CHAPTER III

A Proposal for Training Pseudophakic Motivators To Increase Demand for Cataract surgery.

3.1 Introduction

Eyes are the windows of the soul of the creatures. In developed, under developed, urban, village, where one ever resides, whatever economic classes may be, whatever age or gender, good health (good vision) is a basic need and it is the desire of every individual and also a right of all human beings. However, blindness still exists in our societies. One of the major causes of blindness in the world is cataract. Despite the increased availability of sight restoring surgery, cataract remains the single greatest cause of blindness in society. The World Health Oorganization estimates that 17 millions persons worldwide are currently blind due to cataract. The majority of people with cataract are over 50 years of age. It also estimates that by the year 2020 there will be some 1.2 million people aged 60 years and over in the world with three quarters living in the developing countries. This means, as life expectancy increase more people will develop cataract and will also increase the number of people with blindness. Therefore, blindness represents a serious public health as well as social and economic problem for every country, but especially true for developing countries where 9 out of 10 the world blind live (WHO Fact Sheet, 1997).

In Nepal, prevalence of cataract blindness is very high in comparison with other developing countries. Presently the backlog of cataract cases is 125,000 (WHO, 1999). In Nepal 16,000 (New cases) become cataract blind each year (Upadhyay, 1997). The prevalence of blindness among women is especially very high 74/1000 females verses 53/1000 amongst males. Similarly there is very large gap in the rates between literate and illiterate, i.e. 72/1000 verses 31/1000 (Pokhrel et al., 1998). The prevalence of visual impairment due to cataract is significantly higher among extremely low socioeconomic stratum than among the higher economic stratum (Dandona et al., 1999).

If we examine the distribution of cataract blindness in Nepal, the Narayani Zone has the highest prevalence of blindness (4.4 per 100 population) and contributes 16.8 percent of the total cataract blindness of the country. Lumbini Zone has the second highest number of cataract cases among the 14 Zones of Nepal (Nepal blindness survey report 1981). If we look at the causes of blindness in Nepal, cataract is the major cause of blindness (0.68 percent) and if we examine the types of cataract we can find that senile cataracts account for 98% of cataracts excluding those of unknown etiology. Therefore, senile cataract as a caused for blindness is a major public health problem at present in Nepal.

The most cost-effective eye care intervention for the cataract blind is cataract surgery. Cataract operations have the advantage that they are simple, quick and effective and bring immediate benefit by improved quality of life. Cataract surgery provides a dramatic improvement in vision for many patients (Consumers Research Magazine, 1993) and cataract surgery is highly cost effective intervention: generally sight restored after relatively low cost operation. The cost of surgery varies

depending on the country, the technology used, and whether surgery performed in the hospital or in the eye camp (WHO, on linewww.who.int/inf-fs/fact).

A recent cost-effectiveness study for cataract surgery in Nepal found that, an average cost of US $ 21.71 per operation cataract surgery in Nepal. This suggests that cataract surgery be highly cost-effectiveness relative to other public health investments (Marseille, 1996).

Table: 3.1 Management Cost of Cataract in India (US $)

• Cost of maintenance of a blind person	$ 50 /day
• Cost due to loss of production	$ 50/day
• Total loss per day	$ 1.00
• Total loss per year	$ 365.00
• Cost of restoration of sight to cataract blind	$ 25.00
• Cost of living of Nepal and India is more or less same. At present the total number of cataract blind is estimated in Nepal is = 125,000.	
• Total management cost of the cataract blind = $ 45,625,000.00 (125,000 x 365)	
• Total cost of surgical intervention(125,000 x 25)= $3,125,000.00	
*If we could provide sight restoration to all cataract blind by cataract surgery, we could save $ 42,500,000.00 Which money could use to other public health program.	

Source: Kupfer (1988.)

The cost-effectiveness of public health cataract program in low-income countries has been well documented. Equity is another important dimension of program quality, which has received less analysis here by comparisons of surgical coverage rates for major sub groups within the intended beneficiary population of Nepal blindness program. Substantial difference in the surgical coverage were found

between male and females and between different age groups of the same gender. Among the cataract blind the surgical coverage of males was 70 % higher than that of the females. For both genders, the cataract blind over 55 received proportionately fewer services than younger people blind from cataract. Blind males aged 45-54 had 500% higher rate of surgical coverage than blind males over 65. Blind females aged 35-44 had nearly 600% higher rate of surgical coverage than blind females over 65. This evidence clearly says that program managers should consider to developing methods to increase surgical rates in women and to those over 65 (Marseille and Brand, 1997). This statement clearly says that older cataract blind people of Nepal are not on the priority list for cataract surgery. Appropriate intervention is needed as soon as possible to close the existing gap of the older and younger adult of both genders.

Compared with these costs for care, the economic cost of vision loss from cataract is huge. Loss of sight from cataract often begins in the fifth decade of life. It causes disability that leaves individuals and their families without means to earn a productive living or confines the individuals to custodial care (or that of a relative who is similarly removed from the work force). Such economic loss can be readily reduced or prevented by cataract extraction. In a study conducted in South India 85% of men and 58% of women who had lost their jobs as a result of blindness regained those jobs. A number of those who did not return to work relieved other family members from household duties, thereby enabling them to return to work (Javitt, 1996).

Furthermore, cataract removal improves life. Many of the common progressive symptoms associated with aging such as mental decline, memory loss, and lack of interest in activities can be reversed by removal of cataract. A nation wide study of the Johns Hopkins School of Hygiene and Public Health shows that cataract often impair participation in activities and driving. Removal of cataract and replacement with lens implant (intra ocular lens) invariably improved all measurable qualities of life regardless of age, gender or the existence of other eye disorders (USA Today, 1993). Improved visual function after cataract surgery is highly associated with health related quality of life. Therefore age related declines in health could be obtained by improvements in visual function (Mangione et al., 1994).

A study of visual functioning and quality of life out comes among operated and not operated population in Nepal, suggested that cataract surgery outcomes whether measured by traditional visual acuity or by patient reported visual function quality of life (VF/QOL) are at levels may would consider unacceptably low. It was further suggested that much more attention must be given to improving surgicaloutcomes (Pokhrel et al., 1998). To reduce the high prevalence of cataract blindness in Nepal and to reestablish the quality of life among cataract blind special mechanism has to be arranged in the grassroots level of community which mechanism will fill the existing and desirable gap of the present need of the society. To close the existing and desirable gap we need to develop such a mechanism which will reduce the barriers of the up take a cataract surgery and demand of cataract surgery will be increased. As I have got experience while working in the field for a long time, they themselves are the best problem solver more efficiently if we could empower them in a proper way, than we service providers. To create the demand for cataract surgery, first need to reduce the barriers of cataract surgery, I would highly

motivated to involve the person who had previously cataract blind and now after cataract surgery having good vision. They may be one of the best Motivator among cataract blind and best eye health educator in the community if we could utilize them by empowering with appropriately.

