



Why Do People Remain Cataract Blind Despite Easily Accessible, Affordable Quality Service? Four-year Community-based Study

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ABSTRACT

Introduction: Cataract is a common cause of blindness in spite of providing free or subsidised cataract surgery in Indian sub-continent.

Objective: To understand why patients do not undergo cataract surgery despite availability of services in the vicinity of a low-income group settlement.

Methodology: This community-based survey was done over three years. A door-to-door eye screening was conducted in 2015-16 with a vision centre offering subsidised care. Census method was utilised for data collection. Those with operable cataracts were advised of the need for surgery. On follow-up visits in 2017, 2018, and 2019, those still visually impaired with unoperated cataracts were interviewed (questionnaire-based) to identify barriers to cataract surgery in an urban slum in Pune city, Maharashtra state of India, after ethics permission. SPSS.v16 software was used for analysis.

Result: The authors screened 45,535 individuals in 2015-16. In 2017, 474 still had blinding cataracts. Of them, 85 (25.8%) had undergone cataract surgery in 2018, and 245 still had cataracts. In 2019, of the 245 participants, 47 (24.7%) had undergone surgery, and 143 remained. The main barrier was the high cost (>50%) across all three years, especially among older respondents (2017, 2018: $p=0.006$; 2019: $p=0.01$). The other barriers were family/business obligations, and participants did not perceive cataracts as severe problem. This barrier was significantly more common among males ($p=0.039$) and those with longer cataract duration ($p<0.001$). Respondents with poor vision in the better eye had lower rate of family obligations as a barrier in all years (2017: $p=0.008$; 2018: $p=0.013$; 2019: $p<0.001$).

Conclusion: The community screening and vision centre addressed barriers such as lack of awareness, poor service and distance, but even the subsidised cost was a challenge. Family/business obligations and no prioritisation were other reasons. Qualitative research is needed to understand the dynamics of these barriers and design appropriate interventions.

Key words: Barrier; blindness; cataract surgery.

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INTRODUCTION

In India, nearly nine million people have cataract-related blindness (Global Burden of Disease Blindness and vision impairment collaboration 2019; Vashisht et al., 2022). The National Program for Control of Blindness (NPCB) was launched in 1976 to reduce the prevalence of blindness from 1.4% to 0.3% by 2020 (Varma et al., 2011). Rapid Assessment on Avoidable Blindness (RAAB) surveys in 2006-07 and again in 2016-8 showed 1% prevalence of blindness to be a significant economic burden on the community and the country (Neena et al., 2008; Mannava et al., 2022; Vashisht et al., 2022).

While cataract surgery has a very high success rate and is readily available and affordable, many people remain blind from cataracts, as reported in various studies (Neena et al., 2008; Vashisht et al., 2022; Gupta et al., 2024). Cataract surgery coverage was inadequate in many Indian states despite numerous efforts over the past few decades (Gupta et al., 2024). Lack of awareness (A), bad service (B), cost (C), and distance (D) have traditionally been considered the barriers to access cataract surgery. Numerous studies have reported barriers to accessing cataract surgery from India, but they have recruited patients who presented to an eye hospital's outpatient department (OPD) or an eye camp (Vaidyanathan et al., 1999; Finger et al., 2007; Dhaliwal 2007; Dharmadhikari et al., 2017; Chandrashekar et al., 2007).

This community-based study aimed to identify the major barriers to accessing cataract surgery in the urban slums of Pune city, Maharashtra state of India. This may be the first study to

actively screen and examine cataract-blind patients in the community and to understand why they chose not to undergo surgery despite awareness of the procedure and the availability of good care over a period of four years.

METHODOLOGY

This was a community-based, door-to-door survey, that was conducted in 31 slum areas of Pune City, Maharashtra, India. A vision centre was established in 2015 January, linked to a secondary eye care centre, which provided services at a subsidised rate. The questionnaire was adapted from previous studies (Dhaliwal et al., 2007; Dharmadhikari et al., 2017). The developed questionnaire was pretested to explore the family and community dynamics. A pilot test was done with multiple questions and those that were common were included. The questionnaire also had an item "any other reason." The project team consisted of four community health workers, one Master's in Social Work as coordinator, one data entry operator, two optometrists, a coordinator, and an ophthalmologist.

