Ophthalmic medical assistants

Until sufficient numbers of eye specialists can be trained in Malawi, that country’s “OMAs” will continue to make a signal contribution towards eradicating avoidable blindness

by Moses C. Chirambo

A n acute shortage of skilled manpower in Malawi means that there is only one doctor for every 60,000 people, and one eye specialist for every 1.4 million people. Despite intensive medical training programmes, there is a high population growth of 3.2 per cent per annum so the doctor-patient ratio will not improve. Increasingly, therefore, health care leans on the use of paramedical personnel to fill many gaps. One of those gaps is the staffing of static and mobile eye clinics.

Ophthalmic services in Malawi began in 1956 when an eye unit was established at the Church of Scotland Mission hospital in Blantyre, with 12 beds allocated for medical and surgical eye patients. Two years later the Queen Elizabeth Central Hospital opened, and in 1963 an eye department consisting of a 54-bedded ward and an out-patient clinic was established in the hospital. Its staff consisted of an eye specialist backed by medical assistants and nurses.

Today there are three eye departments staffed by five eye specialists, ophthalmic clinical officers, medical assistants and nurses.

Malawi has large numbers of people blind from preventable and curable causes, and this poses public health, social and economic problems. Unable to work for a living these blind people remain a con-

Graduation day for a new class of ophthalmic medical assistants in Malawi.

Photo Malawi Ministry of Health
Ophthalmic medical assistants

and refraction, diagnosis and treatment including extra-ocular surgery, but also the theory and practice of primary eye care as an integral component of primary health care.

When the course ends, the OMAs should be able to: diagnose and treat common eye diseases in Africa within the limits of their training and equipment; give maintenance therapy to patients with chronic eye diseases or post-operative cases, and assist in distributing aphakic and presbyopic spectacles; perform basic therapeutic and extra-ocular surgical procedures, and render first aid in eye emergencies; participate as a team member in promoting the eye health of the community through health teaching, sanitation and control of communicable diseases; administer a mobile eye unit, including maintaining equipment and ordering drugs and supplies; supervise and give comprehensive care to hospital patients; give treatment and advice on eye health matters (including nutrition) to mothers and young children.

Most OMAs are posted to district hospitals where they set up small static units for eye care. Some are retained at the central hospitals, and a few are assigned to mobile eye units. Since 1969, there have been eight training courses—four in Blantyre and four in Lilongwe.

In the outlying units, most OMAs are allowed to set up their eye clinic in a room that can be darkened as necessary. They receive diagnostic and surgical instruments on completing their training. The work of the units at the district hospitals consists primarily of diagnosis, treatment, patient referral and health education.

Cataract is by far the most common cause of blindness in Malawi, and diagnosis presents no difficulty to the OMAs. They refer cataract patients to eye specialists for surgery when there is bilateral blindness, or unilateral blindness with progressive cataract in the other eye.

Chronic open-angle glaucoma is a more difficult problem for early diagnosis. Patients nearly always come for treatment at advanced stages of optic nerve damage—except for a small number of informed patients who have noticed early signs of transient blurring of vision. The OMA initiates treatment with drugs to reduce the tension, if necessary, then checks on progress every three months. The visiting eye specialist decides whether surgery is needed.

The OMA treats red eyes and trachoma with tetracycline ointment and vitamin A deficiency with capsules on a regular basis; unfortunately many cases are complicated by inappropriate traditional medicines which may cause scarring of the cornea. Indeed having eye health care available on the spot is a most effective form of health edu-
cation and prevention because it deters the local population from resorting to uninformed traditional healers. The OMA assembles the out-patients waiting to be examined and gives them short talks on eye health, emphasising the dangers inherent in using traditional medicine for the eyes. The role that measles and malnutrition play in causing keratomalacia (vitamin A deficiency) is illustrated with picture posters. All these activities help to prevent severe blinding conditions.

Mobile eye units

The mobile eye units make a very important contribution to both curative and preventive eye health care. There is one for each of the three regions, and the ophthalmic medical assistant is responsible for their management.

Their activities include treatment of eye infections on the spot, health education, registration of blind persons, and referral of cataract cases and other complicated cases for specialist care.

Before the visiting eye clinic takes place at a health post or centre, or in a village street, a lecture is given on preventive eye health. Eye patients are urged not to use traditional medicines, because of the risk of corneal damage, and are advised instead to seek help at one of the health centres. The importance of personal hygiene in preventing eye infections is also stressed.

The mobile eye units distribute drugs and equipment to district hospitals and health centres. But the costs are high, so motorcycles are being used by ophthalmic medical assistants and health surveillance assistants in areas where there is a high prevalence of eye diseases and blindness.

What is the response of the local population to conventional medical and surgical treatment? In the early stages, it was hard to overcome the accepted practice of seeking help from traditional healers. In many rural areas, he is still regarded as the man who gives the best and "strongest" medicine. The great numbers of blind cataract patients who return to their villages with their sight restored after successful surgery provide convincing proof that good treatment can be provided at the hospital, but this has not yet appreciably reduced the reliance on traditional healers.

Training ophthalmic medical assistants to provide eye care within the primary health care services has proved effective in reaching the remote country areas where over 80 per cent of the population live. For years to come, certainly until health services reach the stage where sufficient numbers of eye specialists will be available in Malawi, the OMAs will make a significant contribution towards eradicating avoidable blindness.