Although after cataract surgery increase quality of life of the patient, though cataract patient are not demanding service for sight restoration.. Studies not have done yet to find out the reasons of not coming.: the main barriers are: not having escort, not getting family and social support, operation fear, not having money, not having information, misconception, past bad experience of the eye care service misconception and belief. The other reason may be very crowded and big queue in the nearest eye hospital, which may make them disappointment, and there is no other eye hospital nearby the community except Private Nursing home. Therefore study is needed to identify the main barriers to up take a cataract surgery

3.2 Purpose and Aim of the Study

The purpose of the study is to improve the quality of life of those affected by cataract blindness. Due to lack of awareness, misconceptions, traditional belief, not getting appropriate support from the family and society as well as accessibility of health care facility, many cataract patients remain blind in the community. By involving Pseudophakic Motivators and their active participation most of the barriers to up take a cataract surgery will break down. As a result, demand for cataract surgery will increase and the prevalence of cataract blindness in the community will decrease. They also will deliver information, communication and education regarding preventives measures of cataract blindness in the community, which will bring awareness among community, resulting in increased awareness on

preventive measures of cataract and reduced incidence of cataract in the community. Therefore the main underlying interest of this study is to reduce prevalence and incidence of cataract blindness by involving community and with their active participation. Main focus will be given to reduce the prevalence of blindness because it is easy and very urgent problem of the society. The aim of the study in terms of its ultimate impact as a benefit for the population is to reduce prevalence of cataract blindness in Lumbini Nepal.

3.3 Objectives

3.3.1 General Objective

To increase the demand for cataract surgery in Lumbini, the project area, by involving Pseudophakic Motivators in health education.

3.3 2 Specific Objectives

a. To develop and implement training program for Pseudophakic Motivator.

b. To increase demand for cataract surgery from 20% to 60% of cataract blindness (VA less than 3/60) by providing sight restoration in the proposed area, by the end of the project.

c. To develop a new cadre of health educator, Pseudophakic Motivator as a link between the community and health care service.

d. To develop supervision and monitoring system for the Pseudophakic Motivator.

e. To develop self-help group in managing the cataract problem in the community.

3.4 Program Description

In this proposed program, focus on the development of a new cadre of eye caretaker PM, who were cataract blind and received cataract surgery. They are the satisfied clients for the eye care service providers. They can act as Motivator and educators for the cataract blind in the community by breaking down various barriers in preventing the cataract blind from seeking timely eye care. With a positive experience in eye care they can play key role as a change agent in the community and as a link between the community and eye care service providers. Achieving this goal requires capacity strengthening among PM six days training program will arrange for the Pseudophakic Motivator. Which will enhance their communication and motivational skills. Diagnostic, screening and treatment camp also will organize to provide doorstep level service among community and to assess the cataract blindness situation in the given community. To identify the existing knowledge, attitude and behavior of the cataract blind focus group discussion will be organized. Findings of FGD survey will be incorporated in the training of the Pseudophakic Motivators, which will help to break down the barriers of the cataract blind.

Lastly the self-help group is for organizing for the purpose of: bringing the community, to share the feelings among each other, solve the problem among themselves and to involve the community in planning, implementation and evaluation. All these components of the program are explained in details in the following sections.

3.4.1 Focus Group Discussion

To identify the knowledge, attitude and behaviors and the barriers of the cataract blind regarding cataract surgery, focus group discussion (FGD) will be conducted in the project area. The target population of the FGD will be 45v years above age group, who are having visual acuity (3/60 and can count fingers with distance of 3 meters) with both eyes due to cataract.

Three FGD will be organized in the project area before the training of Pseudophakic Motivators. The findings of the FGD will be incorporated in the curriculum of the PM training, which will help to break down the barriers of cataract surgery. FGD guideline is attached in the Appendix C and D.

3.4.2 Pseudophakic Motivator

a. Concept

To create the demand for cataract surgery and reduce the prevalence of cataract blindness a simple applicable and acceptable mechanism has to be established at the grass root level of the community that proposed mechanism is: the development of Pseudophakic Motivators and community empowerment. The reason for focussing on Pseudophakic Motivator is, they live in the same community, they know among each other, and they are the people who can share real experience when they were blind due to cataract and at present life after cataract surgery. Communication can take place among each other without any barriers, which can not be expected, from the health personnel.

Pseudophakic Motivator can create felt need among cataract blind by providing information, education and communication. When the cataract patient realized cataract blindness is as a problem with the efforts of Pseudophakic Motivator then they will demand for cataract surgery.

The main reasons for proposing working through Pseudophakic Motivators is: it is acceptable for the community, does not cost huge money for training, it increases community participation, sharing the responsibility among community and eye care service providers. It is a process of community empowerment, which will help to increase decision making power and self support system of the better health and well being of community.

Pseudophakic Motivator will be formed one self help group where all the target population, leaders of the community will discuss with together to meet the common goal of the society. With the active participation of the Pseudophakic Motivator and self-help group there will be increased demand for cataract surgery with the following working mechanism with Village Development Committee, self-help group and eye care service providers.

i. Each ward of the VDC will have one trained Pseudophakic Motivator, who will work as a contact person for the local authority (VDC), eye care service providers and local community.

ii. Each ward of the VDC will have one self help group, which will have close relation with VDC.

iii. Eye care service providers and village development committee will work as a partnership approach with the support of self-help group and Pseudophakic Motivator.

b. Selection Criteria of Pseudophakic Motivators

Village chairman together with eye care providers will select the Pseudophakic Motivators (PM) with the technical assistance of eye care service providers. The following will be the basic qualifications for PM.

i. Had cataract surgery with intra ocular lens (I.O.L.) and having good vision (satisfied with the visual out come of the surgery).

ii. Living in the same community permanently.

iii. Having good reputation in the community, if possible, religious leaders, traditional healers, or acceptable for the community.

v. Keenly motivated and interested to work as a volunteer in the community.

v. Those who have free time or can give few hours each day for the volunteer work.

c. Expected role of PM

The expected role of PM will be as follow;

i. To act as a front line community leader in the eye cares program of the community.

ii. To identify cataract blinds patient of the community and motivate to them for cataract surgery.

iii. To work as a bridge in between the community and eye care providers.

iv. To form self help group and make people understand of its value in the community.

v. To provide eye health education among community and distribute IEC materials what they received from the eye care service providers.