The examination protocol consisted of five sections: identification, vision testing and lens status, reasons for not having surgery, service indicators for those operated, and anecdotal information from the relatives if the person concerned was not present during the visit.

The first part of the study was completed between 2015 February and 2016 August. It consisted of a door-to-door survey in 31 slum areas, including parts of the Yerawada Area, Phule Nagar, Vishrantwadi, Mental Vasahat, Rajiv Gandhi Nagar, Indira Nagar, and Bharatnagar. The examination protocol

consisted of door-to-door screening by health workers using torchlight. They had been trained for two weeks to detect cataracts, squints, pterygium, and external ocular diseases like conjunctivitis. Visual acuity was recorded at six metres. "Cataract visual impairment" was identified as an obvious opacity in the lens with corrected vision of less than 6/18. These patients were referred to the vision centre, where a comprehensive eye examination was performed. The comprehensive ocular examination included vision testing, refraction, tonometry, fundoscopy, and ocular motility evaluation. For the physically handicapped, infirm, very old, or having any disability, an ophthalmologist conducted a home visit to examine them. The initial examination was performed by a trained optometrist, and the findings were confirmed by a senior ophthalmologist. All eligible patients were advised to undergo cataract surgery.

The methodology details have been published elsewhere (Gogate et al., 2022). The second part of the study was conducted as follows: Counselling for patients with operable cataracts was conducted in groups. They were informed about the diagnosis, treatment modalities, and available choices. They were also informed about the outcomes of non-intervention. They were thoroughly examined, and the diagnosis was confirmed. Surgery was offered at subsidised cost to all, Indian Rupees (Rs.) 4500 (US \$58) or free to the very old, single, widows, destitute, very poor, or those who had no caretaker. The surgeries were performed at the base hospital located three kilometres away.

Health workers re-visited the study participants in 2017 October, 2018 June, and 2019 March

to assess their status. During these visits, those who did not undergo surgery were interviewed and counselled by a community health worker and an ophthalmologist. They were then offered cataract surgery free of cost. Participants who had not undergone cataract surgery were asked about barriers to accessing cataract surgery using a pre-designed questionnaire. The pre-designed questionnaire included 13 closed-ended questions for pre-defined barriers and one open-ended question to identify other barriers to accessing cataract surgery (Annexure 1). Each participant could report as many barriers as they wanted.

The study protocol was approved by the Institutional Ethics Sub-committee of Doctor Dnyandeo Yashwantrao Patil (Dr. D.Y. Patil) Medical College, Pune City (Reference number: IESC/C-91/2019; Dated: 2019 May 15). Written informed consent was taken from each participant.

SPSS Statistics version 16.0 (SPSS Inc., Chicago, Ill., USA) was used to analyse the data. The data are summarised using frequency and proportions. The authors assessed the association of the top three reported barriers with age, gender, visual acuity, and duration of cataracts. To this end, these barriers were compared across various subgroups using the Chi-square test. The subgroups of age, gender, duration of cataract, and visual acuity were considered for comparison. The age groups considered were: group I <50 years, group II- 51 years to 60 years, group III -61 years to 70 years, group IV >70 years. The duration of cataracts (in months) was categorised into five groups: group I (<6 months), group II (7-12 months), group III (12-24 months), group

IV (24-36 months), and group V (>36 months). Visual acuity was divided into five categories: group 1:- 6/6- 6/9, group 2:- 6/12 to 6/18, group 3: 6/24 to 6/36, group 4: 3/60 to 6/60, and group 5:<3/60.

RESULT

During the study period, the team of four community health care workers screened the vision of 44,535 individuals from 9,213 households using torchlight. In total, 535 had unilateral cataracts, and 734 had bilateral cataracts in the initial survey. After examination by an optometrist and an ophthalmologist at the vision centre, 161 (0.36%) had vision <6/60, 118 (0.26%) had vision <3/60, and 43 (0.1%) had vision between 3/60 and 5/60. 208 of them had unilateral cataracts, and 599 had bilateral cataracts with vision <6/18. They were offered subsidised surgery. The status of the study participants during the follow-up period has been depicted (Figure 1).

