AFRICA EYE FOUNDATION
CAMEROON

PROJECT TITLE

A MIXED MEHTOD STUDY TO EXPLORE REASONS FOR LOW UPTAKE OF CATARACT SURGERY BY OUTREACH PATIENTS IN THE LEKIE DISTRICT OF CAMEROON

AFRICA EYE FOUNDATION
CAMEROON

Principal Investigator:

Mathew Mbwogge
Outreach Coordinator, MICEI

Co-Investigator:

Dr Henry Nkumbe
Cataract Surgeon, Medical Director, MICEI

Lead Organization
Magrabi ICO Cameroon Eye Institute (MICEI)

Funding Organization
Seeing Is Believing (SiB)/Standard Chartered Bank S.A

MICEI MAY 2019

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABSTRACT

Background

The Magrabi ICO Cameroon Eye Institute (MICEI) has been involved in community outreach since its inception in 2016. Since then more than 1000 outreach cataract surgeries have been performed. This notwithstanding quite a good number of patients diagnosed of cataract during outreach camps still remain in the community for one reason or the other, reducing the cataract acceptance rate. This study explores some of the reasons for the low cataract surgical win in the Lékié District of the Centre Region of Cameroon.

Methods

This study makes use of a mixed method to carry out 3 focus group discussions (FGD) accompanied by in-depth interviews and short questionnaire. The FGDs were formed by using a snow ball and purposeful sampling technic, to carry out an in depth interview of 29 subjects within different communities. Operated cataract patients were pulled from MICEI's database of operated cataract patients and located with the help of key informants while cataract patients that constitutes the cataract backlog were identified using a snowball sampling technic through the use of trained key informants.

Results

The most prominent barriers to cataract surgery included cost of surgery (86.21%), fear of surgery (58.62%) and lack of awareness (20.69%). Also, 41.4% of those who do not take up cataract surgery turn to traditional medicine and as such availability of traditional medicine turns out to be a barrier itself. Other barriers included no perceived need (17.24%) cultural beliefs and superstition (13.79%) and Negligence (13.79%). A total of 79.31% of subjects gave a positive impression regarding free cataract surgery while just 27.59% of subjects admitted that they were happy with paid cataract surgery.

CHAPTER ONE

INTRODUCTION AND LITERATURE REVIEW

1.1 Introduction

1.1.1 Background

This implies the situation is worse in poor resource settings, regions of low awareness, limited access to eye care and technology like the Sub Saharan Africa(1,2). In countries where community outreach and social marketing still remain relatively new, with the general believe that “a person who is sick comes to the hospital”, cataract surgical acceptance by those screened in the communities remains a real challenge because of fear and doubt (see 1 above). This is further compounded by the experience of poor cataract surgical outcomes from service clubs(3). The research question we wish to address is, ***what are the various reasons for the low uptake of cataract surgery among outreach cataract patients detected by MICEI in the Centre Region of Cameroon?***

1.1.2 Problem Statement

Public health strategy for eye care and the need to increase cataract surgical win falls in line with VISION2020: The Right to Sight, which emphasizes that African countries need a cataract surgical rate of at least 2000 to eliminate avoidable blindness by the year 2020. It is recommended that the cataract surgical rate (CSR) equates the incidence if the above must be realized(4,5). Despite MICEI’s immense efforts in reducing the cost of cataract surgery to the underprivileged, a good number of factors that hinder a good proportion of community diagnosed patients from presenting for surgery are still not masterminded.

1.2 Literature Review

Many studies including Kessy & Lewallen (2007) have identified cost as the main barrier to cataract surgical uptake. This has however been proven wrong by many qualitative studies like Chibuga et al. (2008) and many others. The barriers to the uptake of eye care services in the Cameroon according Okwen M. in CEHJ (2014) include poor marketing, inefficient counselling, traditional beliefs and stigma, household decision making, social barriers, no need, convenience and competing priorities, inaccessibility and poor experience. These factors are also in line with Rotchford et al (2002)

Cataract which is responsible for 50% of blindness and one third of visual impairment has been known to have a well-established cost effective treatment with very high socio-economic returns(6).

Transport cost among ten factors was identified as the main barrier to cataract surgery among women in Cape Town and environs. It was noted that these factors even though were common to both sexes women presented the worse scenario(7).

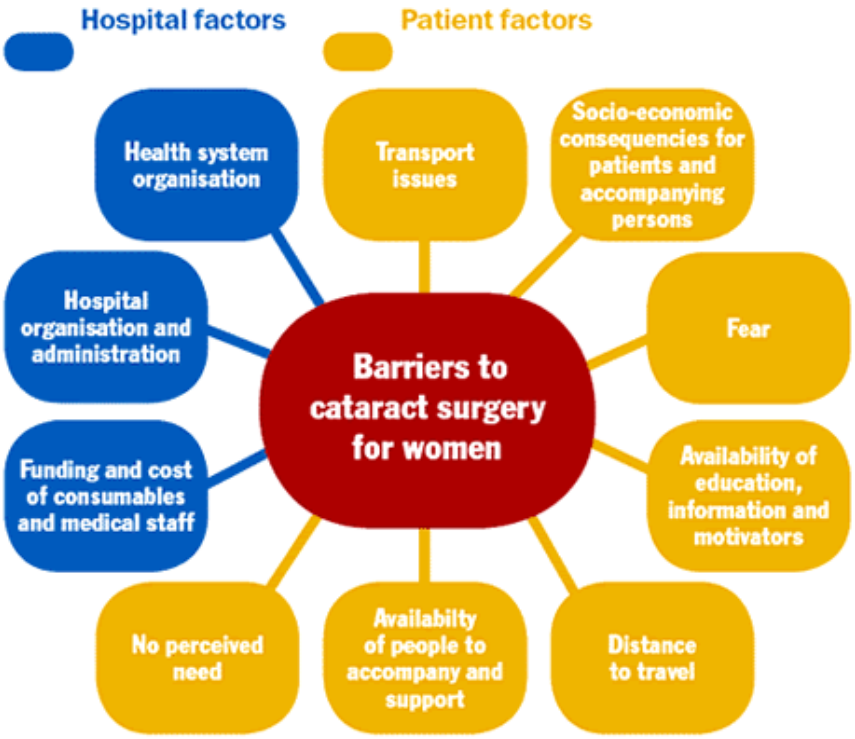

Figure 1: Women Barriers to Uptake of Cataract Surgery in Urban Cape Town, S.A (See 6 above)

Lewallen (2008) acknowledges the fact even though many studies have that cost is the main reason for people not accessing cataract surgery, narrowly concentrating on monetary cost alone may eventually lead to the missing out key social determinants(8). She confirms that successful approaches in restoring vision will be those that focus on the more complex social and cultural issues.

A quantitative study that was conducted in Yaoundé and found out that fear was the leading cause for refusal of free cataract surgery (55.88%) followed by awaiting foreign NGO campaigns (29.42%) and religious convictions (8.82%)(9)

Understanding the barriers to the uptake of eye care has been identified as the second way to improve eye health at the community level. Attempts to social behavioral change towards eye care must begin with discussions with representatives of targeted communities. Involving the community in the change team increases confidence and removes barriers towards new behavior(10)

A study that was conducted in Malawi showed that economic viability and distances to eye care facilities significantly determined patients' ability to accept free cataract surgery. This attest that waving transportation, accommodation, medication and significant portion of the surgical cost does not guarantee acceptance of free cataract surgery(11)

A systematic review of the available evidence of barriers to cataract surgery in Africa revealed that lack of awareness (33%) and cost of surgery (30%) were the main barriers to the uptake of cataract surgery in Cameroon in 2006. Surgical cost (40%) and lack of awareness (17%) were equally known to be the two main barriers in 2007(12).