d. Incentive for Pseudophakic Motivator

Pseudophakic Motivators serve as the pure volunteers of the community who are committed to help the community for the betterment of the health of the community with their own active initiation. One of the greatest incentives will be self satisfaction of their own work and value offered by the community. There will be no direct cash incentive for the PM, even though the following items can be considered as an incentive for the PM as well as for the whole community.

i. 6 days training on communication and motivation, which will develop some skills and knowledge of the individuals, which may be the good assets for the community.

ii. During training they will get Rs. 60 Per day (about 1 US$) as a food allowance.

iii. At the end of the training they will get a certificate.

iv. They will have a right to sign on the referral slips, those patient who comes with referral slip they will get prompt service without queue for surgery and up on PM recommends those who are very poor they will get free service with their recommendation. Therefore accepting their signature in the eye care service is a big incentive for the community and prestigious for the PM.

v. Those PM who refer more cataract patient for surgery, they will get as a prize cost of Rs 3000 (45 US$). Once in a year. From the Eye care service providers (Lumbini Eye hospital).

vi. PM will have good linkage with local authority, self help group and eye care providers as well as in the whole community because of taking new responsibility as a Pseudophakic Motivator which also can be considered as a incentives.

3.4.3 Training

a. Concept

To change knowledge, attitude, and behavior of the cataract blind, Pseudophakic Motivator will be involved in the program, who lives in the same community before taking responsibility as a Pseudophakic Motivator they need to have basic knowledge and skills on communication, motivation and cataract so that they can communicate effectively with the cataract blind, and relatives/family of cataract blind.

In one hand it will enhance the knowledge and skills of the Pseudophakic Motivators. On the other hand training will empower them to work as a Motivator. When they participate in the training program community will give recognition. When the community get any eye problem they will make contact by themselves.

Therefore, this training will not only increase skill and knowledge of Pseudophakic Motivators but also recognition and empowerment.

b. Description of Training

This training program has been design for 6 days in total. The expected participants of the training are over 50 years of age, and illiterate. If duration of training is long they may feel bore. Therefore taking into account of the nature of the participants, training program has been design in to 5 phase. In the beginning there will be two days training and then one-day refresher training every once in two months has been planned.

In the beginning of the program, a-two day training will be organized for Pseudophakic Motivators. The first day of the training will focus on the problem of blindness and its consequences in the society, and role of the community to fight against on it. In this way, they will be tried to motivate them to realize the problem of the community to fight against the problem.

It has been noted that, trainees are from the remote community, old, illiterate, therefore lectures are not effective. The principles of adult learning will be used in the conduction of the training and will be based more on active participation involving group discussion, problem solving and story telling approach more focus will be given on practical exercise and practical applicable than the theory.

Second day of the training will be mostly practical case demonstration. Focus will be on given how to measure visual acuity of the cataract patient and how to identify the operable cataract. Skill will be given by demonstrating practical exercise on how to motivate a cataract blind that refuse sight restoration. On the

second day of the training diagnostic screening and treatment (DST) camp will be organized for the purpose of the practical exposure of the trainees. Efforts will be made for better teaching learning environment by providing practical real experience. Curriculum of the basic training is attached in the appendix. A. Refresher training will be organized every once in two months.

c. Evaluation of Training

Evaluation of training will be done at the end of the day of the training Basic procedure of the training evaluation will be as follow.

i. Input: At the first day, before starting training sessions, I will collect the expectation of the trainees, (what is their expectation from the training) by asking question in a very informal manner. After collecting all the expectation from the trainees, I will make them clear what we will do and what we will not do.

ii. Process: At the end of the day of the training, I will evaluate the appropriateness of the process of the training by asking and discussing among participants, such as how was the day, what was interesting and what was boring, was the schedule conducted smoothly, what could be done more better than this, weakness of the training and observation also will be made for better understanding.

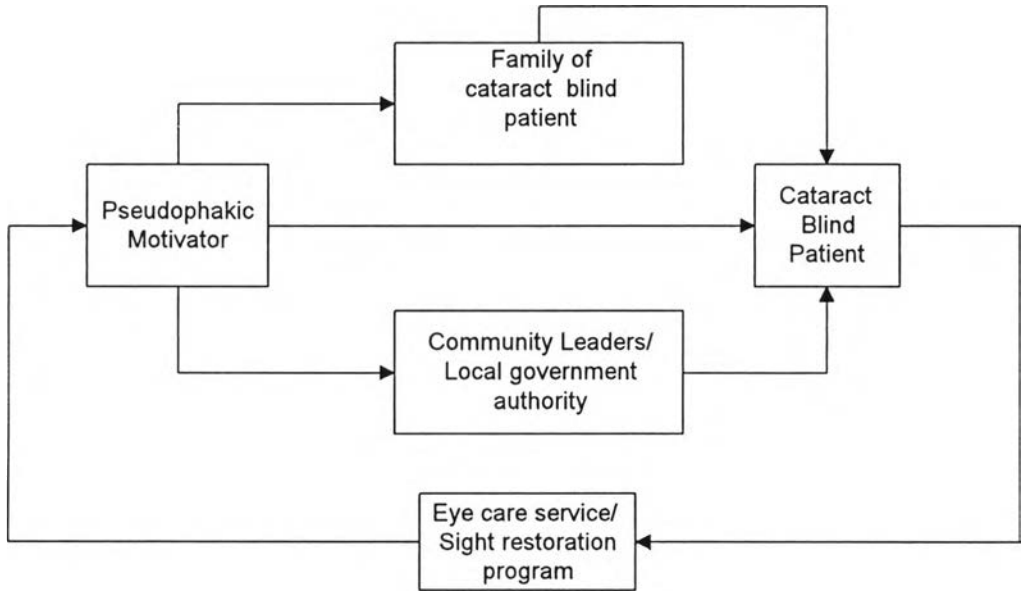
iii. Outcome Skills of the participants will be evaluated during the practical

work by observation such as how they are measuring visual acuity, how they are dealing/motivating with the cataract patient, and some information will gather by asking questions.

d. How does Pseudophakic Motivator Work?

As mentioned earlier there are various barriers to accepting cataract surgery, there fore barriers are one of the various reasons of having high prevalence of cataract in the community. To breakdown the barriers accepting cataract surgery Pseudophakic Motivators will be mobilized by providing basic motivational skills and knowledge. Principally the Pseudophakic Motivator (PM) will be the contact person of the community for the eye care providers, but with the active initiation of the PM the whole community will be mobilized for the prevention and control of cataract blindness in the community. How the PM educate the community, mobilized the community and break down most of the barriers of the cataract surgery as well as how the program will maintain relationship with each other stakeholder will be discussed in the following paragraph.

