



An Assessment of the Level of Awareness of Eye Health Care Services Provided by OneSight in the Gambia

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Abstract

The objective of the Scorecard study was to assess the intervention of OneSight with respect to Awareness of their services in The Gambia and the perception of Gambians on eye care in The Gambia. More specifically in this paper, the scorecard assesses the level at which people are aware of the existence, the activities and the services offered by OneSight in The Gambia. The research employed both quantitative and qualitative methods. The study revealed that the majority of the sampled respondents are aware of refractive error i.e., about 90%. Their major source of information about eye care issues was through radio however, they gather important information from other sources such as healthcare workers and television. Most of the respondents who are aware of eyesight-related problems, typically obtained information through Government clinics, only 2.8% got their information from OneSight. It was also discovered that 94.6% of the respondents sought eye care treatment from health facilities as opposed to a home or local treatments. Based on the findings, practical implications and an agenda for future research are suggested. For instance, it is recommended that OneSight should strengthen community outreach programs, improve its communication strategies, create more visibility, and conduct more publicity events for more awareness about its programme and activities.

Keywords:

Awareness
Eye health care products
Eye health care service
Glasses
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1. Introduction

The Gambia is the smallest country in mainland Africa with an estimated population of about 1.88 million (2013 census) projections. It stretches for 450 km along the Gambia River. Its 10,689 sq. km area is surrounded by Senegal, except for a 60 km Atlantic Ocean front, and 50 % is arable land. The Gambia has one

of the fastest population growth rates, 3.1% per annum in sub-Saharan Africa. The population in mid-2019 was estimated at 2.3 million. The country is among the poorest countries in the world ranked 151 out of 160 on the Human Development Index Report of 2016 with 1/3 of the population living under the international poverty line of \$1.25/ day and 2/3 below \$2.5 per day. Poverty is widespread in the country and is on the increase, particularly in rural areas, which has increased from 64.2% in 2010 to 69.5% in 2015/16. Poverty remains flat between 2010 (48.1%) and 2015/16 (48.6%). The number of people living below the poverty line (i.e. less than \$1.25/day) increased from 0.79 million in 2010 to 0.94 million in 2015/16.

The country could boast of only 1 ophthalmologist and 3 optometrists for the entire country. According to statistics, 1 in every 3 Gambians needs refraction error correction but only half of them are aware they have a problem. Due to the level of poverty of the people cost of a pair of glasses is considered prohibitive. In addition, although The Gambia has a long history of providing eye care services most specifically for cataract and trachoma, however not in refractive error.

As the basis for most development in the world, health constitutes a major priority supporting the socioeconomic development of any country. It is a vital requirement for individual survival and economic development in The Gambia like in any other country. Yet, The Gambia has never had a consolidated health insurance policy to guide and manage the health of the population. Beginning in the 21st century, the Republic of The Gambia embarked on developing a National Health Insurance Policy, employing a consultative and inclusive process. Therefore, a clear need arises for the Government of the Gambia to put in place a National Health Insurance Policy, which provides a framework for sustainable and optimal use of health services for The Gambian society and the Gambian economy.

Health Services are a critical component of development in any country, without which there is hardly any meaningful development. As the adage goes, “a healthy nation is a wealthy nation”. It is against this backdrop that the Government of The Gambia in collaboration with development partners and Non-Governmental Organisations GOs over the years has been striving to provide quality health services to its populace. Several attempts have been made from the first republic to date, to improve the delivery of health services to better the health of the population as a way of reducing the unacceptable prevailing morbidity and mortality rates due to both communicable and non-communicable diseases among other factors.

These efforts are evident through various initiatives undertaken such as the establishment of the “Health Management Information System”, the introduction of the “Cost Recovery Program” started in 1988, which established the “Drug Revolving Fund” and the introduction of user fees as a form of health financing. Also “Bamako Initiative”, was introduced in 1993 as further development on the Cost Recovery Program and the recent research conducted in 2010 to introduce a National Health Insurance Scheme currently under review, Global Fund for Malaria Tuberculosis and HIV/AIDS, OneSight Programme among others. These are further complemented by building more health facilities (Tertiary, Major and Minor) health centres across the country with the establishment of a medical school at the University of The Gambia in 1999 to improve and provide quality health education and services at all levels.

However, the health sector over the years has been under great pressure due to several factors, mainly; the high population growth rate, inadequate financial and logistic support, shortage of adequately and appropriately trained health staff, the absence of a strong health research base to generate data for management, high attrition rate and lack of efficient and effective referral system.

These factors have seriously constrained efforts to reduce morbidity and mortality rates as a result health care delivery throughout the country has not lived up to expectations. The need to have a clear direction to quality of care requires a supportive organizational and strong research base to inform management and policy framework with a strong flexible and knowledgeable leadership, able and willing to take informed risks.

Consequently, OneSight in line with its vision and mission and being fully aware of the challenges faced by The Gambia in fulfilling this fundamental health issue launched its Gambia Initiative. In partnership with Sightsavers UK and the government of The Gambia, OneSight established its first Sustainable Vision Care Project in The Gambia.

The Scorecard study is used to assess the impact of the intervention on *awareness*. Over the last four years, huge investments and efforts have been made by OneSight and its partner institutions to create awareness and provide accessible and affordable eye care services to Gambians across the country. This study intends to assess the level of awareness of OneSight’s eye service products in The Gambia.

The objective of this study is to assess the level of awareness of eye health care services provided by OneSight to Gambians.

2. Literature Review

Several studies on students' utilization of eye health care services concluded that lack of awareness or knowledge was not the only factor causing a barrier to utilization of eye health care facilities but other factors such as accessibility, affordability and availability (Alshammari et al., 2021; Haddad, Bakkar, & Abdo, 2017; Islam, Chakrabarti, Islam, Finger, & Critchley, 2015; Murdoch, Opoku, & Murdoch, 2016).

