Community Eye Health Vol.12 No.31 1999 p36-38

**Journal of Community Eye Health**
An International Journal to Promote Eye Health Worldwide

# Review Article: People Who Don't Use Eye Services: 'Making the Invisible Visible'

**Martine Donoghue BSc MSc**
Research Fellow
Department of Epidemiology & Health
London School of Hygiene
& Tropical Medicine
Keppel Street
London WC1E 7HT
UK

## Introduction

People's use of health services is influenced by a range of psychological, social, cultural, economic and practical ýactors. Eye care services are no exception. Nevertheless, there has been a tendency to assume that if eye services are available then people in need will use them, particularly if they are provided free of charge. This paper will focus upon the poor utilisation of services for the treatment of cataract in developing countries, and the reasons underlying this. The viewpoint examined will be that of the individual with an eye problem.

## Levels of Cataract Surgery Up-take are Low

The effectiveness of prevention of blindness programmes is seriously weakened by the low levels of cataract surgery up-take. The WHO states that globally only a quarter of people in need currently use eye services.[1] This is supported by evidence from studies conducted in India and Nepal which demonstrate levels of utilisation of eye services, and uptake of cataract surgery ranging from 7% to 35%.[2-4]

A misleading impression of good utilisation is created by treatment centres which have a high patient demand. This overlooks the following:

- **A few institutions cannot deal with such a large problem**

There are highly reputable treatment centres which are extremely busy. Yet on balance many other institutions have empty beds and waiting rooms. Furthermore, the overall number of people presenting at treatment centres is a small fraction of those in need.

- **There are high levels of non-compliance with treatment recommendations**

© Community Eye Health
Articles may be freely reproduced or translated provided these are not used for profit.
Published by the International Resource Centre, International Centre for Eye Health, London School of Hygiene & Tropical Medicine, Keppel St, London WC1E 7HT, UK
tel: 00 44 20 7612 7972 email: admin@jceh.co.uk web: http://www.jceh.co.uk

More people consult eye care services than follow through with treatment recommendations. People often do not return for treatment when they have been advised to come back at a later date. This is particularly true for a recommendation of future cataract surgery. These potential cataract beneficiaries are possibly hoping for a 'quick fix' in the form of medication, and do not re-present for the reasons outlined below.

## Who Uses Cataract Services?

Typically eye service users are more likely to be male, live close to the treatment source, and possibly have higher literacy levels.2-4 It is not clear from current research if there are fundamental differences in the health beliefs of service users and non-users.

## Reasons for the Poor Use of Eye Services

The main reasons for not seeking treatment given by people with eye problems in India, Nepal and the Gambia [2-5] are shown in the text box.

- Fear
  - damage /'spoil' eyes
  - miscellaneous fears.
- Cannot leave family/work responsibilities.
- Post-operative recommendations put them off.
- Treatment cost.
- Can manage - treatment not necessary.
- Too old.
- Fatalistic - 'God's will'.
- No escort.
- Lack of transport.
- Distance.

Despite the difference in geographical and cultural settings, there is a remarkable consensus of opinion amongst people about why they do not seek treatment. Perceptions about which are the major and minor barriers to service use vary from place to place.

Important points to note are:

- **'Ignorance' is not the principal problem**

Providers tend to attribute poor user demand to an ignorance of treatment availability and benefit. 'Ignorance' may explain a proportion of eye service non-utilisation but it is not the root cause. It is known that poor service use occurs amongst communities with a good knowledge of eye problems and treatment options, and with outreach free services.[2]

© Community Eye Health
Articles may be freely reproduced or translated provided these are not used for profit.
Published by the International Resource Centre, International Centre for Eye Health, London School of Hygiene & Tropical Medicine, Keppel St, London WC1E 7HT, UK
tel: 00 44 20 7612 7972 email: admin@jceh.co.uk web: http://www.jceh.co.uk

- **Behaviour is rational**

A commonly held view is that people need to be motivated to seek treatment. Individuals are motivated but their motivations differ from that of the provider community. When viewed in context, many of these reasons make sense. For example:

- **Fear**

Fears about treatment such as cataract surgery 'spoiling' eyes may not be irrational. In response to concerns about the quality of cataract surgical outcomes, WHO strongly recommends the need for better monitoring and evaluation systems.[6] It is well known that 'bad news travels fast'. Treatment failures may unfortunately impact more upon community attitudes to eye treatment than all the examples of success.