After a one-year follow-up visit in 2017, out of 807, 149 undergone surgery at the study centre or elsewhere. The authors could identify 474 were still found to be blind or visually impaired with cataracts. This study reports the barriers in these 474 individuals who forms baseline for this study. Of these 474, 325 68.6% of them were women. Their ages ranged from 28 to 98 years (64 ± 9.8 years). The duration of cataracts ranged from one month to 20 years. 443/474 (93.4%) said they/their families knew about the cataract. Vision affected the daily living in some way of 464/474 (97.9%) individuals.

During the 2018 follow-up survey, of the 245 participants who could be contacted,

85 (25.8%) had undergone cataract surgery. In 2019, of the 190 participants who could be contacted, 47 (24.74%) had undergone surgery. At each follow-up visit, health care workers interviewed participants who had not undergone surgery using a barrier questionnaire.

Barriers to accessing cataract surgery reported by study participants at each follow-up period has been tabulated (Table 1). The cost of surgery was a major barrier throughout the study period (Rs. 4500, \$58). It was consistently reported by more than half of eligible cataract patients across all years of follow-up. The second most common barrier reported was family obligations. More than one fourth of the participants did not perceive the cataract to be a serious problem.

The authors assessed the association of age, gender, duration of cataract and vision in the between eye with the three major barriers that is, financial barrier, family /business obligations and do not have a serious problem.

A greater proportion of the respondents in the older age group reported financial barrier for accessing cataract surgery in all the three years of follow-up (2017 and 2018: $p = 0.006$; 2019: $p = 0.01$) (Table 2). There was no association of age with other barriers viz. family obligation and perception of cataract as a serious problem.

The distribution of the major barriers according to the gender were compared (Table 3). Family obligation was reported by a greater proportion of males in the first two years of follow-up ($p = 0.039$). This gender difference in family obligations was not observed in the third year of follow-up. There was no significant difference

in the other major barriers reported by male and female respondents.

A larger proportion of respondents with a longer duration of cataract reported financial barriers in the first two years of follow-up ($p < 0.001$). A lesser proportion of those with a longer duration of cataract reported family obligation as a barrier to accessing cataract surgery ($p < 0.001$) (Table 4). There was no association between the duration of cataract with the perception

of cataract as a serious problem for availing surgery.

A lower proportion of the respondents with very poor vision in the better eye reported family/business obligations as a barrier in all three years of follow-up (2017: $p = 0.008$; 2018: $p = 0.013$; 2019: $p = 0.001$) (Table 5). There was no association between the vision in the better eye vision with financial barriers and the perception of cataracts as a serious problem.

Table 1: Barriers to accessing cataract surgery reported by the study participants at each follow-up period.

Barriers	Year 2017 N = 474 n (%)	Year 2018 N = 245 n (%)	Year 2019 N = 143 n (%)
Do not have money to pay for eye checkup/surgery	272 (57.4)	138 (56.3)	78 (54.5)
Family/harvest/business obligations	188 (39.7)	110 (44.9)	73 (51)
Do not have a serious problem	139 (29.3)	73 (29.8)	43 (30.1)
Able to see adequately	89 (18.8)	46 (18.7)	23 (16.1)
Eye disease/decrease in vision are natural with growing old, and so do not need treatment	55(11.6)	33(13.5)	19 (13.3)
Eye checkups are not a priority because of other health problems	60 (12.7)	29 (11.8)	12 (8.4)
Afraid that seeing someone for an eye checkup would reveal vision loss, and therefore cause worry	48 (10.1)	29 (11.8)	15 (10.5)
The dominant person in the family did not feel the need to seek health care	20 (4.2)	14 (6.7)	7 (4.9)
Do not feel comfortable with the eye doctor/general medical practitioner that I have access to	8(1.7)	4(1.6)	3(2.1)
Have to travel far for eye checkup	15 (3.2)	9 (3.7)	4 (2.8)
Would like eye checkup but other medical problems prevent me from going	30 (6.3)	14 (6.7)	6 (4.2)
Do not know where to go for eye checkup	11(2.3)	7(2.9)	4(2.8)
No one willing to escort for the eye checkup	10 (2.1)	5(2)	3(2.1)
Others - wanted free surgery	141 (29.8)	73 (29.8)	49 (34.3)

Table 2: Distribution of the major barriers across the age groups over the three years of follow-up.

