020 scientific and business meetings as appropriate (recognizing that smaller organisations may not be able to fund frequent attendance, and that contribution can often be made electronically). The organisation should encourage and facilitate the reporting in peer-reviewed journals and at scientific meetings of innovation in and monitoring and evaluation of its development work. This contribution to the evidence on which sector activities must be based should include failures as well as successes. |
| **A.6 Has a reputation among other international development and international ophthalmology / blindness prevention** organisations **for good practices and outcomes.** | Claims made by some organisations are not always accurate. It may be difficult for the occasionally participating ophthalmologist to discern when this is so. Much can be learnt from others in the sector, particularly full-time and long-term employees. |
| **A.7 Receives untied funding from government and large nongovernment agencies specializing in development and/or aid.** | An example is recurrent untied support provided by the Australian aid program of the Department of Foreign Affairs and Trade[1]. To achieve such funding, organisations undergo rigorous auditing processes to receive accreditation status. The ophthalmologist may therefore reasonably assume appropriate and satisfactory governance, administration and project practices if activities are funded by Department of Foreign Affairs and Trade, and if the non-government agency is an accredited agency. |
| **A.8 Values its workers and the contribution they make.** | An organisation that values its workers, whether employed or volunteer, or indigenous or expatriate, will:<br>• Provide a safe monitored work environment;<br>• Ensure workloads are appropriate and achievable;<br>• Encourage and facilitate staff feedback on all aspects of the organisation;<br>• Provide appropriate remuneration and benefits according to Sector and recipient country norms;<br>• Encourage and facilitate staff professional and personal development;<br>• Encourage and facilitate career progression;<br>• Monitor staff satisfaction;<br>• Encourage and facilitate staff collegiality; and:<br>• Likely have low staff turnover. |

| B. For the project: | |
|---|---|
| **B.1 Is governed by a well-considered and frequently consulted project document/ protocol** | The project document/ protocol should be made available to a prospective volunteer/employee ophthalmologist. It should provide no less detail than the following. That the project:<br><br>• Was planned and the document prepared with the full cooperation and agreement of capable in-country partner organisations, other stakeholders and participating individuals;<br>• Harmonizes with the policies and activities of government, other development organisations and other stakeholders in eye and health care both locally and nationally in the recipient country (perhaps as planned and coordinated through a national Vision 2020 or blindness prevention committee), to minimize duplication and maximize benefit (including strengthening of health systems beyond those pertaining to eye care);<br>• Has clearly enunciated achievable aims and objectives, with demonstrable ongoing benefit to recipients;<br>• Has a defined plan and agreed commitment (human, financial and other resources) by stakeholders to ensure ongoing sustainability of activity beyond the life of the project;<br>• Has evaluated possible harm that may be caused and risks to success, and has included harm and risk mitigation strategies;<br>• Precisely identifies human, financial and other resources required; states whether they will be provided by the organisation, partners or others; and provides evidence of their availability;<br>• Has an appropriate mix of local and external workers, and of skill sets, and sufficient time and other resources committed to make the work plan achievable;<br>• Has robust funded monitoring and evaluation of measurable outputs and outcomes as an essential integrated part of the work plan, and has a mechanism to share this information with workers, partners, other stakeholders and the sector more generally;<br>• Has an overseeing committee that includes representatives of the organisation, partners and other stakeholders; and:<br>• Has provision for ongoing refinement of activity, including as a consequence of input from in-country recipients and partners.<br><br>If the ophthalmologist is unsure or unable to judge the content of this document, then advice should be sought from elsewhere. If an organisation has followed good practice guidelines and is committed to transparent and accountable activity, then this should pose no threat. However, on occasion confidentially is required, in which case permission to share the document should first be obtained. |

| | |
|---|---|
| **B.2 Has secured competitive funding for implementation from a reputable funding agency** | Such financing is usually awarded only after careful scrutiny of a project by experienced evaluators anxious to maximise the impact of limited funds. However, this is not always the case. Even so, when a project is funded through a competitive process, the ophthalmologist may expect that it has been crafted with some care and is more likely to be satisfactory than not. |
| **B.3 Complies with in- country legislation, regulation, guidelines and expectations.** | Although the ophthalmologist will not be aware of any or all of the requirements for a particular country, some attempt should be made to satisfy her/himself that the project is appropriately embedded in the local context. Examples of what may be looked for include:<br>• Registration of projects and/or expatriate workers if required;<br>• Compliance with employment and tax legislation concerning local and/or external workers;<br>• Payment of import duty applied to equipment and supplies;<br>• Accreditation with training/educational authorities if activities and legislation require this;<br>• Professional registration for doctors and other workers;<br>• Compliance with or negotiation to change health service practices such as the limitation of scope of practice for some health practitioner cadres (which may, for example, prevent nurses performing peribulbar anaesthesia) or the prohibition of co-payment by patients for care (which may influence financial sustainability of activities);<br>• Use of appropriate medications (type, with regard to expiry date, storage, security and use by various cadres of worker) and equipment (type, maintenance contracts, insurance and security);<br>• Compliance with patient referral pathways and clinical/surgical activity guidelines; and:<br>• Accommodation of cultural expectations regarding health care and its provision. |
| **B.4 Is managed by experienced, competent, engaged and respected administrator(s).** | The ophthalmologist should be satisfied of the administrator's ability and application. The project's past and present workers will likely give valuable insight. The ophthalmologist's experience of university and hospital ophthalmic department administrators and of ophthalmic practice managers will provide a useful benchmark. |

