View

RURAL OPTOMETRY AS AN INTEGRAL PRIMARY HEALTH CARE IN IMO STATE, NIGERIA

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The ability to use the eyes to see the world around is regarded by people everywhere as their greatest gift. We rely on our sense of vision more than all of our other senses put together.

In 1978, the Alma-Ata Declaration endorsed Primary Health Care (PHC) and established the goal of "Health For All By The Year 2000 (HFA 2000)" (1). PHC is defined as essential health care made universally accessible to individuals and families in the community by means acceptable to them at a cost that the country and community can afford (2). Affordability is a key facet of the approach. Indeed, some have seen it as a cheap option for health care in developing countries. It focuses on the provision of preventive and basic curative care at the lower tiers of the health care system because it is less expensive and potentially more effective in improving health status than the higher technology care health instructions (3).

More broadly, the concept of PCH with its emphasis on viewing health development as a part of the whole development process on self reliance, community involvement, should be concerned with the pursuit of social justice through alleviation of health inequalities as is currently being enunciated by the Federal Government of Nigeria through MAMSER (Mass Mobilization for Self Reliance, Social Justice and Economic Recovery).

From the foregoing, it becomes quite clear that eye care or vision care which is the primary concern of the rural optometry programme should be embodied in the PHC programme. Since most rural communities can not pay for or afford the services or have access to the higher technology eye hospitals. Moreover, little is known about eye care in developing countries, hence blindness is rampant which can be prevented only if adequate measures are taken promptly.

The term primary care has received considerable attention within the health profession in recent times. It is a term that is increasingly being used to delineate manpower needs and the relative roles and responsibilities of various health disciplines. In that regard, it can be said that primary eye care is the fundamental basis of the rural optometry programme.

Vertical programmes have been designed to ensure that the techniques and services reach the whole population. It aims at even distribution of resources for eye care among the population no matter how remote. There are about 500 autonomous communities in Imo State, and the rural optometry programme is expected to be made available to them within the shortest possible time and in consonance with the PHC spirit.

The rural optometry is vision care and is therefore a part of mobile health service (MHS) through eye care to the rural community. MHS range from the simplest in preventive care such as community health worker (CHW) visiting distant villages, e.g. UNICEF sponsored Expanded Programme on Immunization (EPI), the flying doctor of mobile doctor services of various state governments in Nigeria, to most elaborate in modern surgery, e.g. the American funded Project Orbis that visits countries worldwide, performing ophthalmic operations.

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On the whole, the primary aim of these services is the same i.e. to increase the access of the rural people to medicare which they would hitherto not receive.

In 1984, the World Health Assembly (WHA) enjoined Universities throughout the world to place themselves at the disposal of the communities to the maximum of their capacity for the promotion of health and provision of health care, and to participate in creating awareness in the general public of the action people can take to promote their health and the health of the community in which they live (4). In apparent response to this call by WHA, the Imo State University instituted the rural optometry programme as its contribution, in part, to the fulfillment of the goal of HFA 2000.

The venue of the clinic is usually a health centre or a school or a private hospital or a town hall or any large building suitable for the purpose provided by the rural community.

Participants (patients) receive a comprehensive eye examination at no cost ass well as proper treatment. Visual screening and visual analysis are also carried out to identify individuals with various ocular manifestations or disabilities such as squints, strabismus, heterotropia, cataract, etc. Each disorder is managed on its merit and where appropriate referral is made to the more sophisticated ophthalmic centre in the University or the General Hospital Eye Centre. The treatment is usually in the form of prescription for glasses, vision training or low vision rehabilitation, use of drugs, etc. for instance vitamin A is given to children to prevent infantile eye damage. The following procedures are usually taken according to the flow chart:

