

Sith Sam Ath



Ms Yang Samphors, a village health volunteer, examines a woman during outreach screening in Kampong Chhnang Province. CAMBODIA

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Patients are registered during the outreach screening at Vien Health Centre. CAMBODIA

40 to 50 per cent actually attend for surgery. The reasons for this appear to be similar to the key barriers described above. While outreach screening can result in a disappointing proportion of referred patients attending for surgery, it provides the opportunity to address some of the problems at their source. These activities help to create understanding about the nature of curable blindness, address concerns about cost and the need for caretakers to accompany patients to hospital, and dispel fear of the operation. The outreach screening is a good forum for addressing people's concerns, although it is important to ensure that there are enough resources available to give this the time it needs during a busy outreach session.

Financial subsidy for surgery (and often for other associated costs such as transport and food) is necessary to obtain a good 'yield' of referred patients. In many people's minds, there is a link between eye camps run in collaboration with an NGO and the opportunity for free surgery. Free surgery might also be provided in the context of World Sight Day or other advertised periods.

Hospitals often have a degree of flexibility in fees charged as part of a cost recovery system, and they often work in co-operation with the eye unit staff or community rehabilitation bodies in administering this.

Training village health volunteers in primary eye care and screening for cataract facilitates the screening process. In one case, the Chief of Training of the hospital has taken on the role of teaching the village volunteers and conducting outreach screening with them. In another case, the eye unit returns

a subsidy of one dollar to the village volunteers for each cataract patient referred. **Involvement of satisfied patients** has also been tried. One doctor makes it a practice to have a person in the screening area who has had successful cataract surgery; the satisfied patient can then explain the process and encourage others to have the operation.

Reducing the fear of the cataract operation

As mentioned earlier, one approach to reducing fear is to allow enough time and resources during outreach activities for discussion with people. In any communications about cataract, the words used can make a difference. For example, one unit has found that words such as 'surgery' and 'hospital' create fear, while words like 'remove the cataract' create more confidence.

One well-established way to reduce patients' fear of surgery is the use of 'ambassadors'. These are people who have had successful cataract surgery. They are urged to talk to people who are blind when they return home and to encourage others to receive the same benefits as they have.

One doctor takes this one step further by telling patients, after a successful first eye, that he will only do the second eye if the patient brings another cataract patient along with him!

Establishing a personal relationship of trust is the key to reducing fear of surgery in the patients. All this knowledge and information will be of little value if the patient does not understand or trust the medical staff.

Overcoming the barrier of the lack of a caretaker to accompany the patient to hospital requires consideration. Two creative ways to help with this have been:

- arranging for several people to come to the surgical unit together, sharing a relative or a village neighbour as a caretaker
- when a person is in hospital without someone to care for them, the hospital social services or the NGO can arrange for someone to be the caretaker.

The NPEH contributes directly to **improving community knowledge of eye health and available services** by:

- broadcasting on radio/TV spots in the whole country
- distributing posters and leaflets about eye diseases to eye units and health centres
- advertising through the medium of TV, based on interviews with ophthalmologists
- using screening camps to increase knowledge of eye care.

Conclusion

Barriers to the use of cataract services will only be removed with time, community education, and reduced poverty. In the meantime, quality medical care, delivered in a way that is sensitive to the needs of the patients, and returning good outcomes to the community, will form the basis of better uptake of cataract surgery in the future.

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Increasing an existing



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Background

Community-directed treatment with ivermectin (CDTI) is the main strategy of the African Programme for Onchocerciasis Control (APOC). It has enabled the programme to reach remote and underserved communities where onchocerciasis is endemic. With CDTI, the community is involved in key decisions about how the drug is distributed and selects the distributor. In this way, a relationship of trust is established between provider and beneficiary. This provides an entry point for expanding activities dedicated to the prevention of blindness.

Christian Blind Mission International (CBMI) began working with the government of Nigeria in 1995 on their onchocerciasis programme. In 2003, this collaboration was broadened to address the prevention of blindness. The structure provided a way to reach the people living far from eye care facilities (in many states, these facilities exist only in the urban centres). In addition to strengthening the eye care services, efforts were made to create awareness and a demand for cataract services amongst rural dwellers. The programme described in this article aims to organise outreach programmes in northern Nigeria and falls within the authority of the Ministries of Health of the states of Kano, Jigawa, Yobe, Taraba, and the Federal capital territory, Abuja.

Outreach centres and services provided

In each state, at least one outreach activity is held every year. Each state chooses a suitable site to reach as many people as possible.

In 2004, a total of 632 eyes with blinding cataract were operated; this figure increased to 768 in 2005. In 2006, between January and July, 1,920 eyes with blinding cataract have been operated. In all these cases, an IOL was inserted.

During these outreach camps, trained

Figure 1. Map showing the states where CBMI works with the Ministries of Health



the use of cataract services: using eye care structure in Nigeria

ophthalmic nurses also attended to trachoma trichiasis patients. This supplements the regular eyelid surgery camps organised by the states. More than 500 eyelids with trachoma trichiasis were operated in 2005.

