Comprehensive Child Eye Health In Nigeria (CCEHiN)

SEEING IS BELIEVING (SiB) PROGRAMME

ENDLINE REPORT OF THE KNOWLEDGE, ATTITUDE AND PRACTICE (KAP) SURVEY

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ACRONYMS

CBM	Christoffel-Blindenmission	NOA	National Orientation Agency
CCEHIN	Comprehensive Child Eyes Health in Nigeria	MSC	Most Significant Change
CEH	Child Eye Health	P.E.	Principal Evaluator
CHEWS	Community Health Extension Workers	PWD	People with Disabilities
DQA	Data Quality Assurance	RRS	Risk Rating Scale
DQS	Data Quality Standard	RRM	Respondent Referral Matrix
FCT	Federal Capital Territory	RQ	Research Questions
FMoH	Federal Ministry of Health	SIB	Seeing is Believing
FRCN	Federal Radio Corporation of Nigeria	SOW	Scope of Work
GoN	Government of Nigeria	KHS	Knowledge Harvesting Session
HANDS	Health Support and Development Program	TBA	Traditional Birth Attendants
HMIS	Health Management Information System	TOR	Terms of Reference
HSS	Health Systems Strengthening	OH	Outcome Harvesting
IDI	In-depth Interviews	OPDS	Organization of Persons with Disability
I.E.	Investigative Evaluator	OM	Outcome Mapping
IEC	Information Education and Communication	QR3	Qualitative Research Methodology
KAP	Knowledge , Attitude and Practices	WHO	World Health Organization
LGA	Local Government Area		
LOE	Level of Effort		
M&E	Monitoring and Evaluation		

FOREWORD

Two in 10,000 children in Nigeria are blind or have severe visual impairment. The leading causes of blindness are cataract, cornea scaring resulting from trachoma, measles, Vitamin A deficiency, eye injuries, infections and harmful traditional practices. (Duke et al., 2013). The negative impacts of vision impairment for children include diminished quality of life, a lack of access to education, and challenges in finding employment in future, with negative effects on economic growth.

Deep-rooted socio-cultural beliefs and harmful practices, which impacts negatively on child eye health have persisted among communities in Nigeria.

Knowledge, Attitude and Practices (KAP) study serves as an educational diagnosis of the community. KAP Study tells us what people know about certain things, how they feel and how they behave.

The main **purpose of** the Seeing is Believing (SiB) KAP **study** was to explore changes in **Knowledge**, **Attitude and Practices** of the communities, paramedical eye personnel and policy makers on child eye health.

The SiB programme KAP study helped to identify gaps within the intervention communities and among the different target audiences in terms of knowledge, attitude and what communities practice. Findings from the study were used to develop strategic behaviour change communication interventions (radio magazine programme, radio and television jingles, print materials and billboards), to help increase awareness about child eye health issues and to improve attitudes and health seeking behaviors among the populace.

I wish to recommend the use of the KAP study findings to Child Eye Health (CEH) stakeholders to guide them in the development of appropriate behaviour change communication messages and materials that will help to increase knowledge of CEH issues, ameliorate harmful practices among caregivers and improve child eye health seeking behaviors of communities in Nigeria.

Mr. Bright Ekweremadu
Country Director
CBM, Nigeria Country Office

ACKNOWLEDGEMENT

One of the components of SiB is eye health promotion, which includes activities geared towards engaging and empowering individuals and communities to adopt positive child eye health behaviors, and create awareness to change harmful practices or attitudes; thereby improving uptake of child eye health service.

A baseline Knowledge, Attitude and Practice (KAP) study was conducted before implementation. This endline study seeks to measure the same by using the same tools and similar methodologies to discern how well the SiB programme worked in improving the knowledge of beneficiaries and changing unwanted attitudes and practices of beneficiaries.

The programme is sincerely grateful to the numerous SiB partners especially, to the National Eye Health Programme of the Federal Ministry of Health led by Dr Eme Okolo. Most importantly, we recognize the contributions of our community partners, Health and Development Support Programme (HANDS), Eleta Eye Institute (EEI) and Community Advancement Initiative for Self–Reliance for their participation in the Media Materials Development meeting. Our sincere appreciation goes to Mr Obasi Obonnaya who served as the Strategic Behaviour Change Communication Lead Consultant.

We wish to acknowledge the efforts of the following persons: CBM-UK Programme Manager, Louise Shute, the SiB Programme Director in Nigeria, Dr Juliana Nathaniel and the Programme Manager, for Cluster 4, Dr Anne Ebri. We also acknowledge the contributions of the SiB Technical Advisors Professor Roseline Duke, Dr Tisan Bagaya and Dr Israel Balogun for their technical support and also Mr Kingsley Adimabua, the SiB Monitoring and Knowledge Management Manager.

We salute the doggedness of Cluster Coordinators and the SiB programme support team and most importantly, the leadership support by the SiB Steering Committee, Internal Agency for Prevention of Blindness and Standard Chartered Bank for their technical and funding supports.

Finally, thanks to the Mr Chidi Hope Agbaraji and Mr Ayowunmi Ogunjobi for conducting the SiB programme KAP baseline and endline studies respectively.

Dr Juliana Nathaniel, Ph.D.
Programme Director
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EXECUTIVE SUMMARY

Eye problem in children can affect their learning and development, therefore ensuring children receive appropriate treatment may help restore their eyesight and improve the quality of their lives. It is therefore also imperative to increase the knowledge of the population as well as care seeking behavior for prevention and management of eye health issues.

This study was to understand the knowledge, attitude and practice of the people on eye care and health practice in programme focal states and compare with previous surveys to identify progress made and barriers encountered for improvement and support. To make the endline as directly comparable to the baseline, the endline survey was conducted in same clusters as the baseline. Hence, the endline systematically accounted for progress against target appropriated for the project highlighted by the research questions.

The endline results show that within the SiB intervention communities, there was significant improvement in the knowledge on eye health problems as well as a reduction in misconceptions and myths related to eye health issues in children. There was also an increase in the care seeking behavior among persons affected by eye health issues, indicating appropriate targeting by the programme. However while more people now go for eye check-up now than before the programme implementation, levels of eye check-up in the population is generally low, despite eye check-up tests being free of cost. Proximity to health facility as well as shortage of clinic personnel were listed as some of the barriers undermining eye health promotion as well as utilization of eye health services. In addition, policy makers agree that child eye health has been majorly ignored by all stakeholders especially the government and that most of the interventions in child eye health are NGO-driven.

It is therefore recommended that, for eye health programmes to be more effective, eye health facilities should not only be located in urban areas, health personnel should be properly trained and services integrated as part of PHC package. Drugs should be provided at a cost that is affordable by the people; as well as leverage on existing and most used media platforms to increase awareness in the general population on eye health issues and where to get needed support and care; including promoting the need for regular eye check-up. Policies should be put in place to ensure that all schoolchildren are screened on an annual basis and that all new intakes receive mandatory screening on admission.

1. INTRODUCTION

1.1. Background

Comprehensive Child Eye Health in Nigeria (CCEHiN) is a three-year (2017-2020) Seeing is Believing (SiB) programme, that seeks to make comprehensive child eye health services available and accessible through promotion, prevention, medical care, rehabilitation and inclusive education targeted at vulnerable children. The SiB programme was implemented in eleven (11) States of the federation divided into four clusters as follows:

Cluster 1: Oyo, Ogun and Osun States;
Cluster 2: the Federal Capital Territory, Nasarawa and Plateau States;
Cluster 3: Kano, Katsina and Jigawa States; and
Cluster 4: Cross River and Akwa Ibom States.

1.2. Project aim and objectives

The aim of the programme is to contribute to the reduction of avoidable blindness and visual impairments through the provision of comprehensive child eye health services to about 1.5 million children aged 0-14 years in selected states of Nigeria.

1.2.1 The objectives of the programme are to:

- Develop skilled and adequate manpower to provide comprehensive child eye health services at various levels of health care in the targeted project areas
- Improve the quality, accessibility and scope of eye health services to children
- Embed child eye health in the policies and programme work of the Ministries of Health and Education
- Pilot strategies for inclusive eye health
- Establish the school eye health programme as a sustainable model to deliver eye health services to children
- Improve the quality of early intervention and education of blind children and children with severe visual impairment

1.2. Overview

Prior to programme implementations, a facility assessment survey was conducted across the 275 health facilities that would be supported by the Comprehensive Child Eye Health in Nigeria (CCEHiN) component of the Seeing is Believing (SiB) programme. The programme was managed by a consortium comprising: Brien Holden Vision Institute and Christoffel-Blindenmission (CBM) as the lead organization. The programme implementation was preceded by a baseline evaluation that was focused on the prevailing knowledge on child eye health in selected communities. Similarly, health facility assessments were conducted across selected facilities. The data were collected from each of the health facilities (HFs) based on the clustering arrangement by geopolitical location done to facilitate program management. The eleven (11) implementing States of the federation were divided into four clusters as follows: Cluster 1: Oyo, Ogun and Osun States, Cluster 2: the

Federal Capital Territory, Nasarawa and Plateau States, Cluster 3: Kano, Katsina and Jigawa States, and Cluster 4: Cross River and Akwa Ibom States.

