

Transitioning from Episodic to Sustained Care in Humanitarian Service

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Recommended Citation

McAlister WH, Weaver JL, Wingert TA, Kramlich K. Transitioning from Episodic to Sustained Care in Humanitarian Service. *Optometric Clinical Practice*. 2020; 2(1). doi: 10.37685/uiwlibraries.2575-7717.2.1.1009. <https://doi.org/10.37685/uiwlibraries.2575-7717.2.1.1009>

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Transitioning from Episodic to Sustained Care in Humanitarian Service

Abstract

Background: Humanitarian missions serve populations needing care and usually provide short term interventions. Traditionally, care provided through humanitarian agencies like VOSH International has been episodic, consisting of a short-term mission placing a team in country for several days. There have been discussions that episodic care is a short term measure which impedes the systematic development of a long term solution to providing the necessary health care. The move toward sustained care is a step in the direction of improving the public health in developing countries.

Method: A survey instrument was mailed to the 26 VOSH chapters in the United States and Canada. Results were tabulated and analyzed.

Results: Sixteen completed surveys were returned for a response rate of 62%. In a one-year period, missions were carried out in 13 countries. There is a strong tendency toward continuity of care with 81% of respondents returning to locations of previous missions and 69% targeting the same population base. There is also a trend toward providing sustained care (such as establishment of a fixed clinical facility) with half responding affirmatively. Nineteen percent of chapters have been involved in the development or enhancement of departments, schools or colleges of optometry in the developing world.

Conclusion: It is exhibited in this study that most teams return to the same areas for future missions and collaborate with other partners with different expertise to create an ongoing presence. This model provides acute care for those needing immediate attention but also enhances the local infrastructure to develop a plan for long term care of this population. This allows for the opportunity to address immediate concerns, build rapport with the community, and use that goodwill and expertise to create long term change. While episodic humanitarian missions have made a profound impact, transitioning from episodic to sustained care improves overall quality of care, expanded services and long-term impact.

Keywords

Humanitarian missions, Sustained care, VOSH/International, Public health

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BACKGROUND

Humanitarian missions serve populations needing care and usually provide short term interventions. While humanitarian aid missions have their place in addressing areas in critical need of health care services, e.g., after a natural disaster where local services are not available, they provide only a temporary benefit to those living in the region. This is immediately very helpful to those receiving services but leaves the population in a position to require services again at some time in the future when they will not be available.

Several humanitarian agencies provide eye and vision care to impoverished populations throughout the developing world. One of the most prominent United States organizations providing such support is Volunteer Optometric Services to Humanity (VOSH) International.¹ Traditionally, care provided through VOSH has been episodic, consisting of a short-term mission placing a team in a country for several days. This level of care is variable but less than ideal. Services of a sustained nature would be more beneficial to patients.²

There have been discussions that episodic care is a short-term measure which impedes the systematic development of a long-term solution to providing necessary health care. It has been recommended that Non-Government Organizations (NGOs) like VOSH International reprioritize their work from direct care to developing human resources and infrastructure in accordance with plans and priorities developed by the local government.³ The move for sustained care and assistance in the opening of optometry schools in developing countries contributes substantially to improving the public health issues. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) from the United Nations General Assembly outlines the most authoritative interpretation of the right to health.⁴ There are four criteria by which to evaluate the right to health--availability, accessibility, acceptability, and quality.⁵ The move toward sustained care is a step in the direction of meeting these criteria. Some effort has been made to this end, but progress has not been measured. Increasingly, teams organizing humanitarian missions have attempted to create a better local infrastructure to improve long-term access for health care services. This is also in keeping with the direction toward sustained care advocated by VOSH International for many years.²

METHOD

In recent years, organizations including the World Health Organization (WHO) have made recommendations suggesting a transition from episodic to sustained care by groups participating in humanitarian services. The purpose of this study was to survey one of the largest eyecare non-governmental organizations to determine if this transition is underway. The survey instrument was mailed to the 26 VOSH Chapters in the United States and Canada. To encourage participation, responses were kept anonymous. Results were tabulated and analyzed. The survey questions contained in the instrument are included in Appendix A along with the results.

