ROUND TABLE WORKSHOP TO DELIBERATE ON EYE CARE
GHANA AND TOGO
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Swiss Red Cross

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CROIX-ROUGE TOGOLAISE

TOGOLESE RED CROSS

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I Introduction

The intention was to organize a round table workshop between two countries on a well-defined theme, emanating from the wish to progress and find new objectives. The Swiss Red Cross, which works in Togo and Ghana on eye care projects with the Ministry of Health and National Societies of the Red Cross of the these two countries, invited stakeholders to a grand regional opening to allow each of them to reflect deeply on their own activities and to find solutions to old problems by means of new approaches.

The participants of the workshop were chosen on the basis of their direct involvement in projects for the fight against blindness. They comprised members of the medical team of the Ministry of Health (ophthalmologists or specialized nurses), Volunteer Coordinators of the Red Cross of Togo and Ghana and Project Coordinators of the Swiss Red Cross.

The objectives of this round table workshop were defined thus:

- To put into operation two programmes for regular exchange
- To identify instances of good working practice, duplicate and adopt them in neighbouring countries.
- To harmonize work approaches between the two programmes
- To use the experience of Togo as a basis to initiate a broad health approach not limited to eye care only.

The workshop was facilitated by two resource persons: Dr. Pierre Huguet from the department for the fight against blindness of the World Health Organization (WHO), who was assigned to evaluate the two projects in 2006 and 2007; and Karl Blanchet, a public health consultant, who has been involved in inaugurating new strategic approaches in terms of quality health care and good administrative performance for the past three years.

1. Similar and different at the same time

This initiative and exchange of experience was the first of its kind for Togo and Ghana.
The two projects are similar and yet different in many areas.

- The two projects have the same objectives: to increase the number of people benefiting from cataract operations.
- They use an approach that targets the same health structures of curative, preventative health care and health education.
- The poor are the principal target group for the two projects, which is why a community based approach with a wide range of volunteers has been put in place, with guaranteed funding to support it.
- The two interventions consist of material, financial and technical support from the Ministry of Health and the Red Cross. These actors are the principal implementers of the project.
- The Swiss Red Cross plays the role of Coordinator and facilitator in making materials and technical and financial resources available to all partners. Its counselling role runs across its team and consultants introduce new ideas and solutions periodically.

It is clear that the objective of this round table workshop was not to compare the two projects in terms of performance. These two eye care interventions present very different approaches, making it impossible to establish clear comparisons. The table below summarizes the principal differences between the two projects.

	Ghana	Togo
LAUNCH DATE	1990	2004
Size of project	In two regions: Upper West and Northern regions. From 1990 to 1995: in one region: Upper West. From 1996 to 2005: in 2 regions: Upper West Brong Ahafo In 2006: in 3 regions: Upper West, Brong Ahafo and Northern Region.	In only one region (Central Region) and the Bassar district Kara region.
Target Population	560,000 inhabitants (Upper West) 577,000 inhabitants (Northern Region)	220,000 inhabitants
Results	CSR 1'539 in 2006	CSR: 333 in 2006
Composition of the Swiss Red Cross team	1 national delegate 2 project coordinators 1 logistician 1 administrator	1 national delegate 1 administrator 1 driver
New approaches	Quality assurance Performance monitoring	Other health projects. AIDS and community health.

The Vision First eye care programme in Ghana started before the Togolese programme and provides a more effective coverage than that of Togo. Logically the human and financial resources available to Ghana are superior to Togo's. It therefore seems that any comparison between the two projects has to take into account the history of these interventions and the contexts in which they operate.

2. Workshop outline

The round table workshop ran for 4 days in the town of Sokode in Togo, in the prefecture of the Central Region where the project for the fight against blindness was commissioned. The workshop was preceded by a 2-day visit from the Ghanaian delegation to some projects in Togo. The delegation visited eye care services at the regional and district hospitals and also had the chance to witness village sensitization programmes.

The two teams brought along posters, visual aids, T-shirts and other educational tools, which were displayed on the walls of the room.

One of the challenges of the workshop was to make it possible for the participants to gain access to reliable and detailed information. The two facilitators helped all the resource persons to prepare their presentations, as they appreciated that synthesizing information in a clear and concise manner was very difficult for some people. The traditional plan for the progress of the workshop was in four parts:

- Situational presentation by the resource persons of the two programmes
- Work in small groups
- Presentation of work in plenary sessions
- Discussions and debates in plenary sessions.

The principal difficulties during the workshop were technical hitches arising from the simultaneous translation. The superimposition of the voices of interpreters and resource persons also caused an inappropriate sound level and made comprehension difficult.

This document presents the results of the different work groups. It has been made comprehensible to the wider reading public and not only to participants of the two projects. It is also hoped that the document will serve as a reference for other countries to draw on the success stories of Togo and Ghana.

II Introduction to the workshop

Madam Cissé, president of the regional committee of the Togolese Red Cross, and Dr. Kondi, national coordinator for the fight against blindness in Togo, welcomed the participants to Togo and to the workshop. They were both pleased that the two countries would be able to share their experiences in this very important programme.
The workshop was officially opened by Regional Health Director of Central Togo, Dr. Kabara, who warmly welcomed the Ghanaian neighbours and wished all participants fruitful deliberations.

Dr Pierre Huguet, facilitator and member of the World Health Organization recalled the different objectives of the workshop and briefly described each day's activities[1].

The first day was basically devoted to the presentation of the two programmes for the fight against blindness. The participants had to be capable of understanding the two projects and to identify the principal points of convergence and divergence.

- During the second day, three principal themes were discussed.
    - Community mobilization
    - Access to prevention and care for the most deprived
    - Quality of care
- The third day concentrated on:
    - Health education
    - Detection and care of visual deficiencies in school children
    - Material resources: supply and maintenance
    - Programme Coordination
- The fourth and last day was dedicated to synthesis.

[1] Huguet. P. 2007. *Round table workshop of the Swiss Red Cross in Togo and in Ghana.* PowerPoint Presentation WHO, Geneva

III Presentation of Togo and Ghana programmes

1. Ghana programme

Mr Seth Addae-Kyereme, delegate of the Swiss Red Cross in Ghana made a presentation on Ghana's[2] Vision First Programme. Mr Addae-Kyereme first described the state of blindness in Ghana and then outlined the resources available for combating it.

The prevalence of blindness in Ghana is estimated at 1% of the population, which represents 200,000 Ghanaians. The number of people suffering from cataracts is estimated at 100,000, with 20,000 new cases each year. It should be noted that the number of cases operated upon each year in Ghana does not exceed 10,000 and a lot of effort is required to enable a comprehensive response.

This weak performance is explained in part by limited resources allocated to the fight against blindness. Ghana has very few specialized staff and substantial differences between the north and south of the country. For example, there is one ophthalmologist for the Northern region only.

On the demand side, in spite of the introduction of National Health Insurance, access to care remains limited for the poorer populace. The World Bank has estimated that 40% of the Ghanaian population is poor and the poverty rate is higher in the north than at the coast.

