Beyond the clinic: approaches to outreach

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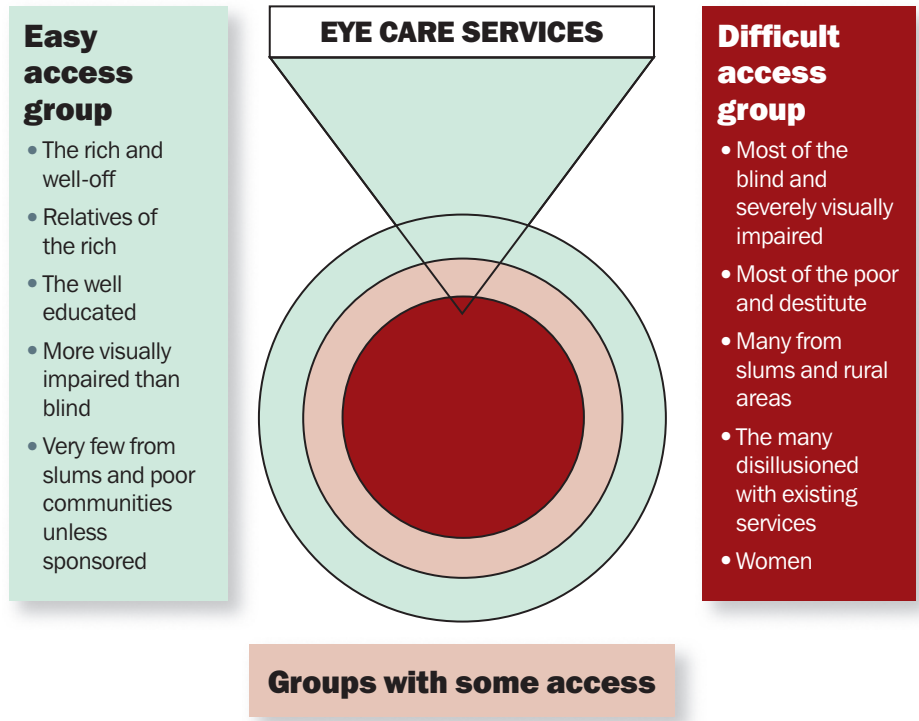
Figure 1. The inequitable nature of current clinic-based and provider-centred eye care



'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**.

Also, as is seen in Table 1 (opposite), most outreach programmes can easily result in increased numbers of patients seen or offered surgery. The real challenge, however, is ensuring their administrative, organisational and financial sustainability for the long term, something that only few countries, institutions or organisations have done successfully so far.

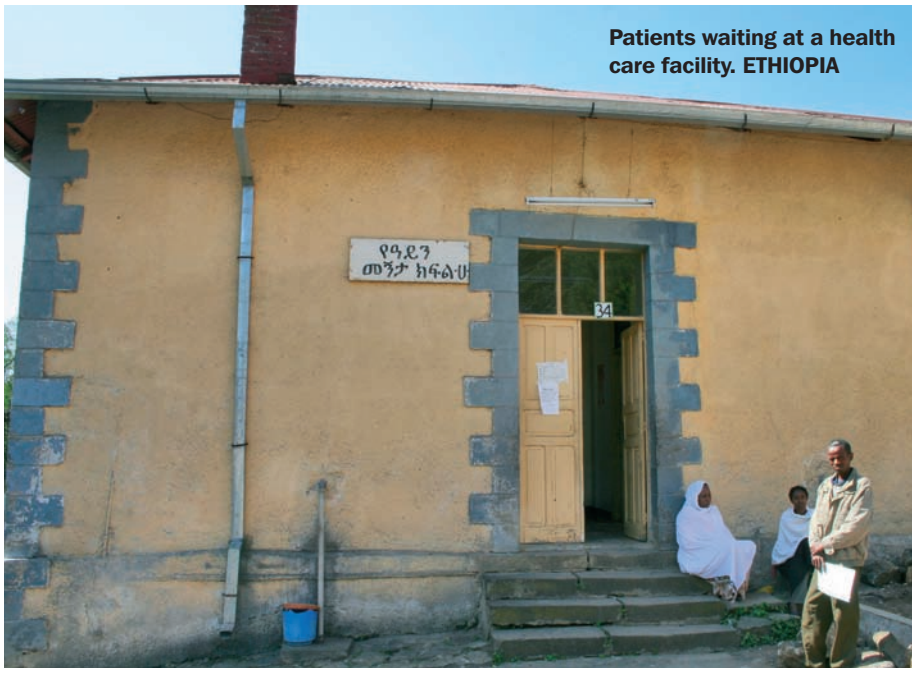
Key components of a good outreach programme

How does one define a good outreach programme? How does one initiate one where none exists, but its need is fully justified? We are still awaiting conclusive evidence on what makes a good outreach programme, its long-term success and benefits, and its replicability. However, lessons learned and experience gleaned over the years would suggest the following as essential elements for any outreach programme.

Careful planning of the programme or what needs to be done before going beyond the clinic

Planning activities must be as thorough as possible, covering at the very least the following areas:

- The proposed intervention zone: its geographic and administrative boundaries, its target population, the other service providers within the catchment area and the specific or complementary roles they're likely to play
- The nature and scope of the outreach programme. Is it i) a mere extension of base unit clinical and/or surgical activities; ii) a programme to screen and bring in more cataract patients for surgery; iii) the first step towards the establishment of a permanent eye care structure and service delivery in the area? In the latter case, what else should be considered at this early stage?
- The capacity of the base eye unit to initiate and sustain the outreach programme and absorb the expected increased workload
- The capacity of the base unit, or its sponsoring institution, to secure or guarantee financial support beyond the traditional three-year life span of most projects. Carrying out outreach activities while generous financial support is available is always the easy part. The real challenge is to sustain them beyond the initial project life span
- The capacity of the team to relate to, partner and work with the community. Skills needed to adequately engage and work with the community are quite different from those needed to be a good eye care professional in a clinic setting. All members of the outreach team should therefore be assessed and offered additional training where needed.



