

Pattern of the health care practices about eye diseases: a community based study

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Abstract

Background: Health care seeking behaviour is influenced by the availability and accessibility of health services. Dependent on these determinants and their interactions, health care seeking behaviour has been considered a complex outcome of many factors operating at individual, family, and community levels.

Objective: To find pattern of the health care practices about eye disease.

Methods: This was a cross-sectional study conducted in the rural field practices area of a tertiary care hospital. The purposive sampling was used to select the study subjects. A total of 160 subjects of age >18 years were studied from 5 villages. From the center of the community, each subsequent household was selected by counting the next 2 or 3 houses in a random direction until the number needed for that community was obtained. Again, the number of households counted and assigned to each community was based on their population size.

Result: The choice of treatment for eye diseases was private (49.4%) followed by over the counter (32.5%) and government (18.1%). Out of those who had government choice, 51.7% had choice of PHC and 34.5% had CHC. The private hospitals (51%) were the main place of treatment for cataract followed by district hospital (14.3%). The main source of information about eye care services was relatives and friends (36.9%) followed by television (30.6%).

Conclusion: There was less utilization of government health facilities in the care seeking of eye diseases among the rural population. Hence, there is a need to strengthen the community to utilize the government health facility through educating the community to have better treatment.

KEYWORDS: Eye disease, health care practices, community

Introduction

It has been reported that worldwide, approximately 285 million people are visually impaired. As per millennium developmental goals of United Nations, goal 3, two thirds of all those who suffer blindness are women. Women make up 80% of those suffering from severe trachoma and 75% of those with cataract are women.^[1]

Health care seeking behaviour is influenced by the availability and accessibility of health services. Dependent on these determinants and their interactions, health care seeking behaviour has been considered a complex outcome of many factors operating at individual, family, and community levels.^[1] One of the impediments to reduce blindness in developing countries is the limited access to appropriate eye care services.^[2] It is reported that, that less than 10% of people in low income countries receive optimal eye care due to limited access to appropriate eye care services.^[3] The situation is further compounded by other barriers such as cost, fear of doctor, and transportation.^[4]

Identifying barriers that hinder people's access to eye care is essential in overcoming the burden of avoidable blindness.^[5] People who live in communities with inadequate or inaccessible eye care facilities tend to seek other alternatives of eye care services. In developing countries, it is likely that substantial eye care information and services are

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sought outside regular eye care system. The use of health care services, including eye care is generally influenced by a range of psychological, sociocultural, and economic factors.^[6] The frequency and severity of symptoms experienced by the individuals affect their self-perception of eye health thereby influencing their eye health seeking behavior.^[7] The data on eye health care practices are lacking especially in north Indian states.

Therefore, the present study was conducted in the rural field practices area of a tertiary care hospital with the objective to find pattern of the health care practices about eye disease.

Materials and Methods

This was a cross-sectional study conducted in the rural field practices area of a tertiary care hospital. The study was approved by the ethical committee of the institute. The consent was taken from each participant before enrolling in the study.

The purposive sampling was used to select the study subjects. A total of 160 subjects of age >18 years were studied from 5 villages. From the center of the community, each subsequent household was selected by counting the next 2 or 3 houses in a random direction until the number needed for that community was obtained. Again, the number of households counted and assigned to each community was based on their population size.

Within each household, only one person was selected for an interview with a semi-structured questionnaire. Each household was considered as a study unit. Selection was based upon the presence of the eldest adult (18 years and above or head of the household; this was to ensure that individuals with autonomy were recruited) in the household.

Recruited respondents were interviewed using the semi-structured questionnaire, which had been developed to contain issues respondents had earlier identified as influencing eye care services. Questionnaire had closed and open ended questions and was developed in English language, pretested, appropriately modified, before the final field administration. The questions were interpreted in the local dialect to allow for those who could not understand English.

Statistical analysis

The responses of the semi questionnaire were used for the analysis. All the variables were coded, entered, and analyzed using the statistical package for social sciences (SPSS) version 16 (SPSS Inc, Chicago, IL, USA). Descriptive results were expressed as frequency and percentage.

Result

The choice of treatment for eye diseases was private (49.4%) followed by over the counter (32.5%) and government (18.1%). Out of those who had government choice,

51.7% had choice of PHC and 34.5% had CHC. The choice of district hospital was only 13.8%. Out of those who had private choice, 60.8% had choice for private practitioners and 39.2% had private hospitals (Table 1).

The private hospitals (51%) were the main place of treatment for cataract followed by district hospital (14.3%). Similarly, private hospital (65.5%) was also the main place of treatment for refractive errors followed by camp (15.5%). The treatment taken for common eye infections was 60.4% at private hospital followed by camp (17%), CHC (13.2%), and district hospital (9.4%) (Table 2).

The main source of information about eye care services was relatives and friends (36.9%) followed by television (30.6%), newspaper or magazines (18.1%), healthcare professional and radio (13.1%) (Figure 1).