The result shows a fair distribution of the Primary Health Centers (PHCs) between rural and urban location in all the clusters except in Cluster 3 where a significant number (70.8%) are located in the rural area. On the other hand, most of the Secondary and Tertiary HFs are in urban locations except in Cluster 1 where a fair rural-urban distribution exists. Staff profiling reveals a variation in the availability of health professionals across the clusters and facility types. Paediatric eye care specialists are not available in the PHCs but a complete team of paediatric eye care specialists (paediatric oriented optometrist, paediatric ophthalmologists, ophthalmic nurses, paediatric oriented optometrists, and paediatric low vision practitioner etc) is available in each of the clusters. Even though the availability of staff fully dedicated to the provision of eye health services is low in the PHCs (<49%), most of them (89.6-93%) have Community Health Extension Workers that can support community mobilization and outreach services.

2. OBJECTIVES

This study was conducted as endline to evaluate the impact of SiB interventions since the baseline KAP survey was conducted February 2018.

The main objective of the survey was to understand the knowledge, attitude and practice of the people on eye care and health practice in programme focal states and compared with previous baseline to identify changes and need for improvement and support.

2.1. Specific objectives

The specific objectives of the survey are is to provide answers to the following research questions:

1. What is the current level of Knowledge, Attitudes and Practices related to eye health at community level; including what is known and done about eye health-related subjects within the various SiB intervention communities?
2. What are the existing knowledge gaps with regard to appropriate health seeking behaviors and obstacles to initiating or completing treatment?
3. What is the level of involvement of communities and health care workers in child eye care management and what are the associated challenges?
4. What are barriers that undermine child eye health promotion, prevention, treatment and management in the community as well as access and utilization of child eye health services within the various SiB intervention communities?
5. What are the perception of policy makers and opinion leaders about child eye health issues and programmes?
6. How do evaluation questions 1-6 compare with the baseline research questions?
7. If any, what progress or barriers have been made since the baseline study?

3. METHODOLOGY

Description of Methods: This study used a mixed method approach, which is both quantitative and qualitative methods. In order to get different perspective of the target populations, respondents were divided into two groups:

- The general community members, i.e. heads of households, men and women
- The opinion leaders at including community leaders and Senior Civil Servants at Ministry of Health and Ministry of Education.

Different instruments and methods (quantitative and qualitative) of data collection was used for the two groups to understand get the perspective of each target population. Survey questionnaire was administered to the general community members while key in-depth interviews (KIIs) were used for other target group.

3.1. Sampling Design

To make the endline as directly comparable to the baseline, the endline survey was conducted in same clusters as the baseline.[1] Hence, the endline survey systematically account for progress against target appropriated for the project as highlighted by the research questions.

Similar steps as the baseline survey was adapted hence multi-stage sampling design was used. The first stage was to identify health facilities within the LGAs across five states (one from each cluster and FCT) where SiB was implemented, and Enumeration Areas (EA) from the National Population Commission (NPopC) were purposely selected as Primary Sampling Units (PSU). At the second stage, households were randomly visited at intervals of five (5) households, and heads of households or adult person in the household surveyed using the household survey questionnaire. The questionnaire was deployed using Kobo Collect platform and Android phones used for data collections.

3.2. Sample Size

In order to be as consistent as possible with the baseline design, same sample size calculation as baseline was used. Hence, equal number of sample was proposed for each state irrespective of population density. N=200 (which will give a total of 1000 responds) was planned for each state but due to time and travel logistics challenges, the end-line survey could not carried out in Cross River state. It also appears that there is no evidence to suggest that baseline survey was conducted in the state.

3.2. Survey Area

Owing to some logistic challenge associated with the SiB implementation partner in Cross River, the endline survey was not conducted in the state. This means that the

[1] REPORT OF KNOWLEDGE, ATTITUDE AND PRACTICES (KAP) SURVEY ON CHILD EYE HEALTH (CEH) ACROSS FIVE STATES IN NIGERIA; 2018

survey only accounted for four (4) states as the representation of the entire project areas.

The table below shows the spread and coverage (in local government areas) achieved during the endline survey:

FCT	No.	Kano	No.	Oyo	No.	Plateau	No
AMAC	80	Bebeji	43	Ibadan North	72	Barkin Ladi	52
Bwari	35	Fagge	41	Ibadan South West	80	Bassa	43
Gwagwalada	44	Kano Municipal	43	Oyo	30	Jos South	54
Kuje	52	Nassarawa	41			Riyom	53
		Wudil	40				

3.3. Data Collection Tool and Survey Instrument

The quantitative data collection was the adaptation of the tool as was used in the baseline survey. The questions were developed through the XLS Form and deployed on Kobo Collect. However, the section on Poverty Index was removed given that it does not have any bearing on the research question, which are focus for this endline survey.

The KII focused specifically on four (4) series of questions aimed to gauging the perception of opinion leaders. These questions were simply drafted on paper.

4. RESULTS/FINDINGS

4.1. Socio-demographic characteristics of respondents

A total of 804 respondent were surveyed across 16 local government areas in four clusters. Gender breakdown reveals that 55% of respondents are males and 45% are females. Response rates across all locations was 93% for quantitative household survey while response rate for the KII with policy makers is 100%.

Furthermore, 48% (n=383) of respondents are resident in urban areas while 27% (n=215) and 26% (n=205) of respondents are resident in rural and peri-urban areas respectively. Average age of sampled respondent is 39 (sd=13.18). This average varies between male respondents at 40 years old and female respondents at 38 years old.

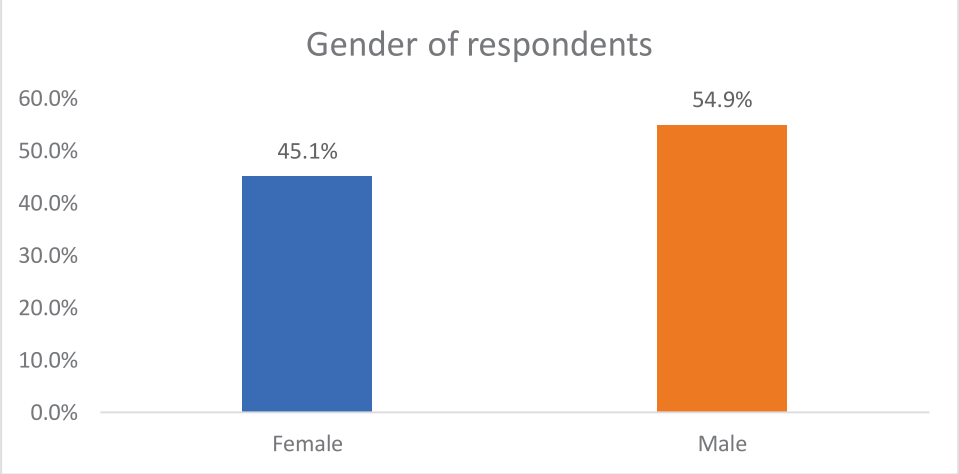

Figure 1: Gender of respondents

About 40% of the respondents were aged 30-40 years old and approximately 33% of them had tertiary or higher education.

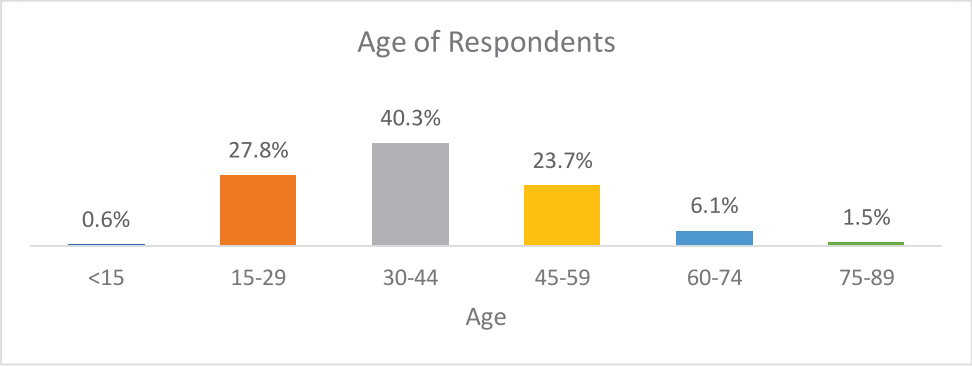

Figure 2: Age of Respondents

While most of the respondents - 68%, reported being married; 21% were single; 95.5% of them reported having less than nine (9) children. Their careers included clerical services, farming, professional technical / managerial, sales & services, skilled

manual workers, students, unemployed, housewife/houseman and unskilled manual workers, with the highest proportion of respondents (30%) working in sales and services. 6% of the respondents declined to provide their occupation.

