

BARRIERS IN RURAL OUTREACH EYE CAMPS – SANKARA EYE FOUNDATION

Dissertation Submitted to



The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

in

Development Management

by

Akshat Sharma

Under the Supervision and Guidance of

Dr. Himadri Sinha

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He comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning

We wish him all the best for future endeavours


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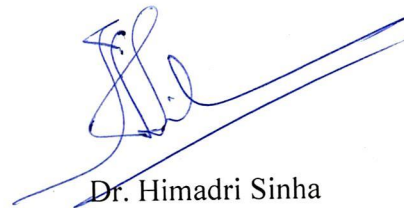
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This is to certify that Akshat Sharma in partial fulfillment of the requirements for the award of the degree of MBA (Development Management) from the IIHMR University, Jaipur has successfully completed his internship at Sankara Eye Foundation, Coimbatore during March 17th - June 13th, 2025.

IIHMR University, Jaipur

Date: 19th June, 2025

A blue ink signature of Dr. Himadri Sinha, consisting of stylized cursive letters.

Dr. Himadri Sinha

Provost, Professor and Dean

School of Development Studies

IIHMR University

DECLARATION BY STUDENT

I hereby declare that this dissertation titled **BARRIERS IN RURAL OUTREACH EYE CAMPS – SANKARA EYE FOUNDATION** is the Bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Akshat

Akshat Sharma

Date: 19th June, 2025

CERTIFICATE

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ABSTRACT

TITLE: Barriers in Rural Outreach Eye Camps – Sankara Eye Foundation

AUTHOR NAME: Akshat Sharma

ADVISOR NAME: Mr. Senthil Raj, Head CORP, Sankara Eye Foundation.

KEYWORDS: Cataract Surgery, Rural Eye Camps, Patient Unwillingness, Barriers to Healthcare, Health Literacy, Daily Wage Earners, Sankara Eye Foundation

BACKGROUND: Cataract remains the leading cause of avoidable blindness in India, disproportionately affecting rural populations with limited access to surgical care. To combat this, organizations like Sankara Eye Foundation conduct free outreach eye camps that provide diagnosis, transportation, surgery, food, and accommodation at no cost to the patient. Despite these efforts, a significant number of eligible patients decline to undergo cataract surgery. This paradox points to deeper, non-clinical factors that influence healthcare utilization in underserved regions.

OBJECTIVE: The objective of this study is to assess the psychological, socio-cultural, and economic barriers that contribute to unwillingness among patients at rural outreach eye camps and to provide evidence-based recommendations to improve patient counseling, and support mechanisms for increasing surgical uptake.

METHODOLOGY: This cross-sectional, mixed-method study was conducted among 48 patients who were eligible for cataract surgery but refused treatment. Data were collected using structured questionnaires and open-ended interviews. Quantitative data were analyzed using frequency distributions and percentages, while qualitative responses were subjected to thematic analysis. Sampling was purposive, focusing on high-refusal cases across multiple rural camps in Tamil Nadu organized by Sankara Eye Hospital, Coimbatore.

RESULTS/FINDINGS: A majority of patients were above 50 years (92%) and from nuclear families (77%) yet lacked practical support such as escorts or caregivers. Major reasons for refusal included: no one to accompany (14.6%), need for family consent (12.5%), fear of surgery (10.4%), and indirect economic concerns despite free services.

Daily wage loss, social obligations, and low health literacy (67% illiterate) further contributed to refusal. Cultural priorities like temple events and familial ceremonies often delayed or prevented surgical participation.

CONCLUSIONS: The study reveals that despite removing direct financial barriers, patients' decisions are shaped by psychological fears, lack of family support, cultural commitments, and perceived economic risks. These barriers must be addressed through targeted interventions such as family-inclusive counseling, visual health education, and community escort programs. Outreach models must evolve to address not just access, but acceptance—ensuring that patients not only receive the opportunity for sight restoration but feel supported enough to accept it.

ACKNOWLEDGEMENT

As I Am Approaching Completion of My Project Report, I Would Like to Take This Opportunity to Acknowledge the Invaluable Contributions to My Study, I Am Grateful While Expressing My Gratitude and Appreciation to My Esteemed Guide **MR. Senthil Raj, Head CORP, Sankara Eye Foundation**. His Unwavering Support, Encouragement and Guidance Have Been Instrumental Incompletion of My Dissertation. Throughout The Dissertation, His Guidance, Discipline, Foresightedness, Insights and Work Ethic Were a Great Source of Inspiration On me.