Figure 3.1 A model for action to combat with cataract blindness applying community participation



One Pseudophakic Motivator will take responsibility for one ward of the village development committee (There are nine wards in each village development committee) where there are 150 to 200 houses and 8,000 to 10,000 population. The expected prevalence of cataract blindness in each ward is about 6 to 7 persons. In the proposed area the pattern of housing is very congested, therefore the whole ward is within walking distance of 30 minutes to one hour. Pseudophakic Motivator can easily access to all the cataract blind individually at a time in the community.

First, Pseudophakic Motivator will make a contact with the cataract blind patient and will listen to him. After listening to the cataract patient; Pseudophakic Motivator can identify what are the barriers/ difficulties of not going for sight restoration. If the barriers are cognitive related such, as fear of operation, belief, misconception or previous bad experience with the behavior of the health personnel or performance, Pseudophakic Motivator will deal directly with cataract patient. Pseudophakic Motivator can demonstrate by using he himself, sharing his experience of what he faced when he was blind and how he is now enjoying at present after cataract surgery. He can tell the changing environment in the eye care service at present like quality of care with advance technology with reform medical personnel. Pseudophakic Motivators are the best persons who can share their real experience in their own local language with the same setting culture.

Pseudophakic Motivator can discuss about the problem with the family of the cataract blind by giving his own example, relatives and the family of the cataract blind patient can get encouragement and develop self confidence seeing the quality of life of the Pseudophakic Motivator. When the family is convinced, they will put

pressure on the cataract patient to go for sight restoration. When there is strong pressure from the family, the cataract patient may not refuse the eye care service.

If the barrier is family (not getting support from the family) then, Pseudophakic Motivator needs to see the head of household. Because of various reasons some of the family members of the cataract blind does not take any interest or not willing for cataract surgery/ treatment of their parents, those who have cataract. During my field visit, I have seen such family the reason usually they give: too old, time to go to haven, very weak, he/she gave all her property to other people, why shall we bother? He/ She gave a lot of trouble when he/she had sight, now let be blind etc.

To solve this family related problem Pseudophakic Motivator need to talk in the group of the family as well as individually particularly those who is the decision maker of the family. In the same time Pseudophakic Motivator will discuss in that issue with the local leaders and self help group too. House hold of the family may not listen or will not give any value of the word of the Pseudophakic Motivator, if the Pseudophakic Motivator is not influential person of the community or if the social relation is not good with that particular family, but the people can not reject the request of the local leaders of the community. To prevent from the isolation of the community people used to follow the idea or words of the community leaders even though that idea is not favorable self-help group also can give social pressure up on the individual to act positively. Therefore, with the help local leaders and self-help group supportive environment can be created in the family for the demand of cataract surgery.

If the barrier is cost or escort then the Pseudophakic Motivators will discuss that issue with the self-help group in the community as well as will raising the issue with the local government to solve the problem. To solve such kind of problem collaborative approach will be followed. With the mutual cooperation, coordination and understanding among eye care service providers (Lumbini Eye Hospital) local government and self-help group of the community will be solved problem by providing needful support among individuals those who are not able to afford the cost of care. 5 to10% of the cataract patient can not pay the cost of the cataract surgery.

When the local government and eye care service providers agreed to work with mutual understanding, close cooperation to each other as a partnership approach, they can provide special assistance (free service) with mutual understanding those who can not afford. Perhaps, eye care service providers also interested to provide free service to a few patients for those, who are very poor and can not afford, but it is very difficult for the eye care service providers to identify who is real poor and can not afford. Local authority also having very small fund, but they are getting trouble where and how to utilize that small budget in a larger population. Therefore, when the village development committee and eye care service providers works with together with close relation and active participation of self-help group, there will no any more problem to get eye care service those who can not afford the cost of cataract surgery. It will be a collaborative effort. Collaboration is more effective than the individual action which provide strong relationship based on desire to solve a problem or discover some thing within the constraints of the collective experience, time, money and environmental wisdom. (Neufeld et al., 1995).

Therefore no cataract patients will remain blind in the community by the effort of the Pseudophakic Motivators and the collaboration of the civil society.

It can not be expected that one Pseudophakic Motivator will work forever .in the community. It is not possible. There will some drop out due to disability, death, migration and other various reasons. Therefore Pseudophakic Motivators training or producing Pseudophakic Motivator will be continuing process for the eye care program. In the beginning, eye care service provider may need to take more initiative but later on the partner (community) will understand the philosophy of the partnership, importance of eye health, collaborative effort and the value of the program, then all partner i.e. local authority, self-help group and eye care service providers will bear equal responsibility. Therefore, as shown in the above diagram the process of the Pseudophakic Motivator and the empowerment of the community will be continue in the community.

3.4.4 Diagnostic Screening and Treatment (DST) Camp

A one-day diagnostic screening and treatment (DST) camp will be organized in each village development committee (VDC) on the second day of the PM training. The camp publicity will be done through newly appointed Pseudophakic Motivators, local government authority, schoolchildren and local leaders of the community. There are mainly three underlying reasons of organizing DST camps in each VDCs.

a. To demonstrate the operable cataract cases among the Pseudophakic Motivators (trainees) for the purpose of to create better teaching learning environment in other words to provide practical experience among trainees.

b. To get the ideas about the prevalence of cataract blindness in that particular community. In this project it is not possible to conduct detail household survey to find out the prevalence of cataract in terms of resources and time. About 70 to 80 % of the total cataract came for check up in the DST camp, when it was well publicized Therefore we can obtain an estimated prevalence of cataract blindness in the community.

c. We are talking about the partnership and empowerment of the community. To establish good relation with target population/ community we need to build up trust with them, by providing doorstep, level eye care services. Organizing DST camp in the community is one strategy to build up the trust with the community. Therefore to build up the trust, to introduce ourselves, DST camp may help as a tools.

3.4.5 Formation of Self -Help Group

This proposed program have been designed in such a way, in which cataract blindness problem may be solved with the organized community efforts. Therefore during training of Pseudophakic Motivator (PM), I will discuss about the importance of forming self-help group (SHG) with the trainees. In the same time I will initiate to the PM and local leaders to form a self-help group in each ward of the village development committee.

Self-help group requires self-motivation i.e. the individual's motivation to improve herself or himself and situations that achievement of full participation in society. This means that the individual must have some choice in determining the direction of her/his life. Self-help means mutual support and empathetic human relationship. It is a group solidarity which enables cataract blind who are

experiencing similar hardship to support each other to overcome common difficulties through the exchange practical information, insight and knowledge gained through personal experience (United Nations, 1991).