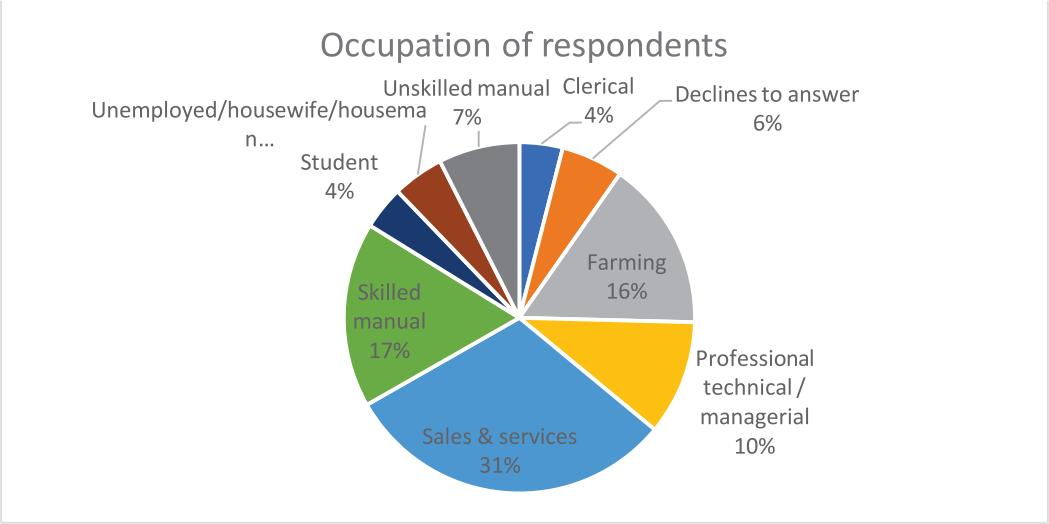

Figure 3: Occupation of respondents

It is noteworthy that 96.5% of the respondents reported monthly incomes less than 100,000 Naria, with average monthly income for all respondents reported at N32,967 (sd=N52,446).

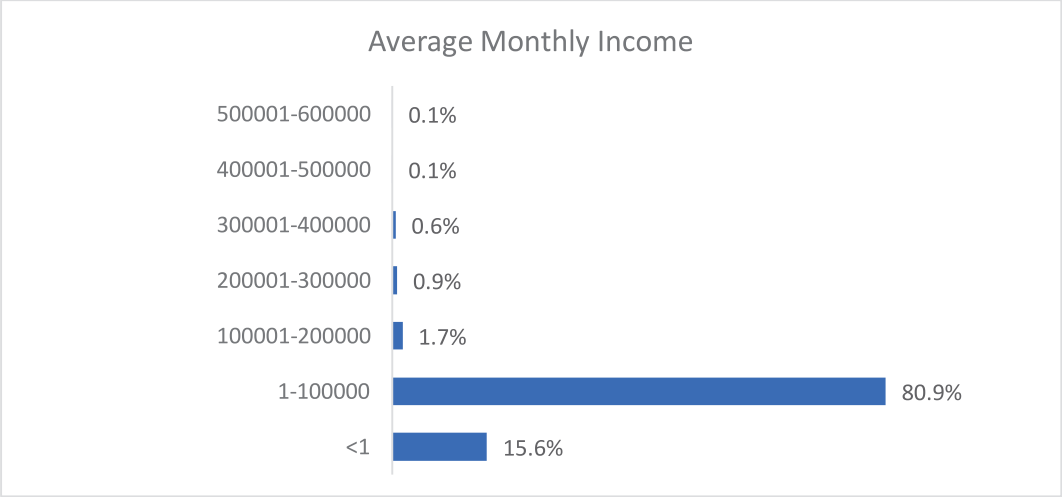

Figure 4: Average Monthly Income of respondents

The study showed that 61% of respondents knew a person or child that had eye problems or was blind, with a higher proportion of them living in urban areas. Fewer respondents, 13% of the respondents across urban, peri-urban and rural areas however reported not knowing a person with eye problem or who was blind.

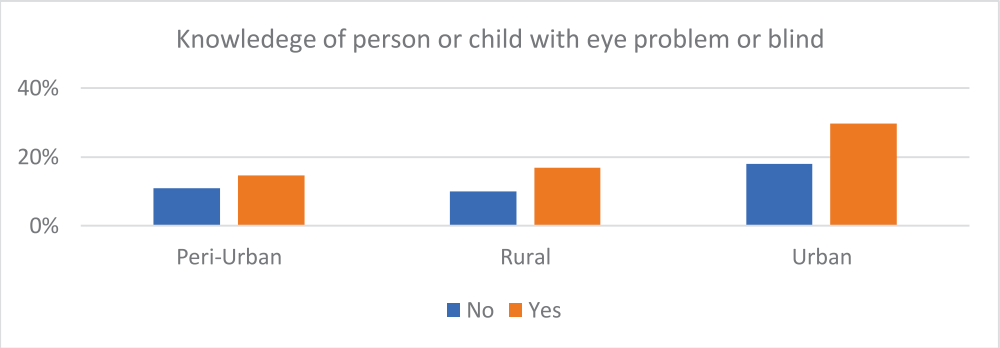

Figure 5: Knowledge of person or child with eye problem or blind

4.2. Government policies and health facilities

Only about three (3) out of every 10 respondents reported to be aware of government policies on eye health issues. While the knowledge appears to be low, it is 15-percentage point higher than the result from baseline. This shows that the proportion of people who are aware of government policies providing for persons with eye problem has more than doubled within the last 3 years (11% vs 26%).

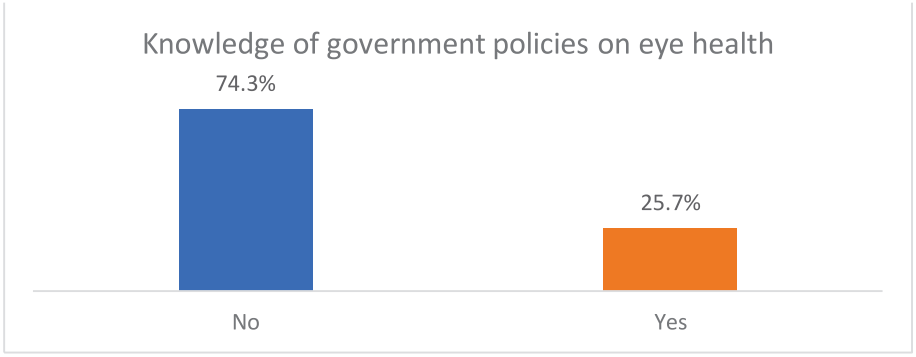

Figure 6: Knowledge of government policies on eye health

Similar to the findings from the baseline survey, the endline survey also asserts that there is not much support coming from the government at the national and state levels with regard to child eye health programme as 67% of respondents agreed that government was not doing enough to support persons with eye problem.

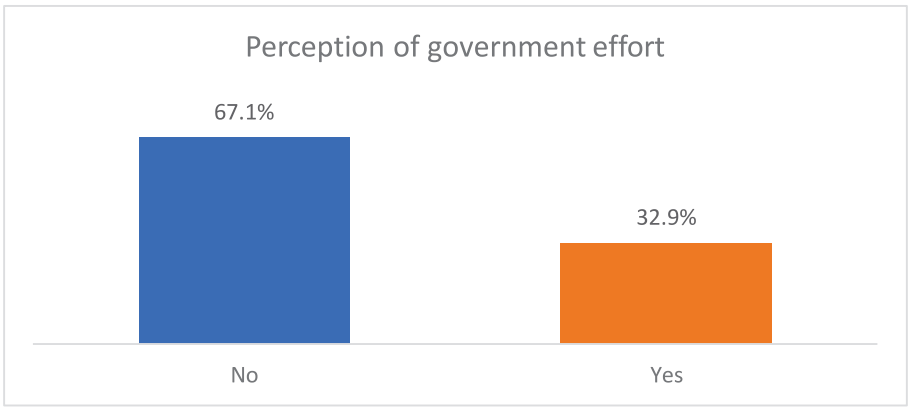

Figure 7: Perception of government effort

"The problem of child eye health has been prevailing without government responding adequately"

Community Leader, Fagge -Kano State

However, when compared against the baseline, the proportion people who reported that government is not doing enough has dropped from 76% in 2018 to 67% in 2020; marking a nine percentage drop.

In the same vein, 82% of the survey population reported they had not been engaged in any kind of program (awareness, training) on Child Eye Health and had no awareness of any Community Based Organization (CBO) working in their communities.

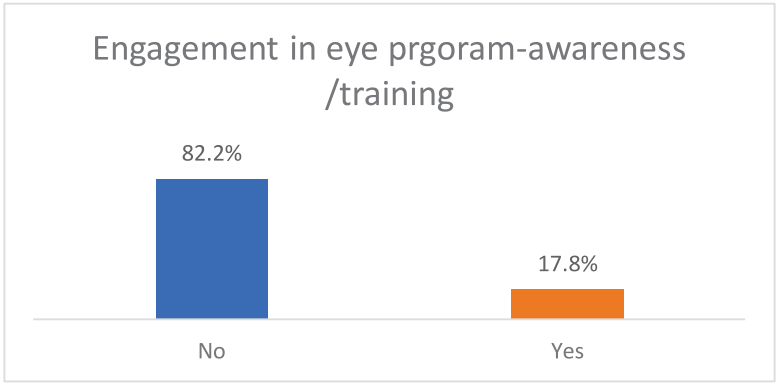

Figure 8: Engagement in eye program-awareness /training

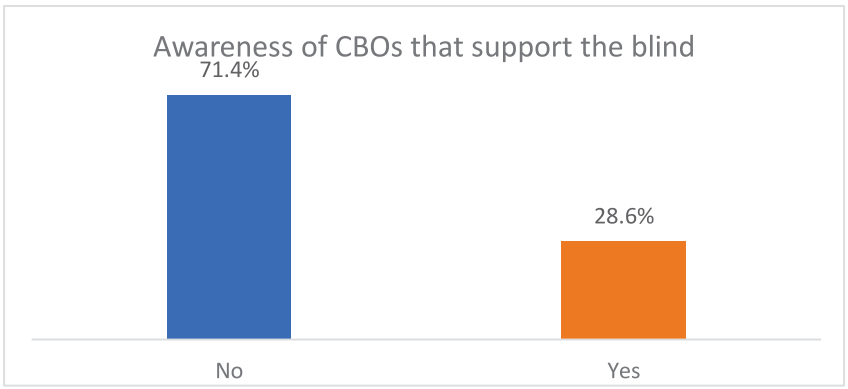

Figure 9: Awareness of CBOs that support the blind

The proportion of people without such awareness is highest in Plateau state with about 95% of sampled respondents in Plateau reporting in the negative; this was followed by Kano at 76%. Oyo state has the highest number of people with awareness of CBOs providing supports for the blink at 46%. When compared against baseline, awareness of presence of CBOs has increased from 3% to 29% at endline.