- **Cost in time and money**

Dealing with direct treatment costs has been a major concern of service providers. This is a very important obstacle to overcome. However, it is only part of the cost borne by service users and their families. The concept of 'time is money' is not only the preserve of the city professional. In fact it has a sharper reality for people living in poverty. Seeking treatment involves leaving day-to-day responsibilities. In an existence of 'work today, eat today' early treatment intervention is a luxury that may be unaffordable. Furthermore, costs are multiplied when other family members are involved, either to fulfil escort or carer roles.

- **Ageism**

Unless actively addressed, there is scope for negative attitudes to old age to become a bigger barrier to treatment. Cataract is an age-related condition. Given demographic forecasts and life expectancy patterns, many of the people requiring surgical treatment will be women and widows. In many communities these are the people who are likely to be forgotten.

- **'I don't need treatment - I can manage'**

To a greater or lesser extent, people report that they are coping and do not perceive a need for treatment/surgery.[2-5] This includes bilaterally blind people too. This is somewhat surprising but possible explanations are that they have good adjustment to their disability with little evident handicap. On the other hand, this response may mask hidden barriers. After weighing up the advantages and disadvantages it is not worth the bother - 'I'll manage'. Currently the explanation is not clear, and requires further exploration.

## Conclusion

We need to raise awareness about the low use of cataract services, and adopt strategies which promote equality in eye service delivery, access and use. People who

© Community Eye Health
Articles may be freely reproduced or translated provided these are not used for profit.
Published by the International Resource Centre, International Centre for Eye Health, London School of Hygiene & Tropical Medicine, Keppel St, London WC1E 7HT, UK
tel: 00 44 20 7612 7972 email: admin@jceh.co.uk web: http://www.jceh.co.uk

do not use eye services know why they do not seek treatment. It is therefore critical that providers ask and listen to the views of their community.

Motivating potential treatment beneficiaries via health education, and social marketing strategies, such as the 'aphakic motivator', have been favoured strategies to improve cataract uptake. It would be a mistake to overlook the importance of social marketing but it is by no means a 'magic bullet'. The test of time plus some evidence[3] has shown that the power of example is not enough. The interplay between social, economic and cultural factors is key to understanding service utilisation, and to developing effective intervention strategies. Many of the reasons specified for poor service use are largely a consequence of poverty, gender inequality and lack of participation in decision-making. Tackling these causes is fundamentally challenging. At a practical level we can begin by:

- improving the evaluation of cataract surgical outcomes.
- providing 'fast track' consultation and follow-up in the community.
- modifying post-operative surgery recommendations to facilitate a quick return to day-to-day responsibilities.
- promoting the benefits of cataract treatment for elderly people.
- maintaining better service information systems so that planners know who uses, and does not use their services.

Central to the success of these efforts is a move from an approach of 'do unto communities' to 'do with communities.'

## Acknowledgements

This article has been greatly influenced by other people, and my research experience in Tamil Nadu, India. Many thanks to the rural communities in Tamil Nadu who so readily shared their views with my colleagues and I from the London School of Hygiene & Tropical Medicine, Aravind Eye Hospital and SPEECH (a local NGO). A special thanks to Professor Astrid Fletcher who has given me the benefit of her expertise on countless occasions, and also made incisive comments on this article. Our research in Tamil Nadu was funded by the Department for International Development (UK Government).

## References

1. World Health Organization. Vision 2020: The Right To Sight. Press Release WHO/12, 18 February 1999. WHO, Geneva.
2. Fletcher AE, Donoghue M, Devavaram J, Thulasiraj RD, Scott S, Abdalla M, Shanmugham CAK, Bala Murugan P. Low Uptake of Eye Services in Rural India: A Challenge for Programmes of Blindness Prevention. Arch Ophthalmol 1999: 117: 1393-9.
3 Brilliant GE, Lepkowski JM, Zurita B, Thulasiraj RD. Social Determinants of Cataract Surgery Utilization in South India. rch Ophthalmol 1991; 109: 584-9.
4. Šrilliant GE, Brilliant LB. Using Social Epidemiology to Understand Who Stays Blind and Who Gets Operated for Cataract in a Rural Setting. Soc Sci Med 1985; 21(5): 553-8.
5. Johnson JG, Goode V, Faal H. Barriers to the Uptake of Cataract Surgery. Tropical Doctor 1998; 28(4): 218-20.
6. World Health Organization. Cnformal Consultation on Analysis of Blindness Prevention Outcomes. 16-18 February 1998. WHO, Geneva.

© Community Eye Health
Articles may be freely reproduced or translated provided these are not used for profit.
Published by the International Resource Centre, International Centre for Eye Health, London School of Hygiene & Tropical Medicine, Keppel St, London WC1E 7HT, UK
tel: 00 44 20 7612 7972 email: admin@jceh.co.uk web: http://www.jceh.co.uk