Discussion

In this study, the choice of treatment for eye diseases was private (49.4%) followed by over the counter (32.5%) and government (18.1%). Out of those who had government choice, 51.7% had choice of PHC and 34.5% had CHC. The choice of

Table 1: Choice of treatment for eye diseases of the family (*n* = 160)

	Number	Percentage
Government	29	18.1
PHC	15	51.7
CHC	10	34.5
DH	4	13.8
Private	79	49.4
Private hospitals	31	39.2
Private practitioners	48	60.8
Over the counter	52	32.5

Table 2: Actual place of treatment of eye diseases visited in last one year? (*n* = 160)

Conditions	Number	Percentage
Cataract	49	30.6
District hospital	7	14.3
Private hospital	25	51.0
Refractive error	58	36.3
CHC	3	5.2
District hospital	8	13.8
Camp	9	15.5
Private hospital	38	65.5
Common eye infections	53	33.1
CHC	7	13.2
District hospital	5	9.4
Camp	9	17.0
Private hospital	32	60.4

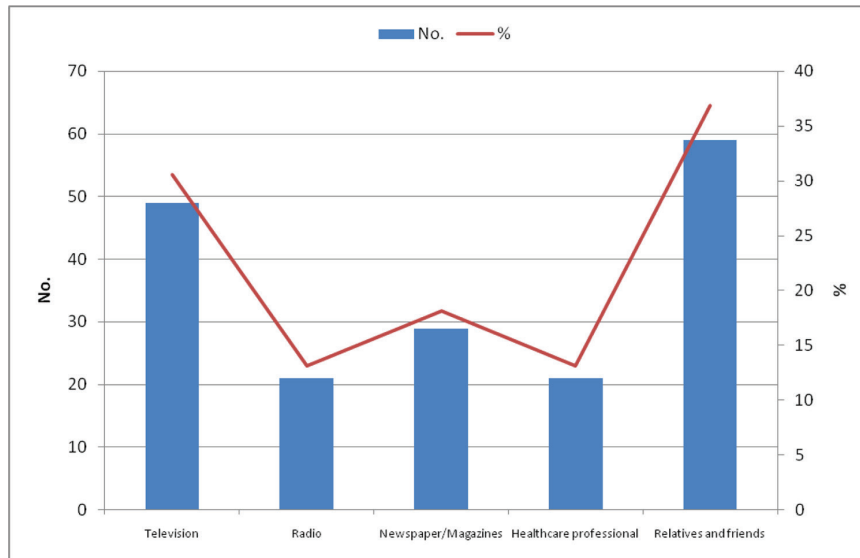


Figure 1: Source of information about eye care services

Table 3: Source of information about eye care services

Source*	Number (n = 160)	Percentage
Television	49	30.6
Radio	21	13.1
Newspaper/Magazines	29	18.1
Healthcare professional	21	13.1
Relatives and friends	59	36.9

district hospital was only 13.8%. Out of those who had private choice, 60.8% had choice for private practitioners and 39.2% had private hospitals. In this study, the private hospitals (51%) were the main place of treatment for cataract followed by district hospital (14.3%). Similarly, private hospital (65.5%) was also the main place of treatment for refractive errors followed by camp (15.5%). The treatment taken for common eye infections was 60.4% at private hospital followed by camp (17%), CHC (13.2%), and district hospital (9.4%).

Limited eye health care seeking at government health facility was observed in this study. This finding is consistent with two separate south Indian studies^[8,9] which found that a large proportion of people in rural populations who required eye care were not utilizing existing eye care services. In a study^[10] of people with diabetes in China, 43% of urban people and 69% of rural people had never had an eye exam. However, 46% of urban and 85% of rural Chinese participants reported never having an eye exam. People living in rural areas in a variety of countries are reported to use less health-care services including antenatal care,^[11] dental services,^[12] and immunizations^[13] compared to people living in urban or suburban areas. In India, proportion of the private hospitals is

nearly 66% of the total hospitals and government own hospitals constituted for around 31% and the local bodies own the rest.^[14] Dhar^[15] mentioned that public health system should be asked to compete with the private sector to attract patients. A study by Prasad^[16] showed that 25.6% of morbidity is due to diseases such as eye diseases. Senyonjo *et al.*^[17] reported that 10.1% (7.7–13.0) self-reported ocular morbidity; 48.6% (40.4–56.8) of them reported seeking treatment. Stephen *et al.*^[18] reported that 54.1% have never had their eyes examined at any health facilities despite reported episodes of eye disease. There are many rural residences using the medicinal plant as self-treatment.^[19] McKeown^[20] explained the medical contribution in decline of mortality and also explained the protection of diseases by immunization and therapy.

One of the limitations of this study was the lesser sample size as well as qualitative assessment could not be done to support the quantitative data.

Conclusion

There was less utilization of government health facilities in the care seeking of eye diseases among the rural population. Hence, there is need to strengthen the community to utilize the government health facility through educating the community to have better treatment.

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