Table 1: Common barriers to uptake of cataract surgery across some African countries (See 11 above)

Country	Awareness		Access					Acceptance			
	Knowledge	Lack of awareness	Transport	Lack of services	Lack of escort	Cost	Cataract immature	No need	Fear	God's will	Old age
South Africa	50							25	25		
Libya	22.9				2.1	4.2	29.2	6.3	6.3	16.7	
Cameroon		17				40	8	10			
Cameroon		33.3				30.1		9.6			
Eritrea					17	30	18	10			
Kenya	34.1				12.2	24.4					
Malawi	11.8		13.2		22.1			23.5			
Rwanda	52				8	16					
Zambia	48.1				4.5	3.8	8.6	3.1	2.8	15.5	

Geneau et al (2007) discovered in a study done in Tanzania that the perceived need for sight and cataract surgery, decision making process in the family and the characteristics of local eye care programs were the three main determinants of the patients' willingness to pay (WTP) for cataract surgery. Quality services and adequate counselling can influence willing to pay (WTP) for cataract surgery.

CHAPTER TWO

RESEARCH RATIONALE

MICEI's community outreach as a cataract case finding strategy is in line with the need to strengthen the eye health component of primary health care which itself constitutes the future priorities of eliminating cataract blindness within the context of VISION 2020(13).

A similar study was conducted in the Upper Eastern Region of Ghana (Gyasi, Amoaku and Asamany, 2007). The research question we are trying to answer is ***"What are the reasons behind cataract patients' refusal to take cataract surgery?"***

MICEI's outreach activities report for the year 2018 shows that up to 41% percent of cataract diagnosed patients constitutes the backlog of cataract blindness within the Center Region (immediate project area) as seen in Figure 2 below. There is urgent need to understand ways of reducing MIICEI's cataract backlog so as to increase her cataract surgical win and meet her objectives and partner obligations.

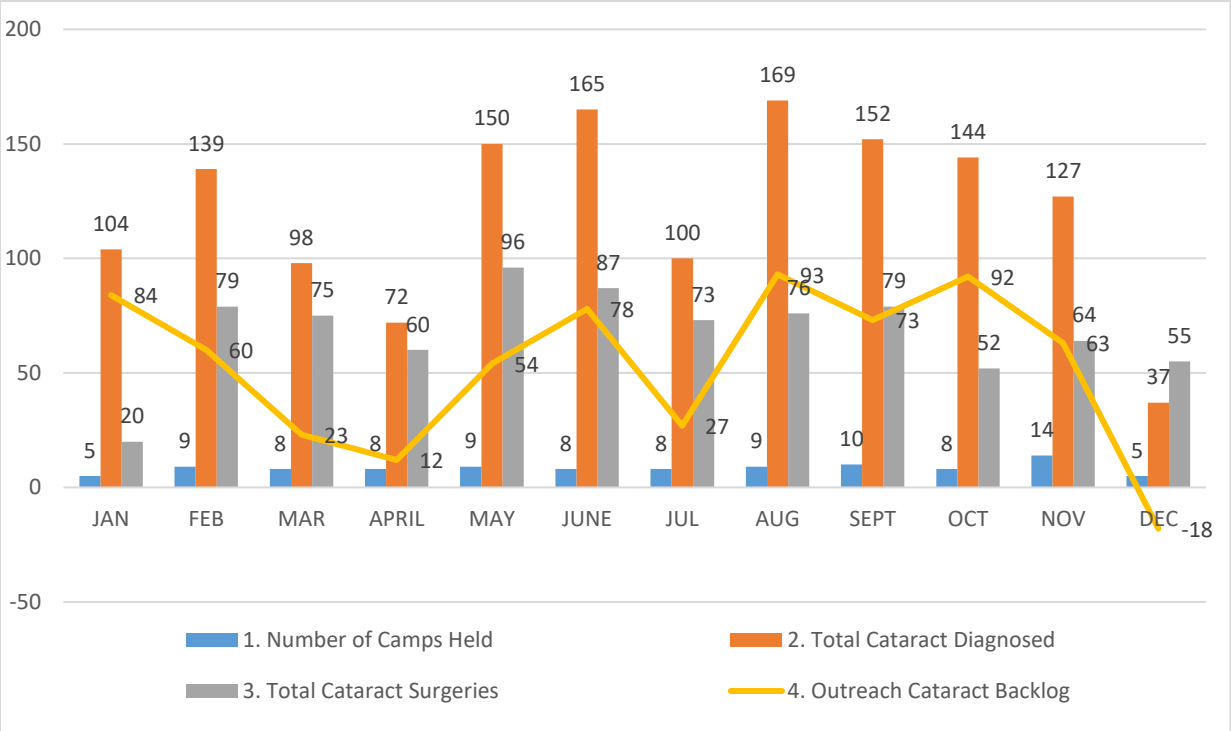

Figure 2 : 2018 Cataract Backlog (Source: Outreach Report, OT Report)

CHAPTER THREE

AIM AND OBJECTIVES

3.1 Aim

To understand the reasons behind the low uptake of cataract surgery amongst patients identified in outreach eye camps of MICEI.

3.1.1 Research Question

What are the reasons for the low uptake of cataract surgery amongst patients identified in outreach eye camps of MICEI?

3.2 Objectives

1. Assess awareness knowledge about cataract and available treatment by the first quarter of 2019
2. To explore barriers to the uptake of cataract surgical services among outreach patients by the first quarter of 2019
3. To understand people's perception about the outcome of cataract surgery by the first quarter of 2019
4. To find out people's perception about free and paid cataract surgery by the first quarter of 2019
5. To obtain the reasons for the unwillingness for uptake of cataract surgery by the first quarter of 2019

CHAPTER FOUR

METHODOLOGY

4.1 Study Design

A mixed method study dominated by qualitative method was used to get the opinions of 29 participants. Three focus group discussions were organized independently in three different communities. The three FGD were complemented by individual in-depth interviews and the individual administration of a short questionnaire

4.2 Study Area

Communities in the Lékié Division, Center Region of Cameroon. These communities included Lenouk in the Monatélé Health District, Elig-Mfomo Urban in the Elig-Mfomo Health District and Nkalngaha in the Evoudoula Health District, making a total population of 3,237 inhabitants.

4.3 Study Population

The target population of this mixed method study includes people from the communities in which MICEI organized outreaches in 2018. This constitutes the immediate project area population

4.4 Sample Size

The study made use of a mixed method study of focus group discussion followed by in-depth individual interviews and short questionnaire with 3 purposefully selected samples/focus groups making a total of 29 participants out of the 30 invited (96.7%).

4.5 Sample Selection

The 3 Focus Group Discussions were purposefully pooled from 3 different communities. Subjects were categorized into 9 direct (3 operated cataract patients and 6 cataract blind) and 23 indirect (family and community members). Each sample (FGD) constituted 1 operated cataract patient, 2 cataract blind, 1 family head/bread winner of the operated patient, 1 family head/bread winner of any of the un-operated patients (or cataract blind), 1 village head of any

of the communities from which cataract blind were drawn, 1 traditional doctor, 1 trained key informant, 1 trained frontline health worker and 1 community member/influential person.