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CHAPTER 1

INRODUCTION

Introduction

In India, cataract is the leading cause of avoidable blindness, particularly in rural regions where access to surgical eye care remains limited due to logistical, economic, and awareness-related barriers. To address this public health concern, institutions like Sankara Eye Hospital have established a wide-reaching model of rural outreach eye camps aimed at screening patients, diagnosing cataract cases, and providing free-of-cost surgical intervention. These camps typically offer a holistic support system that includes transportation, meals, accommodation, and post-operative care at no financial burden to the patient. However, despite this inclusive model, a notable proportion of patients who are medically cleared and counseled at these camps ultimately decline to undergo cataract surgery. This behavior presents a critical bottleneck in the outreach program's effectiveness and raises important questions about the underlying causes of such refusal.

The purpose of this research is to explore and analyze the barriers that prevent patients—who have been selected and offered free treatment - from accepting surgical care in rural outreach camps. The problem being investigated is not related to diagnosis or cost, but rather the psychosocial, cultural, and economic factors that influence a patient's decision-making at the point of care. Often, these decisions are shaped by fear of surgery, absence of post-surgical caregiving, loss of daily income, or the need for family approval. The study is therefore situated in a broader context of understanding how health behavior is affected by personal, familial, and societal conditions in low-resource settings. This is particularly important as such behavioral barriers, if unaddressed, can significantly reduce the impact of public health programs and widen the gap between healthcare access and utilization.

The significance of this research lies in its potential to inform better field-level practices, improve patient counseling protocols, and enhance the design of rural outreach programs. By identifying the reasons behind surgical refusal, this study seeks to strengthen last-mile delivery of cataract care and support Sankara Eye Hospital's mission to eliminate preventable blindness through community-based strategies. Accordingly, the primary aim of the study is to assess the psychological, socio-cultural, and economic barriers that lead to unwillingness among patients at rural outreach eye camps. The secondary objective is to generate actionable

recommendations to improve patient engagement, communication, and support mechanisms, ultimately enhancing uptake of surgical services.

CHAPTER 2

REVIEW OF LITERATURE

Table 2.1: Summary of Literature on Barriers to Eye Care Services and Cataract Surgery Uptake

Author(s) & Year	Study Location	Sample Size	Methodology	Key Findings / Salient Features
Murthy & Raman (2009)	India	NA	Narrative Review	Emphasized the need for robust primary eye care in rural India. Identified lack of awareness and access as core barriers.
Sudhan et al. (2017)	Uttar Pradesh, India	400+	Cross-sectional survey	Found that fear of surgery and low health literacy were main factors for refusal of cataract surgery.
Verma et al. (2012)	Pan-India	NA	Policy Review	Evaluated the National Program for Control of Blindness; highlighted the need for better rural outreach integration.
Thulasiraj et al. (2018)	Tamil Nadu	NA	Case Study	Described challenges in scaling tele-ophthalmology in rural settings; cited myths and fear as common barriers.
Bastawrous et al. (2016)	Sub-Saharan Africa	NA	mHealth intervention study	Mobile eye clinics improved access, but uptake was limited by cultural misconceptions and fear.
Briesen et al. (2010)	Kenya	462 patients	Interview-based qualitative study	40% of eligible patients refused surgery due to fear, absence of escort, and income loss.

Author(s) & Year	Study Location	Sample Size	Methodology	Key Findings / Salient Features
Chan et al. (2012)	Nepal	386 patients	Mixed-methods survey	Identified social stigma, fear of complications, and long travel as significant refusal factors.
Brilliant et al. (1991)	South India (Andhra Pradesh)	2,005 patients	Epidemiological field study	50% of patients diagnosed with cataract refused surgery; major reasons included low perceived need and financial fears.
Gupta et al. (2009)	Bihar, India	300 patients	Hospital-based exit interviews	Found low awareness of free services, poor literacy, and patriarchal consent requirements were top barriers.
Lindfield et al. (2008)	Tanzania	982 patients	Quantitative patient records + interviews	Cultural beliefs and lack of transport were key factors in surgical refusal among rural elderly.