Year	Age group (years)	N	Do not have money to pay for eye checkup n (%)	Family/harvest/ business obligations n (%)	Do not have a serious problem n (%)
2017	≤50	59	24 (40.7)	40 (67.8)	15 (25.4)
	51 - 60	150	83 (55.3)	75 (50)	43 (28.7)
	61 - 70	174	115 (66.1)	59 (33.9)	50 (28.7)
	>70	90	50 (55.6)	14 (15.6)	31 (34.4)
	p-value*		0.006	0.993	0.653
2018	≤ 50	45	12(32.43)	26(70.27)	8 (21.62)
	51 - 60	108	47(67.14)	42(56.8)	19 (25.7)
	61 - 70	115	53(62.35)	35(41.17)	27 (31.76)
	>70	52	26(58.06)	7(22.58)	19 (39.6)
	p-value*		0.009	<0.001	0.252
2019	≤50	34	8(30.8)	18(69.2)	8 (30.8)
	51 - 60	41	29 (61.7)	32 (66.7)	11 (22.9)
	61 - 70	71	33 (64.7)	19 (37.3)	17 (33.3)
	>70	19	8 (44.4)	4(22.2)	7(38.9)
	p-value*		0.021	<0.001	0.552

*Chi-square test

Table 3: Distribution of the major barriers across gender over the three years of follow-up, n (%).

Year	Gender	N	Do not have money to pay for eye check-up	Family/harvest/ business obligations	Do not have a serious problem
2017	Male	148	83 (56.1)	69 (56.1)	40 (27.03)
	Female	325	189 (58.2)	119 (36.6)	99 (30.5)
	p-value*		0.646	0.039	0.447
2018	Male	77	41 (53.24)	38(49.35)	24(31.16)
	Female	168	97(57.73)	72(42.85)	49(29.2)
	p-value*		0.479	<0.001	0.75
2019	Male	44	25 (64.1)	23(59.0)	13 (33.3)
	Female	99	53(51.5)	50 (48.1)	30(28.8)
	p-value*		0.602	0.246	0.176

*Chi-square test

Table 4: Distribution of the major barriers according to the duration of cataract over the three years of follow-up, n (%).

Year	Duration of cataract	N	Do not have money to pay for eye checkup	Family/ business obligations	Do not have a serious problem
2017	≤6 months	79	26 (32.9)	40 (50.6)	23 (29.1)
	7 to 12	121	78 (64.5)	66 (54.5)	40 (33.1)
	12 to 24 months	231	139 (60.2)	73 (31.6)	61 (26.4)
	24 – 36	33	23 (69.7)	6 (18.2)	13 (39.4)
	>36 month	8	5 (62.5)	3 (37.5)	2 (25.0)
	p-value*		< 0.001	< 0.001	0.487
2018	≤6 month	34	15(40.5)	22(57.9)	11(32.35)
	7 to 12	61	42(63.6)	42(63.6)	24(39.3)
	12 to 24 months	121	66(54.54)	41(38.88)	31(25.61)
	24 – 36	14	13(92.85)	5(35.71)	6(42.85)
	>36 month	2	1(50.0)	0	1(50.0)
	p-value *		0.556	0.343	0.085
2019	≤6 month	32	11 (42.3)	14 (51.9)	7 (25.9)
	7 to 12	72	25 (56.8)	31 (70.5)	16 (36.4)
	12 to 24 months	74	35 (55.6)	23 (36.5)	16 (25.4)
	24 – 36	15	6(75.0)	5 (62.5)	4(50.0)
	>36 months	0	0 (0)	0 (0)	0(0)
	p-value*		0.362	0.006	0.362

*Chi-square test

Table 5: Distribution of the major barriers according to the vision in the better eye over the three years of follow-up, n (%).