Reason behind forming self-help group (SHG) is to establish mutual support mechanisms among each other for the purpose of to fight against cataract blindness. Strengthening the participation of the cataract blind in the community. Many cataract patients are remaining blind at home due to not getting meaningful support from the family. A person at old age with disability due to cataract can not make any decision against the family. If he/she does they will not get food and shelter, too. In that situation the self-help group (SHG) can create and give social pressure among the family members of the cataract patient for cataract surgery.

Five to ten percent of the total cataract patient in the community, they are very poor, they can not afford the cost of cataract surgery even though cataract surgery is very inexpensive in Nepal compare to other countries. Being the member of the same community members of the self-help group know the actual financial situation of each other. For those who are real poor and can not afford the cost of cataract surgery, self-help group can advocate /recommend/request to the local government and eye care service providers for needful support. In addition, self-help group also can share experience among each other, discuss, think and act for the better health of all the members of all level of the society.

a. Objectives of Self -Help Group

i. To empowering the community, interact among each other, share the problem and provide mutual support among cataract blind for sight restoration.

ii. To work as a link between community and local authority.

iii. To create social pressure, to solve the problem of cataract blindness as and when necessary.

iv. To establish mutual support mechanism for the demand creation of cataract surgery.

b. Role of Self-Help Group

i. To organized a meeting and discuss about the cataract blindness problem among each other.

ii. Those cataract blind who is not having escort, arrange the escort and send the cataract blind for cataract surgery or sight restoration

iii. For those family who can afford the cost and escort for cataract surgery of their cataract blind individual (parents) but the parents are not getting support, provide social pressure among the family, so that they will take their parent to the hospital for cataract surgery.

iv. For those cataract patient who is refusing cataract surgery because of operation fear, misconception or belief, provide group pressure / motivation to the cataract blind for cataract surgery.

v. For those who can not afford the cost of the cataract surgery, recommend to local authority (VDC) and eye care service providers, so that the cataract blind will get necessary support from the local authority

vi. Organize health education or awareness campaign for the prevention and control of cataract.

vii. Dialogue with the local authority, create appropriate environment and help to the Village Development Committee (VDC) to work as a partnership approach with the eye care providers.

c. Members of Self -Help group

The members of the self-help group with the following criteria will be included for this program.

i. The entire cataract blind person of the community.

ii. Those who are interested age above 50 and over.

iii. Local school teachers.

iv. Those who have had cataract previously (Aphakic/ Pseudophakic)

v. Female community health volunteers of the ward.

vi. Religious leaders of the community.

vii. Pseudophakic Motivators.

viii. Ward chief Of the community.

d. Expected Outcome of the Self-Help Group

The expected outcomes of the self-help group are listed in the following points.

i. Identify the problem

When the cataract patient who are facing problem every day and the community leaders sits with together and discussed among themselves, it will enable them to identify the problem while sharing the feelings among each other. The problem may vary from individual to individual. The self - help group will easily draw the conclusion, the main reason of not going for cataract surgery.

ii. Setting objectives

When they identify the problem of the individual not going for cataract surgery, at the same time they can see many possible solutions of the problems. To solve the individual problem group effort will be made by setting the objectives. For instance, what are the action going to take, when, how, what, to whom etc.

iii. Identify the resources

After setting objectives, the self-help group (SHG) will find out the resources to solve the problem. They will see what kinds of resources are needed, internal or external. Escort, motivation, encouragement, social pressure is considered as internal resources. Money is considered as external resources.

v. Evaluation

The self-help groups can see the performance and outcome of cataract surgery by seeing the quality of life of the cataract patient who come back from cataract surgery. The self-help group can get information about the quality of service, behavior of the health personnel of the eye hospital, facilities being provided in side the hospital, surrounding environment of the hospital by asking with the service users (those who come back from the hospital after cataract surgery) and they can make decision what need to be done further action to get more qualitative service if the existing service is not acceptable or below the standard. Similarly the SHG can note the productivity or economic return of the individual after cataract surgery. Therefore the expected out come of self-help group is more empower, independent and increase decision making power for the betterment of their health of their own initiation.

e. Incentives for Self-Help Group

Cataract blindness is never ending disease in the community and there is no any proven of any preventive measure except surgical removal of lens. To solve this problem, I would like to establish such a mechanism, which will work continuously for ever in the community.

I am proposing partnership approach with the community and eye care service providers. In this proposed program self-help group will be the representative of the community which will have direct relation with Village Development Committee. Eye care service providers will have formal relation with Village Development Committee and informal close attachment with self-help

group. Pseudophakic Motivators will be the contact person of self-help group and eye care service providers.

The following can be considered as incentives of SHG.

i. Getting an opportunity to representation of the community.

ii. Empowerment: identification of problem, setting objective, looking at the resources, evaluating the achievements can be considered as incentives.

iii. Whatever skills, assistance will get from the eye care service providers free of cost regarding to formulate SHG, which is also can take as an incentive.

iv. With the efforts of SHG, whatever change will be occurred in the health of the community and quality of life of the people that will be the biggest incentive for the SHG.

3.5 Study Site

The site chosen for this study is Rupandehi district of Lumbini Zone, which is 300 K.M. South from Kathmandu attach with Indian Border Rupandehi is in the mid western development region of Nepal. This is a plain area and climatically famous hotter place of the country. The total population of this district according to 1991 census is 522,150. This is plain fertile land. Most people are farmer and farm labor. Rice wheat, sugarcane and vegetables are the main crops of this district. There are 69 Village Ddevelopment Committees and two municipalities. Population growth rate is very high in this district because of migration n from the hills. For my study purpose, I have selected 15 village development committee of this district,

which is close to Lumbini, the birth place of Lord Buddha, which is 21 Km. from the district headquarter Siddhartha Nagar Bhairahawa.

The reason of choosing this district is, that it is accessible from my working place Siddhartha Nagar Bhairahawa. Bus service can be used year round to Lumbini. All the village development committees are within surroundings of one to two hours walking distance from Lumbini. I am familiar with the community leaders of that community which may help me to work smoothly.

In this district there are 58 sub health posts, 7 health posts, 4 primary health care centers, one 25-bed district hospital and one 75 bed regional hospital. In the same district there is one 300 bed well-equipped Lumbini Eye Hospital, where I am working.

3.6 Monitoring and Supervision

Continued monitoring and supervision will be carried out through out the project period. This proposed program has designed to some extent as a partnership program with the community and Lumbini Eye Hospital.

