Experiences in rural Kenya: Addressing lack of knowledge

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Building an eye centre in an area where you know there is great need for eye services is not enough. We began our work in Kwale district eighteen years ago after a feasibility study estimated that there were ten thousand people who were blind, thirty thousand with low vision, and about the same number with significant eye disease in the district. We knew that none of them were accessing eye care, but on our first day we saw only one eye patient!

We wanted to know why no-one was coming, so we went into the community to find out. We spoke to chiefs, attended local meetings, visited dispensaries, and went from door to door to ask if anyone knew someone who was blind. When we found a person who was blind, we asked them why they had not come.

Here are some of the answers we received:

- "People may not be able to get to your eye centre."
- "They have no idea that you can help them."
- "They do not understand what you are doing and therefore they are afraid. "

We realised that we had to create better awareness of who we were and what we were doing. We had to talk to people about eye health and tell them that treatment and correction of eye problems were possible. We had to show people what we were doing and what we were trying to achieve.

To do this, we trained traditional healers, women's groups, village leaders, teachers, prostitutes, whichever groups

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A tuk-tuk (three-wheeled taxi) now ferries patients from the main road. KENYA

we knew people listened to. We also gave talks at community meetings and in schools and religious centres.

At first, our scrub nurse did this work by himself between operating lists, using a bicycle to visit different areas.

Then, as the programme expanded, we recruited workers specifically for this role who were based in the community. They had to be respected members of society, literate, and able to get around. We provided a five-day training course at the eye centre, teaching them the basics about eye care and, more importantly, how to get groups of people together in the community and explain everything to them. This included information on how to get to us, how much it cost, and so on. The community workers would then find people with eye problems and arrange for our screening team to assess them in a local school or clinic. They also provided basic advice and brought those with more serious eye disease to the eye centre.

We also invited existing rural health workers, traditional birth attendants, traditional healers, and village leaders for a similar five-day workshop, one day of which would be conducted at the eye centre. Many people wanted to see for themselves that we were acting in an ethical and honest way and not, for example, removing eyes and selling them.

As well as the local population, we also needed to educate our fellow health workers in other facilities about eye care and about our specific services. In a poor rural area such as Kwale, there are many people doing many things in health. So we set up a stakeholders' forum, now under the guidance of the ministry of health, so we could all find out about each other's activities in the field and be able to refer our patients to the right services. This may sound easy, but the work is ongoing, involving long meetings and lots of talking! Excitingly, the government of Kenya is establishing community health extension workers and community health workers in our district. We are trying to encourage these workers to come to us for primary eye care training, and we also encourage them to refer patients to us.

We ask our patients for feedback on an ongoing basis. When they requested a safe means of getting from the main road to the eye centre, we purchased a tuk-tuk (see picture) to provide a free shuttle service. Patients also asked where they could have their blood pressure checked or get help with diabetes control, so we gave a general doctor space to set up a clinic. This brings more people to the eye clinic and also helps our existing patients.

We found that the answer to lack of knowledge was to talk to all those interested and create awareness. We are still learning, but these are the most important first lessons from our project.

Experiences in a capital city: How we market our services

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Lusaka Eye Hospital, in the capital city of Zambia, was established in 2001. We had to work hard to ensure that people knew about it and were coming forward for the eye care they needed. Here are the lessons we learnt.

- We defined our target customers. We serve mostly the west end of the city, so that is where we focus our promotion and education efforts.
- Every now and then, we are invited to speak on the radio and television about an eye condition. When we speak on the radio, we never ask patients to come to our eye hospital. The most important thing is that they seek eye care, so we advise them to go to their nearest eye clinic. Even so, many more patients usually come to us after each broadcast.
- We have a website and this also helps people to find out about our services.
- We regularly have outreach services targeted at all sections of the community. We visit institutions like the police, prisons, factories and other places of work, schools, churches, mosques, and market places. During these visits, we conduct health education and awareness creation, and screen and manage or refer those with eye conditions. We visit each community four times a year.
- Our experience shows that the majority of the patients we see were encouraged to come by people who have been to us before. This would not happen if the quality of service we offered were below standard.
- From time to time, we conduct a survey to find out about patient satisfaction. This has helped us to get better every year.
- We ask our patients if they know anyone in their neighbourhood who has an eye problem. We ask them to invite these people to come along with them to our hospital. For example, we ask patients diagnosed with glaucoma to bring their relatives for free screening.