4.6 Sampling Procedure

Purposeful sampling was used to identify post-operative cataract patients (diagnosed in outreach) and community members in the Lékié Division. A snowball sampling technique was used to include cataract blind in the communities that got diagnosed in outreach camps over the same period but never took surgery. Both sampling was repeated until the required sample size was attained. Post-operative cataract patients were purposefully drawn from MICEI's database of operated outreach patients while cataract blind patients were drawn from MICEI's outreach database of diagnosed cataract patients and assisted by the snowball sampling technique. The rest of the members were drawn from a sampling frame of 3,237 inhabitants.

4.7 Study Variables

The dependent or outcome variable is the cataract surgical uptake while the independent or explanatory variables include barriers leading to the low uptake of cataract surgery. These may include knowledge about cataract, rating of barriers (cost, fear, caretaker, awareness, outcome of cataract surgery, advice, decision making, stigma, contempt, other priorities etc.

4.8 Inclusion Criteria

- Cataract blind patients diagnosed in MICEI's outreach camps in the Lékié Division
- Cataract patients operated at MICEI from the Lékié Division
- Family members of operated cataract patients and cataract blind patients
- MICEI's trained key informants who have been involved in MICEI's outreach.
- MICEI's trained frontline health workers effectively serving in a primary health center
- Community members including village heads, traditional doctors and villagers.

4.9 Exclusion Criteria

- Subjects that refuse to sign informed consent form
- Subjects from communities in which MICEI has never organized outreaches
- Cataract blind not detected by MICEI
- Post-operative cataract patients not operated in MICEI

4.10 Definitions and Classifications

- Post-operative patient is a patient who was diagnosed of cataract in an outreach camp and got operated at MICEI.
- Cataract blind is considered to be patients that were diagnosed of cataract in an outreach camp but failed to take surgery
- Cataract blind is defined as patients with presenting visual acuity in one or both eyes of < 3/60 secondary to cataract(5).

4.11 Interview Team

A research team was formed constituting of the principal investigator, an observer and a key informant. The principal investigator was responsible for developing protocol for institutional review permission, leading the FGDs, translating and analyzing collected data and generating and submitting project report. The key informant served as the facilitator in the pulling together of different members of focus group discussions and translator. The observer took notes during FGD and administered the short questionnaire

4.12 Ethical Considerations

The needed approval to carry out this study was obtained from MICEI's Senior Management. Secrecy was maintained by giving all participants a unique id against analysis. Group discussion were recorded using a tablet with a screen lock. Subject's transport fares were reimbursed. Identified cataract blind who were part of this study were operated for free.

4.13 Data Collection

The FGD were tape recorded together with in-depth interviews. A second person served as an observer and took extra notes. Questions were articulated around the 5 objectives (themes). A short questionnaire was used to capture data on age, sex, marital status, education and occupation after in-depth interviews. Community distances of participants was computed using Open Street Maps and Google Maps online.

4.14 Data Collection Tools

Focus Group Discussions and in-depth interviews were tape recorded using Samsung Galaxy Note 10.1 tablet with some backup notes on A4 papers. Data on socio-demographic and socio-economic status were obtained using a short paper questionnaire.

4.15 Data Analysis

Recorded audio was transcribed word verbatim and analyzed thematically by organizing data into themes. Data was transcribed into excel and then arranged by means of cut and paste into question codes/themes A, B, C, D and E. The responses were further rearranged into barriers to uptake of cataract surgery and ranked. Questions included;

1) What do you know about cataract? Code A
2) What would you say hinders people from taking cataract surgery? Code B
3) What do people say when those who had cataract surgery return to the community? Code C
4) What is your opinion about free and paid cataract surgery? Code D
5) Why do you think some people do not want cataract surgery? Code E

CHAPTER FIVE

RESULTS

This study involved a qualitative component dominant study having to do with focus group discussions accompanied by in-depth interviews of 29 participants from whom socio-demographic (age, sex, marital status and residence) and socio-economic (occupation and education) data were also collected. The FGDs are presented in table 2 below;

Table 2: Presentation of Focus Groups

Participant Characteristic	Frequency	Percent
FGD 1	9	31.04
FGD 2	10	34.48
FGD 3	10	34.48
Total	**29**	**100**

Ages of subjects ranged from 30 – 81 years and the mean age of subjects was 54.48 ± 14.50. Fifteen subjects (51.72%) were aged below 50 years while 14 (48.28%) were 50 years and above. A total of 65.52% of subjects were males giving 19 males altogether. Nineteen of the subjects (65.52%) reported as being married, 5 (17.24%) as cohabiting and 5 (17.24%) as either having divorced, being a widower or widow. Subjects came from 3 different communities including Elig Mfomo, Evoudoula and Lenouk. A total of 12 subjects (41.38%) reported to have done basic primary education, 12 (41.38%) for the secondary, 1 (3.45%) for university and 4 (13.79) reported they have never been to school. Participant characteristics are shown on table 3 below;

Table 3: Participant Socio-demographic and economic Characteristics

Patient Characteristic	Group	Frequency	Percent
Age (years):	< 40	3	10.34
	40 – 49	12	41.38
	50 – 59	5	17.24
	60 – 69	3	10.34
	70 - 79	3	10.34
	80+	3	10.34
Sex:	Male	19	65.52
	Female1	10	34.48
Marital Status:	Married	19	65.52
	Cohabiting	5	17.24
	Single	-	-
	Divorced/Widow	5	17.24

Please continue this table on next page

Continuation of Table 3

Patient Characteristic	Group	Frequency	Percent
Residence:	Nkalngaha	9	31.03
	Elig Mfomo	10	34.48
	Lenouk (Monatélé)	6	20.69
	Monatélé urban	1	3.45
	Akougouda (Monatélé)	1	3.45
	Nkol-Evida (Monatélé)	1	3.45
	Nkolngal (Monatélé)	1	3.45
Employment:	Yes	3	10.34
	No	26	89.66
Education	None	4	13.79
	Primary level	12	41.38
	Secondary (1st cycle)	9	31.03
	Secondary (2nd cycle)	3	10.34
	Graduate (1st degree)	1	3.45
	Post graduate	-	-

Distances of villages participants came from was computed using google maps complemented by open street maps. Distances and drive time of villages ranged from 33km and 1hour 4minutes to 111km and 3hours 9minutes respectively. Table 4 below shows a summary of computed distances and drive time.

Table 4: Participants computed distances and drive time from Eye Clinic

	Focus Group Discussion/Villages	Distances	Drive time
1.	**FGD 1**		
	*Nkalngaha	44km	1:15
2.	**FGD 2**		
	*Elig Mfomo	33km	1:04
3.	**FGD 3**		
	*Lenouk (Monatélé)	100km	2:52
	Monatélé urban	91.2km	2:36
	Kougouda (Monatélé)	111.2km	3:09
	Nkolevida (Monatélé)	101.2km	2:56
	Nkolngal (Monatélé)	97km	2:50
	Average Distance of Patients	**82.5km**	**2:23**

5.1 Objective 1 (Code A)

Based on in-depth interviews, 93% respondents knew that cataract is a disease of the eye that is called “Onyang” in the local dialect. Even though 26 (89.6%) of subjects knew it can be treated either traditionally or in the hospital, just 11 subjects (37.9%) mentioned the hospital as the rightful place for treatment. Altogether 15 subjects (51.7%) reported the use of traditional medicine in treating “Onyang”. Twenty three subjects (79.3%) believe that cataract can be cured traditionally and as such the hospital becomes a secondary resort. This is supported by the statement of Subject 9 of FGD1

“…In the community people place traditional medicine ahead of the hospital, even here they only come when the situation has worsened”

The statement of subject 6 of FGD1 as seen below also support this fact;

“It is something [cataract] that develops in the iris and it is white. I can treat it but if it is more than me I send the person to the hospital”

In FGD2, Subject 2 shows that people turn to the hospital when the situation has worsened.