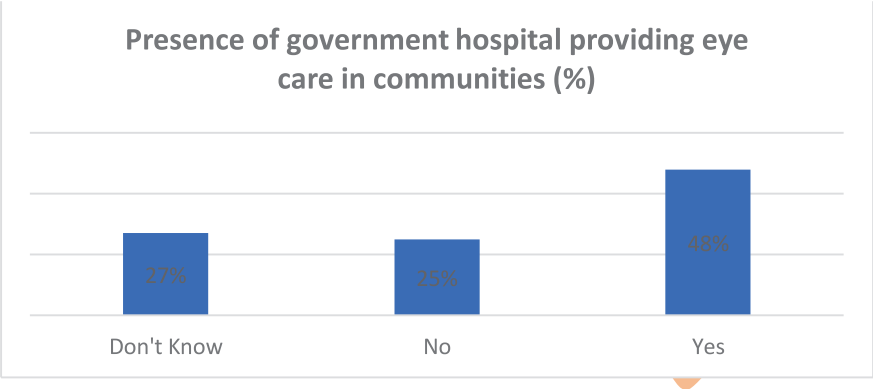

Figure 10: Presence of government hospital providing eye care in communities (%)

When compared against baseline, the proportion of people who are aware of government hospitals providing eye care has increased by 9 percentage point (39% vs 48%); revealing an increase of 23%.

When beneficiaries were asked the kind of services the government hospitals provide, basic eye care (defined as diagnosis, check -up, provision of eyeglasses and eye drops) are most prevailing services provided by the hospitals. For many respondents, medications were provided in addition to check-up while for others, free eyeglasses as well as eye surgery was one of the services that was reported.

4.3. Eye care at community level

4.3.1. Knowledge of child eye health at community level

The study showed that while 61% of respondents reported knowing a child with eye problem, only 22% of respondents live with children with eye problem, of which 53% of them were females and 47% were males; and 88% of them reported that the eye health issue had persisted for longer than an average of 5 years. The data also shows

that there was low knowledge of activities targeted at eye health in the community as 61% of respondents reported that no work had been done in their communities in the past year and consequently no improved knowledge.

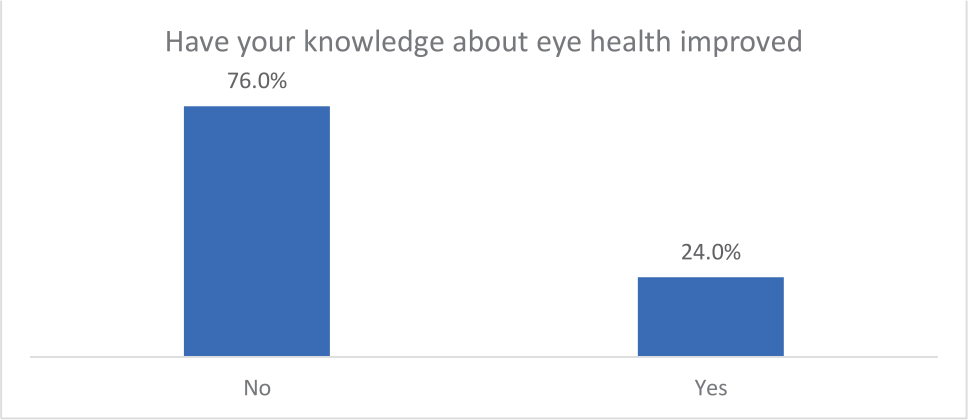

Figure 11: Improved knowledge about eye health in the community.

However, out of the 31% who reported knowing about eye health activities in their communities, 24% of them also reported improved knowledge in areas including need for diagnosis before medicating rather than self-medicating, caring for the blind and visually impaired, preventing eye health issues among others.

According to the KII conducted with Ministry of Education, one of the Directors has the following to say:

> *"from my observation, nearly nothing has changed. It is as though things are going in a circle. However, SiB has really made a lot of efforts in improving eye health awareness and services through its free services and media campaigns. I still believe that to get result at scale, government needs to expand on some of these results".*

It is noteworthy that the proportion of people who reported improved knowledge in eye care is consistent with the proportion who reported living with people with eye health issues. It is therefore likely that the SiB intervention targeted and improved the knowledge of the population most affected by child eye health issues in the communities.

4.3.2. Knowledge on types of child eye problems

Conjunctivitis was the most known eye problem, as it was mentioned by 73% of respondents. This was closely followed by blindness, cataract and glaucoma, mentioned by 56%, 44% and 25% of the population respectively; compared to the baseline, these same eye health issues were top of the list. In the baseline however, Glaucoma was the most known eye problem, while blindness and cataract remained the second and third most mentioned in both studies but with higher proportions in the endline.

Other additional eye health issues mentioned include Onchocerciasis (river blindness), refractive error, optic atrophy and diabetic retinopathy.

Respondents listed amblyopia (lazy eye), color blindness, conjunctivitis (red eye), watering or sticky eyes, strabismus (turned eyes; crossed eyes; squint eyes), refractive error (myopia; hyperopia; astigmatism) and uveitis as the main cause of eye problems especially among children.

4.3.3. Myths and misconceptions on child eye health

Compared to the baseline, this study showed that more people now agree that there are myths and misconceptions about eye heath. At baseline, 55% of respondents had reported that there were no myths and misconceptions on eye health issues, however the endline study shows that only 40% of the study population now believe that there are no myths and misconceptions in eye health issues. This shows a 38% (55% vs 40%) reduction in the widespread of myths and miscaption on eye health issues in the intervention areas.

4.3.4. Risk factors that can expose a child to eye health problem

Environmental factors was mentioned by 85% of the respondents as the leading risk factor exposing a child to eye health problems. While this proportion is significantly higher than 32.5% of respondents in the baseline, it is noteworthy that in both studies, this was cited as the highest risk factor.

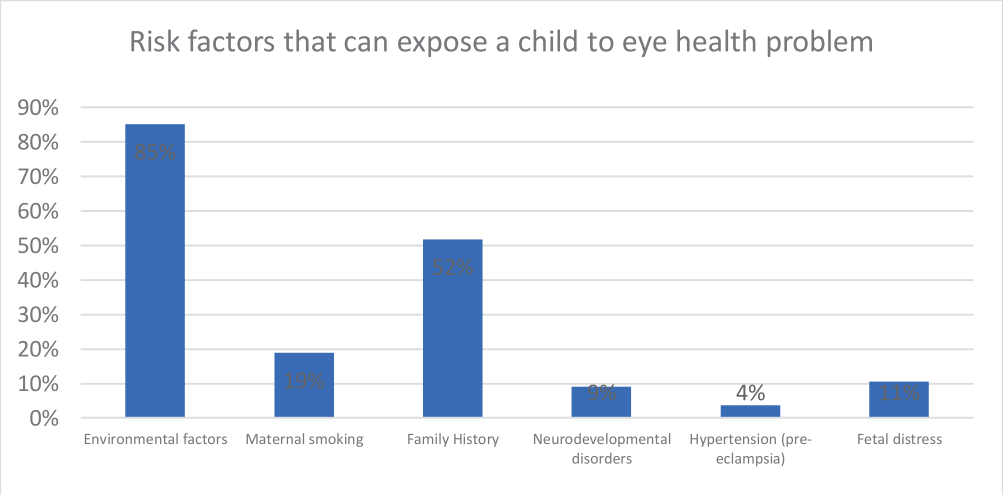

Figure 12: Risk factors that can expose a child to eye health problem

Additional responses also indicated better knowledge on the risk factors as respondents mentioned family history, smoking during pregnancy, fetal distress as predisposing factors for eye health problems. Neurodevelopmental disorders and hypertension were the least mentioned factors.

4.3.5. Health Seeking Behavior

31% of respondents had accessed eye care services in the last 3 years, either for themselves or for their children.