Brise and Leeuw (2015) noted awareness is a key determinant in accessing care. As pointed out by them, one has to be aware of the service to access it. They further buttressed the three significance of awareness: (1) according to them can influence if and how a patient accesses care.

Education can aid awareness and develop perception, (Frazier & Kleinstein, 2009) noted that the level of education can influence access to vision, eye and health care because it may affect the ability to obtain, understand and use information, and influence perceptions about health in general. They further buttressed that individuals with lower educational levels may experience confusion about medication use, have difficulty reading printed material, or have difficulty comprehending health care information (Haddad et al., 2017; Javitt, 1995; Mitchell, Smith, Attebo, & Healey, 1996; Newman-Casey et al., 2015).

Given the aforementioned, they noted that the lack of knowledge about the importance of vision and eye care can prevent a person from recognizing signs and symptoms of vision and eye disorders and disease, obtaining regular eye exams, complying with prescribed treatment regimens and adhering to follow-up care. In conclusion, they pointed out that, the ability to receive health care information and participate in one's care is generally referred to as health literacy. Hubley and Gilbert (2006) lack of knowledge about eye diseases and systemic conditions that have visual consequences can prevent a person from seeking eye care. People may have the perception that if they had an eye disease, they would have symptoms, and that is not always the case. Hence the need to be aware of health issues through health literacy, which in some cases can be aided by education (Attebo, Mitchell, Cumming, & Smith, 1997; Islam et al., 2015; Kacheri et al., 2022).

Shrestha et al. (2018) in a study in Nepal using a population-based cross-sectional study between 2008 and 2016 in eight villages concluded that there was a general lack of awareness and knowledge of common eye diseases. Hence, improved awareness and knowledge are required for prevention, early treatment, and access to eye care.

Muhammad, Adamu, Isah, and Muhammad (2012) studied the populations of Sokoto state in Nigeria are aware of the eye care services and are willing to utilize the services but the utilization rate is low. Quigley (1996), Al Rasheed and Al Adel (2017), Bawazir (2004). There is a need to motivate the population to present themselves to uptake eye services. Using multi-stage sampling, a household-based survey was conducted in 200 clusters of 10 LGAs selected for a population-based trachoma survey. A total of 10840 households were interviewed. 89% were aware of the eye care programme but only 7.6% of the households have utilized the eye services.

Du Toit, Ramke, Naduvilath, and Brian (2006) studied awareness, use, and barriers to the use of eye services in Fiji's Central Province using a cross-sectional survey study design with random clusters of households and concluded that the old, rural, and female, under-utilised conventional eye care services. Also, to improve eye health, planning and implementation of eye care services must overcome under-utilisation by addressing local barriers to uptake through community participation in education and affirmative action (Al-Jedai, Qaisi, & Al-Meman, 2016; Al-Tannir, Alharbi, Alfawaz, Zahran, & AlTannir, 2016).

3. Methodology

The Survey collected information on issues such as respondents' background information i.e. (household demographic characteristics) and awareness of refractive errors among others.

3.1. Survey Design

The sample size for this scorecard survey on refractive errors was set at $n = 3000 + 10\%$ over-Quota (3300 target respondents) – person in the family who can make all/some of the healthcare-related financial decisions for the household was deemed sufficient because it would provide enough cases for subgroup analysis.

3.2. Sample Selection

For this study, the unit of measurement is the household of which individual respondents were drawn from across the whole country within the selected districts and settlements in each of the sampled districts. The sample size of 3300 households is selected across the country in 30 districts using multistage stratified cluster (area) random sampling and PPS (Probability Proportional to Size) approach from Bennett, Lony, Winitha, and Smith (1991). The urban population constitute 60% of the total sample size and the rural population accounts for the remaining 40%. of the total sample size of 3300 that comprises 1320 sampled using the PPS (Probability Proportional to Size) approach from Bennett et al. (1991). The Region is automatically the first stage, the second stage focuses on the districts, and settlements within the districts in the regions were the third stage. In each of the selected districts, the settlements were further stratified into smaller clusters according to the population size of the settlements to allow for their representation in the sample using PPS. The final stage targeted individual respondents or any member of the family who can make all/some healthcare-related financial decisions for the household for interviews in each of the selected sample settlements across the districts within the regions. Hence, the households were the final unit of sampling for this scorecard study.

4. Main Findings of the Score Card Survey on Awareness of Eye Health Care Services

This community scorecard survey applied quantitative and qualitative methods to analyze the level of awareness of eye health care facilities in Gambians.

4.1. Quantitative Analysis

About 200 questions were administered to 3561 respondents. The questions were directed to the heads of households targeting respondents that are responsible members who can give accurate information about household activities. This was achieved with the diversity of respondents across gender and age. The average age of respondents was 40, of this, 50.2% were females, and 49.8% were males respectively. About 54% were heads of households and 48% were primary decision-makers interviewed at the household level. Concerning the educational status of households, 58% of respondents had at least some form of education, with more than 70% of respondents attained a secondary level of education.

The survey covered all the regions in the country with the distribution of respondents by the regional background in the seven Local Government Administrative Areas (LGA) of The Gambia. The number of respondents in Banjul accounted for 6.5%, while Kanifing LGA constitutes 31.9%, West Coast Region (WCR) 31.1%, North Bank Region (NBR) 10.6%, Lower River Region (LRR) 2.3%, Central River Region (CRR) 6.9% and Upper River Region (URR) 10.5% respectively.

Incomes of respondents vary across regions. The majority of our respondents in Banjul, Kanifing Municipality, West Coast Region, North Bank Region and Upper River Region have a monthly income of over GMD¹2,500 (approximately US\$59). The Lower River Region is the region with a lesser proportion of people who fall within this income bracket. Some of our respondents have no monthly income which also represented a good portion of our respondents.