The Vision First Programme has three principal objectives, which are linked to Strategy Vision 2020:

- The first consists of the fight against preventable diseases that cause blindness. This objective is linked to advanced strategies for consultation (at the community level and in schools) and surgical interventions, as well as all the clinical activities that are taking place in the district and regional hospitals. It is necessary to identify and operate on patients suffering from cataracts as well improving the vision of all persons suffering from the defects of refraction.

- The second objective is to reinforce the capacity and competences of staff involved in the fight against blindness. This involves the recruitment of personnel by the Ministry of Health, taking into consideration the needs of the districts as well as the training of support staff such as ophthalmologists, ophthalmic nurses, staff at post, volunteers, Red Cross workers and teachers. The content of training varies according to the category of staff, the clinical area, prevention strategies and administration technique.

[2] Addae-Kyereme S. 2007. *Delivering Effective Healthcare Programme -Eye Care Services in Ghana*. Power Point Presentation. Swiss Red Cross. Ghana.

- The third and last objective is more concerned with material resources. It is about developing and reinforcing infrastructure and necessary equipment for the fight against blindness. With regard to its needs, the programme – that is to say, the three partners – will pool their finances to build resources for eye care in the deprived hospitals according to a hierarchical order defined from the beginning.

Mr. Addae-Kyereme talked about other specific initiatives that have been put in place to respond to certain needs:

- **AACHIB (Action Against Childhood Blindness)**
  - The objective of this activity is to reduce blindness in children of ages 0 to 15 years.

- **VFPS (Vision First Pro Poor scheme)** in the Bole and Jirapa districts.
  - This initiative is a specialized solidarity fund for subsidizing medical fees for the poor. This project has been piloted in two districts.

- **Mobile Surgical Clinics**

- **Financial bonus based on performance**[3]
  Health personnel of the Ministry of Health involved in the programmes are evaluated every quarter according to well-defined indicators and their financial incentives are based on their level of performance.

- **Quality Assurance**[4]
  - This initiative put in place in 2006 aims at improving quality across the board by utilizing well-defined criteria to be adhered to by all stakeholders.

  - Mr Seth Addae-Kyereme's presentation highlighted the main strengths of the programme in Ghana and he did not hesitate to bring to light its main challenges as well.

Strengths

In terms of resources, the programme has the advantage of benefiting from qualified medical staff appointed and managed by the Ministry of Health and from the technical support of consultants from the headquarters of the Swiss Red Cross . The Ghana Red Cross Society provides effective collaboration and regular exchanges. The administration of its programmes is made easier through effective planning, monitoring and exchange of reports and periodic auditing. The relationship between the three partners (Ministry of Health, Swiss Red Cross and the Ghana Red Cross Society) has also allowed effective collaboration and encouraged regular exchanges. It could therefore be said that the availability of long-term financial resources to the Swiss Red Cross has made it possible for the three partners to plan their activities for ten years.

Weaknesses

A few areas need improvement. They primarily concern clinical diagnostics, which can only be estimated due to a lack of specialized material for the verification of information. Again, it is

[3] Blanchet K., Hagan M., Osei-Bonsu P., Addae-Kyereme S., *The right incentive for the right performance in eye care*, 2005, Vision First Programme, Ghana Health Service, The Swiss Red Cross, Ghana.
[4] Blanchet K., Hagan M., Osei-Bonsu P., Bannerman C., Ahorsu F., Asubonteng K., Wanye S., *Quality Improvement in eye care*, Vision First Programme, 2005, Ghana Health Service, Swiss Red Cross, Ghana.

very difficult for the Ministry of Health to recruit new ophthalmologists to work in the north of the country. The second weakness of the programme concerns the management of volunteers, which is not well administered on the supervisory level or in the follow up of their activities. Consequently, it is difficult to evaluate the performance of the volunteers and their impact at the community level either in terms of prevention or in terms of reference. Finally, there is also a financial and material difficulty concerning the running of vehicles, which have become increasingly difficult to maintain after years of usage.

Opportunities

In terms of opportunities, the Vision First programme is beneficial in the national context in that it is linked to the National Health Insurance Scheme, which operates countrywide. Consequently, cataract operations form part of the costs that are reimbursed under the scheme. In spite of frequent ministerial changes, blindness remains a national health priority, which can. be attributed to the favourable context and the general stability of the country. Externally, the Swiss Red Cross has acquired expertise in eye care in Ghana, as well as in other African and Asian countries.

Threats

The main threats lie in human resources directly involved in the programme. It is always difficult to attract qualified staff, doctors and nurses to the north of the country. Again the migration of health staff from Ghana to Europe or to the United States has not declined. Strikes involving health personnel can sometimes hold up services for several days.

With regard to the volunteers, it is a real challenge to continue to motivate them adequately. Additionally, fuel prices, which have gone up appreciably in the past two years, have taken a toll on the programmes.

Mr Addae-Kyereme concluded by affirming that the Vision First programme will follow its primary objectives and will take into consideration all the lessons learnt. The programme will concentrate mainly on the two regions in the North.

2. Togo Programme

Dr Kondi, the National Coordinator of the fight against blindness, presented the context in which the programme has evolved over the years in the Central Region in the prefecture of Bassar [5]. Togo presented its five-year plan, Vision 2020 for the fight against blindness in July 2003; it was approved by the development partners in June 2004. The main national challenge is to equip the country with qualified human resources, either in terms of ophthalmologists or optometrists. The national priorities of managing cataracts and ametrophies have been adopted by the programme of the Central Region.

[5] Kondi G. 2007 National Programme on the fight against blindness. PowerPoint Presentation. Ministry of Health, Togo.

Dr Nonon Saa presented the programme on the fight against blindness in Togo[6].
Eye diseases are among the ten main causes of morbidity in the Central Region. It is estimated that about 1% of the population is blind and more than 80% of the causes of blindness are preventable or curable. Cataracts are the number one cause of blindness and have affected about 50% of blind people. Out of 6,000 blind people, 3,000 suffer from cataracts. Out of the 600 new cases reported yearly, 300 have cataracts. To halt the process, 300 people with cataracts must be operated on yearly, thus reaching a CSR of at least 500 out of 1 million inhabitants and reducing the prevalence of blindness (CRS >2000).

The Objective of the Programme is to improve the management of eye infections and the recording of people with eye problems in the region and the prefecture of Bassar from 2003 to 2013, through detection activities, treatment, prevention and promotion of eye care.

To reach this objective, the programme has put a number of activities in place.
The first strategy is to deploy personnel caring for the sick into the region, since there has not previously been a qualified ophthalmologist in the region.

The Ministry of Health has posted an ophthalmologist to the regional hospital (CHR) in Sokode and five technicians and senior ophthalmologists to the district hospitals. Support personnel should also be trained, especially principal nurses; and additionally 300 volunteers need to be recruited and trained.