“…It is Onyang in Etone [famous tribe]. When you have onyang they can use traditional medicine, it works with the beti [famous tribe] but sometimes it fails, after that you can go to the hospital”

5.3 Objective 2 (Code B)

An average of 6 barriers to cataract surgery was raised in each of the focus group discussions as seen in table 5 below. The most frequent barriers reported were cost of surgery, fear and hospital reputation.

Table 5: Summary of barriers to cataract surgery by focus group

FGD 1	FGD 2	FGD 3
✓ Cost of surgery ✓ Age ✓ Distance ✓ Awareness ✓ Fear ✓ Hospital Reputation	✓ Fear ✓ Cost of surgery ✓ Negligence ✓ Hospital reputation ✓ Immature transport ✓ Distance ✓ Lack of escort	✓ Fear ✓ Cost of surgery ✓ Awareness ✓ Hospital reputation ✓ Poor experience ✓ Cultural beliefs and superstition

The two leading barriers following from individual interviews were **cost of surgery** and **fear**. Twenty five (86.21%) of the 29 subjects declared that lack of money is the reason behind their being unable to take cataract surgery. Seventeen (58.62%) of the subjects declared fear as a barrier. Lack of awareness was ranked the third with 20.69% of respondents declaring that lack of uptake of surgical services is due to lack of awareness. No perceived need was reported by 5 subjects (17.24%) as a barrier to cataract surgery.

As alternative measures, 12 subject (41.38) reported that subjects who do not take up cataract surgery turn to herbalist who burn herbs and apply in the eye but also that a good number of cataract blind stay at home as reported by 8 subjects (27.59%). Just 4 subjects (13.79%) think that patients not taking surgery turn to other hospitals and clinics.

The report of Subject 2 in FGS 3 confirms the above;

"Some people went to Bafia, they did not even know that Obak exists. We used to go to herbalists […..]. Like the ones of Papa we tried to put traditional medicines it did not work. We called the first person came it did not work, the other one said that if I put the medicine two times it does not work then it is not at my level".

Table 6 below gives a ranking of barriers and alternatives measures taken by participants.

Table 6: Summary of Individual impression about barriers to cataract surgery

Barriers	**Frequency**	**Percent**
Lack of money (Cost of surgery)	25	86.21
Fear (appellation, blade, knife)	17	58.62
Lack of awareness (communication, sensitization & ignorance)	6	20.69
No perceived need (too old, rejection, no interest)	5	17.24
Cultural beliefs & superstition	4	13.79
Negligence	4	13.79
Poor experience	3	10.34
Lack of escort (escorts & witnesses)	3	10.34
Hospital reputation (no trust, doubt, suspicion)	3	10.34
Distance (transport plus multiple post-surgical visits)	1	3.45
Alternative Measures		
Traditional medicine	*12*	*41.38*
Nothing (stay at home)	*8*	*27.59*
Other clinics (hospitals, pharmacy, Clandestine drug dealers)	*4*	*13.79*

5.4 Objective 3 (Code C)

All focus group discussion acknowledged that the feedback when operated patients return to the community is always very positive as people could be seen dancing upon their return. Subject 6 in FGD 3 reported the following

"After your campaign I saw a mother dancing at the center [health center] saying she could not see but now she can see, those who did not go said weeh we have missed"

According to the majority of subjects in FGD 3, people are not happy seeing someone operated because of cultural beliefs and superstition. This can be confirmed by the report of one of the members during the group discussion as seen below;

"You already know, in Africans like promising evil to their brothers [….] what is sure is that the person who was blind and is now seeing is like a witch or wizard, as if he has done some magic, has taken the eyes of a sheep to use. People will start commenting that eyes have been purchased and given to you"

The report of an operated cataract patients during the same focus group also confirms this as seen below;

"For me I am sure that one day it can happen because myself I was operated. I even had appointment, maybe 4 but when I got home my village brothers started quarrelling with me saying that OK, we shall then see, since you said you have gone to the hospital [….] they are doing everything to put us uncomfortable [sorcery], also do everything to save us [MICEI]"

A total of 25 subjects (86.21%) reported that the feedback is positive and people are happy when operated cataract patients return into the community. Most of the patients reported that some are happy and others are not. The five main reasons why people are not happy include lack of money to also take surgery (27.59%), hatred and jealousy of persons operated (13.79%), regret (10.34%), no longer able to manage the property of those who were blind (6.90%), cost of surgery (6.90%). Subject 8 in FGD 2 confirms the fact that cost is the reason for some people not being happy as seen below;

"Everybody says it is good. They could not see but now they can see, people eat 3 times a day, there is a bed, dresses. People complain because they do not have the 25,000 FRS" [US$42.86]

The interview with Subject 9 in FGD 2 also confirms the above;

"Those operated here are happy. The ones I know, they went there with sticks on coming back they have thrown them away. The main complaint is that of lack of money"

Table 7: Summary of post-surgical commentaries in the community

Testimonies after cataract surgery	**Frequency**		**Percent**
	Yes	**No**	
Happy with surgery (the operated & community)	25	4	86.21
Complain about hospital reputation	-	29	0
Reasons for not being happy			
Lack of money to take surgery like others	*8*	*21*	*27.59*
Hatred and jealousy of persons operated	*4*	*25*	*13.79*
Those not operated regret for not taking surgery	*3*	*26*	*10.34*
The operated take back their properties	*2*	*27*	*6.90*
There is a lot of money involved in doing surgery	*2*	*27*	*6.90*
Distance is long if they also have to take surgery	*1*	*28*	*3.45*
After surgery cost (cost of appointments)	*1*	*28*	*3.45*

5.5 Objective 4 (Code D)

It was acknowledged in 2 out of the 3 focus group discussions that free cataract surgery was a very good thing and that it will be welcomed in the community. On the contrary members of FGD 3 reported that free cataract surgery raises a lot of suspicion and fear. Also regarding paid surgery, it was reported during FGD 1 that this does not represent an issue if the finality is that people regain sight and that the contribution presently requested from patients is insignificant. Members in FGD 2 also reported that paid cataract will only be good for those who can pay. FGD 3 on the other hand thinks that it is difficult to pay for what you do not know given that many do not understand what cataract is. It was also acknowledged that people are more comfortable to pay if they are told that it is subsidized rather than free. Table 8 below gives a summary of the findings during focus group discussions.

