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Linking people with eye care. VIETNAM

Hannah Kuper/ICEH

Outreach: linking people with eye care

EDITORIAL

Dan Ward
Eye Care Manager, CBM Regional Office, East 1,
PO Box 58004, Ring Road Westlands, Next to Ukay Center,
00200, Nairobi, Kenya.

Several years ago, I had the opportunity to accompany a team from an eye hospital as they went to several locations on what they called 'outreach'. The primary purpose of these trips was to identify operable cataract patients. Many people attended these outreach clinics, but they identified very few cataracts. The second day, I made friends with a couple of primary school children and explained to them that I wanted to find some people who were blind. I asked them to take me through the village to find these people. With the help of these children, I found five blind people, three with operable cataracts. None of these ever came to the 'outreach clinic'. From that day on, I was convinced that we needed a new paradigm, new ideas in order to connect these people with services. Some of the major barriers for blind people are actually within the first 100 metres of their front door.

Service delivery in prevention of blindness is usually based on two different models. The first model focuses mainly on making eye care **accessible** to as many people as possible. This model is best employed in the urban areas of a country, where there are sufficient eye care professionals, but many of the poor cannot afford eye care from their small household budgets due to the high cost of services.

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Editorial Office
Community Eye Health Journal
International Centre for Eye Health
London School of Hygiene and Tropical Medicine,
Keppel Street, London WC1E 7HT, UK.
Tel: +44 207 612 7964/72
Fax: +44 207 958 8317
Email: Anita.Shah@Lshtm.ac.uk

Information Service
Sue Stevens
Email: Sue.Stevens@Lshtm.ac.uk
Tel: +44 207 958 8168

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Establishing high-volume reputable eye hospitals in these areas can reduce the cost of eye services to a level that is affordable for most of the population and leads to a sustainable service. There should be no need for outreach in these areas if this works well. In fact 'outreach surgical camps' in these areas undermine the viability of these sustainable services.

The second model focuses on making eye care **available** to people in need who live far from eye care professionals. These communities are isolated, suffer frompoor infrastructure, and a low-density population, which prohibits the establishment of a high-volume surgical unit. However, there are many people in need of eye surgery in these areas and we need to plan how to reach them. It is in this setting that outreach can be used most effectively.

In my experience, the most effective way to reach these communities has been to train and integrate primary eye care workers into the existing primary health care systems. Ideally, a resident of these communities is identified and trained for this work – what most projects call a community-based rehabilitation (CBR) worker. These primary eye care workers are best placed to penetrate the 100-metre barrier that exists around a blind person's home.

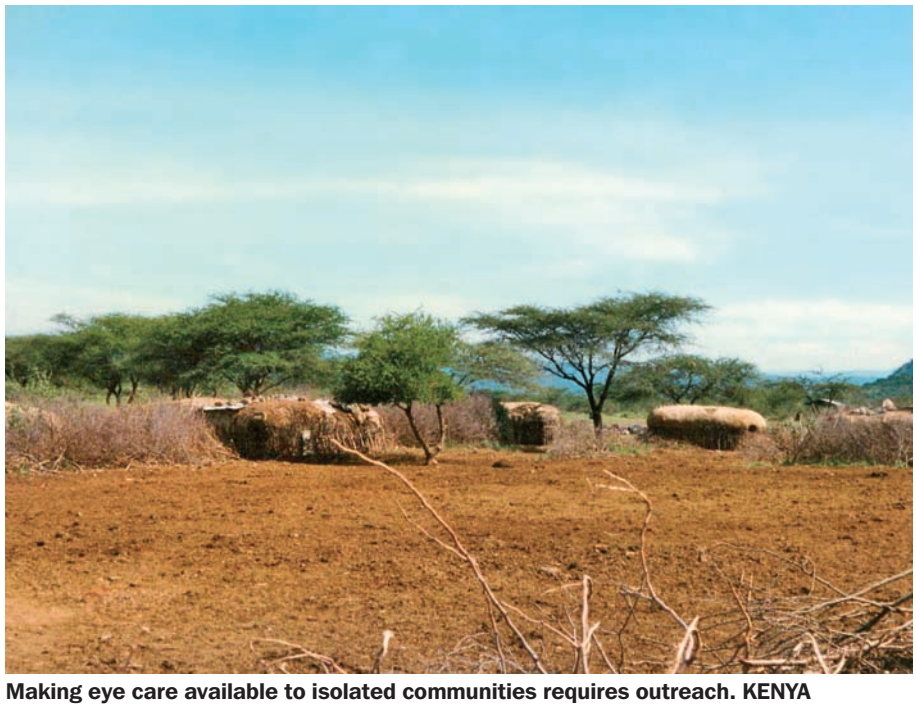
Many rural-based projects conduct what they call 'mobile clinics' in order to bring primary eye care to scattered, isolated communities. One should be careful not to confuse the terms 'mobile clinics' with 'outreach'. Mobile clinics should be a permanent strategy used by rural projects to make eye care available on a well-known and regular schedule to remote communities. It is part of their day-to-day activities for their catchment area. Once they have identified a sufficient number of patients who need specialised services, the decision