The reviewed studies, spanning India, Africa, and Southeast Asia, consistently reveal that barriers to eye care uptake are not only financial or logistical, but deeply embedded in social structures, psychological fears, and cultural beliefs. Across all geographies, a few key patterns emerge elderly patients often decline surgery due to fear or the absence of a trusted escort; literacy levels directly influence the understanding of the condition's severity; and women in patriarchal households may require spousal or family consent to undergo treatment.

In India specifically, the findings underscore that despite free services, dropout rates in outreach programs remain high due to lack of awareness, misinformation, and the opportunity cost of travel and missed wages. Studies from Uttar Pradesh, Bihar, and Tamil Nadu highlight the crucial role of community-based interventions, education drives, and

family-inclusive counseling. Internationally, successful strategies such as mobile screening units, mHealth technologies, and culturally sensitive communication have been shown to mitigate these challenges.

This literature forms a strong foundation for the present study, which focuses on the Sankara Eye Foundation's outreach program in Tamil Nadu. By contextualizing barriers among unwilling patients who refuse free surgery, this research aims to bridge the knowledge gap between diagnosis and action and improve the design of last-mile delivery in rural eye care.

CHAPTER 3

RESEARCH METHODOLOGY

Research Design:

This is a cross-sectional, mixed-method study that combines quantitative analysis with qualitative insights to assess barriers to surgical uptake among rural outreach camp patients.

Research questions:

- ❖ What are the psychological, socio-cultural, and economic factors influencing patients' unwillingness to undergo cataract surgery in rural outreach camps?

Objectives:

1. To assess the psychological, socio-cultural, and economic barriers that contribute to unwillingness among patients at rural outreach eye camps.
2. To provide evidence-based recommendations for improving patient counseling, education, and support mechanisms.

Hypothesis

Null Hypothesis (H_0): There is no significant association between patient-related factors and their unwillingness to undergo surgery in rural outreach camps.

Alternative Hypothesis (H_1): Patient-related factors significantly influence their unwillingness to undergo surgery in rural outreach camps.

Study Setting

The study was conducted in rural and semi-urban locations across Tamil Nadu, where Sankara Eye Hospital, Coimbatore, organizes regular outreach eye screening camps as part of its Gift of Vision initiative. Camps selected represented areas with significant refusal rates for cataract surgery despite eligibility and free support.

Study Population

- **Inclusion Criteria:**

Patients screened and selected for cataract surgery at rural outreach camps but who explicitly declined to undergo the procedure.

- **Exclusion Criteria:**

Patients who were deemed medically unfit or ineligible for surgery based on clinical examination.

Research Approach

The study integrated both quantitative and qualitative assessments:

- **Quantitative Component:**

Structured questionnaires captured demographics, economic background, and refusal reasons.

- **Qualitative Component:**

Open-ended interviews and subjective response sections explored psychosocial and cultural factors in more depth.

Sample Size

A total of 48 unwilling patients were purposively selected over a 3-month data collection period across multiple outreach camps. These patients were identified from the camp records and contacted for consent and inclusion in the study.

Sampling Techniques

- Purposive Sampling was employed to target only those patients who had refused surgery after being diagnosed and cleared for treatment.
- Sampling was stratified based on camp locations to ensure representation from different rural belts.

Study Instruments

- A structured questionnaire consisting of both close-ended and open-ended questions was developed to assess:
 - Socio-demographic characteristics (age, gender, income, literacy, etc.)
 - Type of barrier (economic, cultural, psychological)
 - Specific reasons for unwillingness

- The tool was developed in English and translated into Tamil for field implementation.

Operational Definitions

- **Unwilling Patients:** Patients who were medically eligible and offered free cataract surgery but chose not to proceed.
- **Barriers:** Any psychological, economic, social, or cultural factor that contributed to patient refusal.

Data Collection Procedure

Trained field investigators administered the questionnaire during and after the camps. Patients were interviewed in a confidential setting after obtaining consent. Responses were recorded manually and digitized for analysis.

Statistical and Qualitative Analysis

- **Quantitative Data:**
Analyzed using Microsoft Excel for generating frequencies, percentages, and cross-tabulations.
- **Qualitative Data:**
Open-ended responses were coded and grouped into themes using thematic analysis. Recurring patterns such as “fear of surgery,” “lack of escort,” and “economic hardship” were identified and analyzed narratively.