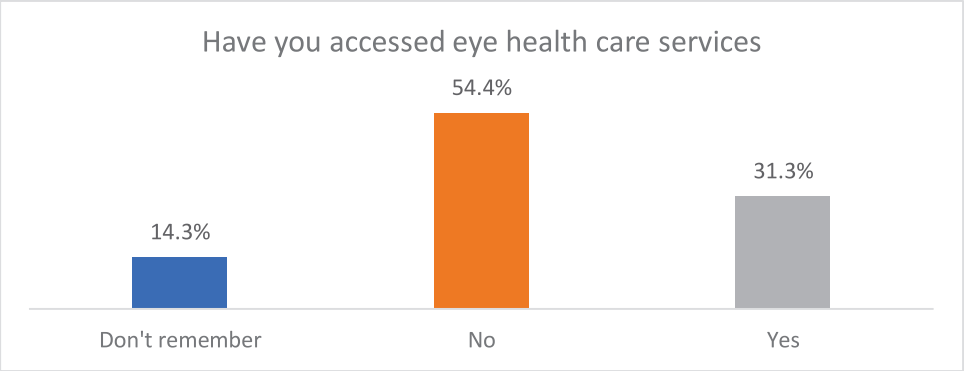

Figure 13: % of persons who accessed eye health care services

This also reflected in the frequency of access to eye health service, as a cummulative 35.1% of respondents reported to have accessed care at least yearly; disgregated, 6.6% accesed care monthly, 12.0% went at quarterly intervals while 15.9% had yearly access. 65% of the population had never gone for a check-up or did not know.

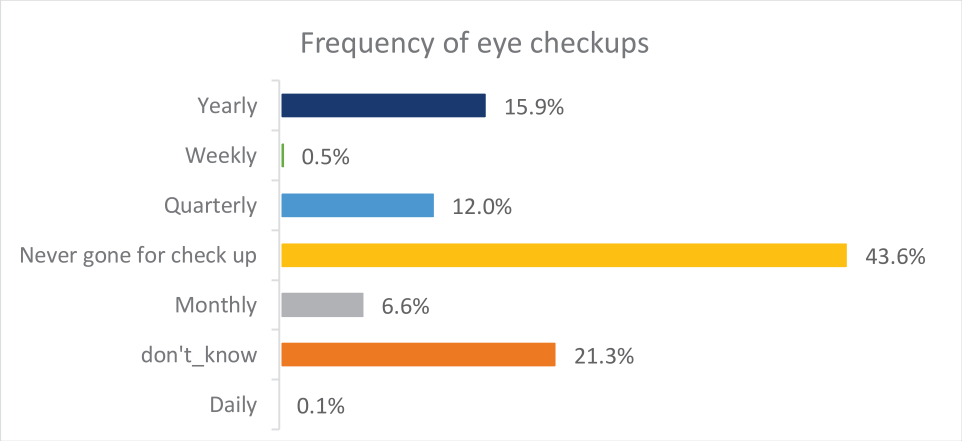

Figure 14: Frequency of eye checkups

When compared against the baseline, more people now go for eye check-up than before; as the proportion of who don't know about eye check has decreased from 77% at baseline to 21%. Similarly, the proportion of people who do quarterly check-up doubled from 6% to 12%; likewise yearly check-up which increased from 11% at baseline to 15%.

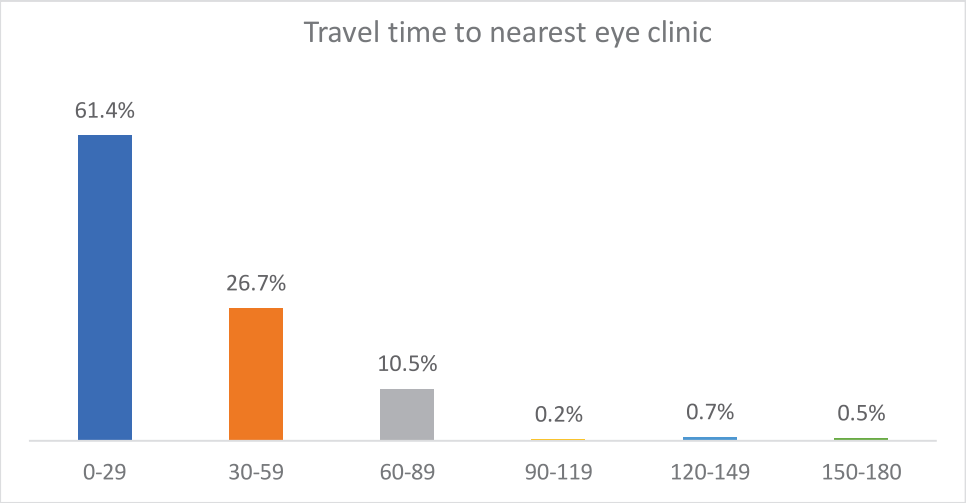

Figure 15: Travel time to nearest eye clinic

The figure above shows that over 60% of the people in the communities could access eye clinics within 30minutes while about 27% required up to an hour to reach the nearest eye clinic. This indicates that clients did not spend a lot of time travelling to access of eye care services in the intervention communities.

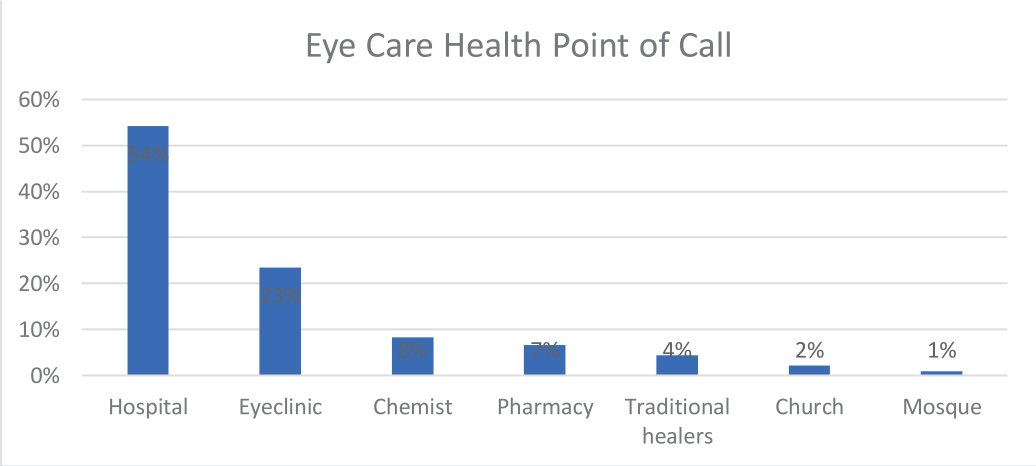

Figure 16: Eye Care Health Point of Call

While travel time to eye health centres for most of the respondents is slightly below 30 minutes, there are still people who reported that that their first point of call for eye health is either traditional (4%) or religious houses (3%). However, similar to the result from baseline, most of the respondent reported to patronize hospital as their first point of call for eye health. On the other, success has been recorded in patronage of over the counter/ non-prescribed medication as proportion of people who go for over the counter drugs (Chemist) has reduced from 14% to 8%. Similarly, patronage of traditional healers and religion houses has reduced very significantly from 12% to 4% and from 22% to 3% respectively. At baseline, only 28% of

respondents recalled ever visiting the hospital/clinic for any form of eye check-up. This has increased to translate into more than 8 (89%) out of every 10 persons now going for check-up.

4.3.6. Cost of eye health services

While the SiB project provided eye health treatment to its beneficiaries for free, quite a number of people still think that eye care services could be expensive. Currently, about one-third of sample respondent think cost of eye health is expensive. Data triangulation reveals that high expenses of health is positive correlated to distance of travel. This means there is a positive association between the people who travel far distance to eye health centres and the people who reported that cost of eye health services is expensive. While this assessment did not dig further, it appears to mean the expensive cost associated with eye services may have to do cost of what it takes to travel the distance between beneficiaries home and health eye clinic.

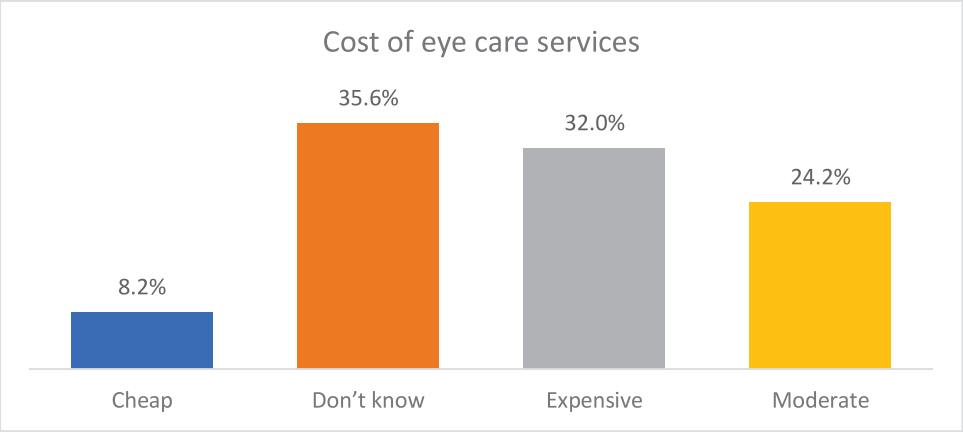

Figure 17: Cost of eye care services

4.3.7. Satisfaction with eye health services accessed

Over half of those who accessed eye health services were unable to say if they were satisfied with the services they received or not, 27% of those who had accesed eye care services reported to have been satisfied while 22% of them stated that they were unsatifsfied.

