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Bridging the gap: Barriers at community level, between service providers and receivers

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"Public-private partnership between the government and the private providers in rural areas can help provide quality health care to rural people using existing government infrastructure."

A large proportion of blindness is avoidable or easily treatable. To address this situation, interventions specific to blindness are required, which will include prevention, eye health promotion, protection, treatment and rehabilitation. The problem of blindness is acute in rural areas and hence the programme must try to expand the accessibility of ophthalmic services in these areas.

Public-private partnership between the government and the private providers in rural areas can help provide quality health care to rural people using existing government infrastructure. In areas where organised medical facilities like small private hospitals or health-related NGOs are absent, training programs can be arranged for existing health practitioners, many of whom may be Registered Medical Practitioners (RMPs) with greater reach in the remotest areas than government hospitals. One option is to build the capacity of such RMPs through training and workshops, so that they are able to prescribe the appropriate drugs and use the medical equipment available in the government hospitals.

Private health care providers can join hands with government to help run primary health centres (PHCs), medical colleges, and hospitals. The current level of service provided by these facilities can be assessed and upgraded, so that they are made more effective and efficient.

Healthcare and civil society organizations

Community health is a field where voluntary agencies have helped develop a variety of models for providing effective eye health care in different parts of the country. Civil society organisations have a varied role to play in healthcare. Some of these organisations have been able to develop village-based health cadres, educational materials and appropriate technology, thus attempting to fill critical gaps in the government health services.

These organizations can become important partners in spreading high quality eye care to the remotest villages in India. The emphasis should be on strategies to increase the reach of the programme to rural / tribal populations, especially poor women and children.

Unutilized Human Resources

A huge human resources base is available in India in the form of volunteers from women's groups, youth groups, self-help groups, the National Service Scheme, community associations, user groups, etc. Unfortunately, these resources are yet to be optimally utilized, as there is no visible or regular system to enrol volunteers, provide them orientation/ training and utilise their services in the voluntary sector on a defined basis.

Gap between Service Providers and Service Receivers

One of the major problems in a country like India is the large gap between the services available and their utilisation by those who most need them. Some of the factors that contribute to these gaps are listed below.

Remoteness: The geographic isolation of some of the areas in rural India makes it difficult for many people to access health facilities and services.

Lack of awareness: Low levels of literacy and education has led to a low level of awareness of eye health issues, particularly in rural areas and urban slums.

Lack of faith in the existing health services.

Religious and cultural beliefs that run counter to good eye health practices.

Lack of public participation.

Strategies to address lack of people's participation:

- Encourage people's participation in implementing government programmes for communities/rural areas by increasing their stake in these.
- Involving people in programme planning, mobilising local resources, and implementing activities.
- Raising awareness among people so that they demand services.
- Taking the assistance of local philanthropic bodies like Lions Club that conduct annual eye camps in the area.
- Bridging the gap between the rural and urban health services.
- Strategies to bridge the gap between service providers and receivers
- Generation of awareness in the community about various eye related problems and their possible remedies, thus increasing the demand for services.
- Selection of local volunteers to interface between the service provider and receiver. They can help in strengthening programmes through community involvement in remote areas.
- Generating goodwill among local health practitioners by relating the success of the effort to their practice. Involving them in the effort would in turn enhance the participation of their patients.
- Forging partnerships with local officials, health workers, private practitioners, NGOs and the community to promote community participation. Involvement of the local authorities can provide the necessary credibility to the effort.
- Strengthening IEC and public awareness for service delivery
- Developing institutional capacity
- Developing human resources for eye care
- Making eye care services affordable, thereby creating physical and economic accessibility.
- The role of various players including government, eye care personnel and private / NGO sectors acting synergistically must be mapped. This can be correlated with information on the disease burden and available resources (human, infrastructure, financial) so as to reach the underserved areas.
- Success stories within the regions should be highlighted.

We need to make consistent and focused efforts to ensure that people in rural areas receive the same kind of care that is available to privileged communities in urban areas. This requires us to proactively design interventions that consider issues of accessibility, affordability and quality.

World Sight Day Activities in India

VISION 2020: The Right to Sight – INDIA Forum and National Programme for Control of Blindness Cell, Ministry of Health and Family Welfare, Government of India jointly celebrated World Sight Day on October 14 at New Delhi. The theme was "Partnership" between the Government and VISION 2020: The Right to Sight – INDIA Forum, INGOs and NNGOs and corporates in eye care in the country.