Year	Vision in better eye	N	Do not have money to pay for an eye checkup	Family/ business obligations	Do not have a serious problem
2017	6/6 – 6/9	25	15 (60.0)	7 (28.0)	4 (16.0)
	6/12 – 6/18	159	95 (59.7)	77 (48.4)	51 (32.1)
	6/24 – 6/36	166	92 (55.4)	69 (41.6)	55 (33.1)
	3/60 – 6/60	83	49 (59.0)	28 (33.7)	17 (20.5)
	< 3/60	32	16 (50)	6 (18.8)	8 (25)
	p-value*		0.842	0.008	0.12
2018	6/6 – 6/9	29	11 (57.9)	11 (57.9)	7 (36.8)
	6/12 – 6/18	107	38 (51.4)	40 (54.1)	29 (39.2)
	6/24 – 6/36	125	56 (62.2)	46 (50.5)	25 (27.5)
	3/60 – 6/60	35	18 (50.0)	10 (27.8)	7 (19.4)
	< 3/60	20	13 (56.5)	3 (13.0)	4 (17.4)
	p-value*		0.624	<0.001	0.118
2019	6/6 – 6/9	11	3 (42.9)	5 (71.4)	3 (42.9)
	6/12 – 6/18	67	23 (53.5)	25 (58.1)	19 (44.2)
	6/24 – 6/36	82	33 (57.9)	35 (60.3)	14 (24.1)
	3/60 – 6/60	22	12 (57.1)	6 (28.6)	4 (19.0)
	< 3/60	9	6 (46.2)	1 (7.7)	2 (15.4)
	p-value*		0.896	0.001	0.085

*Chi-square test

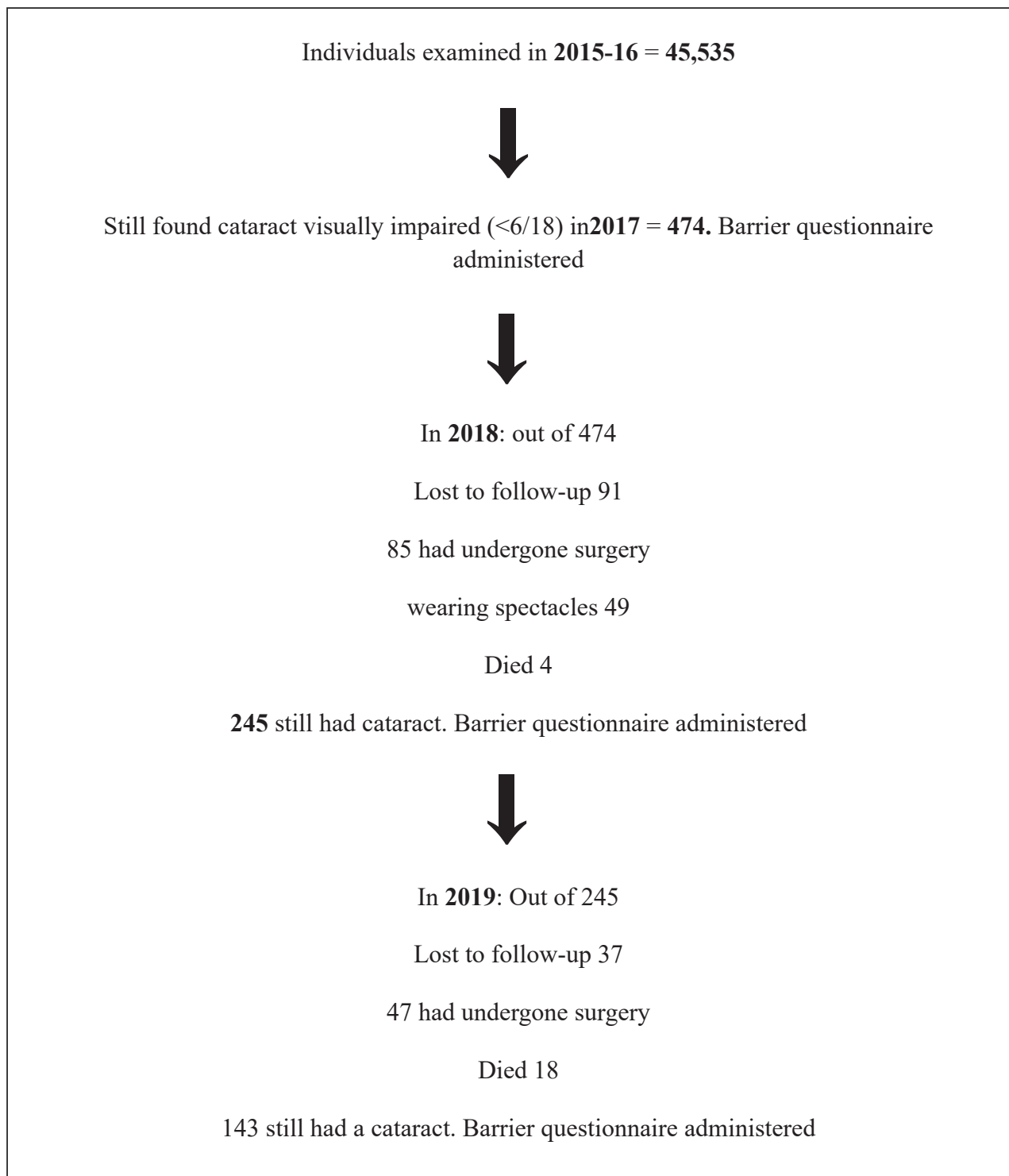


Figure 1: The number and status of participants recruited at baseline and retained at each year of follow-up.