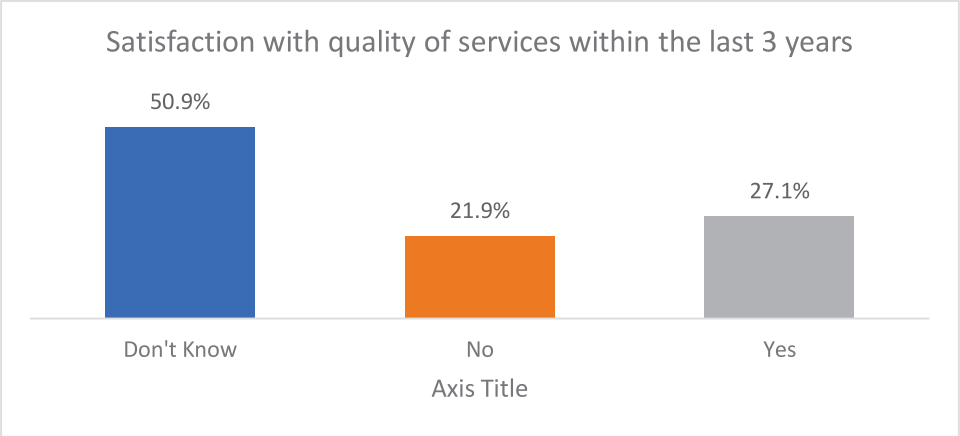

Figure 18:Satisfaction with quality of services within the last 3 years

The study data also showed that most people did not know if individuals in their communities with eye problem were being properly taken care of.

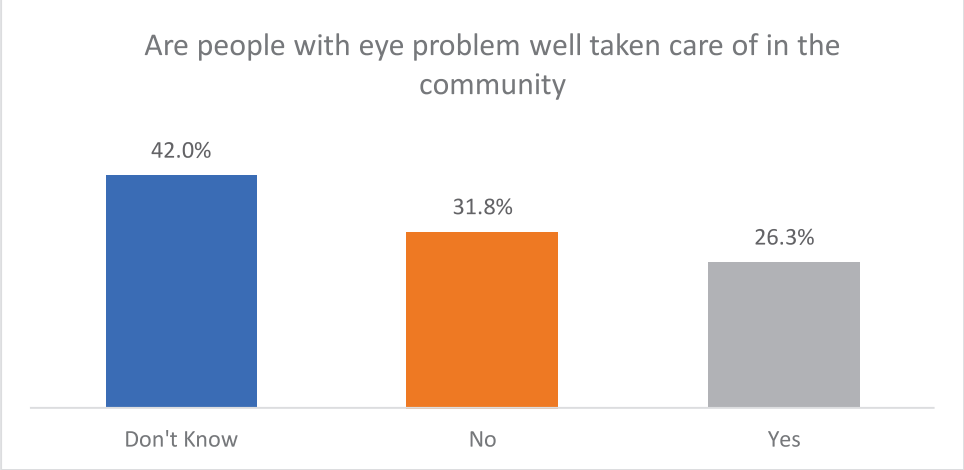

Figure 19: Perception of care for people with eye problem in the community

4.4. Communication and information on Eye Health

Most beneficiaries reported a combination of Television, radio magazine and social media as their media platforms for reliable sources of health-related information, this was closely followed by combination of television and radio magazine; and just television. On the average, 99% of respondents reported watching television up to 19hours per day and about half of them reported having seen an advert on eye care on television, while almost 70% had heard an advert on about eye health on radio.

Observations at the eye clinics across clusters shows that IEC (information, education and communication) materials were visible in all locations. Potentially, these IECs combined to an effective media campaign have translated into improved knowledge and eye health seeking behavior among the people.

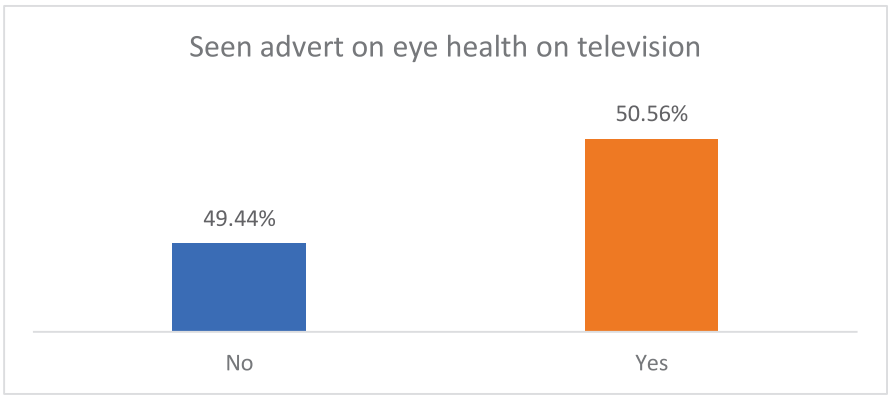

Figure 20: Proportion of people who had seen advert on eye health on television

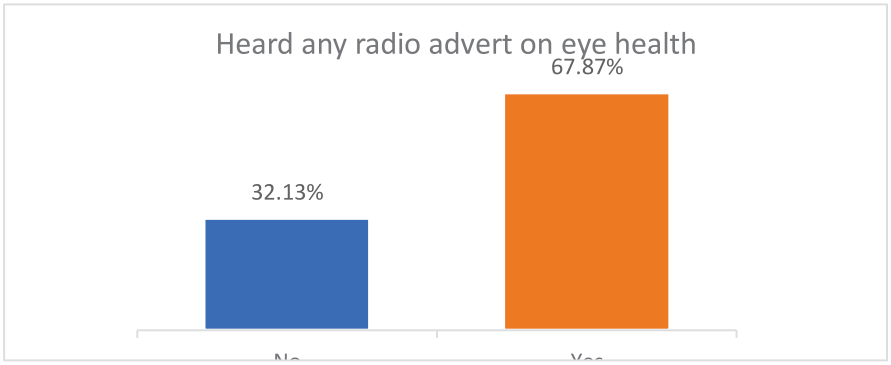

Figure 21: Proportion of people who had heard any advert on eye health on radio

While about a third of respondents stated that they did not use any social media, majority of them Facebook and WhatsApp were the reported to be the most used social media platforms.

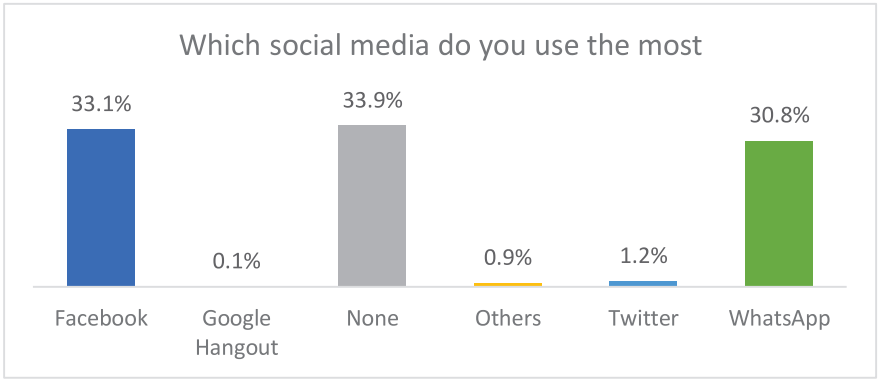

Figure 22: Most used social media

This might not be unconnected to the fact that about 95% of respondents had mobile phones.

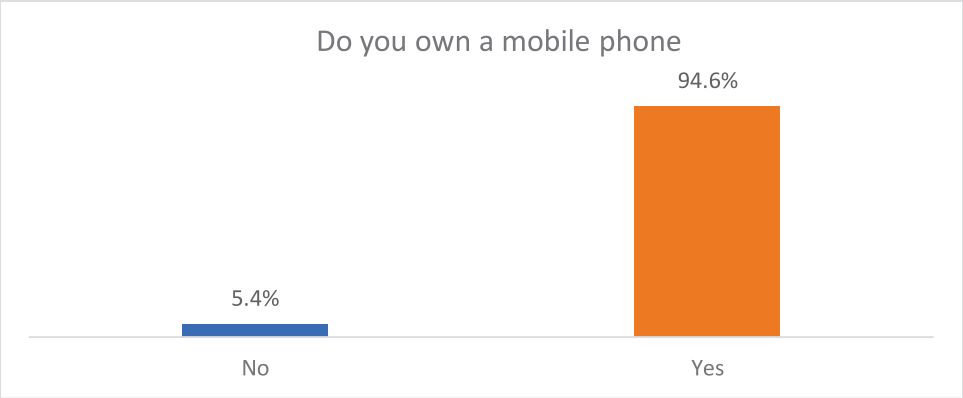

Figure 23: Ownership of mobile phone

5. LESSONS LEARNED

5.1. Lessons learned

This section is a synthesis of the results provided above; arranged as per each research questions highlighted in the study objectives.