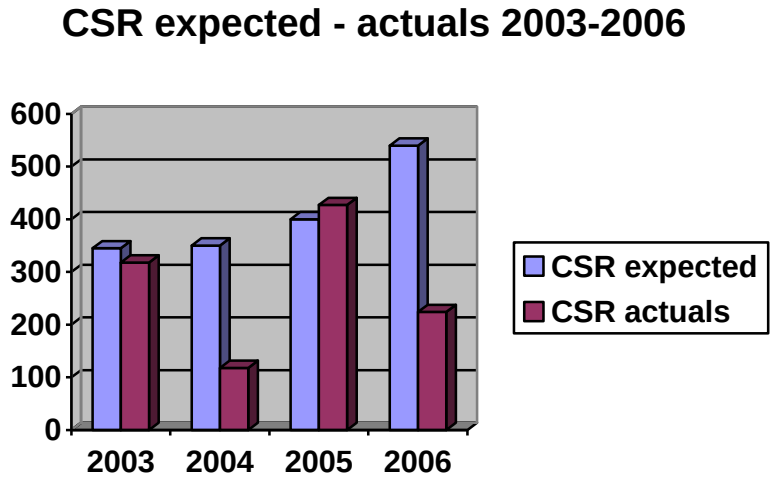
The second activity consists of reinforcing the material capacity of eye care, i.e. buildings and equipment. The optical centre has also been equipped.

In terms of the fight against disease, the programme is concentrating on health education. All the volunteers have been directed to organize awareness raising seminars with the help of visual aids in the villages.. Their activities are supported by publicity on the radio in the various local languages. They then have to identify and refer patients to hospital for consultation and operation.

The table below summarizes the results:

Years	Estimated Population	Expected CSR	Nbr of patients to be operated on	Actual nbr operated on	CSR correspondence
2003	580 000	345	345	183	**318**
2004	587 000	350	206	69	**118**
2005	553 000	400	237	253	**427**
2006	600 000	540	270	134	**224**

[6] Nonon Saa K.B. 2007. *The fight against blindness in the Central Region and the prefecture of Bassar*. PowerPoint Presentation. CHR of Sokodé. Togo.



Performance analysis allows for the quick identification of certain weaknesses in the programme.

At the demand level, the people cannot contribute financially to cataract operations, even though they are largely subsidized by the Swiss Red Cross and the Ministry of Health and the price has been fixed at 15,000 FCFA. Moreover, regular mission interventions in the Central Region from foreign organizations proposing free eye care comprising cataract operations do not encourage the communities to pay for their surgical operations.

At the supply level, in Bassar one nurse is responsible for two posts. They have to cover the needs of the military camp at Kara, thus absenting themselves from their posts several times a week. Regular absenteeism of health personnel discourages patients from coming for consultation. This unavailability of personnel makes it impossible to cover the fifth intervention zone.

At the community level, the basic work done by the Togolese Red Cross and the Togolese Association for the Well Being of the Family (ATBEF) – all trained in eye care – to sensitize the adjoining communities has not yielded the expected results. The effect of this is apparent from the small number of referrals by volunteers to the district and regional hospitals. The real reasons for these failures are difficult to analyse since the information gathered is rather scanty and imprecise.

With regard to the management of the programme, coordination is relatively weak due to the lack of experience of the coordinating doctor, who lacks experience of this type of job. Moreover, the administrator has only put management tools in place recently, following two consultancy missions. This lack of tools has created backlogs and administrative lapses. Again, personnel at all levels do not benefit from regular supervision, which would enable them to improve their performances and share problems with their superiors to find possible solutions.

Perspectives of the Togo programme

One of the biggest challenges is to increase service utilization rates by reducing geographical and financial barriers. For this reason, it is important that nurses increase the number of advanced strategies in order to make a better impact on the number of referrals. However, this necessitates refresher training courses for the volunteers. The conclusions of the studies of

knowledge, attitudes and practice (KAP) effected in 2006 must be analysed to enable appropriate decisions on community mobilization to be taken. The solidarity funds must be provided by different donors in order to increase the number of beneficiaries. The nurses must keep track of the vision needs of school children to ensure that they have properly prescribed spectacles.

The second challenge is in the management of the project. It concerns putting in place supervisory tools at all levels to render the programme effective. It is necessary to involve the prefecture directors of health (DPS) in the administration and supervision of activities on their territory, with a view to making the programme an integral part of the regional health system to ensure sustainability. It is also important to put in place the quality care system (AQS) that has recently been introduced[7].

Two groups, each comprising Togolese and Ghanaian participants, worked on a comparison of the two programmes. The facilitators of the workshop synthesized the results as follows:

3. Similarities of the two programmes

- The prevention of blindness has not been overlooked, but it is not the priority of public health either in Togo or in Ghana.

- Existence of a national programme for the fight against blindness (PNLC) and of a regional plan.

- The intervention of several NGOs at the national level. On the other hand the Swiss Red Cross is the only international NGO working in eye care, in the Central Region of Togo and in the Upper West and Northern regions of Ghana.

- A study on the demands of the populations has been undertaken, but the financial capacities of the populations have not been properly evaluated.

- Not much involvement of civil society in the fight against blindness, apart from the national societies of the Red Cross and ATBEF.

- There is no existing precise data on the specific prevalence of infection in Vision 2020 national and regional priorities. Unconfirmed results of research carried out on the prevalence of blindness in the Northern Region indicate a prevalence rate of 1.7% in the over-40 age group. Research in Togo has not produced a definite result due to non-analysis of data.

- There is similar concentration on the goals and needs of the two programmes in matters of primary and secondary prevention in eye care. On the other hand; the tertiary prevention (rehabilitation) of visual deficiencies does not form part of the domain of intervention of either programme.

[7] Blanchet K., Pekele M., Kondi G., Adjakly E., Pignandi A., Nonon-Saa K., Douti K., Sossah W. 2007. Quality assurance in eye care treatment – *Reference Manual*. Swiss Red Cross. Ministry of Health. Togo.

- There is a detailed organization chart of the programme with specific and written description of tasks for each job.

- Personnel have been provided with adequate training.

- 100% of the expected funding by the Swiss Red Cross has been effectively pledged.

- An operational system of distribution and maintenance of material is in place.

- In the two countries, the state finances staff salaries , the maintenance of materials and buildings and part of the cost of logistics.

- Devolution will be gradually implemented by the transfer of expenses to the health budget.

4. Principal differences between the two countries are at different levels

- The integration of the regional plan is in progress in Togo, whilst it is already effective in Ghana.

- In Ghana, the supervision of health staff by the Swiss Red Cross (and by the Ghana Red Cross for the volunteers) is carried out every quarter. In Togo, there was no supervision until the end of 2006.. However, in 2007 a supervisory tour was undertaken by the Regional Directorate of Health. The volunteers are supervised by district coordinators, but their reports are not available for analysis.

- In Ghana there are annual and quarterly assessments of needs. The Togolese assessment is undertaken yearly.

- In Ghana, the supply system is reliable and it is ably supported by the Swiss Red Cross. In Togo, the new system put in place is to be carried out through the regional pharmacy of the Ministry of Health.

- In Ghana patient contribution to the total cost is lower than that of Togo.

Therefore, the first part of the workshop allowed each participant to gain the same understanding of the contents of the two programmes and an insight into all the stakes involved.

IV Community Mobilization and access to care for the deprived

During the second day, new themes touching on community mobilization and access to care for the poor were dealt with. Some Togolese and Ghanaian participants shared their experiences with the workshop. The two countries have both adopted an approach based on community mobilization through a network of Red Cross volunteers.

It is important that each programme can learn from the best practices of the pilot programmes put in place in Togo and in Ghana.