Table 8: FGD impression about Free and Paid Cataract Surgery

FGD 1	FGD 2	FGD 3
Free cataract surgery ✓ People are happy **Paying cataract surgery** ✓ Current amount is insignificant ✓ Happy the we finally regain sight	**Free cataract surgery** ✓ People are happy **Paying cataract surgery** ✓ Will be good for those who can pay	**Free cataract surgery** ✓ Raises suspicion & fear **Paying cataract surgery** ✓ Paying for what you do not know is difficult ✓ Often, amount to be paid is not to our dimension

A total of 23 subjects (79.31%) reported they were happy with free cataract surgery and that the community will be positive about it. Just 8 subjects (27.59%) gave a positive impression about paid cataract surgery while 3 (10.34%) were indifferent. The 2 main reasons behind not being happy for paid cataract were lack of means (direct and indirect surgical cost) (41.38%) and lack of payment by instalment (6.90%). Table 9 below presents a summary;

Table 9: Individual impression about free and paid cataract surgery

Impression about free surgery	**Frequency**		**Percent**
	Yes	**No**	
Happy	23	6	79.31
Impression about paid surgery			
Happy	*8*	*21*	*27.59*
Indifferent	*3*	*26*	*10.34*
Reasons for not being happy with paid surgery			
Lack of means to pay	*12*	*9*	*57.14*
Lack of installment payment	*2*	*19*	*9.52*
Not sure if it will be a success	*1*	*20*	*4.76*
Fear of surgery	*1*	*20*	*4.76*
Love for what is free	*1*	*20*	*4.76*

5.6 Objective 5 (Code E)

Exploring the reasons why some people completely refuse to take cataract surgery, FGD 1 acknowledged that such people are ignorant about cataract surgery, while FGD 2 and 3 think that it is due to age, fear and cultural beliefs. All 3 proposed measures that could be taken to encourage the cataract blind to take cataract surgery as seen in table 10 below;

Table 10: FGD impression about refusal of cataract surgery and measures of encouragement

FGD 1	FGD 2	FGD 3
Reason for refusal of surgery ✓ Ignorance **Measures of encouragement** ✓ Review price of cataract surgery ✓ Those operated to talk to the cataract blind ✓ Continue educating villages	**Reason for refusal of surgery** ✓ Age ✓ Fear ✓ Cultural beliefs **Measures of encouragement** ✓ Will be good for those who can pay	**Reason for refusal of surgery** ✓ Age ✓ Fear ✓ Cultural beliefs **Measures of encouragement** ✓ Make services available ✓ Continue with campaigns ✓ Create sensitization committees ✓ Those operated to talk to those not operated ✓ Do a census of visually impaired

There are numerous reasons for the complete refusal of cataract surgery, the first being fear (31.03%). Belonging to the witchcraft society is the second reason (20.69%) for some people's complete refusal of surgery. Age was identified as the third reason (13.79%). Other reasons identified included poor experience (10.34%), ignorance (10.34%), lack of means (6.90%), cultural beliefs (6.90%), fear of being a burden to others (3.45%), negligence (3.45%) and drinking habit (3.45%).

Various ways of encouraging people to take surgery were highlighted. The main 3 included the **continuation of screening campaigns, community education and awareness and counselling**, as seen in Table 11 below;

Table 11: Individual impression about refusal of cataract surgery and measures of encouragement

Reasons for complete refusal of surgery	Frequency		Percent
	Yes	No	
Fear	9	20	31.03
Belong to witchcraft society	6	23	20.69
Age	4	25	13.79
Poor experience	3	26	10.34
Ignorance	3	26	10.34
Lack of money	2	27	6.90
Cultural beliefs and Superstition	2	27	6.90
Do not want to be a burden	1	28	3.45
Negligence	1	28	3.45
Drinking habit (will not like to be told to stop)	1	28	3.45

Please continue Table 11 next page

Continuation of Table 11

Reasons for complete refusal of surgery	Frequency		Percent
	Yes	No	
Encouragement for cataract surgery			
Continue screening campaigns	*7*	*22*	*24.14*
Community education and awareness	*4*	*25*	*13.79*
Counselling	*4*	*25*	*13.79*
Spread of word of mouth of those operated	*2*	*27*	*6.90*
In time communication	*1*	*28*	*3.45*
Involvement of community partners	*1*	*28*	*3.45*
Community surgical camps	*1*	*28*	*3.45*
Create village eye health committees	*1*	*28*	*3.45*

CHAPTER SIX

DISCUSSION OF RESULTS

Cataract is a major cause of blindness among the visually impaired in the Lékié Division of the Centre Region of Cameroon. This division stands out to have the highest rate of cataract services since the establishment of the Magrabi ICO Cameroon Eye Institute. Notwithstanding the existence of this reference, center cataract patients still face a lot of challenges accessing available services. Such challenges or barriers can be classed into A (Lack of **A**wareness), B (**B**ad surgery or poor experience), C (**C**ost of surgery), D (**D**istance), E (Lack of **E**scort) and F (**F**ear) etc. Uptake of cataract services in 2018 by MICEI's outreach patients was 59% leading to a backlog of 41%.

We found in this study that knowledge about cataract was 93%. Which suggests that most people have an idea that there exist an eye disease which could render blind if not treated. However their understanding of cataract was superficial and can be associated to the numerous outreach campaigns of the Magrabi ICO Cameroon Eye Institute. Thirteen subjects (45%) acknowledged that cataract can be treated in the hospital. However the knowledge surrounding cataract according to how it is understood by most of the people stems from the traditional context. Within this subset of the population, cataract in the local language is known as "Onyang". The local appellation of cataract (Onyang) does not give one the possibility of being able to distinguish it from other similar eye diseases.

The interview with Subject 8 in FGD 3 below reveals how difficult it might be distinguishing cataract from other eye ailments;

"Cataracte is a French word but with us it is called onyang. It can also be called demana-dis or o-quan-dis, talking of cataract is poorly understood in our setting. We only know that we have eye pains but it is the scientists who tell us it is cataract. It can be treated in the hospital as well as traditionally".

On the contrary Subject 9 in FGD3 gives a much better description;

"Cataract is the opacification of the membrane that permits light to pass to communicate with the brain. It is a disease that can be treated"

A total of 15 subjects (51.7%) reported the use of traditional medicine in treating "Onyang" and 23 subjects (79.3%) believed that cataract can be cured traditionally. It is but obvious that

many only get to the hospital after the use of herbs which may go a long way to determine the quality of cataract surgery.

Our results are not very different from those of a study that was done in the Cape Coast Metropolis in Ghana revealing that 85.6% of adults were familiar with cataract of which 44.83% correctly identified surgery as the standard treatment *(Abdul-Sadik et al, 2018)*. Our results were in accordance with *Lakshmipriya (2017)* in which 97.6% of participants felt that cataract can lead to blindness but this was a far larger study. Contrary to our results (45%) up to 83.7% of subjects in this study knew that surgery was the right treatment of cataract. The results of a study among senile cataract cases in Haryana were just a little lower than ours with 90.1% of the subjects being aware of cataract *(Bhagwan et al, 2006)*.