Victoria Francis

Establishing high-volume eye hospitals in urban areas aims to improve access by making services affordable. INDIA

can be made whether to transfer these clients to a surgical facility or to organise for a surgical team to come to them 'on outreach'.

In many countries, there are no tertiary eye care professionals in rural areas. Most of these professionals (usually surgeons) are based in the urban hospitals for a variety of reasons. We depend heavily on them to provide **accessible** services to the population. They can also be used in outreach eye care projects that are making services **available**. 'Outreach' should be defined as the provision of a specialised service to a location outside the normal service catchment area of the clinic. In order to utilise the services of these professionals in an efficient manner, clients



Victoria Francis

Making eye care available to isolated communities requires outreach. KENYA

Beyond the clinic: approaches to outreach

Daniel Etya'ale
Co-ordinator of VISION 2020 in Africa, Programme for the Prevention of Blindness, World Health Organization, 20 Avenue Appia 1211, Geneva 27 Switzerland.

Introduction

By making the elimination of needless blindness its prime objective, VISION 2020 has introduced a major paradigm shift in the planning and delivery of eye care. For many service providers and other stakeholders in this global initiative, this is both a challenge and an urgent call to move quickly from 'reaching as many as we can' strategies to new approaches that insist on 'doing it right and enough to make a lasting impact'. How does one achieve this in the poorest and neediest parts of the world where service delivery is quite often synonymous with dysfunctional infrastructure, limited access to and use of existing eye care services? This is what makes current discussions on 'reaching out beyond the clinic' so relevant and so urgent.

Daring to come out of the clinic, however, may not be enough in itself to bridge the existing gap between eye care service providers and the millions of blind and severely visually impaired people needing their services in those impoverished areas. To be optimally effective, outreach strategies must be grounded in, and guided by, a clear understanding of the inequitable nature of many eye care services, particularly, but not exclusively, in the developing world. As Figure 1 shows, those who need eye care services the most are often the last to have access to them, if at all. This may be so even when these services are brought closer to their communities, unless specific proactive measures are put in place to seek them out.

A quick overview of current outreach approaches to eye care delivery

The term 'outreach' as it is used today covers a fairly wide range of strategies and approaches, some quite different from each other, but all aimed at providing services to those who otherwise would not come to the clinic. Table 1 gives a summary of the main types, as well as their strengths and limitations. There are variants of each type and different types can be combined in the same projects. Some strategies, like the outreach surgical camps, once the pride of many institutions, have been on the decline for many years, primarily because of the high proportion of poor visual outcomes associated with them and the very limited post-surgical follow-up and refraction services available to patients. In spite of its drawbacks, this is still the preferred strategy used today by many philanthropic organisations offering free cataract surgery in many parts of Africa.