From all the presentations, it could be said that community mobilization has the objective of removing barriers that hinder accessibility to eye care services. We should carry the information to the population to help them understand the type of care they need; for them to better understand the risks of surgical intervention but stress the importance of early surgical intervention as well as provide them with psychological support. Community mobilization allows for orientation and referral of patients who need treatment and medical consultation. It is also wards off certain dangerous traditional practices. With regard to financial barriers, the two programmes have managed to find innovative solutions through the introduction of the solidarity funds.

1. Community Mobilization

Mr Seth Addae-Kyereme[8] presented the approach adopted in Ghana. In his definition of the community mobilization here, the Swiss Red Cross delegate in Ghana explained that community mobilization is a process that provides health education for the community and helps to identify those who need eye care. It is carried out by volunteers or ophthalmic nurses. Community mobilization has thus contributed to bringing health services closer to the people.

Ghana's programme is run on three levels:

- Eye care education carried out by the volunteer corps
- The advanced community strategy carried out by the ophthalmic nurses.
- The advanced strategy in schools for the ametropies carried out by the ophthalmic nurses.

[8] Addae-Kyereme S. 2007. *Community mobilisation in Ghana*. PowerPoint presentation. Swiss Red Cross. Ghana.

Strengths
Ghana has largely benefited from the programme through the presence of the Red Cross volunteers and ATBEF who mobilize the communities. It is true that the budget allocated by the Swiss Red Cross to allow ophthalmic nurses to implement advanced strategies is an advantage that has been brought about the creation of collaborative links between the volunteers and the nurses. The fuel and food costs of the nurses are thus absorbed by the programme. This intervention has yielded very positive results for all stakeholders.

- Consultation sessions in the villages have reached 71,000 people in 10 years
- Nearly 80,000 children have been attended to in schools.
- The necessary medicines for the primary eye care diseases are available at community level.
- 1,000 patients have also received minor surgery.

The volunteers are also able to carry out certain community activities:

- 13,200 people have taken part in health education sessions.

Weaknesses
Community mobilization is often delayed by the bad state of roads and floods caused by the overflowing of the banks of certain rivers in the rainy season. A lot more needs to be done to make the volunteers more recognizable to the people. This can be done through regular visits from the nurse or district coordinator. It is not always easy to keep the volunteers at post because of the benevolent nature of the job. After several years of service, it seems the most important lesson is the benefits of regular volunteer supervision and also volunteer encouragement from the district coordinators and regional Red Cross teams.

The principal lessons learnt and identified by Ghana's group are:

- ***To accompany the volunteers during the start of their activities and to introduce them to opinion leaders.***
- ***Door to door educational sessions have more impact than group sessions.***
- ***It is necessary to harmonize the practice of the volunteers so that they can benefit from the experience of others.***
- ***It is important that collaboration between the ophthalmic nurses, the district coordinator and the volunteers is effective.***
- ***It is important to provide the Red Cross district coordinator with a focal person at the sub-district level.***
- ***The volunteers need moral and professional knowledge, which can be gained through supervisory visits and incentives such as T-shirts and other rewards distributed at the end of the year.***

Mr Noel Koadjo Yandi[9], Regional Secretary of the Togolese Red Cross presented the Togo experience next. Just as in Ghana, community mobilization plays an essential part in improving access to care. On the other hand, the health personnel recognize the importance of the activities of the volunteers.

In terms of weakness, many of the volunteers do not play a model role, failing to apply the rules that will allow community ownership or involve other members of the community in the programme, although it must be said that the time allocated to the training of volunteers is rather short. It is also difficult to restrict the volunteers because of their professional commitments and also because of transfers. It is worth noting that funds allocated for volunteer motivation are rather limited. Another weakness of the programme is the small number of reports written on the performance of volunteers. This explains in part the reason for the weak reports completed by the volunteers. Some of them spend very little time on them, whilst others find the reports a little too complicated to complete.

The main lessons identified by the Togo group are as follows:

- ***The training of volunteers is essential. It is important to give the volunteers refresher training through short courses.***
- ***Opinion leaders must be convinced of the importance of the programme and must support the activities of the volunteers.***
- ***Communities will only accept the programme if it produces concrete results through advanced strategies; it needs to be demonstrated that some people have patronized the services and have benefited immensely from them.***
- ***People who have already benefited from successful cataract operations can play a central role in convincing other community members of the importance of such treatment.***
- ***Volunteers must be regularly supervised, and adequately compensated when they perform well.***
- ***The reporting system must be efficient in order to gather information on the performance of the volunteers and to provide guidance to them.***
- ***Management of volunteers is currently handled by the Ministry of Health, especially the nurses. However, the management of eye care volunteers should be put into the hands of the Togolese Red Cross.***
- ***The Swiss Red Cross must have a well-equipped team capable of supporting the Togolese programme in order to raise it to the level of the programme in Ghana.***

Some discussions were held on the importance of improving nurses' communication skills. However, the group concluded that the nurses must leave the task of education to the volunteers; they must rather concentrate on advanced strategy care and on the hospitals.

[9] Yandi N.K. 2007. *How do you improve social mobilisation?* PowerPoint Presentation Togolese Red Cross Togo.

2. Access to eye care for the most deprived

Mr Evans Kevi, Coordinator for the community approach in the Vision First Programme presented the strategy adopted in Ghana[10]. Mr Kevi revealed that interventions are concentrated in general on the supply aspect, that is to say the medical personnel, drugs and medical equipment. The needs of patients are neglected as a consequence of this, particularly the poor groups who in addition to financial barriers are hindered by traditional beliefs that prevent them from consulting doctors or nurses. The most recent evaluation of the Ghana programme in 2004 has brought to light the disparities that exist in terms of eye care between the different socio-economic groups. This explains why the Ghana programme has placed emphasis on the most deprived since 2005.

In order to reduce financial constraints, the Swiss Red Cross supplies the health services with consumables (implants, sutures, etc.) in exchange for which the Ministry of Health has agreed to reduce the cost of cataract surgery to patients . In addition to this support to the most deprived, the Vision First Pro-poor scheme subsidizes expenses related to cataract operations through this very innovative approach. This scheme was piloted in the district of Bole, Northern Region and in the district of Jirapa, Upper West Region.

The criteria used to determine poverty are listed below:

Level of priority	Criteria
1	Blind in both eyes; on the waiting list for cataract surgery
2	Blind in both eyes; want surgical intervention
3	Blind in one eye; on the waiting list
4	Socio-economic criteria for poverty

The socio-economic criteria are defined by community leaders, who identify potential beneficiaries of the solidarity funds according to predetermined criteria.

With regard to geographical barriers, either the patients are transported to hospital if the programme vehicle is available, or the eye care services come closer to the patients. These are what are termed advanced surgical and clinical strategies. In the first case, the doctor performs the cataract operations in the district hospital as soon as a sufficient number of patients have been identified and in the second a nurse travels to the community in order to provide consultations.

In order to reassure patients and remove any psychological barriers arising from the fear of cataract operations, it is imperative that the volunteers escort the patients to hospital for the medical personnel to explain the procedure to them.

[10] Kevi E. 2007. *Increasing access to eye care service to the poor and the vulnerable*. Swiss Red Cross. Ghana.

The strength of this approach is that it allows better identification of the needs of the population in order to tailor the health services to suit their needs.