Table 6: Comparison of barriers to cataract surgery in recent years across the world.

Author	Country	Year	Population	Main barrier
Lange N	Poland	2023	Nation wide	Cost of medicines for surgery is a barrier, widowed, single more likely to undergo surgery earlier
Omiya D	Nigeria	2024	South east Nigeria, RAAB	Gender is a barrier, so is cost
Ma X	China	2020	Rural China	Better vision
Awidi AA	USA	2023	Nation wide	Those with higher income and insurance are more likely to undergo cataract surgery
Yap JF	Malaysia	2022	Nation wide	Need not felt 43.5% Fear/poor result of surgery 16.2%. Reluctance for surgery is more outside the central zone
Al Sawahili H	Egypt	2020	Sohag governorate, RAAB	Cost 51.5%
Chariwala R	India	2021	Tribal belt of Gujarat, RAAB	Lack of escort 34.3%
Shen W	China	2020	Yunnan minority study	Lack of awareness, knowledge, cost, and fear

DISCUSSION

This study examined barriers to cataract surgery after establishing a vision centre and service facility in the vicinity and following patients for four years. The authors have identified the pattern of barriers to accessing cataract surgery during this period.

In this community-based follow-up study, only 1/4th of the eligible persons with operable cataracts underwent surgery during each follow-up period. A large longitudinal study from Poland (PolSenior) with a 10-year follow-up (2009 and 2019) showed that 1/3 still had

cataracts at the end of the follow-up period (Lange 2023).

Throughout the follow-up period, more than half of the persons with cataracts who did not undergo surgery reported financial barriers. Studies from Karnataka, Andhra Pradesh, and Pune, Maharashtra, have shown that financial factors are the most important barrier to accessing cataract surgery (Vaidyanathan et al., 1999; Finger et al., 2007; Dhaliwal et al., 2007; Dharmadhikari et al., 2017; Chandrasekhar 2007; Awidi et al., 2023). The second most common reason for not availing surgery was family/business obligations, due to which



participants did not prioritise surgery. A study from Delhi in 2007 reported similar attitudinal barriers to accessing care, where with 77% reported they could manage daily work, and 64% reported seeing clearly with the other eye (64%) (Dhaliwal et al., 2007).

A few participants reported logistical barriers, including travel, the availability of an escort, discomfort with doctors, and a lack of awareness of eye facilities. These have been reported to be important barriers to accessing cataract surgery in other studies (Dhaliwal et al., 2007; Lange et al., 2023). Fear of surgery or its outcome, which has been reported to be a barrier in other studies, was reported by a few respondents in current study (Finger et al., 2007; Chandrashekhara et al., 2007). The existence of the vision centre within the community and door-to-door screening with counselling services could have contributed to this finding, and is a positive verdict for the vision centre approach.

Another positive finding was no gender difference in the barriers, except for family/business obligations, which were reported more frequently by men in the first two years of follow-up. The previous publication reported that more women sought eye care in the vision centre, and there was a female preponderance in OPD attendance, spectacle prescription, and surgery uptake (Gogate et al., 2022). The vision centre established in this study had female preponderance in its staffing, population-based door-to-door survey, outpatient attendance, spectacle sale, and surgery uptake (Gogate et al., 2022).

Oniya from Imo, Nigeria, showed that women were twice as likely as men to be blind. There

were more elderly women in eye camps than men (Oniya et al., 2024). Similar results were reported in an Indian study (Gogate et al., 2002). Mailu et al., (2020) in a review, stated that surgical awareness campaigns, the use of successfully operated individuals as champions, the elimination of patient direct and indirect costs, regular community outreach, and the provision of high-quality surgeries. Ramke et al., also reported experimental and quasi-experimental evaluations of interventions to improve access to cataract surgical services, including the use of successfully operated persons as champions; removal of patient direct and indirect costs; regular community outreach; and ensuring high-quality surgeries (Ramke 2018).