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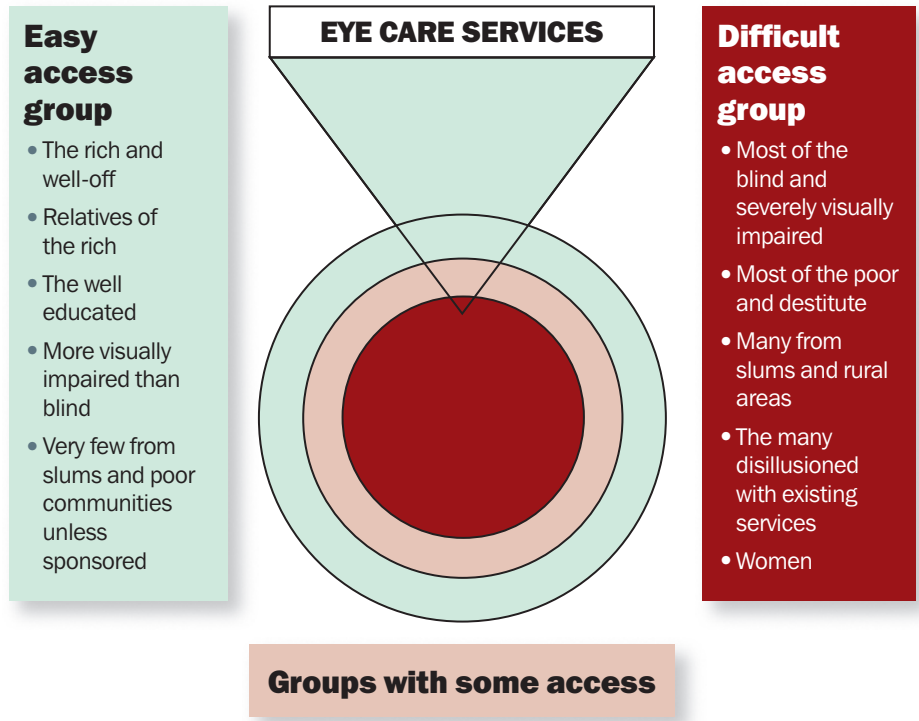
Figure 1. The inequitable nature of current clinic-based and provider-centred eye care



'I was convinced that we needed a new paradigm of outreach to connect people with services'

should already have been identified and collected at a central location. It is not an efficient use of scarce human resources to use ophthalmologists to conduct screening clinics on outreach. Screening should be built into a permanent primary health care delivery system and only specialised services, like surgery, should be catered for through outreach.

Many of us have seen the popular book *Where There Is No Doctor*. The author describes ways to identify and treat ailments in a very practical manner, especially in cases where there is no doctor to give advice. At the end of each section, the author lists those diagnoses that require a visit to the doctor. Where there is no eye doctor, outreach projects can link people with eye care services. The primary health care worker can identify the clients needing to see a doctor. This helps to reinforce the work of the primary eye care worker and also improves the efficiency of the tertiary service providers.

There are too many examples of outreach being driven by the needs of the service providers (remuneration, statistics, exotic locations, charitable works etc.) instead of the genuine service needs within the catchment areas. Out-of-station allowances are paid for this work and many eye care workers depend on this to supplement their income. This should not be a factor in determining when or where to do outreach. Salaries should be set at equitable levels and outreach should only be undertaken when there are justifiable numbers of clients to be seen who require the expertise of eye care professionals that cannot be found in the host project. The first priority is to establish a permanent primary eye care service wherever possible, and then specialised outreach can be conducted to support this service. Outreach should be carefully planned so as not to jeopardise the normal services of the tertiary centre. It does not make a lot of sense to travel for three days to perform 10 operations when one could be doing over 30 per day at one's normal place of work.

There is a popular song that refers to the need to "reach out and touch somebody." Outreach should be planned so that you can count on touching that 'somebody'. Clients in need of the specialised expertise brought by the outreach team should have already been identified, mobilised, and be willing to receive the services offered. A strategy of outreach is justified provided we efficiently combine those projects seeking to provide **accessible** services with those projects making services **available**.