It is true that the impact of this approach is very often limited by the fact that the doctor is not always available to undertake surgical operations in the districts that are a long way from the regional capital. But in Ghana the launch of the National Health Insurance Scheme, which provides free medical access to the indigenous population, would allow solidarity funds to stretch even further. Additional funding would be necessary to ensure that destitute people were not excluded from the system.

Mr Edoh Adjakly, delegate of the Swiss Red Cross in Togo explained the approach used with regard to Togo [11]. The obstacles in Togo are identical to those in Ghana. Togo has also come up with an advanced strategy, which unfortunately has not been implemented so effectively as in Ghana. With regard to the ability of the population to pay, we must realize that the minimum monthly salary in Togo is only 13,000 FCFA. In spite of the fact that the cost of surgery is subsided and reduced to 15,000 FCFA with favourable payment terms, a number of people still find it difficult to make repayments. It must be recognized that the Togo programme is evolving and still at a nascent stage. The volunteers are not able to fully convince the people of the benefits of the programme and they do not get enough support from the nurses, who concentrate on their activities in the hospitals. However, the potential of the radio to relay eye care messages to the communities has not been fully exploited . Up until 2006, the major concern in tackling the management of the most deprived has been a lack of well-defined criteria to determine destitution or poverty.

Lessons Learnt

One of the first lessons learnt, which was identified by the groups, is that it is important to clearly determine the criteria for destitution or for absolute poverty. With regard to both programmes, there was a consensus on the need to affirm that these criteria meet the needs of each. With their years of practice on the programme, members of the workshop agreed to adopt the following criteria that come from an assimilation of what is being done in both Togo and Ghana:

Level of priority	Conditions or criteria	Indicators
1	Bilateral blindness; on the waiting list	Patients who are blind in both eyes
2	Bilateral blind persons (new cases)	idem
3	Socio-economic factors	Those who do not possess farms or cattle, and whose children are unable to pay for the cost of the operation and/or transport.

[11] Adjakly E. 2007. *Swiss Red Cross Cooperation in Togo: An approach for the most deprived populations*. Power Point Presentation. Swiss Red Cross

Further lessons learnt included the need to involve the opinion leaders in identifying destitution in order to reduce stigmatisation and to obtain accurate information on the socio-economic situation of the populace.

V Quality Assurance

Quality assurance is not a new feature of either the Togo or Ghana programmes. A policy document was written in Ghana[12] in 2005 and in Togo[13] in 2007.

Quality assurance is "doing what has to be done at the right time" Quality of care is found at the meeting of performance of personnel caring for the sick and the expectation of patients. In Togo and Ghana, quality care is defined by eight criteria:

- Technical competence
- Access to services
- Effectiveness
- Interpersonal relations
- Efficiency
- Continuity
- Protection
- Buildings

Dr. Wanye, ophthalmologist of the Northern Region teased out some information that clarified the concept and its application[14].
Quality care can be defined according to eight criteria:

Criteria	Description
Effectiveness	The degree of successful care delivery through appropriate diagnosis and treatment.
Efficiency	The relationship between health care services and the cost associated with delivery.
Technical Competence	The competence of caregivers in performing their tasks in accordance with quality standards, protocols and technical and clinical norms.

[12] Blanchet K., Hagan M., Osei-Bonsu P., Bannerman C., Ahorsu F., Asubonteng K., Wanye S., *Quality Improvement in eye care*, Vision First Programme, 2005, Ghana Health Service, Swiss Red Cross, Ghana.
[13] Blanchet K., Pekele M., Kondi G., Adjakly E., Pignandi A., Nonon-Saa K., Douti K., Sossah W. 2007. *Quality Assurance in Eye care – Reference Manual. Swiss Red Cross*. Ministry of Health. Togo.
[14] Wanye S. 2007. *Improving quality of care*. PowerPoint presentation. Ministry of Health. Ghana.

Interpersonal Relations	The level of respect, feedback, active listening and communication between clinical staff and patients.
Access to Care	The level of accessibility to health services in terms of geographical economic, social, organizational and linguistic barriers.
Protection	Confidence level, confidentiality, privacy and the degree to which risks of injury and infection are minimized.
Continuity	The degree to which care is dispensed in a continuous manner and followed up on.
Buildings	The physical aspect of buildings, the level of cleanliness, comfort and any complementary services offered.

The improvement of the quality of care is not an easy task. But it is imperative to ensure that appropriate care is provided to those who need it most. It is also an effective means of motivating health personnel and attracting patients to health services.
Improving the quality of care implies giving more responsibility to health care providers and also involving patients in the management of health services. The ultimate aim of quality assurance is to improve the impact of promotional, preventative and curative care on the health of the people and to increase the use of health care services by the communities.

There are several steps to follow in order to establish a quality assurance system.

- **First Step: Identify the major criteria for quality.**
    - Define the major priorities of eye care; caregivers and patients must be interviewed.

- **Second Step: Define the norms of quality**
    - Clinical protocols, procedures and rules.

- **Third Step: Define quality indicators**
    - The indicators are quantitative data such as ratios, proportions or numbers.

- **Fourth Step: Programme planning, monitoring and processing**
    - This is done through direct observation and inspection.
    - Interviewing of patients.
    - Inspection of archives.

- **Fifth Step: Compile and analyse data.**

The following table presents different indicators of quality chosen by the teams in Ghana:

Criteria	Indicators
Technical competence and efficiency	Evaluation of cataract surgery results. Availability of equipment.
Access to health care services	Patient impression of waiting period and of costs. Waiting time in the hospital waiting room. Rate of patient withdrawal from treatment.
Efficiency	Each ophthalmologist must perform at least 500-700 surgical interventions a year depending on resources available to him/her.
Interpersonal relations	Evaluated through interviews and examination responses.
Follow-up	The follow-up of patients by the Ghana Red Cross is evaluated and analysed regularly every quarter.
Security	Prevention and reduction of the risks of infection, secondary effects and injuries.
Sanitary of buildings	General state of the building, State of the waiting and consulting rooms; comfort and respect for the privacy of patients and the state of cleanliness of the facilities.

In spite of the fact that the reference manual was developed and adopted by all stakeholders in 2005, the implementation of this policy remains very weak; Dr. Wanye explained the reasons for this as follows:

- Quality assurance requires changes in practices and innovations and these usually face a lot of resistance.
- Quality assurance has not yet been integrated in the same way as other routine activities.
- The monitoring of quality assurance has not been rigorously implemented for fear of offending individual sensitivities.
- Eye care health personnel have not been trained in this new policy.

- The introduction of supplementary formulae necessary to carry through quality care has created resistance due to the fact that these formulae create extra work.
- The state of the cleanliness of buildings can be the source of substantial conflict between the medical teams, who do not control external factors, and the maintenance staff of the hospital.

Quality assurance generated a lot of interesting discussion. As stated by one of the participants, even if its practice does not appear to be that effective, it has triggered some awareness among caregivers of the importance of the quality of care. This is already a major step in the right direction.

