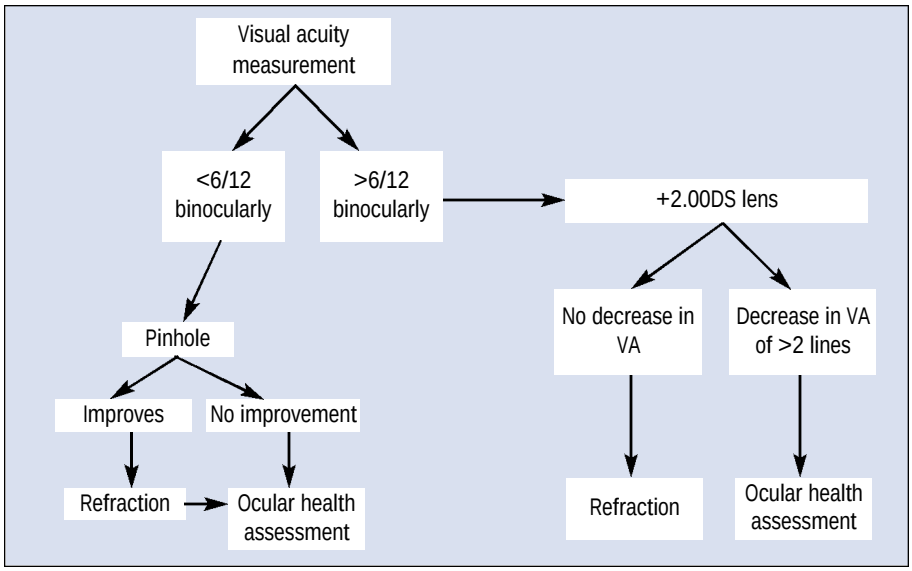

Fig. 2: Screening Children in an Eye Clinic

- Patients with occupational and special needs experiencing better visual acuity with the pinhole
- Patients who are presbyopic.

2. Children

- All children failing the Snellen test (<6/12 binocularly) (Figure 2) but improving with the pinhole test
- Children with better than 6/12 vision but with no blurring of vision with a +2.00D lens
- Children who present with symptoms consistent with refractive error
- Children with tropias.

Screening: False Referrals

Given the percentage of false referrals, children referred for ocular disease evaluation should be referred from the ECP for refraction should no ocular disease be detected.

Malingerers

Malingering could indicate behavioural and other problems or just a desire to wear spectacles and be like parents or friends.

Children failing the Snellen test and showing no improvement in visual acuity could, in fact, be malingerers. Retinoscopy, with cycloplegia, is the best method to determine if a refractive condition exists.

The REWG recommends that children be considered myopic or hyperopic based on the following criteria:[3]

- Myopia: ≤ -0.50D
- Hyperopia: $\geq +2.00$D

Tests for malingering may also use the following techniques:

- Put plano lenses into the trial frame and observe any improvement
- Move the child closer to the chart and then take visual acuity. No improvement indicates malingering.

General Comments

Children with binocular vision of 6/12 or better, with a visual acuity difference between the two eyes of more than two lines on the chart, should be referred for a refraction as amblyopia is a consideration.

If patient numbers are low, the screening protocol could be applied for all patients attending the hospital or clinic, not just the eye clinic patients.

Conclusion

There is great variation in the availability of resources from region to region and country to country. Should the appropriate resources exist then consideration should be given to the 'lowering' of the referral criteria.

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Review Article

Case Finding in the Community: Experience of Jatiya Andha Kallyan Somiti in Comilla, Bangladesh

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Bangladesh, one of the largest and most densely populated countries of the world, has a population of 130 million, with 80% living in rural areas. The National Blindness Survey, 1999-2000, indicated that the prevalence of blindness in the adult population aged 30 and above is 1.04%, of which more than 85% is due to cataract. Eye care services, either Government or private care, are not available to the people of rural areas due to inequitable distribution of services, physical and geographical inaccessibility and financial limitations. Jatiya Andha Kallyan Somiti, Comilla, Bangladesh has developed comprehensive eye care services with financial and technical assistance from Sight Savers International (SSI) and has been providing the following modules of services, beginning in 1994.

New spectacles!