Equipments

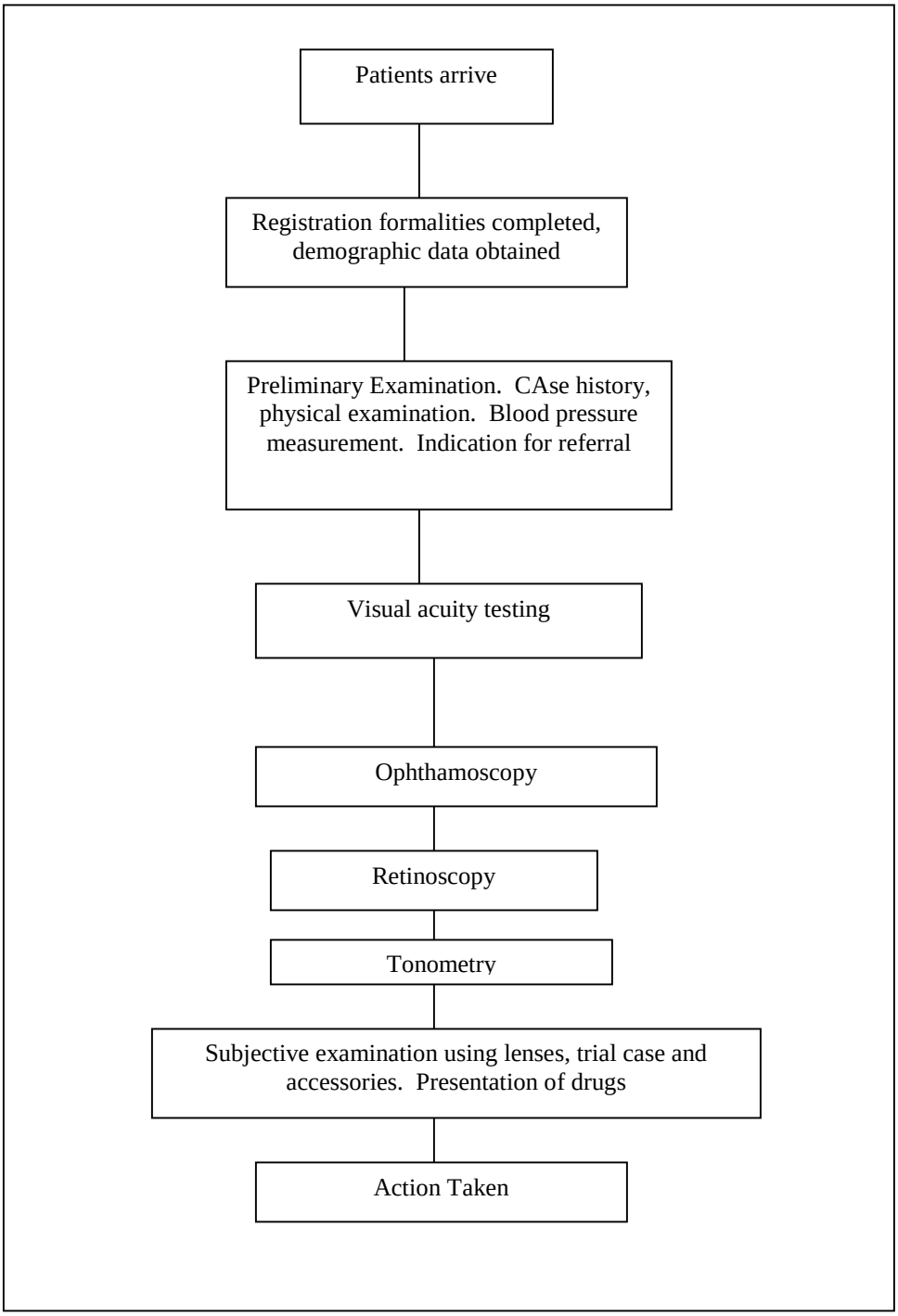
- Pen-torch or torch with 1.5 V batteries, Transilluminator, Ophthalmoscope, Schiotz tonometer, Snellen charts including illiterate letter E, Trial frame, trial case and its accessories, PD rule, Dark or Black Cloth to provide a temporary dark room, Stethoscope and Sphygmomanometer.

The results are usually recorded in this order:

a. complete history
b. naked visual acuity
c. detailed report of external findings
d. ophthalmoscopy - media, fundus, blood vessels, disc
e. static retinoscopy
f. amplitude of convergence and accommodation
g. phoria and duction finding - horizontal/vertical distance/near
h. subjective findings
i. fusion
j. stereoscopic vision
k. colour vision
l. visual fields (confrontation)
m. visual fields central (in people older than 40 years)
n. prescription is given and visual acuity is again obtained
o. corneal tonometry
p. drug treatment and referral.

Since the Alma-Ata declaration (1), health care has been undergoing significant changes and one effect has been establishment of the rural optometry of outreach programme by the Imo State University. This programme which is an innovation of the PHC, is designed to provide services through tremendous impact on the traditional eye care services as it provides vision care at affordable cost to the rural communities where people live and work thus constituting the first element of a continuing health care process (5).