Patients waiting at a health care facility. ETHIOPIA

Lance Bellers

'Daring to come out of the clinic 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 in impoverished areas'

Community involvement and ownership

This should include their approval and support for the programme, their full involvement at all stages of planning and implementation, a clear understanding of the roles and contribution of each party, and a common understanding of how success will be defined and appraised.

Government involvement and leadership

This is particularly crucial where national or district plans exist and have been officially approved by government.

A good monitoring and evaluation system

Such a system would use clear indicators and targets for ongoing monitoring and programme improvement, and to measure success over time. It should also make provision for independent evaluation.

Patients awaiting surgery at an outreach camp. KENYA

David Yorston

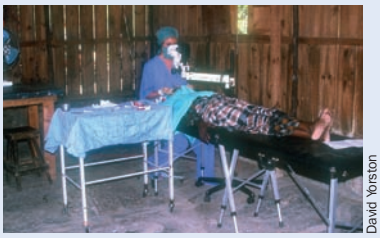
A structure and clear mechanisms for dialogue, problem-solving and co-ordination among all stakeholders

This is particularly critical where several partners are involved in the target area, or where those involved have limited experience of running outreach programmes.

Conclusion

The current gap between eye care providers and the many blind and severely visually impaired needing their services is unacceptable, and could be best bridged through the establishment of permanent eye care structures and services. In the meantime, and given the dysfunctional nature of eye care systems in many impoverished parts of the world, other modalities of outreach will continue to be used, perhaps for many years to come. Outreach programmes, however, are not a panacea. So far, only a few have been able to sustain themselves beyond five years. Many, initially hailed as successful, have turned out to be long-term failures and most 'model' programmes have not been easy to replicate in other settings or work environments; the reasons for this are still poorly understood. As more and better use is made of these bridging strategies, we should try to learn, through operational research, how to have an even greater impact.

Table 1. Summary of current outreach approaches to eye care service delivery

Outreach Type	Main objectives and strategies	Strengths/benefits	Main limitations	Potential for sustainability
A. Surgical eye camp  David Yorston	• Screen and offer surgery on site to as many as possible • Leave team behind for time-limited follow-up	• Often offered at low or no cost • Quick and sometimes only way to offer cataract surgery to many needy people	• Difficult to organise well • Big numbers may actually hide poor quality • Follow-up is often limited to a few days • Because of its free services, may further weaken an 'ailing' nearby eye unit, or delay the establishment of a permanent one in the region	• Low in general, except where long-term local support and commitment can be guaranteed • Often dependent on donor or sponsor support
B. Screening eye camp  Mohammad Muhit	• Screen, refer/ transport candidates for cataract surgery to base unit • Prescribe and provide spectacles for refractive errors • Detect/treat other eye conditions	• Opportunity to bring low/no cost basic eye care services to needy or underserved areas • Quick way to increase uptake of cataract surgery • Early detection possible	• Similar to (A) above • Not 'sophisticated' enough to fully assess or treat patients with suspected glaucoma or diabetic retinopathy • Expensive, hard to sustain without long-term commitment from sponsors	• Low, for the same reasons as (A) above • Could be justified as a means to build up or strengthen existing eye centres, or as a first step towards setting up more permanent structures
C. Mobile eye clinic  Victoria Francis	• A toned-down variant of (B), often organised and run as an equivalent of an Outpatient Department (OPD) of the base eye unit	• Quick way to bring basic eye care services to needy communities at low/no cost	• Quite often too many patients seen too superficially • Quality of care not always guaranteed • When staff is limited, may negatively impact continuity of services at base unit	• Same as (B) above
D. Using/working with community-based rehabilitation (CBR) or other community-based programmes  Bawku Eye Care Programme	• Use an existing CBR programme to deliver primary eye care, detect, assess and refer or transport • Where CBR not available, use community-based and -approved workers, e.g. cataract finders or other health workers	• Excellent at quickly improving access to eye care services or at maximising their uptake • One of the best strategies for the early detection and referral of blind and severely visually impaired children • One the most effective ways to recruit the reluctant cataract blind	• Requires very good organisation and a high level of co-ordination between the CBR programme and the base eye unit • Fairly expensive to run, especially where community ownership or cost-sharing is minimal and community workers are paid to produce results	• Uncertain when the community is a passive beneficiary of these services and/or when most of the running cost is borne out by donors or sponsors • Good to excellent, when true ownership by the community is actively sought and achieved, or some sort of cost-sharing is introduced from the outset
E. Creating Eye (Vision) Centres strategically located in needy areas  Babar Qureshi	• Here priority is given to the setting up of permanent primary and secondary eye units, with the view to improve geographic coverage and access to eye care	• Arguably the best strategy in the long term to offer a targeted area or region compre-hensive eye care services, and to improve access to and continuity of care • Allows time and opportunity for other stakeholders (including the community) to be part of the planning process	• Takes more time to plan and implement, and may therefore not be attractive to those looking for quick results • Disastrous when established in total ignorance of other realities on the ground: existing eye care structures, cost-sharing policies and practices, local rivalries, etc.	Good to excellent, especially: • When planned and implemented in close partnership with the community • When combined with other strategies that proactively seek out the needy and 'hard-to-reach' patients