| | |
|---|---|
| **B.5 Has clearly defined, transparent and functioning management systems.** | For the success of the project and the ophthalmologist's own protection, evidence should be sought of active:<br>• Financial controls;<br>• Stock (including clinical/surgical consumables, petrol and office supplies) management; and:<br>• Infrastructure (including clinical equipment, vehicles and buildings) maintenance and security systems. |

| **C. For the assignment:** | |
|---|---|
| **C.1 Has a mutually agreed documented position description** | At a minimum, this should include:<br>• A stated aim and objectives for the assignment;<br>• An explanation of how the assignment is essential to and integrated with the remainder of the project, and how it contributes to wider aims (for example, those of the government and Vision 2020);<br>• Measurable outputs and outcomes that are achievable in the time allocated;<br>• Specifics of how these outputs and outcomes will be monitored during and Evaluated at the end of the assignment;<br>• Details of project activities to be undertaken;<br>• Evidence of control of all resources (including staff) required to perform he assigned activities;<br>• The extent of authority and responsibility for project decisions made and resources controlled;<br>• Workers for whom responsible, their job descriptions, and how and when reporting will be required from those workers;<br>• Enumeration of any specific project activities not to be undertaken (essentially a documented scope of practice if required to clearly demarcate interaction with other workers); and:<br>• To whom responsible, and how and when reporting will be required to that/those workers.<br><br>The ophthalmologist must ensure that her/his knowledge, skills, experience, aptitude and interest are appropriate and sufficient to achieve the tasks required. It therefore behoves the ophthalmologist to ask her/himself:<br>• "Do I have the capacity to make the contribution required?"<br>• "Is this a contribution that creates maximum ongoing benefit from my time, knowledge and skill?"<br>• "Is this likely to be an experience I will find rewarding, with opportunities to learn as well as give?"<br><br>An assignment should only be accepted if the answer is "yes" to all three questions. Failure to do this will likely result in dissatisfaction by or with the ophthalmologist, and possibly assignment failure with actual and opportunity costs to the project and recipients. |

| | |
|---|---|
| **C.2 Has appropriate preparation and orientation prior to departure and on arrival in-country** | This may include:<br>• Orientation to the ethos of the organisation and how the ophthalmologist should act in order to be a satisfactory ambassador for it;<br>• Explanation of and seeking permission to perform personal checks on the ophthalmologist (which may include a criminal history check[10], contacting professional referees, obtaining evidence of good standing from a professional body and confirming appropriate current medical indemnity);<br>• A contract for services (although many organisations and ophthalmologists forego this for short volunteer assignments, preferring to rely on integrity and protection from other documentation);<br>• Detail of what will be provided by the organisation (which may include airfares, accommodation, meals and out-of-hours transport) and what the ophthalmologist is expected to provide and/or pay for (which may include medical indemnity, vaccinations, a personal first aid kit, meals and entertainments);<br>• Travel and work documentation requirements (most organisations will undertake visa acquisition, professional registration and the like for their workers);<br>• Advice about immunisation and other health issues such as malaria prophylaxis;<br>• Explanation of action to be taken by the individual and organisation if a personal health crisis occurs;<br>• Explanation of personal security issues, how the organisation protects the individual and the required behaviour and responsibilities of the individual;<br>• Description of circumstances (health crisis, natural disaster and civil unrest) that would necessitate evacuation and how this would be accomplished (including how insurance should be activated and by whom);<br>• Explanation of cultural practices and expectations in the destination country;<br>• Language tuition if required (perhaps only salutations and instructions required in clinical practice, such as "look down");<br>• Assisted entry to the project country, region or city (if required to navigate immigration, customs, embassy reporting or registration with local authorities);<br>• Assisted check-in to accommodation; and:<br>• Introduction to staff and familiarisation with the workplace. |
| **C.3 Provides an interpreter** | An interpreter is essential if the ophthalmologist is not fluent in the local language. 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. |