The advantages are immense. Both the clinicians and the optometrists are exposed to various challenges in the rural community. Here, the primary aim is the participation in the coordination of various levels of secondary and tertiary health care through vision care. Clinical cares are provided, while microsurgery including cataract extraction are referred to ophthalmologists, glaucoma consultation, management of retinal detachment if any and other retinal diseases and consultation for ocular emergencies and a variety of ophthalmic problems are meticulously attended to.


Patients arrive
Registration formalities completed, demographic data obtained
Preliminary Examination. CAse history, physical examination. Blood pressure measurement. Indication for referral
Visual acuity testing
Ophthamoscopy
Retinoscopy
Tonometry
Subjective examination using lenses, trial case and accessories. Presentation of drugs
Action Taken

The potential drawback of the programme lies mainly in

i. Travel limitations imposed by bad roads, since most rural roads are bad and water-logged during the rainy season. However, the activities of the Federally sponsored Directorate for Food, Roads and Rural Infrastructure (DFRRI) in this regard have been very helpful.

ii. Availability of transport facilities. Most times, the programme has been unduly delayed or cancelled due to lack of transportation.

iii. Inadequate administrative support and notifying the communities to be visited. When such is the case the turn out of patients needing eye care is usually not encouraging. The function of information dissemination is usually vested on the traditional or local ruler of the community to be visited.

iv. Financial support, though inadequate has been borne by the University. Assistance from voluntary agencies, wealthy individuals, the State or Federal Government or even local government is indicated.

However, there are obvious benefits which outweigh these problems. These include savings in travel cost by the members of the community to be visited to the urban areas to receive the sophisticated medicare, reduced congestion on the already congested hospitals and clinics in the city centres, provides professional support to health workers in remote areas by bringing in the essential drugs and medicare which are usually not available in the rural area or not affordable. On the whole, the rural optometry is promotive, preventive, curative, rehabilitative, effective and affordable by the rural community.

From this report, it can be seen that there is a great measure of resourcefulness in the area of eye care as an integral part of PHC. It is therefore suggested that more extensive participation of the eye care service be undertaken by the other better placed Universities in order to fully appreciate and maximize its potentials and dimensions so that it can be infused into the global efforts to attain the objective or goal of HFA 2000.

Health for all is not a static target but a dynamic way of improving the health of all people, essential eye care will be accessible to all individuals and families in an acceptable and affordable way.

The evolution of health care is measured, in part by the development of clinical knowledge and by specific clinical procedures that become salient features of contemporary health care practice.

Recent advances in eye care technology serve as valid testimony that this evolution or changes occur. Rural optometry or outreach programme is one such innovation. It is eye care or vision care taken to the rural community at affordable and acceptable cost and condition.

Since it is the first or nearest contact between the individual and eye (vision) care service, it is therefore primary health care through vision care.

It is therefore suggested that rural optometry should be embodied in the primary health care programme.

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NEWS

Health Systems Research in Africa

The WHO/AFRO Advisory Committee meeting on June 1990 considered Health Systems Research (HSR) as one way of strengthening health management. The WHO consultancy meeting of December 1990 held in Ghana recommended that each member country and WHO focus their attention to consensus bulding, capacity building and consolidation in order to enhance the development of HRS in the Region.

Fighting AIDS Together

In Ethiopia the situation of AIDS has become a matter of increasing concerning specially after the number of AIDS cases has been shown to increase recently and reports of HIV carriers from paractically all regions of the country. Because of the alarming situation, the Department of AIDS control (DAC), the Ministry of Health, has launched a three-month intensive IEC program on AIDS referred as "Fighting AIDS Together" (FAT), between October 1-December 31, 1990. The main objective of FAT was to encourage a variety of AIDS related health promotion throughout the nation.

During the campaign, with the active participation of the FAT team (consisted of six persons outside the DAC) the Department has been actively involved in preparation of printed materials, educational package and guidelines, distribution of resource materials, educational package and guidelines, distribution of resource materials (leaflets, posters, discussion/teaching cards) to a number of governmental, non governmental and mass organizations. Training was given throughout the nation to various communicators and trainers from governmental and non-governmental agencies and church representatives on teaching methodology on AIDS, Material production, Counselling and Condom Promotion. A number of AIDS committees have been established in many institutions for the purpose of dissemination of AIDS information and to establish links with DAC "HIWOT" (meaning life), a brand name given to condom in Ethiopia, has been introduced to the public in as much as possible and it is now being sold throughout the nation.