Our experience of utilizing community-based health assistants in delivering primary eye care services in a resource-poor setting of Rural Bengaluru, Karnataka, South India

Introduction

India is a country of vast diversity in culture and beliefs. The population of the country is so enormous that there is a difficulty in meeting the health needs of the vulnerable groups, especially in the rural areas. In the field of eye care services, it is known that there is a definite gap in eye care specialists and expected number of people with any eye problem. There is also a gap in the delivery of eye care services to these people, especially people who require an active intervention such as cataract.

Primary health care was a concept visualized by Sir Joseph Bhore in 1946, and this concept was not just the basis of delivery of health-care services in India but was also the basic foundation for health for all strategies which was adopted by the WHO in the late 1970s. The principles of primary health care can be extended to eye care services which have been an important strategy in NPCB. The components of primary eye care include eye health education, symptom identification, visual acuity measurement, basic eye examination, and diagnosis and timely referral. The usage of primary eye care workers has been one of the implications which were thought of due to the lack of trained professionals to fill the lacunae.

Usage of Community-based Health Assistants in Primary Eye Care

The Department of Community Health, St John's Medical College, Bengaluru, with the support of CBM SARO(S) started a Primary Eye Care Unit in the rural area of Mugalur, 35 km from Bengaluru. The main objective of this initiative was to provide cost-effective eye health services and free cataract surgical services. The service currently consists of a designated operation theater (OT) and outpatient department (OPD). It also conducts outreach camps in remote and deserving areas. One of the main reasons for this tremendous progress in eye care services has been due to the hard work of community-based health assistants (CBHAs) who have been employed by the project.

Involvement of the Community-based Health Assistants-methodology

These women were selected initially as a part of hearing impairment project and were soon involved in eye care. They have been trained in the anatomy and physiology of the eye, identification of eye problems, basic assessment of vision, and usage of ophthalmic equipment such as autorefractometer, A-scan, and keratometer. The women selected were in the age group of 20–30 years with basic educational qualification of having passed their high school, who preferably married making them the permanent residents of that community, and who also had an experience of involvement in community developmental activities.

Due to the lack of trained health-care personnel and due to the rapid attrition of refractionists, it was felt that the CBHAs could be involved in the whole range of the activities from screening to surgery. Currently, the project has been managing effectively and efficiently with rapid expansion due to the tremendous input by these health assistants.

Results

The different activities which they have been performing include:
1. Primary prevention
   a. Health education on eye care
   b. Vitamin A administration to children.
2. Secondary prevention
   a. Early diagnosis
      i. Organizing camps in remote areas
      ii. Screening for eye problems in the community

Figure 1: Community-based health assistants screening for refractive error
iii. Screening in schools for refractive errors
iv. Referrals to the base hospital.

b. Treatment
i. Registration in the OPD
ii. Initial assessment – visual acuity using Snellen chart
iii. Assisting ophthalmologist in assessment and recording the diagnosis [Figure 1]
iv. Pre- and post-operative advice to patients
v. Dispensing medicines to patients.
c. Follow-up in their houses

3. Tertiary prevention
a. Telephonic reminders regarding dates for cataract surgery
b. Preoperative procedures – trimming of eyelashes, informed consent, administering preoperative medications
c. OT – assisting the eye surgeon, disinfection of OT, sterilization of the surgical instruments and linen [Figure 2]
d. Inpatient (IP) care – postoperative medications, food
e. Postoperative checkup – vision
f. Follow-up at home [Figure 3]
g. Telephonic reminders for postoperative review
h. Referral for visual rehabilitation.

4. Administrative aspects
a. Record maintenance of outpatient/IP, details of cataract surgery
b. Drug inventory
c. Basic equipment maintenance.

Conclusions
The eye program has been very effective with the usage of CBHAs in all the activities. Thus, inclusive primary eye care has been successful in the implementation of eye health services in the rural areas. It has been an effective strategy for ensuring sustainability and community support. It has also simultaneously empowered the women in their community.

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Conflicts of interest
There are no conflicts of interest.

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