The Finger et al., study from Andhra Pradesh in 2007 showed that a lack of access to funds was the main contributing factor, and stigma, fatalism, and ageism were the main barriers (Finger et al., 2007).

Barriers to accessing cataract surgery across various countries over the past few years have been compared (Table 6). In a study from rural China, those with poorer vision were more likely to undergo surgery (Ma et al., 2024). Those in income-generating activities, physically active, and who had a recent physical examination were more likely to have an eye examination (Ma et al., 2024).

Even in the United States, one of the most developed countries, individuals with higher income and insurance are more likely to undergo surgery (Awidi et al., 2023). Those not working were more likely to report having cataracts. In relatively developed Malaysia,

a RAAB study showed that the prevalence of cataract 26.8%. Need not felt 43.5% and fear/poor surgical outcome 16.2% were the major barriers. Reluctance to undergo surgery is higher outside the central zone of Kuala Lumpur (Yap et al., 2022). In a RAAB study in the Sohag governorate of Egypt, the most frequent barrier was cost (51.5%) (Al Swahli et al., 2020). In a RAAB study from the rural, tribal belt of Gujarat, only 36.4% were willing to pay for cataract surgery (Chariwala et al., 2021).

Shah, in a nationwide RAAB in Nepal, studies the barriers to the uptake of cataract surgery amongst the cataract-blind identified in the survey (Shah et al., 2025). Amongst the cataract blind respondents, the chief barriers were 'need is not felt' (33%), cost associated with surgery (30%), lack of access (13%), fear of surgery (12%), nobody to accompany (6%), and unaware of surgery (18; 3%). Nepal's difficult geography made a lack of access and no one to accompany a significant barrier. Need not felt, and the costs were similar to present study. In the Yunnan minority eye study from China, the main barriers to cataract surgery were a lack of awareness and knowledge, cost, and fear (Shen et al., 2020).

In Rwanda, a relatively less developed country in Africa, where cataract surgery was offered free, those likely to attend the surgical appointment who were literate had less than 8 children, poor visual acuity, access to a telephone in the family, had received a specific date, received a reminder, and reported no difficulty in walking. (Kitema et al., 2021). Many factors go into a patient's (and caretaker's) willingness to undergo surgery and then actually availing it.

Essue et al., tried a novel experiment to reduce the cost barrier amongst the women and the poor in Vietnam (Essue et al., 2021). They evaluated two programs: the first, eliminating medical out-of-pocket costs for small-incision cataract surgery; and the second, Program A, plus a voucher program covering non-medical out-of-pocket costs. Compared with the current, the incremental cost per year for Program A was estimated at \$833 396, and for Program B at \$1 641 835, each representing <0.01% of total health care (Essue et al., 2021). While the second program B was twice as costly, they represented just <0.01% of total health care expenditure.

The authors allowed participants to choose/ tick more than one barrier, as is the case in RAAB studies. No weight was given when multiple barriers were ticked. Only one question was open-ended. A community health worker was present when the response was recorded, so there is a potential for influencing the participant.

The limitations of the study were that the authors allowed participants to choose/ tick more than one barrier, as it is in RAAB studies. There was no weightage given, when multiple barriers were ticked. Only one question was open ended. A community health worker was present when the response was recorded, so there was a potential for influencing the participant. There would be a responder bias as the responses were subjective. There was some loss to follow-up over the four-year period.

The strength of this study is that it was a community-based study. The questions were asked in peoples' homes or courtyards, not when they visited the health centres. Earlier barrier

studies were based on asking patients when they reached the centre about what kept them away. But here the investigators had barriers as ascertained in the community. For the first time, the barriers are being considered not as a snapshot, but over the years on a longitudinal basis. Even subsidised surgery is considered expensive by some patients. And vision and eye care are not a priority for many. More public education is needed to increase awareness about how vision is important, even in sunset years.

CONCLUSION

The community screening and vision centre addressed barriers such as lack of awareness, poor service and distance, but even the subsidised costs were challenge. Family or business obligations and no prioritisation were

other reasons. Qualitative research is needed to understand the dynamics of these barriers and design appropriate interventions.

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