The main lessons identified by the participants are as follows:

- ***The monitoring of quality assurance ought to be implemented as far as possible by a team including regional and district sanitation authorities responsible for ensuring quality care.***
- ***Monitoring tools must be clearly identified and standardized for each programme.***
- ***Basic equipment must be available in each eye clinic to ensure optimal operation.***
- ***Health personnel must be trained on this new approach to ensure its integration into their daily activities.***
- ***The new forms – especially the form for patients with cataracts – must be applied in all cases (see annex).***
- ***This pilot approach must be rigorously followed in order that the two countries can learn from one another and also for the necessary changes to be made after one year of operation.***

The participants refocused their priorities equally with the help of Karl Blanchet, who put in place policies of quality care in Togo and Ghana. The indicators for monitoring quality assurance are practical and easy to follow; the indicators for Togo and Ghana should be harmonized.

VI Health Education

Mr Blaise Sedoh, national HIV/AIDS coordinator for the Togolese Red Cross presented strategies used by the Red Cross in health education[15]. Each health education activity must start with a knowledge, aptitude and practice (KAP) exercise to examine the situation within clearly defined parameters. This first study serves as a standard measure and allows the evaluation of the impact of health education after a certain period.

[15] Sedoh B. 2007. *Developing health tools. Why? Which tools operate well? PowerPoint Presentation*. Togolese Red Cross. Togo.

The main strengths of the participatory approach employed by the Togolese Red Cross are as follows:

- Individuals develop their capacities to become competent in health issues that were hitherto unknown to them (use of correct preservation methods and management of the effects of vaccination on children).
- Individuals use their knowledge and adapt that of others (the incidence of measles, epidemic disease surveillance at the community level, weight of tradition and common use of sharp objects).
- Educational tools are adapted to suit the Togolese context, culture and religion.
- The community identifies with problems under discussion and take up ownership to combat local factors of vulnerability and risk (hygiene and sanitation in the home and the creation of rubbish disposal sites).
- Individuals demand services that they are entitled to (free volunteer HIV screening, etc.).
- The approach facilitates interaction between different actors and partnership between different organizations (collaboration with other institutional actors: planning together with ATBEF and social marketing with PSI).

The limitations of this approach, evident after several years of practice are as follows:

- Educational tools, although varied (boards, images, technical documents, games, cards, posters, T-shirts, calendars etc), are not adapted to suit target audiences such as people living with HIV/AIDS or orphans/vulnerable children (OVCs).

- The good news is that health education stimulates demand, but unfortunately growing demand is not always met with adequate supply. For example, HIV screening tests are not always available although a vigorous campaign is going on to encourage testing. The risk is that the people will stop patronizing the services because the supply does not match the demand.

Mrs Theresa Nobiya shed light on Ghana's[16] programme. She stressed the need to combine the different tools with communication materials:

- Visual tools: newspapers, posters, pictures and demonstrations.
- Audio-visual tools: television, radio, percussion, story telling, conferences and discussions.
- Signs: gesture and dance

Different communication tools should be combined and tailored to suit the target audience. It is important that health education is developed based on operational research, which allows a better understanding of otherwise sensitive and complex issues. Messages can then be adapted to incorporate these sensibilities.

[16] Nobiya T. 2007. *Health education. Which tools operate well?* PowerPoint Presentation. Ghana Red Cross Society. Ghana.

The participants enumerated a number of practices that merit particular attention:

- ***It is important that health education projects are organized sequentially. They should follow this:***
    1. ***Contact opinion leaders in the communities***
    2. ***Identify priority health problems***
    3. ***Identify target population***
    4. ***Analyse all the available information (existing studies, reports…)***
    5. ***Develop appropriate messages***
    6. ***Pre-test the tools***
    7. ***Identify appropriate channels of communication***
- ***A variety of actors play a role in health education: volunteers, opinion leaders, principal nurses, district volunteer coordinators, ophthalmic nurses and all other health providers. The involvement of all these actors promotes ownership and dissemination of the messages.***
- ***The quality of training received by all those involved in health education is a success factor not to be neglected. It is important to leave the training to professional health education trainers.***

VII Children's Eye Care

Besides having a programme that caters for cataract operations for the over 50s, both the Togolese and Ghanaian programmes have an important component which addresses the eye care needs of children. Mr Frederic Anti, the monitoring and evaluation coordinator of the Swiss Red Cross in Ghana, explained how an intervention targeted at children would positively impact their development[17]. It should be noted that 75% of learning and knowledge between the ages of 0 and 5 is acquired through sight. It should also be remembered that some causes of blindness are preventable. In Ghana, there is no reliable data on childhood blindness and in any case the Ministry of Health does not consider childhood blindness to be a public health priority. Blindness is associated with certain traditional beliefs that stigmatize the blind child as being possessed by evil spirits or has bad luck.

Health services must be capable of providing paediatric eye care and must provide specific programmes targeted at school children. In the school programme, a team assisted by schoolteachers tests the vision of each child and prescribe spectacles for all those who need them.

An early detection programme should be put in place for neonatal prevention (nutrition and vitamins) Health care services in Ghana are capable of carrying out this activity, but the lack of epidemiological data is a big challenge. The result is that the Ministry of Health is not aware of the magnitude of the problem.

[17] Anti F. 2007. *How to improve identification of children who need eye care or Spectacles*. PowerPoint Presentation. Swiss Red Cross Ghana.

Mr Akouté Yovo, an ophthalmic nurse in Blitta district, presented the activities undertaken by Togo[18]. The different causes of blindness among children as a general rule are the opacity of the cornea due to measles, lack of vitamin A, neonatal ophthalmy and the consequences of traditional medicine, congenital cataracts, congenital glaucoma and bilateral trauma.

Togo's programme has a number of advantages that allow it to integrate services targeted at children without much difficulty. All nurses have been trained in the detection of refraction defects, which is not the case in Ghana. The programme has detection equipment to care for ametrophy and the optical centre in the regional hospital in Sokode has recently been renovated and re-equipped. Moreover, the request made by the Regional Director of Health for school interventions has been favourably received by the education directorate.

In spite of all these positive attributes, the school intervention programme has not been that aggressive and did not really take off until the beginning of 2007. However, it is now expected that each nurse will visit at least 10 schools a year to identify children who need help. Furthermore, the optical centre is not yet operational because of weak management structures. For example, children's spectacles are never available. There are two other obstacles. Some families cannot afford to pay for the spectacles because they find them too expensive. Additionally, spectacles are associated with the elderly.

The principal good practices that will bring about early detection and the treatment of refraction defects in children are listed as follows:

- ***The organization of detection in schools is an effective approach.***
- ***Teachers can be very active in detection if they are provided with some training.***
- ***A trainer should be designated to coordinate activities at the district level.***
- ***Innovative methods should be devised to bring the optical centres closer to the population so that the optometrist can regularly offer outreach programmes.***

The participants also resolved to define a common approach to school interventions in both Togo and Ghana. This approach consists of two steps:

- Step 1: To determine the prevalence
  - Study of the population
    - In schools
    - Children aged between 6 and 16 years
    - In an urban setting but especially in rural areas
  - To determine a sample
    - To identify schools and population
    - To select 10% of school-going children
  - Conduct a study of prevalence

[18] Yovo A. 2007. *How do you improve the identification of children needing eye care and eye glasses?* PowerPoint Presentation. Ministry of Health. Togo, Blitta.