RESULTS

Sixteen completed surveys were returned for a response rate of 62%. In a one-year period, missions were carried out in 13 countries (See Appendix A). The survey queried how many patients received care on each mission. The number of patients receiving care on each mission

ranged from 500 to 3,700, with a mean of 1,805 and a median of 1,500. The survey asked what percentage of encounters were for medical eye care versus vision care. Responses indicated that medical eye care ranged from 2% to 20% with a mean of 10% and a median of 11%, and vision care was provided to all patients.

On 44% of the missions, along with one or more optometrists, an ophthalmologist was in attendance. When an ophthalmologist accompanied the trip, the surgeon most commonly performed cataract extraction or pterygium removal, with each procedure performed on 57% of those missions. Glaucoma procedures were performed on 14% of trips accompanied by ophthalmologists.

Sixty-three percent of the respondents had partnered with other groups in providing eye and vision care. Included in this were other health care professionals, charitable and service organizations, governmental agencies, U.S. schools and colleges of optometry, foreign educational institutions, other VOSH chapters and/or other NGOs (See Appendix). This indicates a trend to working in partnerships, with 81% of responding VOSH groups stating they would do so in the future.

There is a strong tendency toward continuity of care with 81% of respondents returning to locations of previous missions and 69% targeting the same population base. Whereas earlier mission trips consisted of optometric services over a short intense time period approximately a week in length, there is now a movement toward providing sustained care (such as establishment of a fixed clinical facility) with half responding affirmatively. The impetus of this movement in VOSH began in the early 2000's. At that time, VOSH was serving the needs of 100,000 patients annually with periodic missions consisting primarily of providing refractive services and basic medical eyecare, and dispensing recycled spectacles. According to Dr. Michael Listenberger, who authored a history of this organization, this VOSH model worked very well for thirty years, connecting U.S. optometric teams with people around the world who needed eye and vision care. Providing periodic hands-on care changed lives, but this approach can reach only a small part of those with visual needs.^{6(pp188-189)} As one approach to expanding access to optometric care, this survey indicates that nineteen percent of VOSH chapters have been involved in the development or enhancement of departments, schools or colleges of optometry in the developing world, including Nicaragua, Vietnam and Uganda.

CONCLUSION

It has been suggested that success and sustainability of humanitarian health programs require collaboration of all stakeholders that have roles in financing, regulation and delivery of services in the targeted nation.^{7,8} It is shown in this study that most teams return to the same areas and collaborate with other partners possessing a different expertise to create an ongoing presence. This process provides acute care for those needing immediate attention but also enhances the local infrastructure to develop a plan for long term care of this population. This allows for the opportunity to address immediate concerns, build rapport with the community, and use that goodwill and expertise to create long term change. By having demonstrated their concern for the overall health of the population, the mission teams have worked to improve local resources by upgrading clinical equipment, providing training for local personnel, and educating decision

makers in regard to public health implications. In this way, humanitarian missions returning to the same location can begin to have a long-term impact on the region. Through relationships they establish in country, plans can be made to expand the resources available to local inhabitants. These long-term relationships provide an opportunity for discussions that evaluate what is currently being done with a goal to improve services for the future. These conversations imply that the ripple of positive effect from the mission will continue to expand.

As mentioned in the comments to the survey, some groups participating in mission trips have been returning to the same area for over thirty years. They have grown into multidisciplinary efforts that incorporate various medical specialties, optometry, pharmacy, physical therapy, nutrition, and nursing, as well as health care administrators and business planners. For example, during a sample one-week mission trip, the team spends one day acclimating to the area and working with local resources to prepare for the days of providing clinical care. They then provide clinical care to the local population for five days before returning home. Students on the team are required to spend a two-hour time frame (on two separate occasions) with a health care service that is not their own profession. This is to have them spend a meaningful amount of time with providers from two different services to get different perspectives on patient care. The administrators and planners work with local authorities to discuss ways to create systematic improvements for long term impact. Ultimately, this trip creates a learning community that participates in a collaborative, common experience with another culture, providing service that involves integrating all the aspects of their education and clinical experiences along the way. The nature of the experience requires students on the trip to process the information they acquire and its meaning in a new way and seek new solutions for improving the local delivery of care.