1. **What is the current level of Knowledge, Attitudes and Practices related to eye health at community level; including what is known and done about eye health-related subjects within the various SiB intervention communities?**
    - The proportion of people who have improved knowledge on eye health is consistent with the proportion of people living with people with eye health issues. It could be inferred that the targeted criteria for SiB was focused on the most affected population of the community; hence the level of result that has been conducted was noticed among this group.
    - Knowledge of eye health problem has significantly improved and this improvement correlates with reduction in the percentage of people with misconception about eye health. For instance, awareness on activities of CBOs on eye health treatment increased from 3% to 29%; knowledge about government policies has more than doubled as about 3 out of every 10 persons is aware of government policies as against 1 out of every 10 persons at baseline. Also awareness of government hospitals providing eye health clinic increased by 23%.
    - It is also known that people now believe than it is important to do regular eye check-up as the percentage of people who regularly visit clinics for check-up has increased.
    - To a very large extent, knowledge in the various aspects of eye health appears to have translated into some positive practice. The percentage the population who don't go for eye check-up has reduced by more than two-third (77% vs 21%) and the frequency of eye check-up has reduced

for those who yearly (6% vs 12%) and those who quarterly (11% vs 15%) check-ups. Similarly, the proportion of people who resort into self-care has reduced by more than half. More than 8 out of every 10 persons now go for regular eye check-up (defined as check-up yearly or less) as against 23% at baseline.

2. **What are the existing knowledge gaps with regard to appropriate health seeking behaviours and obstacles to initiating or completing treatment?**
    - Very few people still patronize religious houses (3%) and traditional healers (3%). While the number of people who patronize these has reduced, we still do not know what the incentives are for these patronage.
    - Despite the eye health check-up being free, it is not entirely clear why most (65%) of the respondents have never gone for check-up. It is also important to state these respondents were able to demonstrate strong awareness of eye health problems.

3. **What is the level of involvement of communities and health care workers in child eye care management and what are the associated challenges?**
    - The level of involvement of communities is evaluated using the new knowledge that community members reported to have acquired as a result of the project. This involvement revolves around some of the myths that have been demystified. Using salt water to wash eyes is reported as not effective in curing eye health problems. Also, eye health problem is not solely related to the food children eat but proper nourishment of children with fruits such as carrots, and apples could improve eye health.
    - The level of involvement of health care workers is evaluated in terms of their functions as reported by the sample respondents. While health workers reported that sometimes they are overwhelmed due to shortage of staff, they also reported that increased visibility of IEC materials around eye clinic and improved duty of care for patient are their responsibilities.

4. **What are barriers that undermine child eye health promotion, prevention, treatment and management in the community as well as access and utilization of child eye health services within the various SiB intervention communities?**

- While the various community outreach programmes implemented by SiB can be reported to have resulted into improved knowledge, there still appears some barriers to undermining eye health promotion as well as utilization of eye health services. While there is no harmonized consensus on what government should do, some respondents still believe that government is not doing enough. Some reported that government should give monetary incentive to people suffering from eye health problems while reported that more eye clinics and more doctors should be provided. Distance to eye clinics is also a barrier identified in the course of this study and this could have informed one of the reasons why some respondents reported that more clinics should be open.
- Though the SiB programme provided transport to beneficiaries of the programme, additional gaps preventing seeking appropriate care from the study by none beneficiaries was proximity to health facility, as over 45% of respondents lived more than 30 minutes away from the health facility.
- Some beneficiaries (27%) reported to be satisfied with the eye care services they received. Poor quality service could possibly deter people from accessing services and making referrals when needed.

5. **What are the perception of policy makers and opinion leaders about child eye health issues and programmes?**
    - There is still largely beliefs among the policy makers that child eye health has been majorly ignored by all stakeholders especially the government except for the new policy introduced in the previous year. They noted that most of the interventions in child eye health so far are NGO-driven.
    - Poor health seeking behavior and lack of money are given as some of the challenges facing an improved eye health system among the populace.
    - Reports from the Ministry of Health affirms that for instance, a lot has been achieved in reducing the impact of cataract, glaucoma and reflective error in the communities supported by SiB. For this reason, quite a number of caregivers know where to go for eye health.
    - For eye health programmes to be more effective, policy makers affirm that eye health centres should not only be located in urban areas, health personnel should be properly trained and drugs should be provided at a cost that is affordable by the people.

6. **How do evaluation questions 1-6 compare with the baseline research questions?**

- Across all key results, there are marked improvement when compared against baseline. However, there is still consensus (similar to the result from baseline) that government has majorly ignored eye health programmes.

7. **If any, what progress or barriers have been made since the baseline study?**
    - Progress have been made around improved knowledge on eye health issues and health seeking behavior. While misconception around eye health still persist, the number of people who believe these mis-conceptions have reduced when compared against baseline.
    - Attitude towards first point of call for eye health issues have improved as lesser number of people now patronize traditional healers.
    - Awareness on child eye health issues is not widespread although progress has been made between now and project inception.
    - Shortage of staff as reported by health worker is potentially a barrier to improved eye health. Wrong perception especially by people who do not have anyone with eye health problems and who have not been sensitized is potentially a barrier as these people could reinforce and spread myths and mis-conception on child eye health.
    - Policy makers expressed opinions that child eye health programmes are NGO-driven and there are remarkable improvement in the communities housing the health facilities supported by SiB.

6. CONCLUSION

This endline KAP study therefore shows that there have been some increase in the levels of knowledge, and health seeking behavior associated to eye health at community level within the various SiB intervention communities; and a reduction in the myths and misconceptions related to eye health issues. However, while respondents demonstrated strong awareness of eye health issues and eye health check-up being free, most of the respondents have never gone for check-up.

While the various community outreach programmes implemented by SiB have possibly resulted into improved knowledge, there still appears some barriers undermining eye health promotion as well as utilization of eye health services. Some gaps preventing seeking appropriate care from the study among none beneficiaries was also proximity to health facility as well as shortage of clinic personnel.

The perception of policy makers and opinion leaders about child eye health issues and programmes is that all stakeholders especially the government, except for the new policy introduced in the previous year have majorly ignored CEH; most of the interventions in child eye health so far are NGO-driven.

For child eye health programmes to be more effective, policy makers affirmed that eye health facilities should not only be located in urban areas. Health personnel should be properly trained and drugs provided at a cost that is affordable by the people. Furthermore, the need to leverage on existing and most used media platforms to increase awareness in the general population on eye health issues and where to get needed support and care; including promoting the need for regular eye check-up.

7. RECOMMENDATIONS

- Leverage on existing and most used media platforms to increase awareness in the general population on eye health issues and where to get needed support and care; including promoting the need for regular eye check-up
- Work in closer and concerted collaboration with government structures to reduce the cost of eye care as well as create awareness on services available in eye health centers.
- Community-based interventions that engage and work directly with community members to improve their knowledge and attitude to child eye health issues as well as actively promote appropriate health seeking behaviors (possibly through active and tracked referrals) should be further intensified.
- Eye health programmes should include sensitization sessions that address the myths and misconceptions around child eye health issues as well as promote the benefits of regular eye check-up and appropriate care seeking behavior; vis-a-vise the cost of eye health/treatment.
- Eye health centers should not only be in urban areas, but also situated or integrated into rural health /primary health care services to make them accessible and drugs should be provided at a cost that is affordable by the people.

Annexes

This section includes all the tools (household survey questionnaire and KII question) as used for this Endline KAP Survey

RESPONDENT INFORMATION SHEET
PLEASE READ TO THE RESPONDENT:
Hello, my name is _____ and I am conducting interviews today on behalf of Christoffel Blinden Mission- Seeing is Believing Project (CBM -SiB) We are asking for your help to identify the need of the community on how to prevent children from going blind by answering some questions The question I will ask you will be basically to know your opinion about eye problems in this environment and to know if there are medical facilities or clinics where eye services are provided. The questions will take about 15 minutes to complete. All information that you provide us will remain strictly private and confidential. We will not write your name on any of the questionnaires and it will not be linked with your information. It will not be possible to identify you in any information we release or use. We will not discuss your individual answers with the staff members. Whether you decide to take part in this survey is voluntary – this means that you do not have to answer these questions. Whether you take part or not will not affect any future care that you receive. Additionally, you may decline to answer any question or withdraw from the interview without giving a reason. If you have questions about *this survey*, please contact the Lead consultant any time at this number +2348033495409. Do you have any questions at this time? You can take as much time as you need to decide whether you would like to continue with the interview. Do you need more time to think about it? If not, may I continue with the interview? Thank you for your time. Sincerely, *Dr Juliana Nathaniel* SiB Programme Director
I certify that I have read the Respondent Information Sheet and have explained this survey to the participant, and that s/he understands the nature and the purpose of the study and consent to the participation in the study. S/he has been given opportunity to ask questions which have been answered satisfactorily.