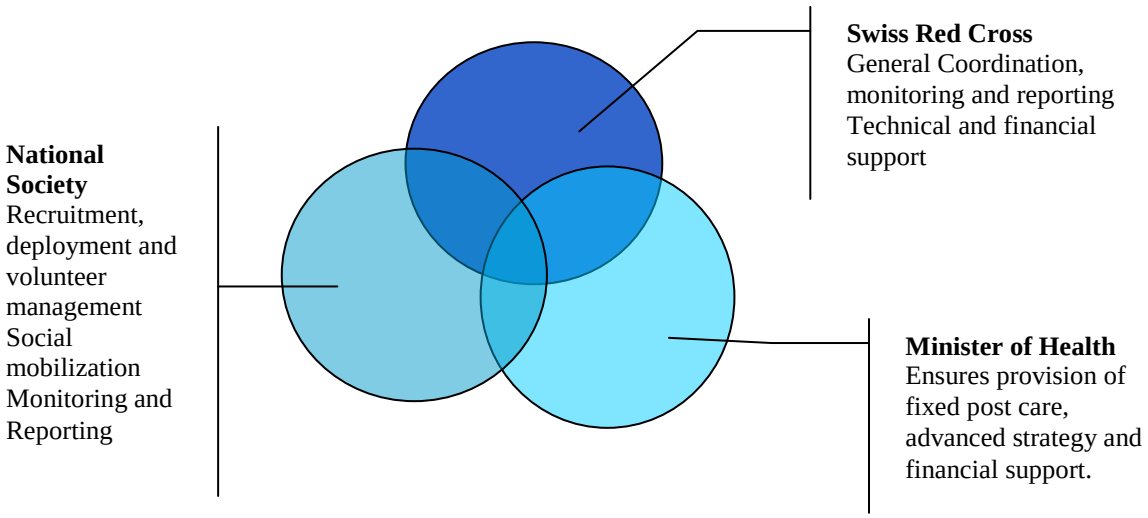
- Step 2: Intervention procedures
    - To identify children who need spectacles
        - To train teachers
        - Ophthalmic nurses lead this advanced strategy activity
        - Media publicity
        - Development of communication, support and education
    - Reference
        - In eye care centres in individual cases
        - In schools for advanced strategies
    - To obtain parental consent
        - Written form of consent
        - Completed forms
        - Invitation of parents to schools
    - Clinical Procedures
        - Register pupils with assistance of teachers
        - To evaluate their visual acuity (volunteers or teachers)
        - Bi-ocular motor functions (optometrist)
        - Examination of anterior and posterior chambers (ophthalmic nurse)
        - Procure spectacles for pupils with visual acuity between 6/18 and 5/10.
        - Provide free treatment for all minor pathological cases
        - Schedule appointments for serious cases
    - Follow up
        - In district hospitals
        - In schools by teachers

VIII Coordination

Mr Yandi, Regional Secretary of the Swiss Red Cross introduced some concepts of coordination. As explained in the preceding chapters, an eye care programme cannot be effective without the combined efforts of all stakeholders. In terms of health structure, it is imperative to put in place a level of collaboration between the Minister of Health and an international organization, the Swiss Red Cross. Furthermore, it is important to coordinate the activities of the volunteers with those of the ophthalmic nurses and the chief nurses in post. At the community level, the list of stakeholders involved in health education is very long. A mechanism should be put in place to share information about each other's activities. This is referred to as programme coordination.

Discussions and debates centred on the different mechanisms to be put in place to ensure effective and efficient coordination.
The lessons learnt are listed as follows:

- ***A programme must be clearly defined by a strategy, a plan of action and a name, the name Vision First for example. The action plan is a working document that details the roles and responsibilities of the different actors.***
- ***A convention should be drawn up between the Ministry of Health, the Swiss Red Cross and the National Society to formalize the collaboration links with a clear definition of the roles of each actor in the programme.***
- ***The responsibilities of the three actors are outlined by the following diagram:***



- ***The Swiss Red Cross should have one coordinator for the health structure and a second for community mobilization.***
- ***A quarterly steering group meeting should be held between the actors to analyse monitoring results and adjust annual action plans accordingly.***
- ***The monitoring results must be made available at the quarterly meetings and a monitoring team put in place. The Ministry of Health and the National Society must submit all reports and figures to the actors before the quarterly meeting.***
- ***The financial accounts must be audited by the Swiss Red Cross periodically***

IX Conclusion

The lesson sharing workshop between the eye care programmes of Togo and Ghana provided tangible outcomes for an enhanced understanding of the various potential solutions for better access to eye care services. The workshop revealed that, although the two programmes are implemented within different health systems, the issues and obstacles faced at both community and health service levels are very similar.

A certain number of conclusions, at the supply, demand and programme management levels, were drawn by the participants and should be highlighted for better management of the future orientation of both programmes.

In terms of education, the principal lessons learnt and identified are:

- Opinion leaders must be convinced of the importance of the programme and must support the activities of the volunteers. To accompany the volunteers at the start of their activities and to introduce them to opinion leaders.
- It is important that collaboration between the ophthalmic nurses, the district coordinator and the volunteers is effective. The volunteers need moral and professional support, which can be gained through supervisory visits and incentives such as T-shirts and other rewards distributed at the end of the year.
- Volunteers must be regularly supervised, and adequately compensated when they perform well. The level of knowledge and practice of volunteers need to be regularly monitored and updated.
- People who have already benefited from successful cataract operations can play a central role in convincing other community members of the importance of such treatment. It needs to be demonstrated that some people have patronized the services and have benefited immensely from them.

The principal good practices that will bring about early detection and treatment of refraction defects in children are listed as follows:

- The organization of detection in schools is an effective approach.
- Teachers can be very active in detection if they are provided with some training.
- Innovative methods should be devised to bring the optical centres closer to the population, so that the optometrist can regularly offer outreach programmes.

In terms of supply, the priority is currently the quality of eye care services. The main lessons identified by the participants are as follows:

- The monitoring of quality assurance should be implemented as far as possible by a team including regional and district sanitation officers responsible for ensuring quality care. Health personnel must be trained on this new approach to ensure its integration into their daily activities.
- Monitoring tools must be clearly identified and standardized for each programme.
- Basic equipment must be available in each eye clinic to ensure optimal operation.

In terms of programme management, the key lessons learnt are listed as follows:

- A convention should be drawn up between the Ministry of Health, the Swiss Red Cross and the National Society to formalize collaboration links, with a clear definition of the roles of each actor in the programme.
- A programme must be clearly defined by strategy, plan of action and name, the name Vision First for example.
- The action plan is a working document that details the roles and responsibilities of the different actors. A quarterly steering group meeting should be held between the actors to analyse the results of monitoring and adjust annual action plans accordingly. The results of monitoring must be made available at the quarterly meetings and a monitoring team put in place.

This experience of lesson sharing between professionals of two neighbouring countries has been a great opportunity to identify new approaches and evaluate achieved outcomes. This type of meeting will now be organised on a regular basis every two years.