Photo: Murray McGavin

Module -1: Hospital Surgery
Module -2: Eye Clinics
Module -3: Under – 5 Clinics (1996–2000)
Module -4: Community and Patients' Screening Programme Activities
Module -5: Community Based Rehabilitation (started in 2000)

Currently, only a few District Hospitals in Bangladesh provide eye care services, whereas the need is incredible. Present data on blindness in Bangladesh, taken from the National Blindness Survey, 1999-2000, indicate that the causes of blindness in people aged 30 and above are as follows:

How Community Eye Care Services were Planned

Understanding the fact that most people live in rural areas where the services are either scanty or absent, the eye care programme of Jatiya Andha Kallyan Somiti was developed in such a way that the rural population could have easy access to quality services. The following were the major planning principles:

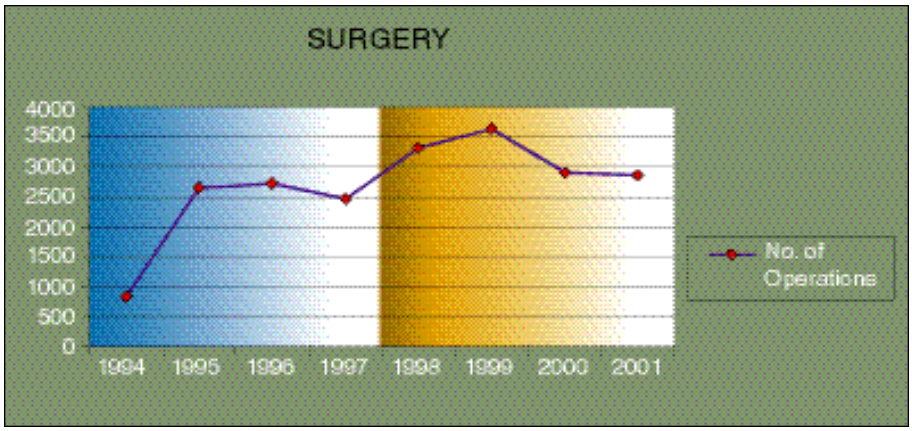
- **Efficiency**: Maximum utilisation of limited resources available to Jatiya Andha Kallyan Somiti, Comilla, Bangladesh, reducing wastage, and avoiding duplication
- **Effectiveness**: Developing the best course of action to accomplish the project goals and objectives in the light of social needs in rural Bangladesh
- **Quality of care**: Offering the best standard of care possible in Bangladesh
- **Equity**: Well distributed services and at a cost that people can afford.

From the above planning principles it is clear that there are two major areas in this eye care work:

- Awareness raising
- Patient screening programmes and surgical interventions.

Both of these require active and strong community participation.

In our Modular Eye Care (MEC) Programme we have successfully encouraged community participation in various ways. Community participation has not only allowed us to achieve our objectives, it has also achieved a significant and sustainable impact through our work, by creating informed communities who are aware of eye health care.



Background to the Modular Eye Care Programme

Before our Modular Eye Care Programme was launched, Sight Savers International funding was available for eye camps in the community, where cataract operations where performed in rural areas. Programmes generally did not educate people, particularly the clients, on follow-up care; what to do in case of emergency, for example, in respect of infection and communicable eye disease; how to prepare a balanced diet with cheaply available vitamin-A rich food for their children, or how to develop a kitchen garden to grow nutritious and vitamin-A rich food stuffs, etc. All the ophthalmologists were urban based, and so eye care in rural Bangladesh was in the hands of traditional healers. They used to provide treatment for cataract through couching which caused blindness for many helpless and poor people.

The other groups active in the field were service clubs, many of which held eye camps on a commercial basis. The poor, rural cataract patients were the worst affected, as much of the cataract surgery was sub-standard. Most damaging was the absence of post-operative services for the patients operated on in eye camps and many became blind due to post-operative complications. We have treated many eye camp patients like this at our Hospital's outpatients' department (OPD).

The provision of post-operative care for the patient is not only essential for good service delivery, it must also be viewed as an individual human right. Eye camp organisers generally did not offer proper post-operative care. Why was this the situation?

- People were not properly advised or educated
- They were not aware of their needs
- They were not informed as to how they should maintain their eye health
- People are poor and totally unaware of their rights.

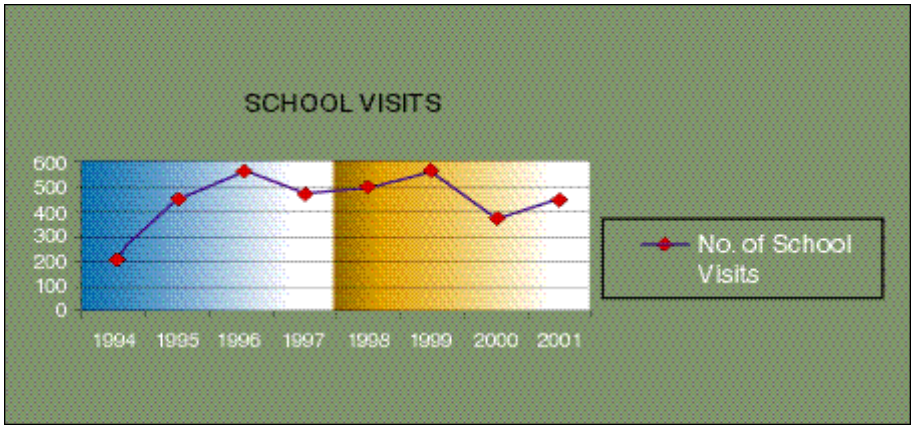
There are several other reasons why we need to educate poor communities about eye health care. Therefore, the need for community participation and education can never be underestimated. It is interesting to note, in this context, that people do not spontaneously access the facilities even if these are taken to their doorsteps.