Cost of cataract surgery represented the most prominent barrier to cataract surgery with 25 subjects (86.21%) reporting that they lack the means to afford cataract surgery. The second leading barrier was fear as confirmed by 58.68% of subjects. The rate of cost of surgery of this study was slightly lower than what was found in the Upper East Region of Ghana (91%) reported by *Gyasi et al (2008)*. Another study by *Rotchford et al (2018)* in rural South Africa found out that 45% of subjects acknowledged fear as a barrier, lower than what we found. Results obtained in Tanzania by *Kessy and Lewallen (2007)* showed that 79% of subjects stated lack of funds as a barrier to cataract surgery but also that 44% of subjects had other reasons for not taking surgery. The results of *Krakauer et al (2008)* regarding cost (83%) in an urban West African community were not very different with ours. The percentage of subjects who reported fear as a barrier was much higher than in their study (37%). The results of *Kameni et al (2014)* about reasons for the refusal of free cataract surgery in Yaoundé, were just slightly low than ours regarding fear (55.88% as opposed to 58.68%). The sample was more than twice larger than ours.

The results of RAAB plus diabetic retinopathy study in Yaoundé revealed that 31.7% of subjects did not feel the need for cataract surgery and 19% due to cost and 19% due to lack of awareness were the main barriers to cataract surgery(14). Our results about cost of surgery as a barrier were not very different from those of M*ehari et al (2013)* undertaken in Ethiopia (91.8%). Results from RAAB studies performed in Cameroon in more than a decade ago revealed cost of surgery and lack of awareness as the principal barriers *(Aboobakar & Courtright, 2016)*. A close look at the barriers from both RAABs shows that between 2006 and 2007, the rate of awareness fell by close to 50% (from 33.3% to 17%) while the rate of cost of surgery increased by 32.9% (from 30.1% to 40%). This is not surprising because as health systems developed with the advent of VISION2020 it is but normal that awareness increases

over the years. Also, as a result of increasing cost of living and a fall in the international cocoa and coffee prices on which these villagers primarily depend, more and more people are living below the poverty line of US$2 per day and as such the number reporting cost of surgery as a barrier should increase.

In this study, 86.21% of subjects reported a positive feedback upon their return from cataract surgery which was not very different from the results of *Rajiv et al (2003)* in which 90% of subjects reported satisfaction 6 weeks after surgery. *Faisal et al (2016)* during the 10th International Conference on Clinical and Experimental ophthalmology showed that about 90% of patients were satisfied with their cataract surgery which is a little higher than ours. The results of the Alcon study in the US were a little lower than ours with 76% of subjects acknowledging satisfaction. It is good to note that while the above studies focused on individual satisfaction, our study focused on community satisfaction following the return of cataract patients.

The results of our study indicate that up to 79.31% of subjects are quite happy with free cataract surgery. This is in line with our previous analysis regarding cost of surgery as a barrier. The study in Kwale district, Mombasa, Kenya found that up to 90% of subjects admitted that free surgery is good *(Briesen et al, 2010)* which was 1.1 times higher than what we found. This was also the case of the results of Celone (2012) in a study in Ghana, reporting that 95.2% of subjects wanted free surgery (1.2 times higher than ours). The variation could be explained by the fact that one of the communities had a very poor experience regarding cataract services and optical dispensing accompanied by strong cultural beliefs.

Our results also fall in line with those of *Kameni et al (2015)* who noted that fear (55.88%) and waiting for foreign NGOs (29.42%) were the main barriers to free cataract surgery in Yaoundé. This is because foreign NGOs were offering free cataract surgery without any guarantee for sustainability which made the communities a kind of believe that this will assume a continuum. Further analysis show that only 27.59% were comfortable and thinks that the community will be comfortable with paid surgery. This may be explained by the fact that community outreach in most communities in the Centre and other Regions was started on the foundation of free cataract services and mostly done by foreign NGOs. A service that started as free becomes more difficult to be paid for because it becomes a question of mentality. Our results show that lack of means accounts for more than half (57.14% of 21 subjects) why people are not comfortable with paid surgery which also go to confirm why people go for free cataract surgery.

Our study identified fear (31.03%) and witchcraft (sorcery) (20.69%) as opposed to fear (55.88%) and waiting for foreign NGOs (29.42%) in *Kameni et al (2015)* as the two principal reasons for complete refusal of taking cataract surgery. Other important reasons in our study include age (13.79%), ignorance (10.34%) and cultural beliefs and superstition (10.34%). *Briesen et al (2010)* found in their study in Mombasa, Kenya that 12% of the subjects refused cataract surgery due to fear which was far lower than what we found probably because our sample size was more than 3 times smaller and only those who were cataract diagnosed took part in their study. Based on our results, offering free cataract surgery is not a guarantee that a significant increase in acceptance rate will be met, as confirmed by *Lawellan and Courtright (2000)* and *Aboobakar and Courtright (2016)*. One community was particularly against free surgery as a result of poor experience regarding surgery and eyeglass dispensing.

Participants suggested different ways through which cataract blind could be encouraged to take up surgery with the most prominent being the continuation of free screening campaigns (24.14%), education and awareness raising (13.79%) and counselling (13.79%).

Study Limitations

- This study was limited to 3 focus group discussions because we could not reach out the 1 focus group due to network problems. May be this could have brought a plus and improved our results
- This study was limited to the Lékié Division within the Centre Region of Cameroon because we were looking at communities with poorest and best surgical acceptance rates but perhaps the results could have presented more diverse opinions if the focus group were drawn from different divisions
- The male to female ratio was 1.9:1 which could have led to most of the responses and opinions favoring the men. However, individual in-depth interviews gave subjects the chance to be to be explicit enough.

CHAPTER 7

CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

This study was to find out the different reasons responsible for low cataract uptake within the primary project area of MICEI. A number of factors were identified with the most important being cost of surgery (86.21%), fear of surgery (58.62%) and lack of awareness (20.69%). It is important to note that 41.4% of those who do not take up cataract surgery turn to traditional medicine which have become a secondary but rather strong barrier towards cataract surgery. Based on our findings it is important for MICEI to consider effective, affordable, accessible and sustainable community cataract screening programs. A tiered pricing system will ensure that the vulnerable receive surgery even if they cannot pay while also bearing in mind that offering free cataract surgery does not guarantee increased uptake of cataract surgical services.

7.2 Recommendations

Recommendation around cost include the following;

- Implement a sliding scale pricing policy that will waive contributions of the very poor towards cataract surgery.
- Increase the number of camps during cocoa and coffee seasons for diagnosed patients to take the best possible advantage of their income. It is possible for camps to be planned on a daily basis during these seasons.
- Reduce cost of surgery through the cost of consumables by producing locally branded medications (at least the most used). Identify a staff in the pharmacy department to train on production of simple but fast moving medications like is presently done at the Mulago Hospital in Uganda.
- Reduce the number of post cataract surgical visits to be made by patients. MICEI through a convention could train primary health workers as primary eye care workers to assist in follow-up.
- Reduce patient commitment to US$25.5. Evidence show that the current contribution made by patients is still high for them to be able to pay with ease.

Recommendations regarding fear include;

- MICEI should identify and train dedicated staff that can make a career in patient counselling. This will promote commitment, career and personal development. It is important for this to be a follow-on service to such staff that in turn will lead to mastery.
- MICEI should seek to maintain good surgical outcomes through good case selection in outreach and confirmation at base hospital.

