

CHAPTER I

Introduction

One of the greatest challenges facing world ophthalmology today remains the unacceptably high prevalence of operable cataract blindness in the developing world. The establishment of national and international cataract programs, frequently funded and supported by international agencies, has achieved a steady increase in the number of cataract operations performed. But current levels remain too low to tackle the backlog of cataract blind estimated to be 16 to 20 million and to stem the rising world incidence consequent with the aging population (Arnold, 1999).

Cataract is opacity of the natural crystalline lens of the eye and remains the most frequent cause of blindness in the world today. The World Health Organization estimates that 50% (17 million) of the people currently blind worldwide are blind due to cataract. Because of increasing life expectancy and the resulting expansion of the elderly population, prevalent of blinding cataract are expected to double by the year 2010.

Although significant progress has been made in identifying risk factors for cataract there is no proven primary prevention or medical treatment. Surgical removal of cataract remains the only proven therapy and is successful in restoring vision in 94% of persons without other concurrent eye disease. This technology is widely accepted by the developed countries and increasingly available in the developing world (Javitt, 1996). Fundamental to the sustainability of cataract programs and to overcoming patient barriers to the surgery are the questions of cost as well as many other factors.

Patient barriers to cataract surgery are also important. Although some of these barriers, such as, availability and proximity of surgical facilities, can be addressed others, such as barriers of ignorance, low motivation, and impoverishment remain difficult to overcome. Educative and advertising drives are vital and marketing relies on a quality of surgical outcome. Perhaps the most effective Motivator is a previously blind patient following a successful vision restorative operation who educates and motivates others (Arnold, 1999).

The older person, the more chance there is of developing a cataract. The majority of people with cataract are over 50 years of age. This means that, as life expectancy increases more people will develop cataract and the number of blind will increase. By 2020 there will be some 1.2 billion people aged 60 years and over in the world with three-quarters of those living in the developing countries. The loss of eyesight is one of the most serious misfortunes that can fall a person. Around 38 million blind people and 110 million cases of low vision that are at risk of becoming blind. Thus, the global burden of serious visual impairment is estimated to be 148 million people (WHO, 1997). The estimated worldwide prevalence of blindness is 0.7% ranging from 0.3% in the established market economic of Europe to 0.6% in China to 1% in India to 1.4% sub-Saharan Africa (WHO, 1997). Blindness represent a serious public health, social and economic problem for the countries. It is especially true for developing countries where 9 out of 10 the world blind live.

This thesis is organized in the following manner. In the second chapter there is a general discussion on cataract blindness situation in Nepal. The prevalence of cataract comparison has been made between south East Asian countries and Nepal. Evidence shows that Nepal has the fourth highest prevalence of cataract blindness among South

East Asian countries. The leading cause of blindness of Nepal is senile cataract, amounting to about 74% of total blindness. The prevalence of cataract blindness distribution varies from region to region within the country. Narayani Zone has the highest and Lumbini has the second highest prevalence and largest share of cataract blindness in the country. The description of the problem situation and an extensive analysis of the factors responsible for this problem follow this. Then the consequence of the problem is explained. Following the consequence of the problem, barriers to uptake of cataract surgery has been explained and then why treatment for cataract blind is being questioned.

There are various public health problems in Nepal including cataract blindness such as tuberculosis, leprosy, diarrhoeal diseases, maternal death etc. why so much emphasis has been given on cataract. This entire question has been answered. And finally the ways to reduce and prevent cataract blindness in the community are explained. Up till this time there is no proven method to prevent cataracts except surgical removal of lens. Therefore, the focus is on how to bring the cataract patient to the hospital for cataract surgery and sight restoration. Due to lack of education and low level of awareness, still many people of Nepal are not coming forward themselves for cataract surgery. Following this statement it is explained about the possible solutions, and chosen intervention. The intervention has been chosen, involving Pseudophakic Motivators and health education. Involving Pseudophakic Motivator means here, empowering the community for the betterment of their own health by providing scientific information by their own people who are satisfied with the eye care service provided by the hospital. Following this statement, the health belief model used, putting main emphasis on how does it work or how Pseudophakic

Motivators can bring a change in knowledge, attitude and practice among cataract blind patients in the community.

In the third chapter explains about the statement of cataract blindness problem. Following this statement of problem, quality of life and economic return after cataract surgery are explained. Next how Pseudophakic Motivators perform their work in a actual situation, how they break down the existing barriers to cataract surgery are explained. Following this, purpose of study, aim and objectives of the project are discussed.

To achieve the aims and objectives of the project, screening eye camp, planning of knowledge attitude and practice survey, training for Pseudophakic Motivator and training evaluation are planned. Following training evaluation selection criteria of Pseudophakic Motivators (PM) role and responsibilities, and incentive for PM are discussed. After detail discussion of the roles and responsibilities of PMs, the empowerment of the community in planning, implementation, and evaluation of the health care has been discussed. Formation of self-help group (SHG), and their roles, responsibilities, incentives and expected outcomes are discussed. Following this, a plan for supervision and monitoring is discussed. Subsequently, human resources, and technical requirements, information recording system and sustainability of the program, including quality of care, is discussed. Sustainability is having high relationship with quality of care or quality of service, therefore, quality of care is the heart of the theme of sustainability. Right after that evaluation of the project is discussed. Then the budget has been calculated for the purposed project. At the end of this chapter an activity implementation plan has been included. Chapter four (IV) describes the data exercises. For the purpose of testing the proposed instrument

(questionnaire) a data exercise was undertaken in an Indian community in Bangkok which is explained in this chapter.

References

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