Ethical Considerations

- The respective department heads have thoroughly reviewed and discussed the ethical aspects related to the proposed dissertation topic. Based on their evaluation, they have confirmed the ethical appropriateness of the study and have granted approval to proceed with the research.
- Ethical clearance was obtained from the Institutional Ethics Committee of IIHMR University.
- Participation was strictly voluntary, and patients were assured that refusal or withdrawal would not affect their future access to care.

- All data was anonymized, and confidentiality was maintained throughout the research process.

CHAPTER 4

RESULT

Introduction to the Results

This chapter presents the findings of the study conducted on the barriers faced by patients who refused cataract surgery despite being screened and offered free treatment during rural outreach eye camps organized by Sankara Eye Hospital, Coimbatore. The analysis is based on a sample of 48 unwilling patients, and results are presented in descriptive format along with relevant percentages and thematic analysis.

4.1 Demographic Context

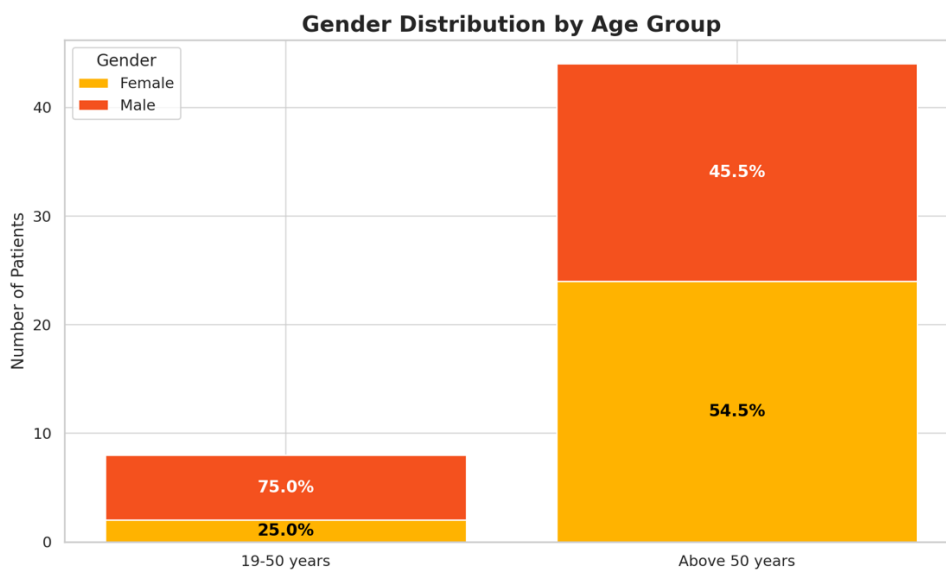


Figure 4.1: Distribution of respondent patients as per age and gender

Out of 48 patients who were interviewed, 4 (8%) were from 19-50 years age group and 44 (92%) belonged to above 50 years age group (Fig. 4.1). In 19-50 years 75% were male and 25% were female. Similarly, in above 50 years age group, 54.5% were female and 45.5% were male (Fig. 4.1). In contrast, the above 50 age group had a more balanced gender distribution, with 54.5% females and 45.5% males. This aligns with the higher prevalence of cataracts in elderly populations and underscores the relevance of targeting senior citizens in outreach screening efforts.

4.2 Psychological Barriers

Table 4.1: Patient-Reported Barriers to Undergoing Cataract Surgery

Reason for Unwillingness	Percentage (%)
No one to accompany	14.6%
Need family consent	12.5%
Fear of surgery	10.4%
No one to take care after surgery	8.3%
Loss of wage	4.2%
Distance problem, old age	4.2%
Surgery not required can manage without it	4.2%
Old age, No one to accompany	4.2%
Loss of wage, Fear of surgery	2.1%
Surgery not required can manage without it, No one to take care after surgery	2.1%
long travel, old age	2.1%
Grandson ill	2.1%
Family member death	2.1%
Loss of wage, Surgery not required can manage without it	2.1%
Postponed due to any occasions	2.1%
Nama Karanam of his grandchild	2.1%
Distance problem, Loss of wage, Need family consent	2.1%
Temple Function	2.1%
No one to take care of grandson	2.1%

Fear of surgery, Need family consent	2.1%
Fear of surgery, No one to accompany	2.1%
No one to take care after surgery, No one to accompany	2.1%
Distance problem	2.1%
No one to take care of livestock's	2.1%
long travel	2.1%
Distance problem, Loss of wage	2.1%

Table 4.2 presents a breakdown of the reasons cited by patients for refusing cataract surgery despite being eligible and offered free treatment. The most frequently cited barrier was “No one to accompany” (14.6%), followed by “Need family consent” (12.5%), and “Fear of surgery” (10.4%). Loss of wage—both as a direct and underlying factor—was reflected in 22.9% of responses. Other reasons included lack of caregiving support (8.3%), long travel/distance, and cultural obligations such as attending religious events or family functions. These responses demonstrate that the barriers are interlinked and multidimensional, requiring solutions that go beyond free surgery and address household, emotional, and logistical support needs.