Recommendations regarding awareness raising include all but not limited to;

- Do regular eye health talks over the radio and TV channels for continuous patient education. MICEI to capitalize on its partnership with the National Radio and Television Corporation (CRTV) (presently not utilized to optimum), in awareness raising.
- Do CD spots of cataract surgery success stories to run during outreach campaigns or as a separate event during community gathering of the elderly.
- Coordinator to develop a field visit schedule that aligns with Health District Coordination meetings during which all community health volunteers are expected to be present.
- Implement a self-check motivation mechanism for community health volunteers including frontline health workers through a fee-for-referral (F4R) service to key informants and primary health workers regarding all referred cases.
- Seek to align eye care program with government health programs like vaccination weeks, vitamin A, ivermectine, mectizan and treated mosquito nets distribution.
- Work closely with churches, women groups and other service clubs
- Acquire motorbikes for newly recruited Camp Organizers for MICEI to take full control of the sensitization program
- Acquire a 4X4 vehicle dedicated to outreach and adapt a loud speaker for awareness raising. Present vehicle availability does not met with all the outreach demands.
- Coordinator to be installed and trained on ArcGIS, software used by Lands and Survey Technicians and other applications that will improve planning for awareness raising.

REFERENCES

1. Rotchford AP, Rotchford KM, Mthethwa LP, Johnson GJ. Reasons for poor cataract surgery uptake-a qualitative study in rural South Africa [Internet]. [cited 2018 Jul 30]. Available from: https://onlinelibrary.wiley.com/doi/pdf/10.1046/j.1365-3156.2002.00850.x
2. Plan S. Iapb Africa Human Resources for Eye Health. 2014 [cited 2017 Oct 18];2014–8. Available from: https://blogs.lshtm.ac.uk/iceh/files/2014/03/IAPB-Africa_HREH-Strategic-Plan_2014-2023.pdf
3. Briesen S, Geneau R, Roberts H, Opiyo J, Courtright P. Understanding why patients with cataract refuse free surgery: the influence of rumours in Kenya. [cited 2018 Jul 30]; Available from: https://pdfs.semanticscholar.org/d642/9d296d512089e2b91f287ce4c35bd6b39ac5.pdf
4. INTERNATIONAL CENTRE FOR EYE HEALTH A Manual for VISION 2020: The Right to Sight Workshops. 2005 [cited 2018 May 27]; Available from: https://s160131.gridserver.com/wp-content/uploads/manual-for-vision-2020-the-right-to-sight-workshops.pdf
5. Barriers to Cataract Surgical Uptake in Central Ethiopia. [cited 2018 Jul 30]; Available from: www.meajo.org
6. Ackland P. Review Article The accomplishments of the global initiative VISION 2020 : The Right to Sight and the focus for the next 8 years of the campaign Accomplishments to Date. 2006;
7. Shah A, Astle W, Wiafe B, Ingram A, Mwanga M, Glassco C. Barriers to the uptake of cataract surgery for women in urban Cape Town Enhancing the SAFE strategy through collaboration, participation, accountability and sustainability [Internet]. Vol. 18, COMMUNITY EYE HEALTH JOURNAL |. 2005 [cited 2018 Oct 7]. Available from: https://www.cehjournal.org/wp-content/uploads/download/ceh_18_53_080.pdf
8. Lewallen S. Poverty and cataract-A deeper look at a complex issue [Internet]. Vol. 5, PLoS Medicine. 2008 [cited 2018 Oct 6]. p. 1647–8. Available from: www.plosmedicine.org
9. Giles K, Noche Christelle D, Noatina Blaise N, Wang L, M Lai JS, Wang N. Barriers to Free Cataract Surgery in Yaoundé. Ophthalmol Res An Int J [Internet]. 2015 [cited 2018 Mar 19];3(12):23–7. Available from: http://www.sciencedomain.org/review-history.php?iid=642&id=23&aid=6358
10. Rawsthorne M. Working with Communities: Critical Perspectives. 2011;27(88). Available from: https://cgscholar.com/bookstore/works/working-with-communities

11. Schulze Schwering M, Finger RP, Barrows J, Nyrenda M, Kalua K. Barriers to Uptake of Free Pediatric Cataract Surgery in Malawi. Ophthalmic Epidemiol [Internet]. 2014 Jun 5 [cited 2018 Oct 7];21(3):138–43. Available from: https://www.tandfonline.com/doi/full/10.3109/09286586.2014.892139
12. Aboobaker S, Courtright P. Barriers to Cataract Surgery in Africa: A Systematic Review. Middle East Afr J Ophthalmol [Internet]. 2016 [cited 2018 Oct 7];23(1):145–9. Available from: http://www.ncbi.nlm.nih.gov/pubmed/26957856
13. Ackland P. The accomplishments of the global initiative VISION 2020: The Right to Sight and the focus for the next 8 years of the campaign. Indian J Ophthalmol [Internet]. 2012 [cited 2018 Mar 6];60(5):380–6. Available from: http://www.ncbi.nlm.nih.gov/pubmed/22944746
14. Cameroon: Blindness, Diabetic Retinopathy - Women Mostly Affected! - allAfrica.com [Internet]. [cited 2019 Jun 3]. Available from: https://allafrica.com/stories/201802160511.html

1. PARTICIPANT INFORMATION SHEET

Project Title: Mixed method study to explore reasons for the low uptake of cataract surgery by outreach patients in Cameroon

Principal Investigator: Mathew Mbwogge

Aim and Objectives of the Research:

Aim

To understand the reasons behind the low uptake of cataract surgery of MICEI's outreach cataract patients in 2018.

Objectives:

1. Understand people's knowledge about cataract and available treatment by 2018 ending
2. Find out patients' barriers to the uptake of cataract surgical services by 2018 ending
3. Understand people's perception about the outcome of cataract surgery by 2018 ending
4. Find out people's perception about free and paid cataract surgery by 2018 ending
5. Find out the reasons for the unwillingness for uptake of cataract surgery by 2018 ending

Procedure: Each participant who is voluntarily recruited to this study will answer a short questionnaire and partake in a recorded group discussion.

Participation in the study is voluntary and participants own the right to refuse to participate in the study or withdraw consent at any time without reprisal.

Address of the principal Investigator: International Reference Eye Hospital (MICEI), Obak, Lékié Division, Centre Region, P.O. Box 35223 Yaoundé.

Tel:+237 660 962 498

2. NOTICE D'INFORMATION

Titre : Etude mixte pour explorer la raison d'être de manque d'acceptation de la chirurgie de la cataracte par les malades de MICEI diagnostiqués en stratégie avancée.

Investigateur Principal : Mathew Mbwogge

Objectifs de la Recherche :

Objectif général :

Comprendre pourquoi les cas de cataractes diagnostiqués en stratégie avancée ont du mal à accepter la chirurgie.

Objectifs spécifiques :

1. Chercher à savoir avant la fin de 2018 ce que pensent les gens dans la communauté par rapport à la cataracte et le traitement
2. Comprendre les barrières de la chirurgie de la cataracte avant la fin de 2018
3. Comprendre le point de vue des communautés par rapport à la qualité de la chirurgie de la cataracte
4. Chercher à savoir comment les communautés considèrent il la chirurgie de la cataracte payante et gratuite.
5. Chercher à savoir pourquoi certaines personnes refusent la chirurgie de la cataracte

Procédure : Un questionnaire sera administré aux participants qui seront recrutés pour l'étude de manière volontaire. Les participants participeront à une discussion de groupe enregistrée

La participation à l'étude est volontaire et tout patient a le droit de refuser de participer à l'étude ou de retirer son consentement à tout moment sans représailles.