The study assessed the awareness of the respondents regarding their knowledge of OneSight, the sight defects that can be enhanced by wearing corrective glasses, existing vision centres and other vision sight services providers in the country and the proximity within the locality of the respondents. As disclosed by the findings of the study, a significant proportion of the respondents (84%) indicated that some people do have imperfect eyesight. Most of the respondents noted that their source of knowledge came through normal social networking and government eye clinics (See Figure 1).

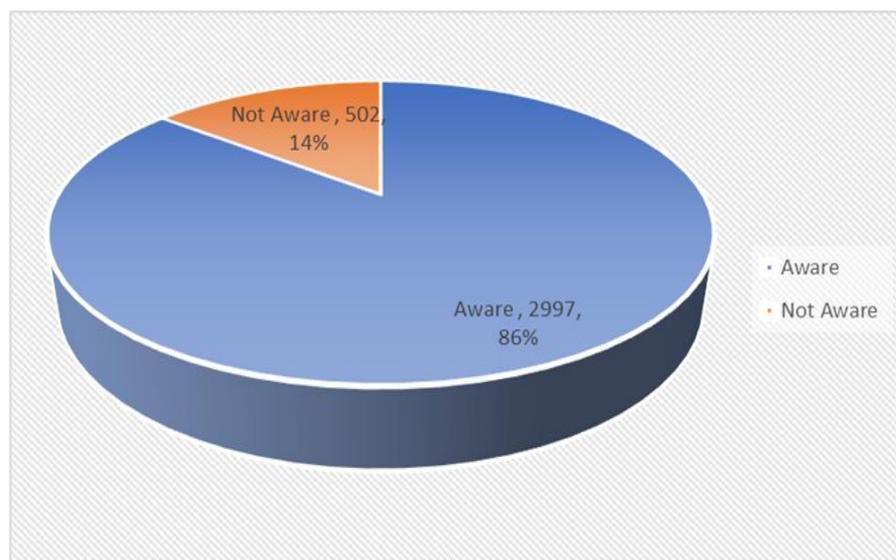


Figure 1. Awareness of imperfect eyesight.

Most of the respondents are aware that some people suffer from imperfect eyesight. 2,997 (86%) of the respondents know that some people have imperfect eyesight while 502 (14%) said they don't know.

Information about imperfect eyesight was sought from Sight Savers, OneSight, Government Eye Clinics, Sheikh Zayed and others. Given that over 86% of the respondents are aware of imperfect eyesight, we decided to investigate their source of information about imperfect eyesight; from Table 1 we observe that most of the respondents (37.3%) acquire information from Government eye clinics. The respondents who obtained information from Sight Servers and Sheikh Zayed represented 3.9% and 6.6% respectively. Only 2.8% revealed that their source of information about imperfect eyesight is from OneSight. The majority of respondents said their information source on imperfect eyesight was from other sources such as local clinics, pharmacies, traditional communicators, social networks etc.

¹ Gambia's Currency.

Table 1. Source of information about imperfect eyesight.

Eye care Service Providers	Frequency	Percent of Total
Sight Savers	118	3.9%
One Sight	87	2.8%
Government Eye Clinic	1134	37.3%
Sheikh Zayed	201	6.6%
Others	1503	49.4%
Total	3043	100%

The source of information about imperfect eyesight varies by region. It is observed that across all regions the source of information about imperfect eyesight was mostly through other sources (such as local clinics, pharmacies, traditional communicators, social networks etc.) and government eye clinics. The source of information about imperfect eyesight through OneSight is low in Kanifing and West Coast Regions (less than 3%) and almost non-existence in Banjul, North Bank, Lower River, Central River and Upper River Regions.

Given the findings, it can be inferred that the majority of respondents have some knowledge about imperfect eyesight and know that glasses aid vision. When asked whether respondents or members of households ever heard about service providers that help remedy eye-related problems, a significant proportion of more than 80% answered in the affirmative, while 12% said they do not know. (See Figure 2).

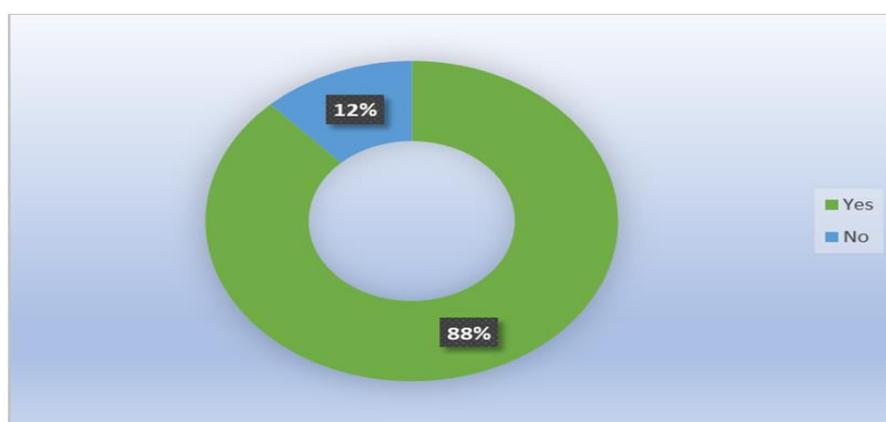


Figure 2. Awareness that corrective glasses can enhance eyesight.

The level of awareness by region indicated that Kanifing and West Coast Regions scored the highest (29% and 27%) respectively, on the issue of whether or not eyeglasses can enhance eyesight. This is obvious because there is a high literacy rate with most of the economic activities being undertaken in these regions as the economic hub of the country (See Figure 3).