4.3 Socio-Cultural Barriers

Table 4.2: Household Composition and Marital Status of Unwilling Patients

Family and Living Arrangements	Percentage (%)
Alone	6.2%
Joint/Extended Family	5.2%
Married	27.1%
Nuclear Family	38.5%
Widowed	22.9%

A majority (77%) lived in nuclear families, while 13% lived alone. Despite these living conditions, many patients reported having no one to accompany them for surgery or care for them post-operatively, revealing a disconnect between household structure and functional support.

4.4 Economic Barriers

Table 4.3: Environmental and Living Conditions of Unwilling Patients

Environmental Conditions	Percentage (%)
Borewell/Handpump	3.1%
Community Tap	13.5%
Concrete	13.5%
Hut	13.5%
Individually Tap	33.3%
Tiled roof house	22.9%

According to the data, 33.3% of patients had access to individual tap water, suggesting a moderately developed household setup; however, a notable proportion still relied on community taps (13.5%) and borewells or handpumps (3.1%), indicating that nearly 1 in 5 patients faced limitations in water access. In terms of housing, 22.9% lived in tiled-roof houses, 13.5% resided in huts, and only 13.5% had concrete housing. The fact that over 36% of patients lived in non-concrete or semi-permanent structures reflects low socioeconomic status and possible vulnerability. This environmental baseline is significant because poor housing conditions and inadequate water access often serve as proxies for poverty, limited mobility, and low health literacy—factors that can directly hinder surgical acceptance. Individuals living in such fragile environments may face heightened daily survival challenges and caregiving burdens, which deprioritize preventive or restorative health measures, including cataract surgery, even when they are offered at no cost.

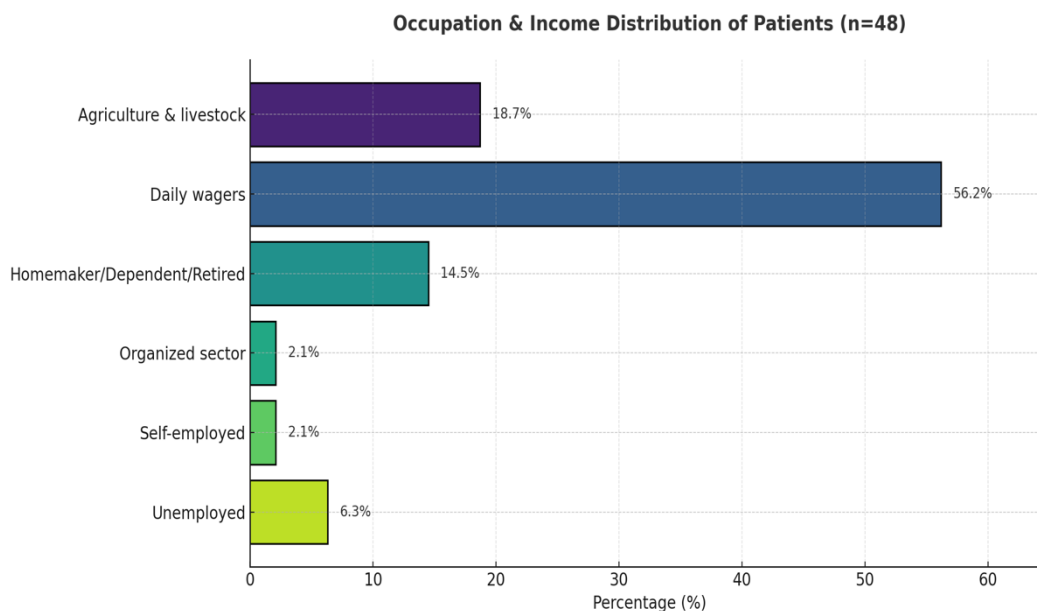


Figure 4.2: Occupation and Income Source Distribution of Patients Who Refused Cataract Surgery

The graph indicates that a majority of the patients (56.2%) were daily wage earners, followed by those involved in agriculture and livestock (18.7%), and homemakers, dependents, or retired individuals (14.5%). Smaller proportions included unemployed patients (6.3%), those in the organized sector (2.1%), and self-employed individuals (2.1%). This distribution suggests that most patients rely on occupations that may be disrupted by time away from work, which could influence their decision to decline cataract surgery despite it being offered at no cost. Even when surgery is offered at no cost, perceived loss of income, lack of job security, and daily subsistence priorities play a critical role in patient refusal.