Despite, in the initial phase community may need extensive encouragement, support, motivation and positive feelings to build up the trust with the partner (Lumbini eye care program). Monitoring is the process of observing whether an activity or service is occurring as planned, and as scheduled. One ophthalmic assistant will be assigned to make regular contact with pseudophakic Motivators, local leaders will provide the necessary support as and when necessary. One of the most influential monitoring tools of the program will be the referral slips sent by Pseudophakic Motivators. In other words operable cataract referred by

Pseudophakic Motivator for cataract surgery and sight restoration. The another more important monitoring measurement will be, the involvement of the community in the training program, which will be measured by the attendance of training and meeting registers, and support provided to the poor people those who can not afford as well as receive assistance from the government.

Supervision is an important part to achieve the objective of the program. This proposed program is needed strong regular supervision to make the success of the program. Basically, there are three stakeholder in the program i.e. self-help group, village development committee and Pseudophakic. To support them, to encourage them, to provide technical skills and regular motivation one ophthalmic assistant will be assigned to work as a supervisor, who will make them available once in two months. Supervisor will provide new skills as needed to the pseudophakic Motivator and self-help group. If there is any problem/misunderstanding among VDC and Lumbini Eye Hospital, Pseudophakic Motivator, self-help group, the supervisor will try to solve the problem in the spot. If the problem is serious, beyond the capacity of the supervisor, then the same supervisor will be responsible to coordinate the VDC Chairman and Hospital Director of Lumbini Eye Hospital to solve the problem in time.

3.7 Human Rresource and Technical Requirement

As mentioned earlier this proposed program has been designed as a partnership program between village development committees (local authority) and Lumbini eye care program. All the non-technical matters, which can be handled locally, supposed to be handle or will be managed by the local community and the Lumbini eye care program will manage technical aspects. In the initial phase,

community may need to understand their role, responsibilities, their strength so they may need more encouragement, managerial support, frequent reinforcement which will be provided by the Lumbini eye care program as a partner. To carry out the program successfully directly or indirectly the team efforts of the Lumbini eye hospital is essential. Basically for the field purpose, one ophthalmic assistant will be assigned to work as a co-trainer during training period and the same person will be assigned to work as a supervisor for monitoring and supervision as well as follow up purpose. I, myself will work as a master trainer during training and refresher training and other time as a resource person for the ophthalmic assistant who has taken responsibility for monitoring and supervision of the program. All the medicine and equipment for the diagnostic, screening and treatment (DST) camp, will be arranged as per the standard list of the DST camp of the Lumbini Eye Hospital.

3.8 Information and Recording System

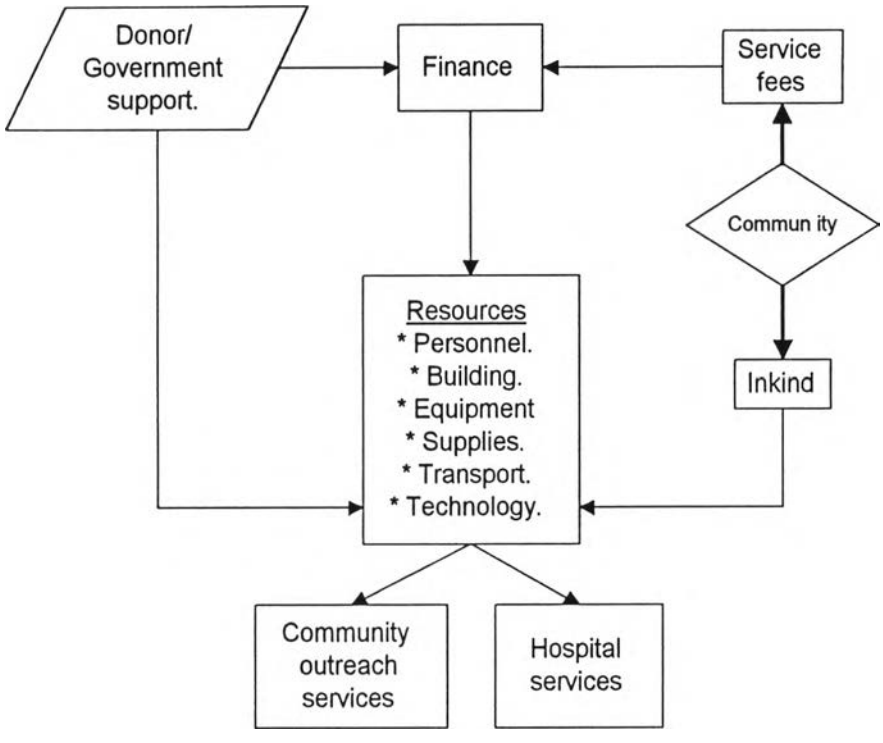
All the information of the program will be recorded in the Lumbini eye hospital. Baseline survey findings, list of the operable cataract i.e. screened during screening eye camps, and referral slips received from the patients i.e. those who are referred by Pseudophakic Motivators, will keep record in the Lumbini Eye Hospital. Operated cataract patient's list of the project area will keep separate record in the operation theater (OT) register of the hospital and referral slips will keep in the outreach department of the hospital. Monthly report of the operated cataract of the project area and a copy will be given to the respective village development committee for their information and encouragement. All the Pseudophakic Motivators will be given detail information all about achievement of the program during monthly reviewing meeting.

3.9 Sustainability

Most of the community development oriented organization desire to exist or sustain and through which willing to provide continue service in the community as per the mission, vision and goal of the organization. There is one Chinese proverb regarding sustainability which I like very much i. .e. "Instead of giving fish, better to give fishing rod" if we give a fish to somebody they can have only one or two days, if we could teach to them how to catch a fish they can have for ever. Service receiver need to take initiation and responsibility to solve the problem so that program can exist for a long time. Sustainability can be defined as the ability of the system to produce benefits, valued sufficiently by users and stakeholders to ensure enough resources to continue activities with long term benefit (University of Maryland). The Canadian Public Health association (CPHA) identifies five main components required to achieve sustainable development, which are; a) Technical sustainability, (b) Political sustainability, (c) Financial sustainability (d) Managerial sustainability and (e) Social sustainability. Instead of social sustainability, UNICEF (1992) has used the term cultural sustainability.

Taking into account all the above mentioned five points, the proposed program has planned in such a way which will be sustainable in the community with their own active participation. The following diagram illustrated, how the program will be sustainable.

Figure 3. 2 Resources Finance and Service



Source: Green (1994).