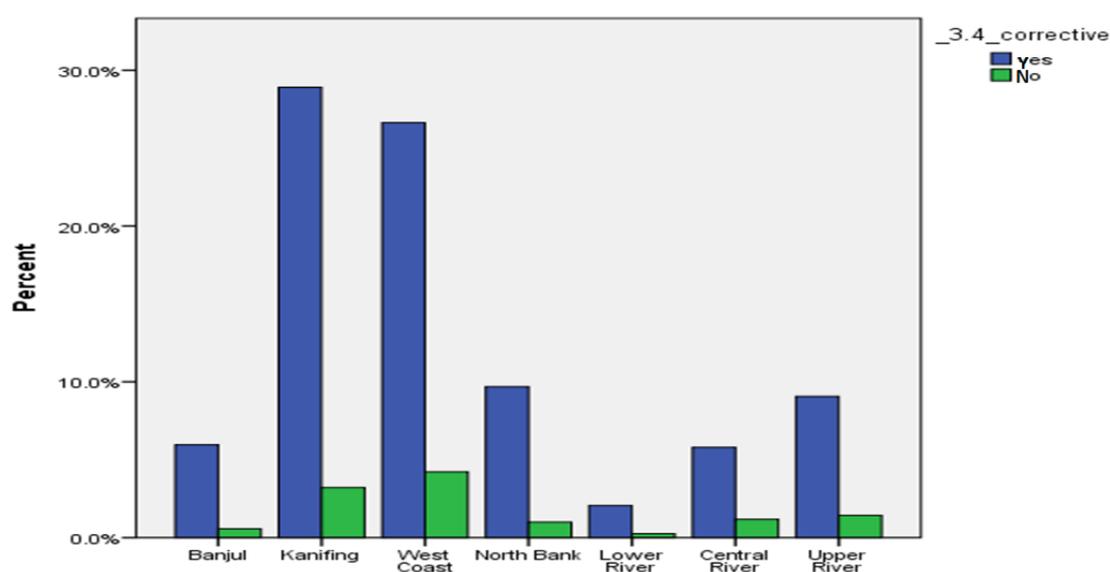


Figure 3. Awareness that glasses can enhance eyesight by region.

Many people are aware of refractive error through the Government clinics and other facilities as alluded to in the foregoing. The results are shown in Table 2. The awareness of the existence of OneSight was one of the variables assessed in the study. About 16.4% of the respondents ascertained that they are aware of OneSight as an eye care service provider in The Gambia. This shows that 83.6% of the respondents have no idea of the existence of OneSight. This is not a surprise since OneSight work in collaboration with Vision Centers in various government healthcare facilities across The Gambia to develop capacities and strengthen their infrastructure.

Table 2. Awareness about the existence of one sight.

Awareness	Frequency	Percent
Yes	564	16.4%
No	2868	83.6%
Total	3432	100%

Of the 16.4% who responded that they are aware of the existence of OneSight, 50.2% got their source of information through radio announcements (see Table 3). Only 4.1% receive information from Newspapers, which are mostly used by urban educated respondents. About 6.4% by television for those respondents have access to the Television network, while 14.1% are Healthcare workers (Nurses, Dispensers, Doctors etc), and 25.2% reported that they knew about OneSight through relatives and friends.

Table 3. Sources of information about the existence of one sight.

Source	Frequency	Percent of Total
Radio Announcement	267	50.2%
Television Announcement	34	6.4%
Newspaper	22	4.1%
Healthcare Worker	75	14.1%
Friends or Relatives	134	25.2%
Total	532	100%

Sources of information about the existence of OneSight vary by region. Figure 4 shows radio as the main source of information for Kanifing and West Coast Regions. Similarly, radio stood out to be the principal source of information for other regions except Banjul and URR using friends and/or relatives and healthcare workers in addition to word of mouth respectively.

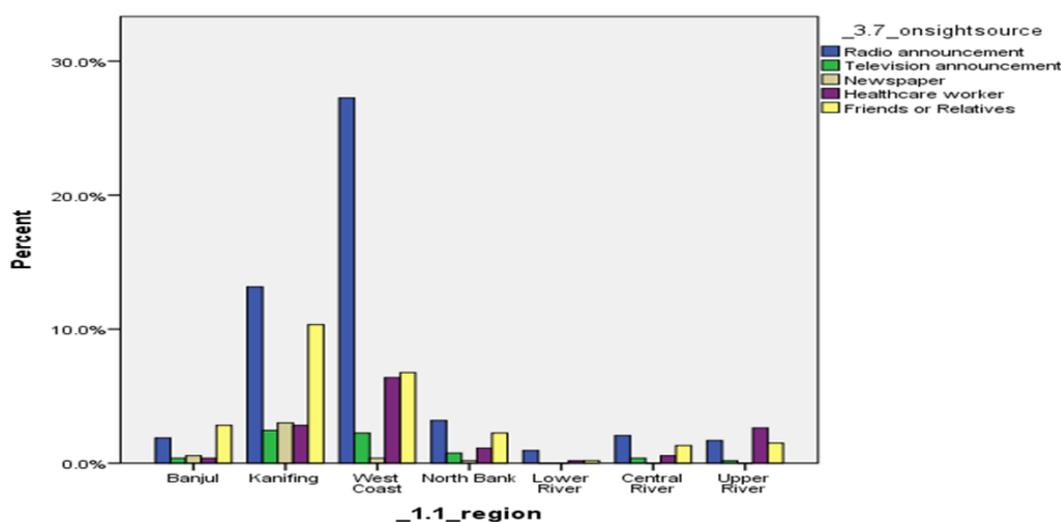


Figure 4. Sources of information about the existence of onesight by region.