The World Sight Day Celebrations were inaugurated with a lighting of the lamp by the honourable Minister of Health and Family Welfare Government of India, Dr. Anbumani Ramadoss on the evening of October 14. On the eve of World Sight Day, the Minister inaugurated a two-day Workshop on "Enhancing Community Participation through Public – Private Partnership in Eye Care" scheduled for 15th and 16th October. To reflect the Partnership, "VISION 2020: The Right to Sight", was represented by Dr.G.N. Rao, the President of IAPB on the dais. The Minister dedicated the following in the august presence of 200 delegates from different parts of the country.

1. Release of Brochure of the National Programme for the Control of Blindness for 2000 – 2007 under the 10th Five-year plan.
2. Launch of VISION 2020: The Right to Sight – INDIA - Confederation of INGOs and NNGOs nationwide.
3. Launch of the web site of VISION 2020: The Right to Sight – INDIA .
4. Unveiling the mascot "Eye Champ" to promote eye donation.
5. Felicitation of leading international and national organisations and eminent persons devoted to eye care in India.

These honoured at the national level were Dr.G.Venkataswamy, Chairman of Aravind Eye Care System, Madurai and Dr. L.P. Agarwal former Chief of Dr.R.P. Centre for Ophthalmic Sciences, New Delhi (posthumously). International organisations felicitated were Christoffel-Blindenmission (CBM), Lions Clubs International Foundation (LCIF), Operation Eye Sight Universal (OEU), ORBIS International, Seva Foundation, and Sight Savers International (SSI)

National organisations that received mention here were Aravind Eye Care Systems, Dr.R.P. Centre for Ophthalmic Sciences, L.V. Prasad Eye Institute, and Sankara Netralaya

The Minister also presented IAPB Awards to Dr Damodar Bachani and Dr Rachel Jose of the Ministry and Mr Thulasiraj and Mr Nagarajan from the NGO sector on the occasion. This was followed by the screening of the film on "VISION 2020: The Right to Sight– INDIA" produced for the occasion.

The celebrations continued with a two-day workshop on "Enhancing Community Participation through Public – Private Partnership" attracting 110 participants from different parts of the country, with focused dialogue on initiatives of VISION 2020: The Right to Sight – INDIA.

SEWA's community eye health programme: Bridging the gap between service provider and communtiy

Self-Employed Women's Association (SEWA) Rural Team

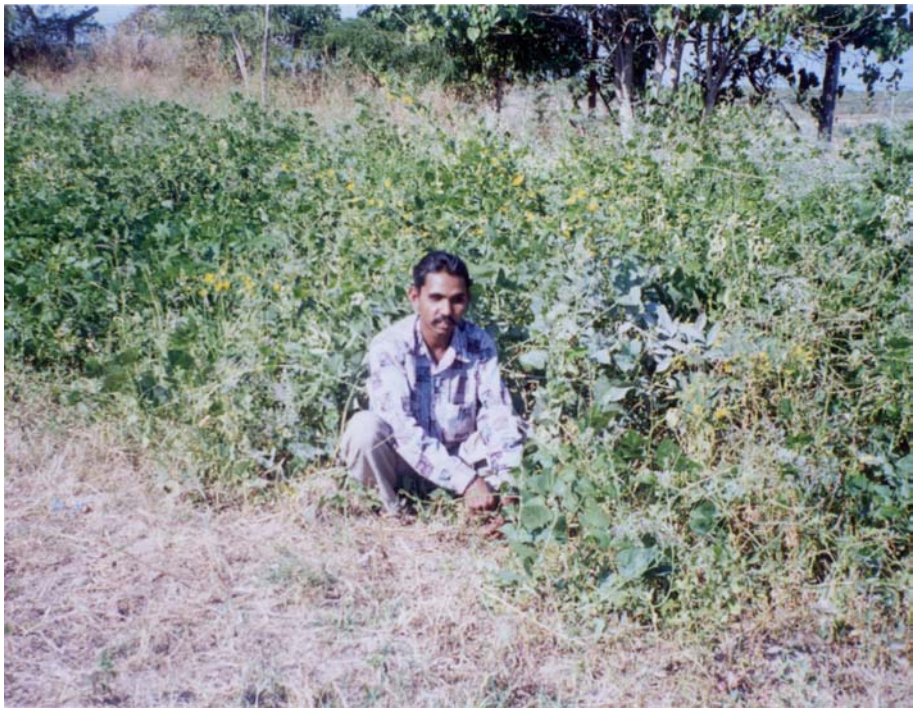
There are more than a million incurable blind persons in India (0.1% of the total population). About 80% of them live in rural areas where there is hardly any opportunity for them to become at least reasonably self-dependent. The nationwide rehabilitation coverage is approximately 4%. SEWA-Rural undertook a Community Based Rehabilitation of the Blind (CBR) programme in four interior tribal blocks covering a population of 400,000.