All the patients operated during outreach activities are reviewed at the site of the outreach. They are asked to return to the clinic one week after discharge, and again after six weeks. If there is any problem, they are asked to return immediately. Similarly, if the patients run out of medicines, they are advised to go to the clinic and not to wait for the appointed date. In certain cases, the ophthalmic nurse travels with the patient from his or her area to ensure proper follow-up.

Using the river blindness control structure to create demand for cataract surgery

The CDTI structure is used for the distribution of ivermectin (Mectizan®) drugs to all community members in the endemic areas. Since the distributors are volunteers selected by the communities, and reside within the communities we found that, with additional training, they could take on additional responsibilities. They attended a two-day primary eye care training programme, including one day of field practice, on how to recognise and refer preventable or curable eye diseases prevalent in the communities.

This category of workers has been helpful in identifying cataract patients and referring them for surgery during the outreach programmes. They undertake the following activities:

- creating awareness about cataract blindness among the rural dwellers, using local languages
- identifying the cataract blind persons during annual house-to-house distribution of the drug
- informing the local government co-ordinator of the blindness prevention programme about the number of cataract blind persons identified in each village
- educating the clients about modern treatments, which yield better results, and discouraging them from accessing the traditional couching technique for cataract, which is widely used and dangerous
- informing the clients of the costs of the operation; this is usually shared between the patient, the local government area (LGA), the state government, and CBMI, so that the individual is expected to pay only what he or she can afford
- breaking down barriers to the uptake of such services; this is achieved by reassurance, by escorting patients to the venue of the surgery, and by ensuring that all is accomplished properly. In this way, results will speak for themselves, persuading even the

pessimists in those communities

- reminding the clients to go back for periodic review (post-operative care).

Roles of partners in the outreach programmes

The Ministry of Health organises the outreach programme. Its role is also to:

- create awareness by linking up with the LGAs and communities
- screen all cataract blind patients to identify those to be operated
- provide the facility and power source for use during activities
- provide hospitality for the team
- participate in operating (where they have an ophthalmologist)
- determine the outreach centres
- ensure LGA and community involvement
- plan annually for regular and consistent visits to outreach centres.

LGAs are directly responsible to the people in the communities. Their role is to:

- provide the necessary publicity
- provide mats and money for food during the eye camps; this applies to those instances when the LGA has directly sponsored camps to be organised in its domain
- participate in all activities before and during the outreach.

The community members with eye problems:

- use their own resources to reach the site of the outreach
- provide for their own subsistence over the number of days they will spend at the surgical camp site.

The host community:

- mobilises volunteers for crowd control and to assist in carrying patients to and from the theatre.

Influential individuals and groups

contribute to the success of the camp by:

- organising some of these programmes
- directly sponsoring patients
- allowing their houses to be used by the entire team.

The international organisation, CBMI, provides the surgery team, usually from CBMI-assisted eye projects, to perform the operations during the outreach programme. The team works to ensure the following:

- advocacy and dissemination of information before the arrival of the team
- patient satisfaction with the services provided
- maximum output during outreaches
- minimum waiting period for the patients
- judicious use of time and facilities
- effective use of the personnel
- availability of equipment and consumables
- affordability of services so that no willing client is denied the services.



Outreach surgery camp in progress. NIGERIA

Cost-sharing and sustainability

Patients are expected to pay some amount for the cataract services that they will receive, which will depend on the cost-sharing formula chosen for a particular outreach. In determining the cost that patients are to pay, consideration is given to the very poor, poor, and rich patients. In most cases, the majority of beneficiaries are poor. This makes it very difficult to establish a dividing line to categorise or segment the payment. Subsidy is provided across the board to enable patients to take up the services. In a few instances, full sponsorship helps very poor patients to benefit from the operation free of charge.

Outcomes and lessons learnt from outreach activities

We have noticed some positive developments arising from outreach activities. For example, states are identifying personnel to be trained as ophthalmologists, so as to fill this gap in human resources. In several states, individuals and organisations have sponsored cataract surgery camps for the benefit of community members: in 2005, more than 500 cataract blind patients were beneficiaries under such gestures.

The main challenges we have faced are:

- poor mobilisation in areas non endemic for onchocerciasis, leading to poor utilisation by patients
 - lack of steady supply of electricity
 - inadequate logistic arrangements
 - free eye camps threatening the sustainability of permanent eye hospital services.
- How have we coped with these challenges?

Firstly, an advance team from the VISION 2020 Support Programme arrives at the camp venue to ensure that adequate mobilisation and effective arrangements are made before the arrival of the surgery team. Secondly, plans are underway to procure a stand-by portable generator to complement the ones provided by the states during eye camps.

Conclusion

This case study demonstrates how eye care services have been extended by using the entry point of an existing prevention of blindness infrastructure. This was facilitated by a productive relationship between the state government health authorities and an international organisation.