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

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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.

Utilized 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.

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.
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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.

Lack of faith in the existing health services.

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

Lack of public participation.

World Sight Day Activities in India


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.
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 Nethralaya.

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 community

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

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2. Vitamin A distribution
3. Support for follow up of measles vaccination

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 than 75%. More than 7000 patients approached these workers for primary
Blind persons get together for some music

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.

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M - Male; F - Female; C - Children

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.

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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