This scorecard study analyzed the members of households who stopped working owing to physical impairment such as poor eyesight, impaired mobility and hard to hear. Figure 5 shows that 7.4% of the members quit their jobs because of poor eyesight, 6.0% stopped working due to impaired mobility, whilst 6.3% complained of being hard to hear. Generally, as observed in the findings physical impairment is not seemingly a problem. However, there is no need for complacency as health is a critical factor in development.

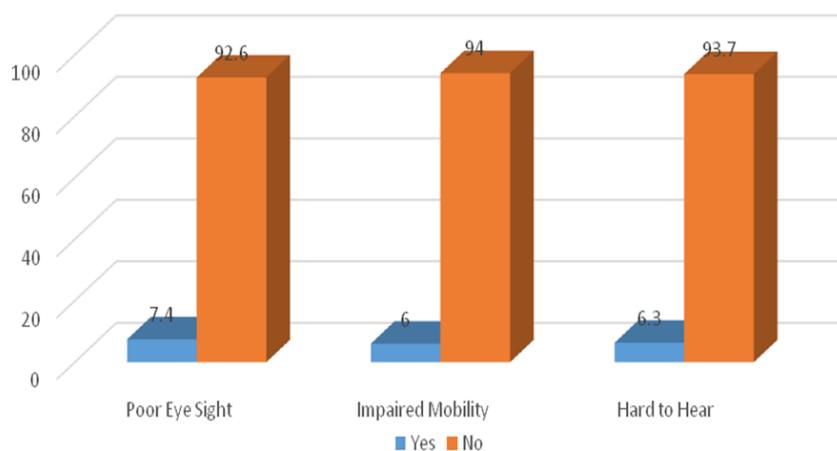


Figure 5. Household members that stop working.

The community scorecard survey assessed the health-seeking behaviour of the households across all the sample communities. Table 4 disclosed that 94.6% of the respondents utilized the services of health facilities for their imperfect eyesight. Only 2.8% recourse to traditional healers to remedy their eyesight problems. Home treatment accounted for 1.8% and others with 0.8%. The high response rate for people’s knowledge about the value and importance of conventional medication as opposed to traditional and local treatment has increased significantly. This perhaps could be a result of health sector sensitization programs conducted in the country and interaction with the health sector services providers.

Table 4. Health-seeking behaviour.

Health Seeking Behavior	Frequency	Percent of Total
Health facility	3323	94.6%
Traditional eye care	97	2.8%
Home treatment	65	1.8%
Others	28	0.8%
Total	3513	100

Table 5 analyses the status of myopia and hyperopia and the possible solutions. More than 90% reported that they are aware of refractive errors and their possible solutions. About 7.8% had a low level of awareness of refractive errors and their possible solutions. This manifests that there exists a high level of awareness of eyesight problems and possible solutions. Notwithstanding, most of the respondents confirmed that they cannot relate their refractive errors to causes. This in short implies that they are generally not aware of their eye problems.

Table 5. Awareness of refractive errors.

Awareness	Frequency	Percent of Total
Yes	3208	92.2%
No	272	7.8%
Total	3480	100%

When the issue of the willingness of respondents to recommend a child with eye-related problems to wear corrective glasses to enhance the child’s vision was asked, more than 68% responded that they will recommend their child to wear corrective glasses, while 31.6% responded otherwise. Hence, this assertion shows that most people allow their children or ward to use corrective glasses to enhance their vision as indicated in Table 6.

Table 6. Recommend a child to wear corrective glasses.

Recommend	Frequency	Percent of Total
Yes	2392	68.4%
No	1103	31.6%
Total	3495	100%

The test of association between gender and awareness of imperfect eyesight showed a positive correlation between gender and imperfect eyesight. There is no statistically significant relationship between the two variables at 0.05 levels (2-tailed) as generated by a Pearson chi-square statistic of 0.883 and a p-value of 0.347. The relationship between region and awareness of refractive error is statistically significant with a Pearson chi-square statistic of 58.146, and p = 0.00 (<0.005).

4.2. Qualitative/Focus Group Discussions (FGD) Analysis

Analysis of the qualitative dimension (FGDs) of this scorecard survey was conducted to complement and triangulate with the quantitative information to have a better understanding of the prevalence of refractive errors and their associated causes as well as solutions sought and other eye-related diseases in the country. Focus Group Discussions always disclose the hidden information that cannot be disclosed by the quantitative approach, such as the social dimension of the problems, how it affects the research subjects, the extent to which they are affected, and the coping strategies used until lasting solutions are found to the problems.

One FGD was conducted per district within each of the sampled villages in the districts to have 30 FGDs for the whole country. This was considered enough given the homogeneity of the characteristics in the districts with regard to the variables under consideration for discussions. The study ended up with 28 districts due to unseen circumstances.

The issue of awareness was discussed using a three-pronged approach. The first point of discussion enumerated participants' level of awareness about OneSight and its operations in The Gambia, the second discourse focused on awareness of refractive errors by the participants and the third is awareness of solutions to refractive errors.

4.3. Level of Awareness about OneSight and its Operations in the Gambia

More than 90 per cent of the participants across the FGDs conducted, said they were not aware of OneSight, some even said "We have never heard of OneSight, we are hearing it for the first time" – Pallen Wollof, while others said, "We heard their name through radio but never had the opportunity to physically interact with them" – Diabugu Batapa, and other participants said, "We are aware of Sight Savers but not OneSight" – Taibatu Wuli East.

Similar sentiments regarding people's limited or no knowledge about OneSight have been raised by the majority of the focus group discussions, particularly in the North Bank Regions of the River Gambia. Even in Farafenni where OneSight is working in partnership with the government eye clinic when FGD was conducted, this is what one of the participants has to say; "We are not aware of OneSight and myself I have an eye infection" - Farafenni. Invariably, in the FGD conducted in Yalal Tankong Jala, the group said; "We had once received some visitors here from Farafenni, with some white guys among them but we don't know who could they be? We have never had any interaction with OneSight".