Please tick one box: ☐ **The Respondent declines to be interviewed**	
☐ **The Respondent agrees to be interviewed**	
Name of interviewer: _____	**Position: _____**
Signature: _____	**Date: _____**

INTERVIEW AND SITE INFORMATION			
PLEASE COMPLETE BEFORE THE INTERVIEW.			
I1 QNUM	Unique questionnaire number	_ _____/ _ _ ____/ _ _ _ ___ [use state initials/EA code/Serial number]	
I2 STATE	Name of state	_____	
I3 LGA	Name of LGA	_____	
I4 SETTLE	Name of Settlement	_____	
I5 EA	Enumeration Area	_____	
I6 DATE	Today's date	_ _/ _ _/ _ _ _ _	

		(dd / mm / yyyy)	
I7 LOCATION	Type of location	Urban.....1 Rural.....2 Peri-Urban.....3	
I7 GPS	Coordinates	Latitude_____ Longitude: _____	

KNOWLEDGE ON EYE HEALTH

READ TO RESPONDENT: *"I will ask you some questions about what you know on eye health especially among children. Please bear in mind that there is no right or wrong answer"*

READ QUESTIONS TO RESPONDENT. DO NOT READ OUT ANSWERS UNLESS STATED.

K1 (EKNOP)	**Do you know of anybody/Child with eye health problems?** **Like, The Blind**	Yes.....1 No.....2	Skip to K2
	Is the person related to you?	Yes.....1 *No.....2*	

K2 (EHTPE)	*What are the different kind of eye health problems you know in children?* (Select all that the Respondent mention)	a. Blindness b. Cataract c. Conjunctivitis (Apollo) d. Glaucoma e. Blindness f. Onchocerciasis (River blindness) g. Refractive error h. Diabetic retinopathy i. Pterygium j. Phthisis/absent globe k. Macular degeneration l. Optic atrophy m. Other _____	
K3 (MCASE)	*What are the main cause of eye problems especially among children?* List all that the Respondent can remember	_____ _____ _____ _____ _____ ___	
K4 (EPRISK)	*What are the risk factors that can expose a child to eye health problem?*	_____ _____ _____ _____ _____ _____	
K5 (MYMIS)	**Are there myths and misconception about eye problems especially in children?**	Yes……1 No……0	

K6 (HWCAT)	**What category of healthcare worker is trained to provide eye health services?** ***(List all the categories the respondent mentioned)***	_____ _____ _____ _____ _____ _____	
K7 (LIVECE)	**Do you have or live with any child with eye health problem?**	Yes……1 No……0	Skip to B1
K8 (DURATN)	**For how long has the problem existed?**	_____ Years	
K9 (CAGE))	**What is the age of the child?**	_____Years	
K10 (CSEX)	**What is the sex of the child?**	*Male……0* *Female……1*	
K11 (NATEP)	**What is the nature of this eye problem?** **Describe in a sentence**	_____ _____ _____	

BEHAVIORS IN SEEKING TREATMENT (ATTITUDE)
PLEASE READ ALOUD: *"Now, I would like to ask you some questions about people's behaviour when there is an eye health situation especially among children."*

B1 (ACCEYP)	Have you or your child accessed any form of eyecare services in the last 3years	Yes……1 No……0 Don't remember…99	Skip to B3
B2 (SPCMTH)	Were you satisfied with the quality of services you received then?	Yes……1 No……0 Don't know……999	
B3 (EHCHLG)	Where do/would you go, if you have eye health challenge? (Select all that the respondent mention)	a. Church b. Mosque c. Hospital d. Eye clinic e. Chemist f. Pharmacy g. Traditional healers h. Others____	
B4 (EYCHK)	How often do you go for eye check-up for you and/or your child?	a. Daily b. Weekly c. Monthly d. Quarterly e. Yearly f. Don't know	
B5 (ECOMM)	Are people with eye health problem well taken care of in your community? The blind	Yes……1 No……0 Don't know……999	
B6 (EYCOST)	What is the cost of accessing eye services in your community and its environs?	a. Expensive b. Moderate c. Cheap d. Don't know	
B7 (DISTEC)	How long does it take you to get to the nearest health facility providing eyecare services? In minutes If not known, enter 0	_____minutes	

B8 (SATISF)	How satisfied were you when you accessed the eyecare services?	a. Very Satisfied b. Satisfied c. Somewhat satisfied d. Not satisfied e. Don't know	

INFORMATION, EDUCATION AND COMMUNICATION			
READ TO RESPONDENT: *"I will ask you some questions about what media platform you use and which ones you rely on for health-related information".* READ QUESTIONS TO RESPONDENT. DO NOT READ OUT ANSWERS UNLESS STATED.			
C1 (MED HLT)	**Which of these media platform are your most reliable sources of health-related information?** Select All That Apply.	A. Newspaper B. TV C. Radio Magazine D. Social Media E. Village Announcer F. Any other media G. Does not use media H. Declines to answer	
C2 (WTC TV)	**How long do you watch TV in a day?** Write '999' If The Respondent Doesn't Know	_____ hours	
C3 (SOM D)	**Which social media network do you use most?**	Facebook.....1 Twitter.....2 WhatsApp.....3 Google Hangout.....4 Others.....5 None.....0	

C4 (MR WTH)	**What media do you read or watch most often?** Read Out Answer Options to Participant. Circle "1" For All That Apply. I. Newspaper (NEWSP) ..... J. TV (TV) ..... K. Radio (RADIO) ..... L. Magazine (MAGAZ) ..... M. Internet (INTERNET) ..... N. Any other media (OTHMED)..... O. Does not use media (NOTUSE)..... P. Declines to answer (MEDMIS)	Yes No A. .....1.....0 B. .....1.....0 C. .....1.....0 D. .....1.....0 E. .....1.....0 F. .....1.....0 G. .....1.....0 H. .....1.....0	
C5 (GSM)	**Do you own a mobile phone?**	Yes .....1 No 0	
C6 (EVER)	**Have you ever heard any radio advertisement on eye health?**	Yes.....1 No.....0	
C7 (ECTELV)	**Have you ever seen any Television advertisement on how to care for the eye?**	Yes.....1 No.....0	

DEMOGRAPHICS

READ TO RESPONDENT: *"I would like to ask you some questions about yourself including your age, education and living conditions, in order for us to ensure our services are reaching everyone in the community."*

READ QUESTIONS TO RESPONDENT. DO NOT READ OUT ANSWERS UNLESS STATED.

D1 (SEX)	OBSERVE RESPONDENT'S SEX	Male .....0 Female 1	
D2 (AGE)	**What is your age?**	_____ years	
D3 (EDU)	**What is your highest level of education?** PROBE IF THE RESPONDENT COMPLETED THIS LEVEL OF EDUCATION, OR ATTENDED SOME OF IT, AND CIRCLE THE CORRESPONDING NUMBER.	None / non-formal.....1 Some primary.....2 Completed primary .....3 Some secondary, vocational or technical.....4 Completed secondary, vocational or technical...5 Some tertiary or higher .....6 Declines to answer 999	
D4 (MAR)	**What is your marital status?**	Single .....1 Married .....2 Widowed.....3 Divorced.....4 Declines to answer.....999	
D5 (CHILD)	**How many living children do you have?** If Respondent Has No Children, Write '0'.	_____ Children	
D6 (INCMNT)	**What is your monthly income in naira?**	_____ *(NGN)*	

D7 (RELEC)	**Do you have a child or relation with eye health challenge?**	Yes……1 No……0 Decline to answer……999	
D8 (JOBC)	**What is your occupation, that is, what kind of work do you mainly do?**	*Unemployed/housewife/houseman……1* *Farming……2* *Unskilled manual……3* *Skilled manual……4* *Sales & services……5* *Clerical……6* *Professional technical / managerial……7* *Student……8* *Declines to answer……999*	

GOVERNMENT AND POLICY			
READ TO RESPONDENT: "*Now I would like to ask you about your knowledge of government policies and programmes to support persons with eye health problem. Like The Blind* READ QUESTIONS TO RESPONDENT AND CIRCLE THE NUMBER CORRESPONDING TO THE RESPONDENT'S ANSWER.			
G1 (EYPOL)	**Do you know of any policy in Nigeria that provides for persons with eye problem? E.g. The blind**	Yes .....1 No 0	
G2 (GOVEH)	**Is there any government hospital around you where people with eye problems are treated?**	Yes .....1 No 0	Skip to G5

		Not sure……..999	
G3 (SERV)	**Name the kind of services they provide**	1…… 2…… 3…… 4……..	
G4 (HOSNR)	**How far is the nearest government hospital providing eye health services from here? In minutes**	_____(minutes)	
G5 (GOVEN)	**Do you think government is doing enough for people with eye problems? The Blind**	Yes .....1 No 0	
G6 (GOVDO)	**What do you think the government should do to support people with eye problem? E.g. The Blind** _____ _____		
G7 (CEHPRO)	**Have you been engaged in any kind of program (awareness, training) on Child Eye Health?**	Yes .....1 No 0	
G8 (EYCBO)	**Is there any community based organization here that provide any form of support for the blind?**		Yes……1 No……0

The link to the tool as deployed on Kobo is found below:

https://odk.enke.to/preview?form=https://xlsform.opendatakit.org/downloads/wfus6p8p/SiB_Tool.xml

Level 1: Perception	Level 2: Detailed sub-questions	Level 3: Probe
Assessing perception of opinion leaders on Child Eye Health	1. What are your opinions about child eye health?	
	2. In the last 3 years, has anything changed concerning health seeking behavior of people around child eye health? If Yes, what has changed?	
	3. What would you consider as the challenges affecting child eye health?	
	4. Do you think there are any programme addressing these challenges?- If there are, what are they?	