

Foremost amongst these, in developing world settings, are the processes of improving the social and environmental situations where people live and work as well as the furtherance of personal and collective skills, e.g., literacy and improved health awareness.

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Table: Elements of Health Promotion : Relevance and Application of Health Promotion to Ophthalmology

Healthy Public Policy	<ul style="list-style-type: none"> • Development of formal eye care policies and target setting at national, district and local levels. • Design, implementation and evaluative research of cost recovery schemes, e.g., cataract surgery.
Personal Skills Development	<ul style="list-style-type: none"> • Training of community eye health promoters and health professionals in community eye health. • Literacy programmes – both in terms of general and 'basic health literacy' skills.
Community Participation	<ul style="list-style-type: none"> • Involvement of the community in planning, implementation and evaluation of eye care programmes. • Incorporation of community members in eye care service delivery, e.g., ivermectin tablet distribution.
Supportive Environments	<ul style="list-style-type: none"> • Nutrition programmes (vitamin A supplementation, fortification programmes). • Accessibility to sanitation and safe, drinkable water, relevant to the prevention of trachoma.
Re-organisation of Health Services	<ul style="list-style-type: none"> • Integration of eye care services in existing local primary health care programmes. • Increased focus on research into eye conditions as well as on 'appropriate' service delivery mechanisms.

Review Article

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

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Introduction

People's use of health services is influenced by a range of psychological, social, cultural, economic and practical factors. 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**

More people consult eye care services than follow through with treatment recommendations.² People often do not return for treatment when they have been advised to come back at a later date. This is particu-



Levels of cataract surgery up-take may be low

Photo: Murray McGavin

larly 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 Gambia²⁻⁵ 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

• **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



An 'aphakic motivator'!

Photo: Murray McGavin

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 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



Lack of transport may be a factor in poor use of eye care services. A bullock cart brings this patient to a primary eye care clinic in India

Photo: Murray McGavin

marketing but it is by no means a 'magic bullet'. The test of time plus some evidence³ 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*.'

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Review Article

Mobilising Resources Within the Community: 'Mobilising the Unmobilised'

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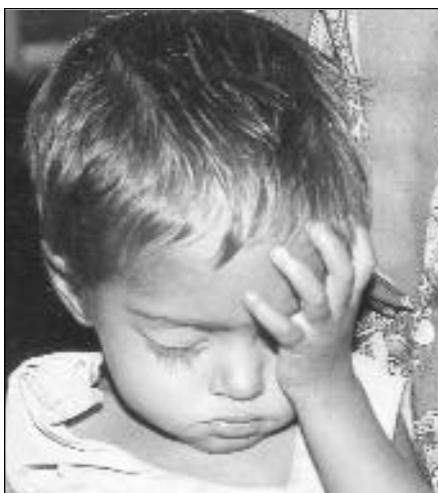
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Introduction

Every community has evolved ways of preventing and managing disease through its own understanding of the causes of illness. Health care is provided at many levels by many different groups of people. These include mothers and family members, traditional practitioners and private and public health workers. The contact between people and health workers through an equitable health system can lead to better understanding of the choices available to the people in addressing their health needs. It also offers an opportunity to improve people's health. At every level the capacity of people can be enhanced and the range of choices they have to protect their health problems can be increased.



The distress of painful eyes: a child in Bangladesh

Photo: Murray McGavin

Access to Health Care

Many people lack access to health care and also lack the basic health-related knowledge which would allow them to control their environment and/or their behaviour in the interests of their health. As a result, preventable and curative health conditions frequently lead to death or disability and, even when they do not, are a common reason for poor families becoming even poorer and without hope. Women and children face considerable additional difficulties in receiving health care, compared with men, and also are frequently allowed only limited participation in decisions concerning their own or their family's health. This has a significant adverse effect upon their health and upon their health-seeking behaviour. The problem is not that solutions are unavailable, but rather providing these solutions to individuals and communities who require them.

• Using existing community resources

Health issues are social needs which cannot be fully met through exclusively medical approaches. Mobilisation and better use of existing resources (human, social and financial) can lead to a significant improvement in health. The aim should be to empower communities with basic health knowledge (preventive and basic curative), so that they can make better decisions with regard to their environment and their health. Empowering communities may be done by working directly with all sections of the community or through the existing groups/institutions or through selected volunteers. In Bangladesh, Save the Children (UK) worked with and through men, women and children of the project area (see below). The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), through its Chakoria project, worked through existing self-help groups (mosque committee, school committee,



Communities should be empowered with basic health knowledge

Photo: Murray McGavin

market committee, local youth clubs). Several government health care projects (Primary Health Care Intensification Project, Thana Functional Improvement Pilot Project) had experience of working through selected volunteers. The National Diarrhoea Control Programme uses schools and scouts. The National Immunization Programme uses mosques and schools.

• Traditional practitioners

Every community has traditional practitioners. They are available, accessible, affordable and enjoy the confidence of the community. Some of their practices, however, may be harmful. When the health system recognises their strengths, works with them without ignoring them, their efforts will then support the health system. Thus, improving the existing indigenous resources of the community results in optimal use of resources for sustainable improvement of quality, equity, relevance and cost-effectiveness in health care. In Bangladesh, Save the Children (UK) working with the popularly known 'Village Doctors', demonstrated effective results. Also, the National Diarrhoea Control Programme and the Acute Respiratory Tract Infections Programme are working with them.

• Material resources

Material resources may also be mobilised within the community for health care. In Bangladesh, through philanthropic contributions (giving donations), several health facilities have been developed. If communities feel the need of health, they are willing and capable of arranging the resources required to deliver health care. The ICDDR,B's Chakoria project has demon-