## Stamping out blindness

To the Editor: The South African Post Office for the first time joined forces with the rest of the world to create awareness of blindness and its prevention by issuing a stamp and commemorative envelope on World Sight Day (13 October 2005). The SAPO releases stamps on diverse themes each year, and as both ophthalmologist and enthusiastic philatelist I persuaded them to issue a stamp with the theme of prevention of blindness. It was unveiled by the CEO of the SAPO at a function held at Nelson Mandela Academic Hospital Complex in Mthatha on 14 October 2005.
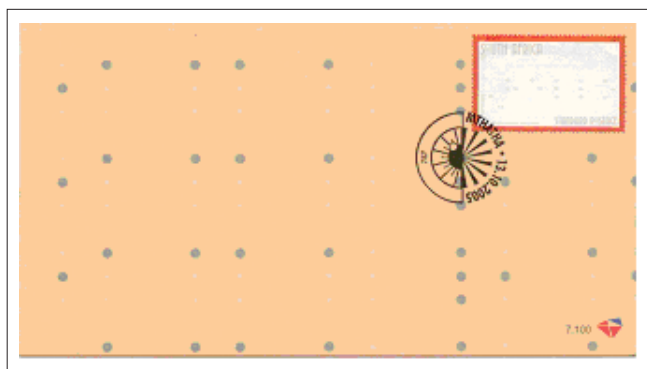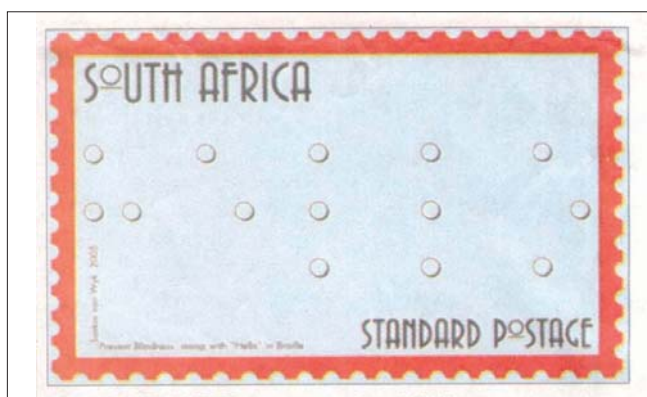
Designed by Saskia van Wyk and described as the most stylish ever to have come from the SAPO's philatelic department, the stamp is minimalist with only a coloured outer frame and white inner area. The word 'Hello' is embossed in Braille.

During the same period, the Department of Ophthalmology at Nelson Mandela Academic Hospital also organised a Cataract Blitz, which was supported by the Bureau for the Prevention of Blindness and the Lions Club of Mthatha and sponsored by Pick 'n Pay and the Rotary Club of Kempton Park. Two hundred and eighty free cataract operations were performed. Minister of Health Dr Manto Tshabalala-Msimang lent her support to the Cataract Blitz, and the MEC for Health (Eastern Cape) Dr Bevan Goqwana presented long-service certificates to staff in the Department.

Juzer Surka
Professor and Head
Department of Ophthalmology
Walter Sisulu University and
Nelson Mandela Academic Hospital
Mthatha, E Cape

Improving the quality of cause-of-death statistics in South Africa – some practical steps

To the Editor: The national statistics office, Stats SA, has come a long way from manual processing of cause-of-death data and publishing the underlying cause data after a lag of 5 years. Stats SA has now succeeded in accomplishing three remarkable goals: (*i*) coding of causes of death using the latest World Health Organization (WHO) classification (*ICD-10*), (*ii*) production of multiple-cause data; and (*iii*) use of automatic coding in selecting the underlying cause of death. All these achievements help to improve the timeliness of cause-of-death data, to ensure international comparability, to reduce errors in the selection of underlying cause, and to preserve the wealth of cause-of-death information available for each reported death.

However, as previously discussed in this *Journal*, a closer look at the cause-of-death data shows that the quality is mediocre. As the adage goes, recognition of the problem is the first step towards solving it.

Improving the quality of cause-of-death data rests on two central pivots, namely targeting physicians and targeting the civil registration/vital registration (CR/VR) system.

In targeting physicians, one of the short-term strategies to be adopted is to mount CPD courses on the scope of *ICD-10* and the proper completion of the death notification forms. The physician does not need to know the *ICD-10* codes but rather how the causes of death have to be written and sequenced in order to reduce ambiguity at the coding stage and arrive at a clear code. This training should include a component on how 'leading causes of death' are arrived at and their policy implications. Miscoding of a cause of death could lead to reduction in its rank among other causes of death. In the long term, the content of CPD courses should be included in the curricula of medical schools. Another long-term strategy is to encourage physicians to relocate to rural areas. Since about half of deaths take place in rural areas and many such deaths are not properly certified, encouraging physicians to relocate to rural areas will not only help to improve health status in those areas but will indirectly help to improve quality of certification. This is being partly addressed by the existing community

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service programme for graduating physicians. However there is room for imaginative incentive programmes to retain physicians in rural areas such as the one adopted in Ontario, Canada (**http://www.oma.org/cme/**)

In targeting the vital registration system, the statistical organisation should activate and formalise the dormant medical assessor and querying systems. The automatic selection of underlying cause of death does not work for all cases. Some cases are rejected by the system. Such cases could be queried with physicians and/or referred to the medical assessor. In Australia, the Australian Bureau of Statistics (ABS) has an in-built query subsystem in their cause-of-death processing system. In that subsystem, information from rejected forms is automatically outputted onto a standard form and posted to the relevant physician for querying.

The statistical organisation should be encouraged to conduct periodic evaluation of internal consistency among medical coders and undertake occasional external review of all steps of the coding process.

Further, the statistical organisation should be encouraged to continue strengthening in-house and external training of nosologists and place value on long service. Good-quality nosologists are very hard to get and the available ones should be valued and used to train new recruits.

Lastly, the statistical organisation should be encouraged to make full cause-of-death data available to researchers as done elsewhere. Limited demographic information on cause-of-death data can only lead to limited analyses. Researchers need to get all the non-confidential information (everything else beside name, ID number and physical address) in order to pinpoint the problem areas in data quality and do further analysis on the data.

Sulaiman Bah

Department of Epidemiology
University of Limpopo
PO Box 215
Medunsa
0204

Myths, magic and medicine

To the Editor: I found your editorial with the above title[1] extremely interesting and thought-provoking. Indeed, patients in virtually every health care discipline consult such providers