| | |
|---|---|
| **C.4 Has appropriate practices and standards for any clinical component** | The onus is on the ophthalmologist to ensure that any clinical component of the project:<br>• Uses appropriate well-maintained equipment (in the case of electrical equipment, protected by voltage stabilisers, with stand-by generators as required) and instruments;[11][12]<br>• Uses appropriate in-date medications and other clinical consumables;[11][13]<br>• Has documented clinical protocols adhered to for:<br>  ▪ adequate sterilisation of surgical instruments;[14]<br>  ▪ management of clinic, ward and operating theatre activities;[15]<br>  ▪ clinical pathways;<br>  ▪ clinical care[16] (with evidence-based minimum standards[17]);<br>  ▪ recording service data;<br>  ▪ recording and monitoring outcomes;[18]<br>  ▪ clinical audit;<br>  ▪ implementation of improvement suggestions arising from review of adverse outcomes; and:<br>  ▪ monitoring patient satisfaction.<br>• Protects and promotes patient well-being;<br>• Does not discriminate on the basis of ethnicity, age, gender, religion or inability to pay for services; and:<br>• Offers, if appropriate, supervised, in-service, sustainable, high quality training of local health practitioners. The training should be initiated and developed in such a way that clinical activity has fair prospect of continuing at a high standard beyond the duration of the assignment and project. |
| **C.5 Has a transparent complaints resolution process** | The ophthalmologist and all fellow workers must have access to this process. They must also be subject to this process and bound by its outcomes. |

| | |
|---|---|
| **C.6 Has appropriate formal debriefing at assignment end** | This should involve a two-way assessment/evaluation and comment by and of the organisation/project and the ophthalmologist. Fair appraisal with positive and negative assessments presented in a nonthreatening manner is essential. The aim should be best patient outcomes via continuous quality improvement of the organisation and its projects and workers, and of any future contribution the ophthalmologist may make to the same or similar projects.<br><br>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. |

## 3. References


1. Department of Foreign Affairs and Trade (2014) Australian aid: promoting prosperity, reducing poverty, enhancing stability Canberra: Department of Foreign Affairs and Trade. Available at: http://dfat.gov.au/about-us/publications/Documents/australian-aid-development-policy.pdf (Accessed: 07 June 2016).
2. 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).
3. OECD (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).
4. United Nations. Sustainable development goals: 17 goals to transform our world. Available at: http://www.un.org/sustainabledevelopment (Accessed: 07 June 2016).
   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. 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.
6. Australian Council for International Development (2014) Code of Conduct. Available at: https://acfid.asn.au/sites/site.acfid/files/resource_document/ACFID-Code-of-Conduct-vOCT14.pdf (Accessed: 30 May 2016).

7. The International Agency for the Prevention of Blindness. Member Directory. Available at: http://www.iapb.org/member-directory (Accessed: 10 June 2016).
8. The International Agency for the Prevention of Blindness. VISION 2020: The Right to Sight. Available at: http://www.iapb.org/vision-2020 (Accessed: 3 June 2016).
9. RANZCO (2013) Child protection policy Sydney, NSW: RANZCO. Available at: https://ranzco.edu/about-ranzco/our-organisation/policies (Accessed: 5 June 2016).
10. RANZCO (2012) Guidelines for Donated Items of Equipment of Consumables Sydney, NSW: RANZCO. Available at: https://ranzco.edu/about-ranzco/our-organisation/policies (Accessed: 5 June 2016).
11. 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.
12. Ramke, J., Du Toit, R. and Brian, G. (2006) 'An assessment of recycled spectacles donated to a developing country', Clinical & Experimental Ophthalmology, 34(7), pp. 671-676.
13. The American Society of Cataract and Refractive Surgery and The American Society of Ophthalmic Registered Nurses (2007) 'Recommended Practices for Cleaning and Sterilizing Intraocular Surgical Instruments', Journal of Cataract and Refractive Surgery, 33 (June).
14. Cox, I. and Stevens, S. (2002) Ophthalmic Operating Theatre Practice: A Manual for Developing Countries. London: International Centre for Eye Health.
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. International Clinical Guidelines. Available at: http://www.icoph.org/enhancing_eyecare/international_clinical_guidelines.html (Accessed: 5 June 2016).
17. Limburg, H. (2002) 'Monitoring Cataract Surgical Outcomes: Methods and Tools', Community Eye Health, 15(44), pp. 51-53.

## 4. Record of amendments to this document

| Page | Details of Amendment | Date amended |
|---|---|---|
| Entire document | Created | 12/05/2012 |
| Entire document | • Reviewed<br>• Minor changes throughout<br>• References updated | 07/2016 |