In the context of Nepal, all most all eye health care givers are non-governmental organizations and private sectors. Most of the eye hospital are run by charitable not profit making social organizations. The main source of income of these organizations is service charge (surgery fee, bed charge and registration fee), in kind donation from the community (land, building furniture and voluntary work), and support from the donors as well as supports from the local government. It is expected that if eye hospital could provide high quality service to its clients, resources, finance and service will flow continuously as shown in figure 3.2. By involving community (Pseudophakic Motivators) patient flow rate will increase. The main source of income of the eye hospital is cataract surgery. Due to increasing life expectancy, anyone can expect more and more incidence of cataract in the future. With the involvement of the community, there will increase demand of cataract surgery. Therefore, organization will have more resources, to conduct and continue

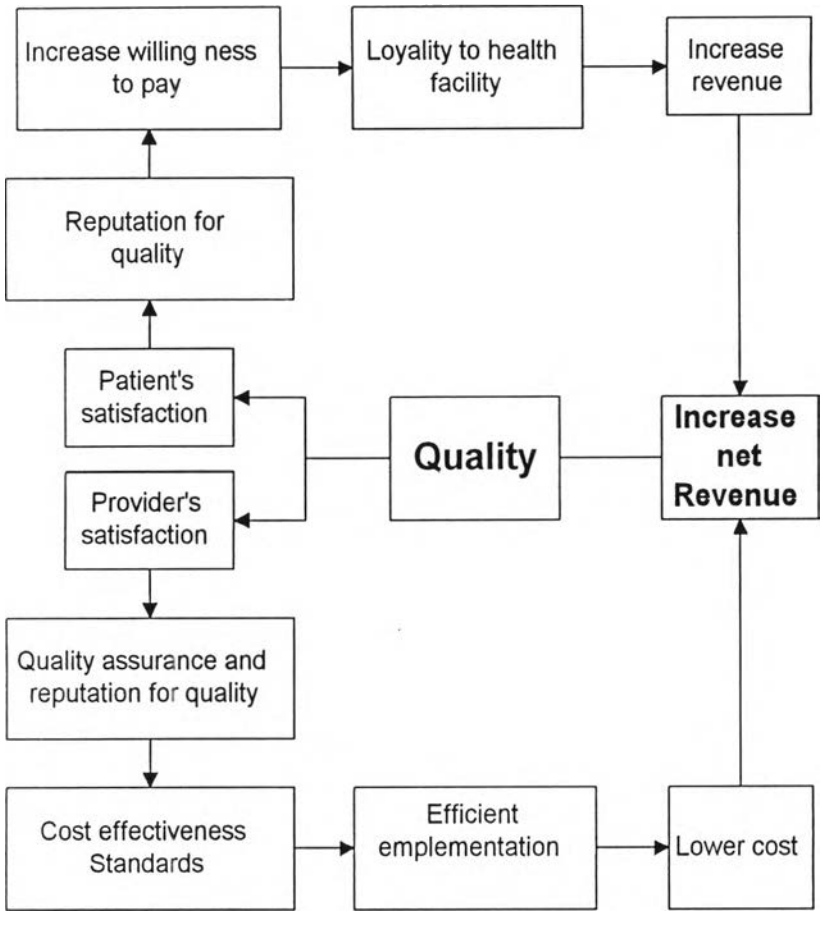
Pseudophakic Motivator training and community out reach program in the future and that will be the most cost effective marketing service approach to sustain the organization.

Social emotional exchange, expressing feelings, providing supports or empathy, communication among community members, making friendship, group relationship and developing the habit of self supporting and telling the true for the motivation of cataract blind is the main expected area of work of the Pseudophakic Motivators. MMotivators will be above 45 to 50 years of age. As per the Nepal culture in the rural area old people are not busy as adult. As far as possible, the family does not give them heavy workload. If they could contribute one or two hours a day for volunteer work, it will more than enough. They can share feelings while going to hat bazaar (fairs) or resting time. Usually village people used to gather during evening after meals in one spot of the community and tells jokees, story and religious songs, and shares the feelings among to each other. Pseudophakic Motivators can use the same time for educating and rising awareness on cataract blindness among community. Those, who bring new information in the community, community gives special regards and status to them, for the sakee of prestige also, Pseudophakic Motivators will continue to educate and motivate among cataract blind nearby their community. On the other hand, they will have direct relationship with eye care program. Their words, signatures, will be respected by the eye care service, which will provide some sort of prestige and empowerment in the community. Again, as per the Hindu culture helping to other is getting directly space in the heaven. Therefore, culturally also voluntarily work is highly appreciable in the rural community. Therefore there is higher probability to sustain the program in the community.

"A health service is sustainable when operated by an organizational system with the long term ability to mobilize and allocate sufficient and appropriate resources (manpower, technology, information and finance) for activities that meet individual or public health need demands" (Ingvartheo and Olsen, 1998). This statement is strongly supported with the proposed project. Taking in to account this definition, all the resources (manpower, finance, technology and information) will be mobilized appropriately, which will met the individual needs or demands of the community.

To reduce the prevalence of cataract blindness in the community in a sustainable health care development, quality of health care service and involvement of community is only way at present condition in Nepal. When the quality of service exist, feeling of willingness to pay of the patient will increase, patient satisfaction and positive perception of the patient is the strong determinants of service utilization. When the same group of people those who are satisfied with the service could involve in the program, combination will be matched to generate demand of service, in result revenue will increase due to patient increase. So that organization will be in a position to provide qualitative eye health care service in the community in a sustainable way. The following flow chart will make clearer how the organization will provide sustainable qualitative eye health care service in the community.

Figure 3.3 Flowchart of Cost Recovery



Source: Wouters (1995).

If revenues from user fees are sufficient to cover all the cost of the organization then the organization can pay and think quality improvement, especially those, which enhance the cost effectiveness of the health sectors. If revenues from users fees are greater than variable costs, then surplus can be used to enhance the services or reduce the need for public subsidies. In the long run from users fees will cover all the costs, so that organization can deliver sustainable eye health care service in the community. Therefore, quality of health care service and involvement of community is one of the best techniques of sustainable health care service in the community.

3.10 Evaluation

The proposed program will be evaluated in two stages. Situation analysis, or concurrent evaluation. Base line information will be collected during Pseudophakic Motivator's training. During training a day diagnostic screening and treatment eye camp will be held in the center place of the village development committee. Community will be informed through different channels like students, local governmental authority and Pseudophakic Motivators. If there is well publicized, more than 70% cataract cases can be expected to come for check up. Therefore, this screening camp's record will be used as a existing cataract blindness situation at present in the community, considering about 20 to 30% of the data may need readjustment.

When program will start then situation will be analyze continuously. Whatever problems are encountered on the way of implementation, problem will rectify on the spot applying the planning spiral approach. This on going evaluation during implementation period I would address as concurrent evaluation, which is continues process of the program.