Community Level

1. ***What are the services?***

Awareness raising activities:

- Informing the community about preventive eye care
- Informing the community about service provisions
- Referral for treatment.



Motivational activities:

- Encourage the utilisation of eye care facilities
- Remove fear about surgery
- Offer IOL implantation
- Establish linkages (and referral) with service facilities.

2. *Who will deliver the services?*

- Health Assistants
- Family Welfare Assistants
- Others (NGO workers).

3. *How should the services be delivered?*

Health Assistants:

- Group counselling during EPI (Expanded Programme of Immunisation) and 'diarrhoea' camps
- Interpersonal counselling
- Flip chart.

Family Welfare Assistants:

- Group counselling during door to door visits
- Interpersonal counselling
- Flip chart.

4. *What are the training needs?*

- Orientation about primary eye care needs
- Dissemination of information about eye care
- Motivational techniques.

Community Services

PSP: Patients' Screening Programme (Outreach Clinics)

- Organise and conduct PSPs at pre-planned venues within the programme district
- Offer treatment to patients with minor eye problems
- Identify patients who need surgical services and refer them to the Base Hospital for surgery.

The total number of patients treated from 1994 to 2001 was 453,220 – as outpatients at the community level. The total number of operations done during the same period was 21,452. Of these, about 99% of cases were for cataract surgery.

During 1994-1995, a Medical Officer visited each satellite centre once a week. There were two Community Workers in each satellite centre. Gradually we felt the need of earlier intervention to prevent blindness, by serving the under - 5 children in the satellite centres. In late 1995, we decided to change our programme and include under - 5 clinic services. From the beginning of 1996 we posted a permanent medical team in each satellite centre and our Medical Officer started attending the centres 6 days a week. Unfortunately, we have not been able to continue with satellite centres beyond 2000. However, we are continuing the PSPs in 10 Districts and through this we offer services to 9 million people.

School Sight Testing

- Conduct sight testing programmes in all schools within the community in order to identify children with refractive errors and refer them to the PEC centre/ MEC base for treatment/ surgery
- Disseminate health and eye care knowledge among the school children
- Motivate school teachers to act as volunteers - to make the community aware of the services offered by the MEC programme and encourage them to use the services.

In school sight testing programmes we tested about 192,384 students and 11,914 students were referred to patient screening programmes (PSP), mainly for the correction of refractive error.

The school teachers were only familiar with EPI for the children. They had no idea about the need of sight testing and primary health and eye care knowledge. After hearing about blindness prevention activities from our community organisers, the teachers have gradually shown interest in our programmes. It is gratifying to note that now the teachers are inviting us to give more lectures and conduct sight testing programmes.

Counselling Sessions, Community Group Meetings and Other Activities

- Organise and conduct discussion, motivation and counselling sessions for the people/ patients at the OPD of the Base Hospital and Rural Centres
- Organise and conduct village/community level group meetings in order to disseminate information on eye health care, general health care, food, nutrition, etc., and for better health care and motivation of people to use the eye care services
- Develop a trained volunteer core in the rural community as auxiliary forces to stimulate community participation and supplement work in the community
- Networking with local community groups, e.g., literacy classes for women.

In our country, people are used to attending meetings for political, religious or credit programmes. They had never thought of eye care group meetings. Initially they were unwilling to come to the counselling sessions and tried to avoid them. Soon, however, they realised the importance of eye care messages given in the sessions and were actively working to organise more sessions in the villages. It was also observed that the women were shy to attend such meetings. The personal and effective motivation by the PEC organisers encouraged village men and women to show interest in the group meetings. The flip chart on primary eye and health care, prepared for use in the group meetings, also broke the monotony of the lectures delivered by the workers. In many cases, established community groups, organised for rural micro-credit schemes, were utilised to save time and avoid duplication of effort where possible. In some cases we were supported through the help of Ansars (cadre of auxiliary security forces) and village defence police (volunteer core organisation). They required training in basic knowledge of eye care.

A total number of 126,887 people attended these meetings to improve awareness about eye care.

Conclusion

Motivational work is required to increase the accessibility of services to the rural people. Who will do it? Can an 'outsider' (not belonging to the community) do it? It is not possible. This requires community help and intervention by the community leaders. Those people who are unwilling to access the services, inmost caseswill listen to their community leaders. In our experience, therefore, the most effective way to improve accessibility for the people is the intervention of the community leaders.

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