

Health Promotion and Community Participation in Eye Care Services

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Introduction

'Never underestimate the power of individuals to change the world – indeed that is the only way it happens'

Margaret Mead

In 1986, an international conference was held in Canada that reunited government health representatives from nearly all the world's countries. This event signalled the formal recognition of the concept of 'health promotion' as expressed in the unanimously agreed 'Ottawa Charter for Health Promotion'.¹ Following the declaration on primary health care of Alma Ata in 1978, the Ottawa Charter signalled a recognition of the many aspects and influences concerning health and illness, not only as applied to industrialised but also, importantly, in the so-called 'developing countries' of the world.

The Ottawa Charter and Health Promotion

The Ottawa Charter, as a strategic document, outlined the five key practical elements that are included in health promotion (See Table):

- Healthy Public Policy.
- Personal Skills Development.
- Community Participation.
- Healthy and Supportive Environments.
- Re-organisation of Health Services.

Community Participation and Eye Care Programmes

This article focuses on the role of active public participation in community eye care programmes, particularly in developing countries. It should be pointed out, however, that the potential success of health promotion in practice is closely associated with a comprehensive approach that integrates as

many of the five components of health promotion as possible.

As described in the Ottawa Charter, 'community participation' is relevant in the process of empowerment and increased involvement of the members of communities. This relates to problem identification and decision-making, collaboration in planning for health care delivery and, finally, active participation in the implementation of health care programmes – essentially local control of services to improve the health of individuals and of communities.

While it may be generally understood what 'community participation' refers to, in practice it is important to recognise that community involvement invariably differs from one setting to another. The reasons for this are many but principal amongst them are the socio-cultural, economic, geographic, educational and gender differences which exist across specific settings. More importantly, with reference to eye care issues, the nature and types of the eye diseases from one area to another influence the type and degree of local involvement in eye care services. Two particular, though differing case studies of effective community participation in eye care, are reported from Uganda and India. The western Uganda ivermectin distribution programme involved community members in the control of onchocerciasis² and, in India, the incorporation of community members in rural appraisal surveys identified factors concerning barriers to and up-take of eye services in rural communities.³ The benefits of community participation from these two examples have been demonstrated – in Uganda, by decreased per-person treatment costs, increased ivermectin coverage, increased collaborative integration between health authorities and community structures and, in India, by increased understanding of the barriers to up-take of services, especially for cataract surgery.

Additional benefits of community participation in health-related issues cited in relevant literature include:

- the increased sense of responsibility and control over individual health and that of the community.
- empowerment of individuals through increased knowledge, awareness and the



Informing the community. Literacy and improved health awareness

Photos: Pak Sang Lee

development of new skills through participation.

- greater understanding of local conditions.
- the appropriate and effective incorporation of traditional, indigenous experience in eye care service delivery.⁴

Finally, the increased accessibility and up-take of eye care services can be positively affected through increased community involvement, particularly relevant in the desirable reduction of preventable blinding conditions such as cataract.

The Global Initiative: Vision 2020

In terms of the Global Initiative for the Elimination of Avoidable Blindness, a strong case must be made for the further promotion and acceptance of active community involvement in eye care service development, implementation and evaluation. Active community participation has a vital contribution to make towards reducing the magnitude of preventable blindness caused by the five major causes of blindness particularly identified in the Global Initiative – cataract, trachoma, onchocerciasis, childhood blindness (especially due to vitamin A deficiency) and refractive errors and low vision.

It is important to understand, however, that 'community participation' is not an overall answer to all problems. Rather, active community involvement should be considered an important resource input in eye care programmes that need to be encouraged, accepted, recognised and supported by existing health care delivery systems. Access to health-related information by community members is only one necessary example of how health care providers – both government and non-government – can improve the skills of community members and so increase the effect of community involvement towards prevention of eye problems.

Finally, in regard to the broader aspects of health promotion, the effectiveness of community participation in eye health is significantly linked with the other four elements identified in the Ottawa Charter.

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.

References

- 1 Ottawa Charter for Health Promotion – First International Conference on Health Promotion. Ottawa, Canada. World Health Organization/Health and Welfare Canada/Canadian Public Health Association. 1986.
- 2 Kipp W, Burnham G, Bamuhiga J, Weis P, B ttner DW. Ivermectin distribution using community volunteers in Kabarole district, Uganda. *Health Policy and Planning* 1998; **13**(2): 167–73.
- 3 Fletcher A *et al.* Barriers to using eye services and recommendations to improve service up-take – research findings and international workshop recommendations. Madurai: India. 1998.
- 4 Zakus JD, Lysack CL. Revisiting community participation. *Health Policy and Planning* 1998; **13**(1): 1–12.

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

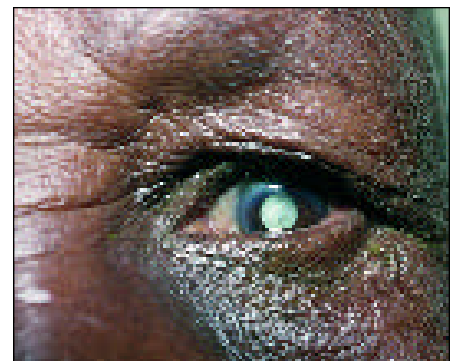
A misleading impression of good utilisation is created by treatment centres which have a high patient demand. This overlooks the following:

- **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.