Trainee Ophthalmologists Perspectives of Actions That Can Eradicate Couching In West Africa.

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Abstract

To know the perspectives of trainee Ophthalmologists on actions that can lead to eradication of couching in West Africa (WA), a cross section survey of 27 trainee Ophthalmologists attending Community Eye Health course using structured self-administered questionnaires was carried out. Most trainees were acquainted with and would likely support actions that will eradicate couching as follow: increased cataract surgical rate 24 (88.9%), good cataract surgical outcome 25 (92.6%), documentary to enlighten the public on ocular complications of couching 23 (85.2%), social marketing of cataract surgical services 22 (81.5%), making cataract surgical services affordable 23 (85.2%), increase societal level of education 21 (77.8%), improving the standard of living of the people 20 (74.1%), occupation rehabilitation for couchers 21 (77.8%) and enacting effective law prohibiting couching 13 (48.1%). Overwhelming majority of the trainees was well acquainted with possible ways to eradicate couching and are likely to support actions that would lead to its eradication. Good cataract surgical outcome is likely to be most effective and should be a top priority.

effective. Coordinated combined actions may be necessary to eradicate couching in West Africa.

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Prohibitive law on couching is unlikely to be as

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Introduction

If there is a traditional ophthalmic practice that dies hard it is couching. In West Africa especially Nigeria, couching remains unabated and many couched eyes with lost vision are frequently seen in ophthalmic clinics across the sub-region. Couching is an ancient treatment for cataract still found in Africa and Asia. The procedure involves mechanical displacement of cataractous lens using a sharp instrument by a traditional eye surgeon/healer- a 'coucher'. Usually, the coucher and his patient are seated facing each other. Having steadied the head of his patient with one hand the coucher introduced couching needle with his second hand through the pars plana to displace the cataractous lens into the vitreous through vigorous rocking movement of the couching needle.[1-4]

Couching has many demerits to justify its

Eradication: it is crudest form of cataract

Surgery. Modern cataract surgery producesbetter visual outcome. Couching is bedeviled with complications such as hyphema, uveitis, endophthalmitis, glaucoma, optic nerve atrophy and retinal detachment. Furthermore, usually the coucher does not apply aseptic technique/use unsterile instrument and no provision for follow up/visual rehabilitation after surgery. Frequently, couching leads to ocular morbidity/mortality. Overall, the procedure is unsafe.[1-7]

The aforementioned demerits notwithstanding there are some relative advantages from couching

which sustained it for millennia: the service is available at patient's doorstep, the procedure is made affordable (payment is flexible: cash, kind or installment), the coucher has social network (service is marketed), and coucher is accessible. Above all, the patient believes the coucher could make him see. Indeed, some couched eyes do have immediate visual improvement.[2-5]

Studies abound on couching with many authors concluding it as unsafe and suggesting measures towards possible eradication. [3,5,8] The trainees Ophthalmologists as the heir to and future implementer of these evidence based scientific findings need be acquainted with these measures towards couching eradication. Towards the end of a 6- week Community Eye Health course in Kaduna, in 2006, a cross section survey of trainee Ophthalmologists was carried out with the objective of ascertaining their perspectives on actions that can lead to eradication of couching in the West African sub region.

Materials And Methods

This was a cross section survey of trainee Ophthalmologists from 23 different hospitals with each hospital serving as a sampling frame. The study population was trainee Ophthalmologists in West Africa. The trainees who consented to participate in the study were included while those who refused consent were excluded. Self-administered structured questionnaires were distributed to the 27 consented trainee Ophthalmologists out of 34 who attended Community Eye Health (CEH) 2006 module by the end of the 5th week of a 6- week course held between 27th of February and 7th of April 2006. These were collected until the end of the 6th week course of CEH 2006 module at the venue of the module, seminar room of the Department of Community Ophthalmology, National Eye Centre (NEC), Kaduna.

The 27 out of 34 trainees who attended the course and participated in the study were from 23 different hospitals as follow: Lagos University Teaching Hospital, Idi-Araba, Lagos; Ahmadu Bello University Teaching Hospital, Shika, Zaria; University of Port-Harcourt Teaching Hospital, Port-Harcourt; University of Calabar Teaching Hospital, Calabar; University of Benin Teaching Hospital, Benin City; University of Ilorin Teaching Hospital, Ilorin; University of Nigeria Teaching Hospital, Enugu; Jos University Teaching Hospital, Jos; Aminu Kano Teaching Hospital, Kano; Murtala Muhammad Specialist Hospital, Kano; National Hospital, Abuja; Federal Medical Centre, Gusau; Central Bank of Nigeria Clinic, Abuja; Nigeria Air Force clinic, Lagos; Eye Foundation, Ikeja, Lagos; Borno State Eye Hospital, Maiduguri; General Hospital, Itigidi, Cross River State; Ministry of Health, Ilorin; Ministry of Health, Kaduna; Ministry of Health, Sokoto; Christian Blind Mission International Hospital, Maiduguri; United Methodist Church of Nigeria Hospital, Taraba and Government Hospital, Aflao, Ghana.