On the South Bank of The River Gambia; East of the Greater Banjul Area, the following communities recur similar opinions of no knowledge about OneSight and as quoted in the box below:

"We have no idea about OneSight but we are well aware of eye infection. We have people here with eye issues such as blindness, watery eyes, short/long sightedness and eye pain and itching" – (Gambisara).

"I heard some say OneSight is in Basse, but I don't know how true the statement is. OneSight existed in Basse for 2 to 3 years and they treat all types of eye ailments. They are hosted at Basse health centre", by one of the Participants – (Gambisara).

"We are not aware of OneSight and eye illness is common now. I have an eye infection and I have to travel to Kombo to get treated. I know people with cataracts. Most people with eye problems here either go to Basse or Kombo" - Suduwol.

"We only heard of OneSight through the radio news but never had any profitable interaction with them. We travel to either Soma or Farafenni for treatment, those health facilities are equipped to handle any eye infection. They test, diagnose and operate on patients and also sell glasses. The price of glasses ranges from D250 –D500" - Sankandi.

"We are not aware of OneSight and we know that whoever has an eye infection must visit a hospital. People here start with Bwiam and later proceed to Kanifing if Bwiam could not produce the results they expect. We are lucky to have our son who is working at Sulayman Junkung Hospital in Bwiam as an eye specialist. He is very helpful whenever one visited Bwiam" - Sintet Tamba Kunda.

"We are not aware of OneSight and any eye-infected person goes to Bwiam, Sibanor or Brikama to receive attention. I know someone who was operated on with cataracts in Bwiam, Apollo is a common eye illness, especially this time of the year. Some also complain of blurred vision" - Mayork.

Surprisingly FGDs conducted in the three districts of Banjul disclosed no knowledge about OneSight and its operations. Here are the findings quoted during the discussions:

"No knowledge of OneSight and anyone with an eye infection goes to the hospital" - Banjul South.

I have heard of them on the radio saying they are here to help with eye illness but have not had the opportunity to physically interact with them. People with an eye problems go to the hospital - Banjul North.

"We have never heard of OneSight and never heard of their existence in the Gambia. Anyone with eye issues goes to hospital" - Banjul Central.

The same opinions were upheld from Tampoto to Kanifing Municipal Area districts, most of the FGDs confirmed limited or no knowledge about OneSight and its operations in the country. These are what they have said as indicated in the Quotes below:

"I have never heard of OneSight, not from either the radio or people. Anyone with eye issues visits Sibanor, Kasayne, Somita and even go up to Bwiam for treatment" - Tampoto.

“We know OneSight; we have two of our sons working with them. Musa Darboe is one and Dodou Colley is trained here to give people first attention before referring them to Brikama” - Kafuta.

“We are not aware of OneSight and had no prior interaction with them. We know that people with an eye problem go to either Brikama or Kanifing as there is no health facility here” - Tujereng.

“Never heard of OneSight” – Jambangjelly.

“I am aware of the existence of OneSight but had no interaction with them. I have seen the labels on vehicles. Whoever has an eye problem is referred to Brikama eye care unit as it is the focal point in the region” by one participant – Jalanbang.

“I saw their name labelled on cars but had no positive interaction with them. All those I know with an eye infection, goes to Brikama health centre”, by one participant - Brikama Wellingara.

“We knew them through radio but had not received them physically” - Busumbala.

According to FGDs findings, only two communities out of 28 said they had some knowledge about the existence of OneSight in the country. These include Janjanbureh in Fuladu West, who confirmed observing the presence of OneSight near Bansang and KMC as quoted by the community members below:

“We are aware of their existence, and they are residents in Bansang and work at the hospital. They once came here, sensitize people, tested, treated, and gave glasses to some people. When they came here, ‘Taka Titi’ (the town Crier, informant, and announcer) was busily involved in helping to spread their news. People with eye problems here go to Bansang as the only major health facility around, examples of eye infections include; cataracts, red eye, watery and itchy eyes, and Apollo”

“I am aware of OneSight, they once came to my ward in Bakau to sensitize the people. OneSight came to the council (KMC) requesting two people from each ward to train and use them as focal persons called Optical lead to be as an interface between the NGO and the people. OneSight is collaborating with Sheikh Zaheed and they are hosted at Serrekunda hospital” - KMC.

These are those who are literate, the majority of who reside in urban and/or growth centres such as; Janjanbureh and Kanifing Municipal Area said “they do see their signboards and vehicles crisscrossing or passing by with labels of OneSight in addition to radio announcement, television programmes and physical interaction with the patients.

People’s limited or no knowledge about OneSight across the country perhaps could be due to various reasons crucial among which were the lack of OneSight’s frequent and direct contact with the populace as an independent organization, limited or no outreach services, absence of infrastructure of their own and the fact that OneSight operates in partnership with government and other stakeholders – SightSavers and Sheikh Zayed through their infrastructures in the country.

Despite the few cases of people’s knowledge of the presence of OneSight, their services are felt across the country through their partners.

According to poverty studies conducted in the Gambia, shows that North Bank Regions of the River Gambia compare to the South Bank are less privileged in terms of access to development services, infrastructure and opportunities. Hence, has the highest incidence of poverty and therefore stood out to be the poorest region in the country.

4.4. Aided and Unaided Awareness

The second discourse focused on awareness of refractive errors by the participants. The issue of refractive error was further discussed in “awareness aided” and “awareness unaided” to gauge the level of participants’ knowledge of refractive errors. Also, to assess their source of knowledge about those having imperfect eyesight and possible solutions used to make eyesight better.