Adresse complète de l'investigateur principal : Hôpital Ophtalmologique de Référence International (MICEI) à Obak, département de la Lékié, Région du Centre, B.P. 35223 Yaoundé. Tel : +237 660 962 498

3. INFORMAL CONSENT FORM

I, the undersigned, Mr / Ms / Miss.....
Have been invited to participate in the research work entitled "Mixed Method Study to Explore Reasons for Low Uptake of Cataract Surgery", whose principal investigator is **Mathew Mbwogge**, Outreach Coordinator with Magrabi ICO Cameroon Eye Institute.

I understood the information notice that was given to me about this study.
I received all the answers to the questions I have asked.
I understand that I am free to accept or refuse to participate.

I freely agree to participate in this study under the conditions specified in the information notice.

Done at ……..... Date.....…....

Principal Investigator **Participant**

4. FORMULAIRE DE CONSENTEMENT ECLAIRE

Je soussigné, Mr/Mme/Mlle ……
Avoir été invité(e) à participer à l'étude intitulé « Étude mixte pour explorer les raisons de la faible acceptation de la chirurgie de la cataracte», dont l'investigateur principal s'appelle **Mathew Mbwogge,** Coordonnateur de la Stratégie Avancée à Magrabi ICO Cameroon Eye Institute.

J'ai bien compris la notice d'information qui m'a été remise concernant cette étude.
J'ai reçu toutes les réponses aux questions que j'ai posées.
J'ai bien compris que je suis libre d'accepter ou de refuser d'y participer.

J'accepte librement de participer à cette étude dans les conditions précisées dans la notice d'information.

Fait à ..... Le.....

Investigateur Principal **Participant**

5. SHORT QUESTIONNAIRE

1. Study ID : ☐☐ **2. Date (Day/month/year) :** ☐☐☐☐☐☐

3. Participant's ID : ☐☐

B. SOCIO DEMOGRAPHIC VARIABLES

4. Participant's year of Birth: **19** ☐☐

5. Participant's Sex:
- Male 1 ☐
- Female 2 ☐
- Prefer not to say 3 ☐

6. Participant's Marital Status
- Married 1 ☐
- Cohabiting 2 ☐
- Single 3 ☐
- Divorced/Widow 4 ☐

7. Participant's Place of Residence : _____

C. SOCIO-ECONOMIC VARIABLES

8. Who is responding? Administer by eligible person: 1 ☐ Administer by proxy : 2 ☐

9. Are you employed?
- Yes 1 ☐
- No 0 ☐

10. What kind of work do you work?
_____

E. EDUCATION

11. What is your highest level of education attained?
- None 0 ☐
- Primary 1 ☐
- Secondary (O/L) 2 ☐
- Secondary (A/L) 3 ☐
- University 4 ☐
- Post University 5 ☐

Thank you for taking the time to complete this questionnaire

6. FICHE TECHNIQUE

1. No d'Étude : ☐☐ **2. Date (jour/mois/an) :** ☐☐☐☐☐☐

3. No du Participant : ☐☐

A. VARIABLES SOCIO-DEMOGRAPHIQUES

4. Année de naissance du malade : **1 9** ☐☐

5. Sexe du Participant :
masculin 1 ☐
féminin 2 ☐
Ne se prononce pas 3 ☐

6. État matrimonial du participant
Marié 1 ☐
Cohabitant 2 ☐
Célibataire 3 ☐
Divorcé/veuve 4 ☐

7. Lieu de résidence du participant : _____

B. VARIABLES SOCIO-ECONOMIQUES

8. Qui répond ? Administrer par personne admissible : 1 ☐ Par un proche : 2 ☐

C. OCCUPATION

9. Êtes-vous employé dans une société ?
Oui 1 ☐
Non 0 ☐

10. Quel genre de travail faites-vous habituellement ?_____

D. EDUCATION

11. Quel est votre niveau d'instruction atteint ?

Aucun 0 ☐
Primaire 1 ☐
Secondaire (BEPC/Prob) 2 ☐
Secondaire (BAC) 3 ☐
Université 4 ☐
Masters et plus 5 ☐

Merci d'avoir pris le temps de remplir ce questionnaire

7. FOCUS GROUP DISCUSSION GUIDE

Study Objectives:

1. Understand people's knowledge about cataract and available treatment (Theme 1)
2. Find out patients' barriers to the uptake of cataract surgical services (Theme 2)
3. Understand people's perception about the outcome of cataract surgery (Theme 3)
4. Find out people's perception about free and paid cataract surgery (Theme 4)
5. Find out the reasons for the unwillingness for uptake of cataract surgery (Theme 5)

QUESTIONS

CODE 1: What do you know about cataract?

Probes

- How is it called in your community and what do people think about it?
- Do you think it can be treated and how?

CODE 2: What would you say hinders people who want cataract surgery from taking cataract surgery?

Probes:

- Suppose someone wants surgery, what may disturb him/her from finally taking surgery?
- Do they go to other places for cataract surgery? If so where and why?

CODE 3: What do people say when those who had cataract surgery come back to the community?

Probes:

- Are they happy with the surgery? If not why?
- Do people usually complain and about what?

CODE 4: What is your opinion about free and paid cataract surgery?

Probes:

- How do people consider free cataract surgery in your community?
- How do people consider paid cataract surgery in your community?

CODE 5: Why do you think some people do not want cataract surgery?

Probes:

- Are there any reasons that may make someone not to want to take cataract surgery?
- What can be done to encourage people to take up cataract surgery?

8. GUIDE DU DISCUSSION DE GROUPE

Objectifs

1. Comprendre les connaissances des gens sur la cataracte et les traitements disponibles
2. Découvrir les obstacles à l'utilisation des services de chirurgie de la cataracte
3. Comprendre la perception des gens sur les résultats de la chirurgie de la cataracte
4. Découvrez la mentalité des gens à propos de la chirurgie de la cataracte gratuite et payante
5. Découvrez les raisons de la résistance de certaines personnes à la chirurgie de la cataracte

QUESTIONS

CODE 1 : Que savez-vous de la cataracte ?

- Comment s'appelle-t-il dans votre communauté et qu'en pensent les gens ?
- Pensez-vous qu'elle peut être traité et comment ?

CODE 2 : Selon vous, qu'est-ce qui empêche les personnes qui souhaitent subir une opération de la cataracte de subir une opération de la cataracte ?

- Supposons que quelqu'un veut la chirurgie, qu'est-ce qui peut l'empêcher de se présenter pour la chirurgie ?
- Est-ce qu'ils vont dans d'autres endroits pour une chirurgie de la cataracte ? Si oui, où et pourquoi ?

CODE 3 : Que disent les gens lorsque ceux qui ont subi une opération de la cataracte reviennent dans la communauté ?

- Sont-ils satisfaits de l'opération ? Si non pourquoi ?
- Les gens se plaignent-ils habituellement et de quoi ?

CODE 4 : Quelle est votre opinion sur la chirurgie de la cataracte gratuite et payante ?

- Comment les gens envisagent-ils la chirurgie gratuite de la cataracte dans votre communauté ?
- Comment les gens considèrent-ils la chirurgie de la cataracte payante dans votre communauté ?

CODE 5 : Pourquoi pensez-vous que certaines personnes ne veulent pas la chirurgie de la cataracte ?

- Quelles sont des raisons qui peuvent empêcher quelqu'un de vouloir subir une opération de la cataracte ?
- Que peut-on faire pour encourager les gens à se faire opérer de la cataracte ?