Included in the questionnaires were socio-demographic data of the trainees such as: age, sex, marital status, place of work, designation and duration in ophthalmic training. Others were actions that can eradicate couching in West Africa such as: increased community literacy level, health education of the general populace on the blinding complications of couching, making cataract surgical services affordable, improved standard of living, increased cataract surgical rate, good cataract surgical outcome, social marketing of cataract surgical services, occupation rehabilitation of couchers and effective legislation prohibiting couching.

The questionnaires were collated and analysed using SPSS 12.0.1.

Results

Twenty seven out of 34 trainees (74.9%) from 23 different hospitals including 22 from Nigeria and one from Ghana who attended Community Eye Health (CEH) 2006 module in Kaduna, Nigeria, consented, filled and returned the questionnaires. They included 17 (63.0%) trainee Fellows {14 (51.9%) senior registrars and 3 (11.1%) registrars}and 10 (37.0%) trainee Diplomates. There were 19 (70.4%) men and 8 (29.6%) women with a male to female ratio of 2.4:1. Their ages ranged from 31 to 50 years with a mean of 37.3 ± 5.97 and modal age of 32 years. Twenty-four trainees (88.9%) were married and 3 (11.1%) were single. The duration in ophthalmic training ranged between 1 and 6 years with a mean of 2.9 ± 1.8 year.

Table 1 shows the distribution of the trainees by their views on actions that can lead to eradication of couching in West Africa. Good cataract surgical outcome (F) is most supported while prohibitive law on couching (I) is the least supported among the actions.

Discussion

All trainees were from hospitals in Nigeria save one from Ghana. However, the study is representative as yearly records of attendees of the module since inception in 1994, showed more than three quarters were always from Nigeria.[9] The observed male preponderance in this study reflects gender bias in Ophthalmology as has been previously reported.[10]

Studies abound on couching with many authors concluding it as unsafe and suggesting measures towards possible eradication.[3,5,8]

The trainees Ophthalmologists as the heir to and implementer of these evidence based scientific findings need be acquainted with these measures towards couching eradication. Most trainees were acquainted with actions leading to eradication of couching and are likely to support actions that would eradicate couching.

Increase community level of education in the society will most likely dissuade people from tradition as well as false beliefs that promote couching. Ignorance has been found to be one main reason for opting for couching.[6] Public enlightenment using documentary on complications of couching most likely will discourage people from patronising couchers, as people will be better informed. Public information campaigns on the existence of a more effective and safer alternative to couching will put an end to the ancient practice of lens couching.[5,8]

Improved standard of living most likely would enable people to afford orthodox eye care. However, couching might be in some instances more expensive than modern cataract extraction as the traditional healer was often paid partially in kind and the price paid varied according to the patient's ability to pay.[5] Making Cataract Surgical Services (CSS) affordable is most likely encouraging uptake of CSS to the detriment of couching. Most patients who patronise couchers are not necessarily uneducated but are largely poor.[11] Good cataract surgical outcome will advertise CSS resulting to appreciable uptake of CSS to the detriment of couching.

This arguably, will lead to elimination of couching. Good cataract surgical outcome rank highest among the actions likely to lead to eradication of couching in this study.

It is important to improve the quality of ophthalmic services in order to provide cataract patients with the best, most accessible and least expensive services possible.[5]

It would be gratifying if couchers can be occupationally rehabilitated, as it is a potent action towards couching eradication. This can be achieved by encouraging couchers through incentives, to opt out of couching and engage in other vocations that will serve as alternative means of livelihood which will guarantee their dignity,

Table 1: Distribution of trainees by their views on actions that can eradicate couching

Actions that can eradicate couching	Trainees with positive view (%) n = 27	Trainees with negative view (%)	Undecided (%)
A Increase the literacy level of the community	21 (77.8)	3 (11.1)	3 (11.1)
B. Public enlightenment using documentary on ocular complications of couching	23 (85.2)	3 (11.1)	1 (3.7)
C. Making cataract surgical services affordable	23 (85.2)	3 (11.1)	1 (3.7)
D. Improve the standard of living of the people	20 (74.1)	5 (18.5)	2 (7.4)
E. Increased cataract surgical rate	24 (88.9)	2 (7.4)	1 (3.7)
	25 (92.6)	1 (3.7)	1 (3.7)
F. Good cataract surgical outcome	22 (81.5)	3 (11.1)	2 (7.4)
G. Social marketing of cataract surgical services			
H. Occupational rehabilitation of the couchers	21 (77.8)	5 (18.5)	1 (3.7)
I. Enact law prohibiting couching	13 (48.1)	11 (40.7)	3 (11.1)

independence and any other values that matter to them.

Couchers can actually be engaged as cataract rate workers which can boost cataract surgical rate. This will require support from government and other stake holders in eye care industry. Laws prohibiting couching can only be effective if combined with other actions as there is existing law prohibiting non- medical personnel from performing surgery yet couching persist.[3] This should be the least priority among actions necessary to eradicate couching as 40.7% of the trainees were opposed to its use.

Concluding, an overwhelming majority of the trainees was well acquainted with possible ways to eradicate couching and are likely to support actions that would lead to its eradication. Good cataract surgical outcome is likely to be most effective and should be a top priority. Prohibitive law on couching is unlikely to be as effective.

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