As revealed by the FGD findings, participants’ levels of awareness of refractive errors were generally very low about 7.4% (2 out of 28 communities). Because the issue of refraction is a little bit technical and scientific, not all educated people do understand what it is all about, unless into the medical profession or specialized in eye care. Notwithstanding, about 11% (3 out of 28 communities) confirmed their sources of information about imperfect eyesight unaided from either Sight Savers, Government Eye Clinics and Sheikh Zayed with no specific mention of OneSight. Aided awareness regarding refractive issues, was discussed by asking questions about whether they have difficulty threading a needle, seeing small objects that are closer or difficulty reading street signs at a distance. These were raised to determine whether participants are myopic/short-sighted or hyperopic/far-sighted. There were varying answers provided between those who are farsighted against those shortsighted. The findings disclosed that the majority claimed to be shortsighted meaning when the objects are closer, they have difficulty in identification.

Access to information in the Gambia varies depending on the region and location within the region in addition to the medium of communication. By and large, the FGDs were conducted across all the regions in the country, participants confirmed receiving their awareness information largely through radio, and health staff in the eastern part of the country, whilst in the west mostly through the TV for those in the areas with reception. Also, in rural Gambia traditional communicators include community criers and/or announcers.

On the North Bank Regions of the River Gambia, most communities received their news as quoted below by the participants:

“We receive information relating to health through radio and other people are a source for news” - Taibatu.

“We always receive awareness advice from public health personnel, one of whom lives with us in the village. Some important news is also related to us through the Alkalo. Radio can be an important medium for the dissemination of information, but people here would prefer to listen to music than important announcements. Face-to-face information dissemination is the best medium and has a lasting effect” - Ndungu Kebbeh.

“We mostly receive information or important news through the radio. MRC use to come here from time to time to test and treat people, especially the children and the old. They also do advice and give important information” - Doobo.

“We get information through the radio and only a few have a television, but the majority is without television” – Yalal Tankong Jala.

4.5. Awareness of Solution

Similarly, communities in the South Bank, East of Greater Banjul does receive development and health-related message mostly as indicated in the quotes below:

“We receive most information through radio most especially from Radio Basse and Radio Gambia plus others” - Gambisara.

“We often receive information through Basse Community Radio that people will come to treat eyes and will give glasses. Glasses will cost range between GMD250 to GMD1300” - Suduwol.

“We receive important news through the radio. Whenever there is news about a specialist visit to major hospitals, people will rush to seize the opportunity” - Sankandi.

“We receive news or information through radio or chief” - Mayork.

“We receive news from radio, television, newspapers, and the internet. We also person news or important information through the word of mouth” - Kafuta.

“We always receive awareness advice from public health personnel, one of whom lives with us in the village. Some important news is also related to us through the Alkalo. Radio can be an important medium for the dissemination of information, but people here would prefer to listen to music than important announcements. Face-to-face information dissemination is the best medium and has a lasting effect” - Ndungu Kebbeh.

For Greater Banjul Areas the most popular channel for receiving important development and health messages are Radio, Television and Print media (News Papers). This has been reiterated by the FGDs as quoted below:

“We access news through radio, television and/or newspapers” - Tujereng.

“We receive information through the radio, television, newspapers and internet” - Jambangjelly.

“We receive news through radios, television and from the Alkalo, then it filters down to the clans (Kabilos) and the people” - Jalanbang.

“We always receive information from radios, television, posters, billboards and the hospitals and health centres” – Brikama Wellingara.

“We receive news from radios or television and sometimes receive important information from medical personnel” – Busumbala.

“We often receive news through radio, television, newspapers, mobile and from person to person through the word of mouth. Workshops and seminars can be other platforms to sensitise and spread important information” - KMC.

For the three districts in Banjul, participants said; “We receive news or information through the electronic and print media - Banjul South, “Radio, television and councillors are the main source of important news” – Banjul North, whilst Banjul Central confirmed receiving important news/information through radio, television, and newspapers in addition to the use of a PA system to get important information across to the public.

As disclosed by the FGDs, the most recommended channel for disseminating information to the public in The Gambia, irrespective of location is through radio that everyone listened to. The existence of community radios across all regions has improved access to important news and needs further strengthening.

4.6. Awareness of Solutions to Refractive Errors

Awareness of solutions to refractive errors is the most critical component of this scorecard survey as it is the domain area of OneSight’s intervention in The Gambia and other countries alike. Solutions sought to refractive errors correlate to the individual’s and group’s knowledge of refraction. There is a high correlation between the level of awareness of individuals and groups on their health-seeking behaviours, and in this case, the refractive errors and the types of solutions sought.

In most developing countries including The Gambia, health-seeking behaviours are constrained by low levels of awareness, insufficient health facilities, inadequate doctors, and other health staff, high doctor-patient ratio, poverty, and limited supply of drugs. These are compounded by the centralization of development with limited outreach services that consequently inspire the rest of the population especially those in the rural areas resort to traditional methods of health solutions to their health problems.

The Focus Group Discussions conducted in the country across all regions confirm people’s change towards conventional health solutions against traditional methods with the limited knowledge acquired. However, much is desired to further improve on this trend.

When participants were asked about their awareness of solutions to refractive errors, numerous solutions to eye-related infections were provided most of which hinge on traditional methods. The reasons given were; inadequate availability of services, infrastructure and transport cost to nearest service centres, waiting time and other associated costs. These constrained most of them and eventually influence their recourse to local methods they know, which are less expensive even though they have some scientific implications. The most disturbing issue is most of them cannot explain the causes of their eye.

infections, nor can they differentiate which ones are due to refraction because of limited or no knowledge at all on refractive errors.