SEWA-Rural is a voluntary organisation engaged in overall development of the community around Jhagadia for the past 24 years. Activities of the organisation include running a 75-bed general hospital, a comprehensive eye care programme, CBR, a community health project, the Vivekananda Gramin Tekniki Kendra, and several women's development programmes. We implemented CBR so as to make our decade-long eye programme comprehensive in every respect.

We finished our first round of CBR activities in the Jhagadia block in 1998. When the second block in Valia was nearing completion, we planned to introduce all the components of primary eye care, as an innovation, into the new CBR programme. We realised that quite a bit of the preventive and health promotion work and part of the curative work could be done by grassroots workers; this provided the impetus to combine primary eye care with traditional CBR.

The two new blocks located 100 kms from the headquarters, were very remote, entirely tribal, and devoid of any healthcare facilities. After considerable deliberation we included additional primary eye care tasks as follows.

1. Cataract detection, referral and follow up
2. Vitamin A distribution
3. Support for follow up of measles vaccination



A blind client busy farming

"Quite a bit of the preventive and health promotion work and part of the curative work could be done by grassroots workers."

4. School eye check up
5. Primary treatment of eye and minor ailments
6. Health education in the community to create awareness about eye care

The project began in January 2001 and was completed in March 2004. The project area was divided into 14 clusters and 14 workers were selected. Each worker was assigned a population of 15000. Special training in primary eye care tasks was provided to these workers along with training in rehabilitation. The duration of the project was extended to three years from the conventional two years. The first training module for the selected workers comprised information about the blindness situation, eye diseases, primary eye care, history of rehabilitation and methodology. The survey and Module II training comprising various components of rehabilitation followed this. The scheduling was done such that they were able to combine primary eye care with rehabilitation.

Over the past ten years, we have been able to perform no more than 200 surgeries each year in these areas in spite of organising approximately 10-12 diagnostic camps. However, during the project period the number of surgeries increased to nearly 500 per year. Similarly, we could examine almost all the children in primary schools with the help of these workers. The vitamin A coverage was raised to more then 75%. More than 7000 patients approached these workers for primary

treatment of other minor ailments, indicating the high level of acceptance of these workers in the community.

The table below shows our achievements over the three-year period of the project covering a population of approximately 200,000.

In short, the addition of primary eye care to the traditional CBR activities (that focuses only on rehabilitation of the incurably blind persons) increased the overall compliance. The most important fact that emerges from this pilot project is that the local grassroots level workers function as an effective link between the service provider and the community, making the whole programme more effective.

Though the coverage of CBR is only 4% countrywide, it is a good idea for all those involved in CBR to provide primary eye care also as an integral component of the overall activities.

Blind persons get together for some music

CBR activities					Primary eye care activities	
Details	M	F	C	Total	Details	Total
Blind Clients trained	49	57	25	131	Vitamin-A Distribution Anganwadi	56939
Blindness Certificate issued	48	47	24	119	School Eye Screening	25661
O&M & ADL Training	49	57	25	131	Spectacle Distribution	158
Bus Pass Issued	42	30	17	89	Measles Vaccination	7641
Govt. pension scheme	13	12	12	37	Primary Treatment	6179
Integrated Education Programme			14	14	CHC Operative work	197?
Enrolled in Blind School			7	07	Diagnostic Eye Camps	76?
Economic Rehab. training	20	10		30	Cataract Operations	1348
Started economic activities	15	6		21	Health Education (H.Ed) – total attendance	50834
Loan from Sewa Rural	14	6		20	Field H.Ed. Sessions At Night	38
Sent to TATAWADI fansa for agricultural training	6			6	School H.Ed. Sessions	215

M - Male; F - Female; C - Children

Call for contributions

The Indian supplement to Community Eye Health invites contributions from eye health professionals who are engaged in or have an interest in community health. Articles can focus on any aspect of community eye health, ranging from medical and epidemiological perspectives to socio-economic and culture-based analyses. The main focus of the journal is to highlight ongoing work in community eye health around the country, and to provide useful information to practitioners in the field. Articles should be no longer than 1200 words and cite no more than six references.

Please address contributions and correspondence to:

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