Pippa Wysong
in Toronto

HAVING western-trained ophthalmologists fly in, do a couple dozen surgeries and then leave is not the best way to reduce cataract blindness in the developing world. What's far more useful is to help ophthalmologic services in developing countries better manage the cataract removal resources they already have so they can perform a larger number of surgeries, in a sustainable way.

“The major issues in African healthcare are not medical, they are management issues. How do you organise structure? How do you get people in for services? How do you use people most effectively?”

This was a key message from Paul Courtright Dr PH, an ophthalmic epidemiologist who lives in Tanzania and is helping improve cataract surgery systems throughout eastern Africa. He described his efforts in Africa at the annual meeting of the Canadian Ophthalmological Society.

“The major issues in African healthcare are not medical, they are management issues. How do you organise structure? How do you get people in for services? How do you use people most effectively?” he asked.

Dr Courtright is co-director and a founder of the Kilimanjaro Centre for Community Ophthalmology (KCCO), located in Moshi, Tanzania. The centre, which opened in 2001, provides training programmes and does research to help with the delivery of sustainable and replicable ophthalmology services throughout eastern Africa. It is affiliated with Tumaini University.

“We work with hospitals one at a time and have relationships with five different hospitals covering a population of about 12 million people,” he said.

He argued the reason many cataract sufferers in Africa aren’t getting treatment is largely due to organisational problems.

“People in Africa are not lined up waiting to get surgery, there aren’t waiting lists. Even if we build a beautiful hospital and staff it with superb surgeons, it doesn’t mean people are breaking down doors to get in,” he said.

Yet there are huge numbers of people who would clearly benefit from cataract removal. The discrepancy lies in the fact that there are problems in how services are provided, ranging from getting people to hospital, to making the time in hospital well spent, to inefficiencies in how staff do their jobs.

“They often have productivity problems in Africa, and our first approach isn’t to train more eye care providers. What we need to do first is to improve the productivity of existing providers,” he said.

KCCO expertise has been used in the Kilimanjaro Christian Medical Centre (KCOC), and in the regions of Singida, Mara, Tanga, and now Masaka in Uganda.

Dr Courtright is also working with centres in other eastern African countries, setting up programmes to train and mentor people to manage and organise their centres and resources better. It’s vital to have local people trained as managers; who wants to rely on outsiders all the time?

The programmes developed in Tanzania are being used as models to help with programmes in other regions. While reproducibility of the approach is important, Dr Courtright noted that every area has its differences.

The KCCO staff includes an economist, a medical anthropologist, and people with education backgrounds. There are also external faculty from Ethiopia, Kenya and Malawi.

In the case of the KCOC, part of the job was to find out why people weren’t coming in for surgery even though the hospital had no shortage of supplies or physicians. A survey in 2002 revealed that fewer than 10 per cent of people with cataracts living within an hour of the hospital had received surgery. The Kilimanjaro region and neighbouring Arumeru has a population of two million.

Research revealed a number of limiting factors including affordability, transportation problems, and complex social issues that limited the ability, specifically for women, to go for surgery.

Offering cataract removal for free doesn’t automatically increase the numbers either.

“We found there is no relationship between the price for surgery and the numbers operated on. It’s not an issue of price as long as that price is within reason for families. What we’ve learned in the past few years is that willingness to have surgery is actually quite complex,” he said.

Further research showed that more than 80 per cent of families in the region could reasonably afford $14 for cataract surgery, and so the price was set at that.

“It pays for the transportation from the site to get them to the hospital, the surgery, the medicine and pays to get them back to where they came from. It costs us more than $14 to do the surgery but that is the price that the patient pays,” Dr Courtright said.

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A package price is important so the patient doesn’t have any out-of-pocket surprises. The hospital didn’t have all the services totally up in one place before, so patients never knew what they were getting for how much, which contributed to a distrust of the hospital.

In the case of women, many won’t admit their sight is impaired because it means they become an unwanted burden on the family. Women can’t get the surgery without agreement from the family, who are also the ones who may accompany them to hospital. Cultural barriers must always be taken into account.

To address this cultural aspect, a counselling service designed to help the families (not just the patient) understand what the cataract surgery is all about was set up at the KCOC.

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Research is an important aspect of KCCO projects, since evidence is the best way to help people see where the problems are, figure out appropriate solutions (every place has different challenges), and later, track how things have changed.

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Another aspect of change at the KCMC was to improve efficiency within the hospital. That is, getting people in and out as quickly as possible.

Initially, when patients arrived they couldn’t go to the eye clinic until they’d gotten their patient chart — and it usually took upwards of three hours at the main hospital. That meant the surgeons never got to start early.

“We put in our own registration system — computerised. That took a bit of convincing the hospital,” he said.

In one hospital the KCCO team worked with, there was only one operating table. That meant the physician had to wait for patients to be prepped on the table before surgery, and then had to wait for them to leave before the next patient was brought in. To increase efficiency, a second table was brought in. More sets of surgical instruments were bought so one set could undergo sterilisation while another was in use.

Another aspect to improve efficiency in hospital is making sure each person is doing the job he or she was trained for.

“When in many African hospitals you’ll find ophthalmic nurses responsible for mopping floors and other menial tasks, as well as doing their nursing duties,” Dr Courtright said.

Efficiency in the department improves if nurses can focus on the duties they’re trained to do, and other people are hired to stick to the administrative and janitorial jobs.

Change doesn’t happen overnight, and it’s not a matter of giving a few people a couple of lectures on the topic. The KCCO operates with a mentoring philosophy, leading staff through the process of change. Introducing change at any centre can be a challenge since people are often resistant to change.

“Our staff visit these hospitals fairly regularly. It helps them go through the next stage of change. Unless we can mentor people through this stage we won’t get there,” he said.

He also advises introducing changes in phases, and sprinkling in a few short-term achievable goals so staff can have a sense of accomplishment.

When KCCO began efforts at the KCMC in 2001 the number of surgeries done at the hospital was about 700 per year. “In three years of getting a programme up and running there, we’ve tripled that number; we’ve gone from having five ophthalmologists to only four and they’re not working extra hours,” he said.

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