The most common solutions used by the communities across the country for eye infections irrespective of whether refractive or otherwise are quoted as follows:

“People still use traditional treatment methods, some use “DALA BENO”, a small grain cereal put in the infected eye. For an eye that pains and swells, some use a hollowed horn, fill it with water, put fire inside and use the steam to heal the eye. “FARA JAMBA YELEBALO, PATEH KULEO, JAMBA KASALA, BAKO GIYO and DUMU KOSO” are common practice still active today. I have witnessed people undergoing such treatments and it works for them. Apollo is treated with salt water” - Tujereng.

“Without westernised treatment, some people switch to localize treatment some of which include washing the face with still water early in the morning before engaging outsiders, others include the use of “JAMBA KASALAH, KEROSINE, BAMBU TULO” etc.” – Jambanjelly.

“Apollo” is a local name for a certain type of eye infection; some people use white soap to wash their eyes, while others “Never die leaves” scientifically known as “Morenga”. The leaves are crushed, soaked in water and used as an eye drop if not using a conventional eye drop. Hear what one of the participants has to say:

“Another common eye infection we are familiar with is called; “NYA FALINGO, NYA MEN YELEMATA, NYA DIBO” in Mandinka, scientifically known as Cataract. Our Alkalo has “Wulo FINKO”, an eye that is wide open but cannot see. Without hospital treatment, we wash an infected eye with salt water, use some leaves as herbs to wash the eye, another ancient practice is the use of steel water to wash eyes early in the morning before engaging outsiders”.

Those mentioned above are among the many solutions used in The Gambia based on their beliefs and found to be working for them. The Gambia is a small and cohesive society, the variances are not much for the herbs mentioned in the quotes as they are available in all regions in the country and accessible without cost.

These findings revealed that 35.7% of the total communities contacted for FGD in North Bank Regions of the River Gambia (CRR North and URR North); reported that due to low level of awareness, insufficient access to eye care services, inadequate health infrastructure, and limited outreach services just to name a few leading to more utilization of traditional methods of solutions despite their negative implications scientifically. Hence, much room is desired to improve the health service delivery and its concomitants in particular in the North Bank Regions of the country.

5. Discussion of Findings

Generally, the awareness of the respondents about OneSight, both the quantitative and the FGDs recorded very low ratings (15% and 7.1% respectively). Despite this low rating, their services are felt by the partners they are working with. This is consistent with OneSight’s strategy for sustainability as they are hosted in government health facilities to give ownership to the people through the Government. One core philosophy of OneSight’s operation is to take a “back seat” and allow the National Eye Health Programme to take the lead. OneSight is involved in the supervision, monitoring, advising, and sharing of expertise. As noted by some experts OneSight is the “Unsung Hero” behind the proliferation of eye care services in The Gambia.

With regards to the awareness of refractive errors, the analysis indicated that more than 90% expressed their awareness and solutions. Compared with the FGDs participants provided numerous solutions to eye-related infections most of which hinge on traditional methods. Reasons given were inadequate availability of services, infrastructure and transport cost to nearest service centres, waiting time and other associated costs. These constrained most of them and eventually influence their recourse to local methods they know, which are less expensive even though they have some scientific implications. The most disturbing issue is most of them cannot explain the causes of their eye infections, nor can they differentiate which ones are due to refraction because of limited or no knowledge at all on refractive errors.

The utilization of health services mainly depends on the knowledge of the services users and also hinges more on the cost, nearness to the services and the conviction of the users. According to the findings of this study; more than 90% of the respondents utilized the services of health facilities for their imperfect eyesight, whilst only 5.4% recourse to traditional healers, home treatment and Others to remedy their eyesight problems. The high response rate for people’s knowledge about the value and importance of conventional medication as opposed to traditional and local treatment has increased significantly. This perhaps could be a result of health sector sensitization programs conducted in the country and interaction with the health sector services providers.

6. Conclusion and Recommendations

6.1. Conclusion

Generally, the community scorecard survey revealed a lot of issues that could be of importance to OneSight to improve its activities in The Gambia. There is a high level of awareness of refractive errors and solutions; as a result, it portrays positive health-seeking behaviour toward conventional treatment as confirmed by the study.

Overall, the study disclosed that over 85% of the respondents are aware that some people do not have perfect eyesight. Most of them, however, noted that this knowledge of eyesight issues was obtained through their normal social life and interaction with government eye clinics. Only 3% of the respondents learnt of eyesight-related issues through interaction with the various vision centres. This was further confirmed by the FGD results that, more than 90% of the panel members were not aware of OneSight. Only one out of every 10 people is aware of the use of corrective glasses to enhance defective sight. Similarly, over 70% of households are aware of service providers that help enhance eye-related problems. Both the quantitative and qualitative findings confirmed respondents' awareness of OneSight, through radio announcement which is the major source of information for almost all the respondents in the country, the other sources includes friends and relatives, healthcare workers, television announcement, and newspaper respectively. It was also clearly established that most respondents are aware that glasses can improve short or long-sightedness. Their primary choice for this eye defect is not to purchase glasses but to purchase an eye drop from the health centre. About 75% would consider an eye drop as a primary remedy, 23 % would consider corrective glasses and the remaining 9% would consider some form of home treatment due to poverty. Hence, it is evident that people are aware of eye-related problems, but they have little knowledge about the existence of OneSight because of their invisibility.

6.2. Policy Recommendations

- Strengthen outreach services to underserved communities across the country.
- Promote, expand, and strengthen primary health care services with the inclusion of eye specialists in the country.
- Promote mobile medical Ambulance services.
- Strengthen the health sensitization program with the inclusion of refractive error messages and their related causes.
- Close the disparity in the demand for health services between Urban and rural.
- Improve the infrastructure and logistic requirements of the health services in the country.
- Provide adequate, qualified health professionals in all regions of the country.
- Provide acceptable incentives for health professionals serving in the hinterland of the country to ensure retention.

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