As we move away from traditional missions providing direct care on an interventional basis, it is important to acknowledge the good that has been done; the shortcomings have been already outlined. Humanitarian missions are not population based, but on an individual basis the impact has often been profound. Most participants have a few favorite encounters where a patient who would otherwise have been functionally blind from uncorrected refractive error can now lead a productive life. It is callous to suggest these missions have not been of value. There is substantial merit to the simple humanity of caring and sharing with people in need, because “it may not matter to the world--but it matters to them.”^{9(p94)} While there have been some with concerns about the approach of mission trips, this study would seem to indicate that those organizing the missions continue to adjust their approach to create something that will be left behind after they are gone. This seems to be an approach that everyone can support.

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APPENDIX

1. In which countries did your chapter conduct missions last year?

Mexico (6)
Honduras (3)
Dominican Republic (2)
Colombia
Dominica
El Salvador
Fiji
Haiti
Jamaica
Nicaragua
Panama
Peru
Philippines

2. Approximately how many people received care on each mission?

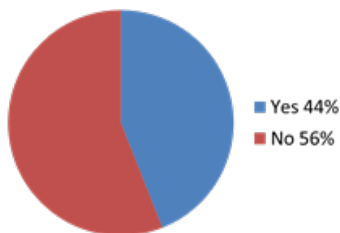
Range 500 – 3,700
Mean 1,805
Median 1,500

3. Approximately what percentage of encounters were medical eye care (vs. vision care)?

Range 2 – 20%
Mean 10%
Median 11%

4. In any of the missions, were you accompanied by an ophthalmologist?

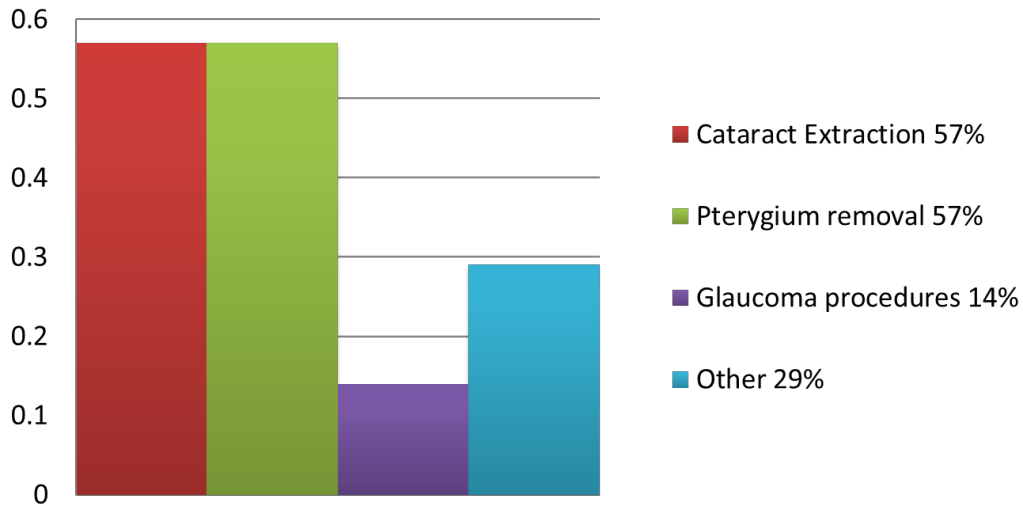
Yes 44%
No 56%



5. What type of surgeries were performed?

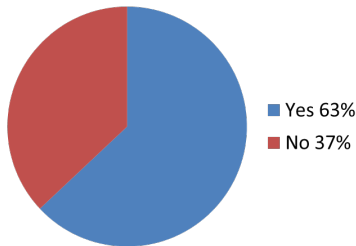
Cataract extraction 57%
Pterygium removal 57%