Annexes

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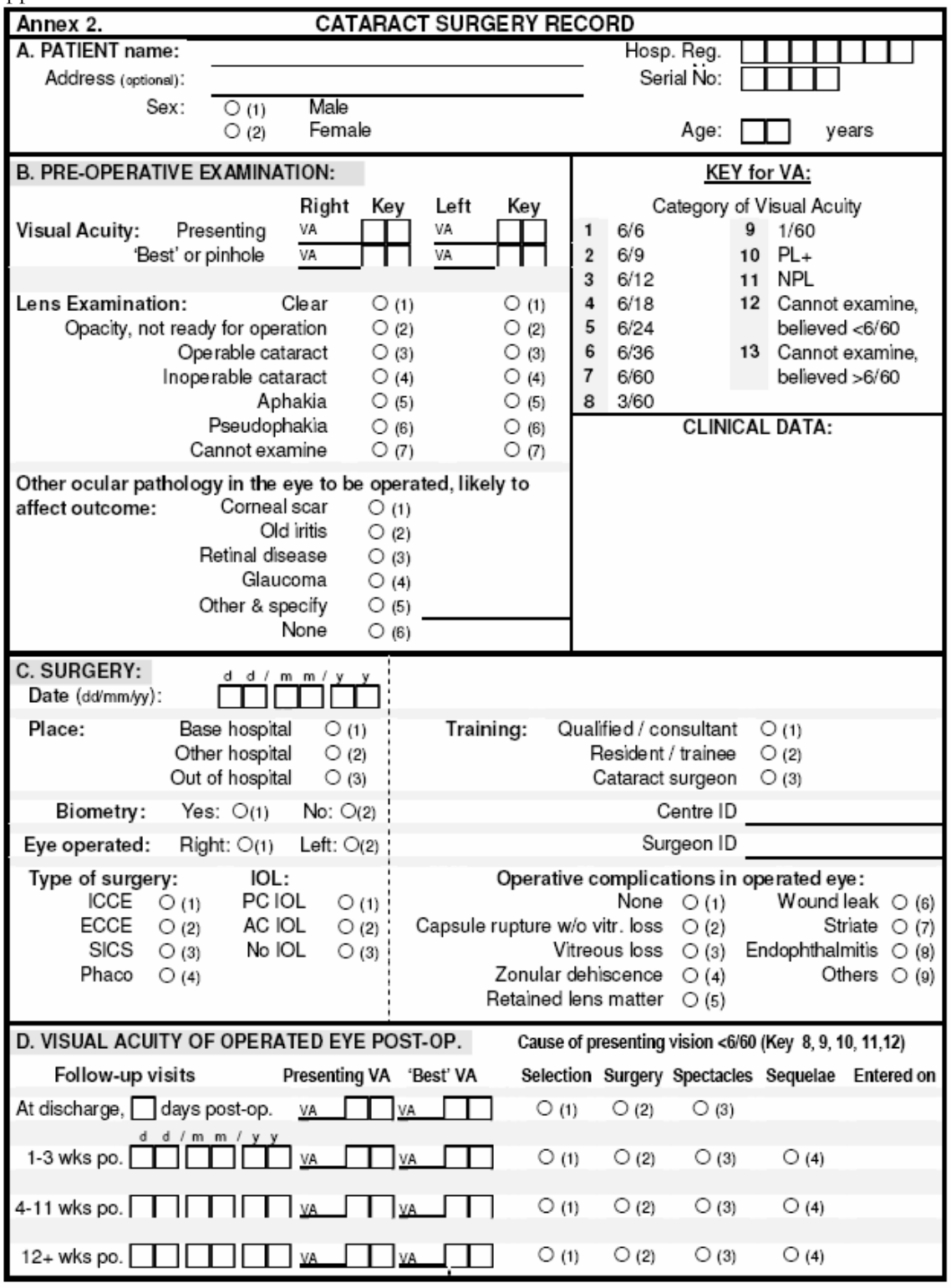
Appendix II[19]



Annex 2. CATARACT SURGERY RECORD

A. PATIENT name: _____ Hosp. Reg. ☐☐☐☐☐☐☐

Address (optional): _____ Serial No: ☐☐☐☐

Sex: ○ (1) Male ○ (2) Female Age: ☐☐ years

B. PRE-OPERATIVE EXAMINATION:

		Right	Key	Left	Key
Visual Acuity:	Presenting	VA	☐☐	VA	☐☐
	'Best' or pinhole	VA	☐☐	VA	☐☐
Lens Examination:	Clear		○ (1)		○ (1)
	Opacity, not ready for operation		○ (2)		○ (2)
	Operable cataract		○ (3)		○ (3)
	Inoperable cataract		○ (4)		○ (4)
	Aphakia		○ (5)		○ (5)
	Pseudophakia		○ (6)		○ (6)
	Cannot examine		○ (7)		○ (7)

Other ocular pathology in the eye to be operated, likely to affect outcome:
Corneal scar ○ (1)
Old iritis ○ (2)
Retinal disease ○ (3)
Glaucoma ○ (4)
Other & specify ○ (5) _____
None ○ (6)

KEY for VA:

Category of Visual Acuity

1	6/6	9	1/60
2	6/9	10	PL+
3	6/12	11	NPL
4	6/18	12	Cannot examine, believed <6/60
5	6/24		
6	6/36	13	Cannot examine, believed >6/60
7	6/60		
8	3/60		

CLINICAL DATA:

C. SURGERY:

Date (dd/mm/yy): d d / m m / y y ☐☐ ☐☐ ☐☐

Place: Base hospital ○ (1) Other hospital ○ (2) Out of hospital ○ (3)

Training: Qualified / consultant ○ (1) Resident / trainee ○ (2) Cataract surgeon ○ (3)

Biometry: Yes: ○(1) No: ○(2)

Centre ID _____

Eye operated: Right: ○(1) Left: ○(2)

Surgeon ID _____

Type of surgery: ICCE ○ (1) ECCE ○ (2) SICS ○ (3) Phaco ○ (4)

IOL: PC IOL ○ (1) AC IOL ○ (2) No IOL ○ (3)

Operative complications in operated eye:
None ○ (1) Capsule rupture w/o vitr. loss ○ (2) Vitreous loss ○ (3) Zonular dehiscence ○ (4) Retained lens matter ○ (5)
Wound leak ○ (6) Striate ○ (7) Endophthalmitis ○ (8) Others ○ (9)

D. VISUAL ACUITY OF OPERATED EYE POST-OP.

Follow-up visits	Presenting VA	'Best' VA	Cause of presenting vision <6/60 (Key 8, 9, 10, 11,12) Selection	Surgery	Spectacles	Sequelae	Entered on
At discharge, ☐ days post-op.	VA ☐☐	VA ☐☐	○ (1)	○ (2)	○ (3)		
1-3 wks po. d d / m m / y y ☐☐ ☐☐ ☐☐	VA ☐☐	VA ☐☐	○ (1)	○ (2)	○ (3)	○ (4)	
4-11 wks po. ☐☐ ☐☐ ☐☐	VA ☐☐	VA ☐☐	○ (1)	○ (2)	○ (3)	○ (4)	
12+ wks po. ☐☐ ☐☐ ☐☐	VA ☐☐	VA ☐☐	○ (1)	○ (2)	○ (3)	○ (4)	

[19] WHO, *Developing an action plan to prevent blindness at national, provincial and district levels*, World Health Organisation, International Agency for Prevention of Blindness, 2004.