3.11 Post Evaluation

At the end of the project, the independent team of evaluation will carry out post evaluation. There are two main issues that need to be considered determining who carries out evaluation. Firstly what are the skills required, and secondly it is advantage or disadvantage to involve from people directly involved in the activity being assessed? Outsiders, who are not directly in the service and who are considered to be impartial. But they may not have any idea about the project area, target population, and knowledge about the whole situation of the project. Service providers,

who may be seen to be biased but they have detailed knowledge, information and whole idea about the project. Therefore the evaluation team will be formed from the mix group, that is one technician will hire from out side in the project, who will be the chief evaluator, one from the community (project area) and one from the Lumbini eye care program. So that team could work perfectly and independently evaluation team will collect the following information to answer the achievement of the project.

Outcome information: to describe the situation after the activity, taking into account the baseline information, which is collected during screening eye camp. They will also see the whole project as per the stated specific objectives of the project in the beginning of the program. The main measurement will be the achievement of the program i.e. increases demand for cataract surgery. Input information, which describes the resources used in the program. Whether the resources has been properly used or not.

In the last the expected information is process information, which describes the implementation process of the activity. Mainly, process of training, process of the screening eye camp, selection process of Pseudophakic Motivators, supervision and monitoring process, process of community mobilization and resources mobilization and applied approaches for cost effectiveness and cost benefit (Green, 1994).

3.12 Budget

Title	Description	Amount in Rupees
1. Trainer	Dally allowance for trainers 2 trainers x 300 per day x 30 days	18,000.00
2. Trainees	Training Allowance @ 60 x 135 persons x 2 days	16,200.00
	Tea and small Nasta @ 10 x 135 x 2 days	2,700.00
3. Training material	Primary eye care booklet @ 20 x 135	2,700.00
	Cataract poster @ 10 x 135	1,350.00
	Training register @ 100 x 1	100.00
4. Supports	Dally allowance for driver @ 200 x 15 days	3,000.00
	Fuels for vehicles 10 lit @ 15 x 15 times	2,250.00
5. Materials	Vision chart @ 20 x 135	2,700.00
	Referral slips @ 20 x 135	2,700.00
	Certificate @ 10 x 135	1,350.00
	Dot pen, white paper, masking tape, marker pen , chalk, etc	1,000.00
	Hand bills health education materials	2,000.00
6. Screening camp	Torch light @ 100 x 2	200.00
	Battery for torch light and ophthalmoscope @ 20 x 15 pairs	300.00
	Register for camp record @ 100 x 1	100.00
	Essential medicine for camp purpose @ 500 x 15 times	7,500.00
	(Medicine will not distribute to the patient free of cost, there will provision of selling medicine those who needs.)	
7. Refresher training, follow up and review meeting	Dally allowance for technician @ 300 x	45,000.00
	Dally allowance for driver @ 200 x 5 times x 15 VDC	15,000.00
	Fuels for vehicle @15 x 10 Lit. x 75 times	11,250.00

8. Prize	Prize for best Motivators cost of RS 3000 for each quarter (3000 x 4= 12,000.)	12,000.00
9. Supervision cost	1 person @ 300 x 10 days per month x 12 months	36,000.00
10. Evaluation	(a) 3 persons x @500 x 10 days = 15,000.00 (b) Fuels for the vehicle 500.00 (c) Driver's D.A @ 200 x 10 days = 2000.00	17,500.00
11. Contingency		10,000.00
	Grand total of the project cost =	2,10,500.00 (US$ 3095) 1$ = Rs 68

3.12 Activity Work Plan

Activities	Year/Month (number denotes the month July-7, June -6)											
	2000						2001					
	7	8	9	10	11	12	1	2	3	4	5	6
Meeting with staff of Lumbini eye hospital												
Meeting with VDC chairman and local leaders.												
Selection of Pseudophakic Motivators												
Pseudophakic Motivators training with Diagnostic screening and treatment camp.												
FGD Survey												
Data Analysis												
Implementation												
Monitoring and supervision												
Refresher training and follow up												
Evaluation												

References

Annemarie, W. (1995). Improving quality through cost recovery in Niger. Health Policy and Planning 10 (3), pp. 257-270.

Brilliant, G. E. & James, M. L. (1991). Social determinants of cataract surgery utilization in south India. Archive Ophthalmology, 109, pp. 584-589.

Cataract removal improves life (1993). USA Today Magazine, 122(2581), p. 113.

Evans, R.G. & Stoddart, G.L.(1994). Why some people are healthy and others are not? In M. L. Barer, R. Marmor, G. Robert, & G.D.Walter (Eds.). Detreminants of Health, p. 30. New York.

Goode, S.V., Faal, H. & Johnson, J.G. (1998). Barriers to the up take of cataract surgery. Trop. Doct., 28(4), pp. 218-220.

Health situation south East Asia. Estimated prevalence of cataract blindness in South East Asia. World Health organization South East Asia Region. 1999.

His Majestry's Government of Nepal, Ministry of Health Department of Health Services (1996). Female community health volunteer. Annual Report of Health Service, p. 143.

Kupfer, C. (1988). Management cost of cataract in India. In: World Blindness and it's Prevention, pp. 174. Edited by International Agency for Prevention of Blindness.

Lawrence, P., Seddon, M.G., Oravej, J.M. & Mangione, C.M. (1994). Improved visual function and attenuation of declines in health related qualities of life after cataract extraction. Arch Ophthalmology, 76, pp. 713-717.

Marseille, E. (1996). Cost-effectiveness of cataract surgery in public health eye care program in Nepal. Bulletin of the world Health Organization, 74 (6), pp. 319-321.

Marseille, E. & Brand, R. (1997). The distribution of cataract surgery services and public health eye care program in Nepal. Institute for Health Policy Studies, University of California.

Marseille, S. & Gilbert, S. (1997). The cost of cataract surgery in public health eye care program in Nepal. Institute for Health policy studies, University of California.

Olsen, I.T. (1998). Sustainability of health care: A frame work for analysis. Health Policy and Planning, 13 (3), pp. 287-295.

Regmi, G., Shrestha, S.K, Negrel, A.D., Ellwein, L.B. & Pokhrel, G.P. (1998). Prevalence of blindness and cataract surgery in Nepal. British Journal of Ophthalmology, 82, pp. 600-6005.

Shrestha, A.R., Gharti, M.P. & Snellingen, T. (1998). Socioeconomic barriers to cataract surgery in Nepal. British Journal of Ophthalmology, 82 (12), pp. 1424-1428.

United Nations. (1991). Self-help organizations of disable persons. Annual report, pp. 10-11

WHO (1997, February). WHO Fact Sheet, 146.