Glaucoma procedures 14%
Other 29%

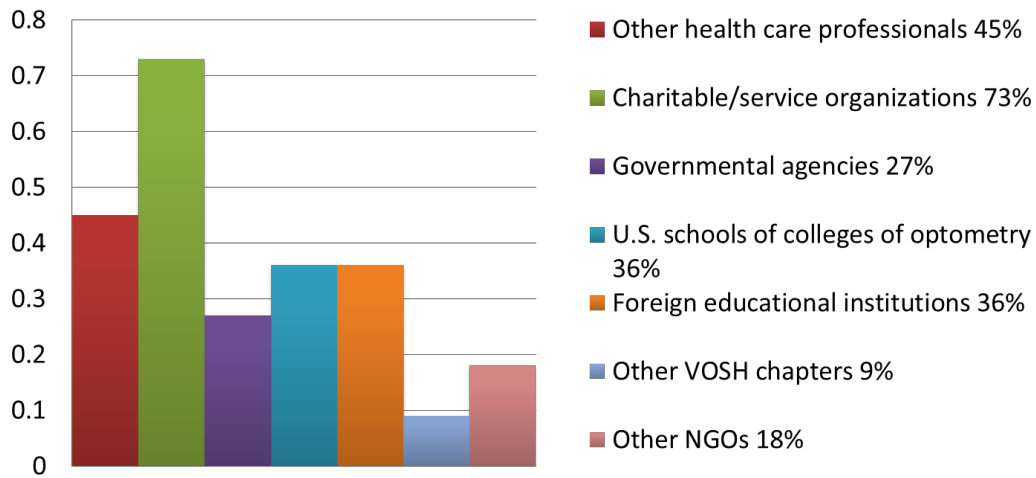


6. Have you partnered with any other groups in providing eye and vision care services?

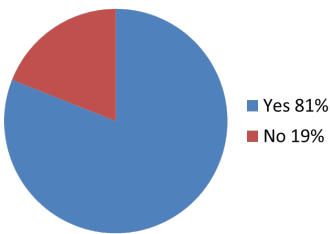
Yes 63%
No 37%



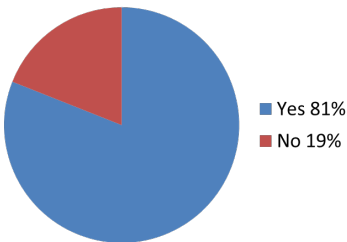
7. With which groups did you partner?
Other health care professionals 45%
Charitable/service organizations 73%
Governmental agencies 27%
U.S. schools of colleges of optometry 36%
Foreign educational institutions 36%
Other VOSH chapters 9%
Other NGOs 18%



8. Do you plan to work on partnerships for your efforts moving forward?
 Yes 81%
 No 19%

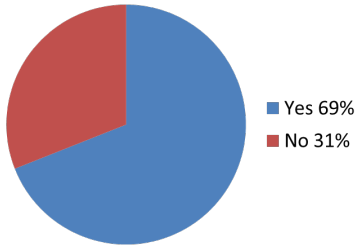


9. Did your chapter visit the same location(s) as in previous years?
 Yes 81%
 No 19%



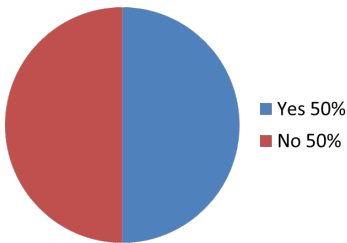
- 10. Has there been an attempt to provide eye and vision care to the same population base?**

Yes 69%
No 31%



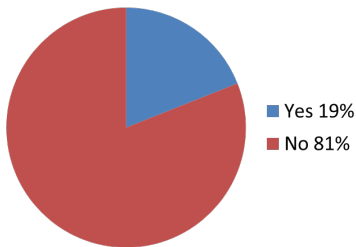
11. Has your chapter established a sustained care environment (such as a fixed clinical facility)?

Yes 50%
No 50%



12. Has your chapter been involved in the development or enhancement of a department, school or college of optometry in the developing world?

Yes 19%
No 81%



Comments from respondents:

Our mission provides basic eye care to people who have no access to any eye care services at all. Some governments are more amenable than others and make bringing additional medical/optometric services to this demographic of their population a possibility. We have been going to the same area in Mexico for 35 years. We also have a trip to an area in Jamaica that goes every 2 years for at least 10 years.

Although mission trips can help develop partners, VOSH teams, including SVOSH, should always have supporting sustainability as the primary mission. SVOSH chapters in the US can do this by partnering with international SVOSH chapters on a one to one basis, to work together on missions as well as interact educationally and socially as fellow optometry students. Pick an international SVOSH chapter to partner with, make contact, and see how you can work together as chapters moving forward.

Establishing student VOSH chapters at foreign optometry schools and then partnering with them on VOSH campaigns provides a cross-cultural learning experience while providing typical VOSH services. Referring surgical patients to non-profit ophthalmology clinics abroad supports those organizations while providing patients with the best option for affordable surgical care. We encourage other chapters to do the same.

It is true that sustained services would give a long lasting effect in these areas and it must be through opening optometry schools.