Table 4.4: Distance from Patient Residence to Nearest Health Facility

Distance to Health Facility	Percentage (%)
3-5km	58.3%
Below 2km	27.1%
Above 5km	14.6%

The data shows in (Table 4.2) that 58% of respondents lived 3–5 kilometers away, 27% lived within 2 kilometers, and 15% were located more than 5 kilometers from a health center. These findings indicate that for a considerable number of patients, physical distance remains a barrier, especially for elderly individuals who may have difficulty arranging transportation or navigating unfamiliar settings. This also increases reliance on escorts, which as shown in earlier sections, is often lacking.

4.5 Literacy and Information Gaps

Educational Qualification of Patients (n=48)

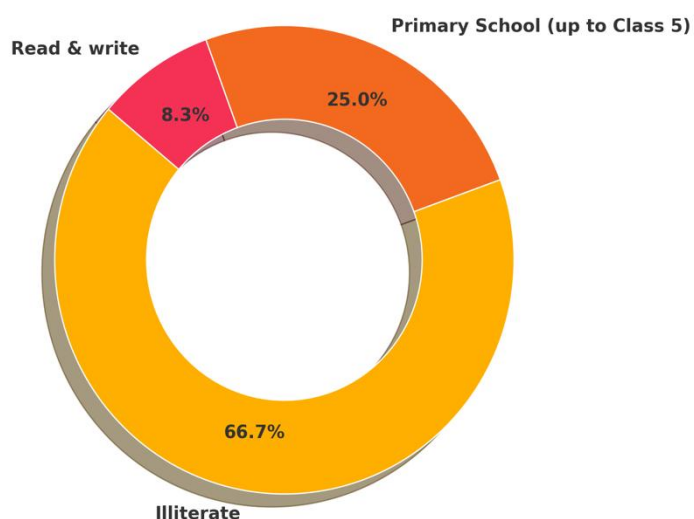


Figure 4.3: Educational Qualification of Patients Who Refused Cataract Surgery

The data shows that a significant proportion of patients (67%) were illiterate, while 25% had completed only primary school. Only 8% had the ability to read and write beyond a basic level. This low level of formal education has a strong correlation with misconceptions about cataract surgery, such as fear of the procedure or the belief that surgery is unnecessary. The lack of health literacy limits patient understanding of risks, benefits, and long-term vision outcomes,

making this a key barriers to surgical uptake.

Table 4.5: Access to Technology and Media Among Patients Who Declined Cataract Surgery

Technology and Media Access	Percentage (%)
Government TV	32.3%
Keypad	36.5%
LCD TV	4.2%
LED TV	8.3%

No TV	5.2%
No phone	10.4%
Smartphone	3.1%

The data captures the patients' access to communication and information channels. 73% of patients owned keypad mobile phones, 6% owned smartphones, and 21% had no mobile phone. Regarding television ownership, 65% had government-distributed TVs, 17% had LED TVs, and 10% had no TV at all. This limited access to digital and visual media significantly restricts the effectiveness of awareness campaigns and follow-up communication. It underscores the need for non-digital, community-based outreach such as in-person counseling, audio announcements, and visual posters in local languages.

CHAPTER 5

DISCUSSION

Introduction to the Discussion

This chapter discusses the key findings of the study and interprets them in the context of existing literature on barriers to cataract surgery in rural settings. It also presents the strengths and limitations of the study.

5.1 Interpretation of Key Findings

The present study aimed to explore the barriers that contribute to patient unwillingness to undergo cataract surgery despite being screened and offered free treatment during rural outreach eye camps. The results showed that a complex interaction of socio-economic, psychological, logistical, and cultural factors prevents patients from accepting surgical intervention.

A significant proportion of patients were aged above 50 (92%), consistent with the epidemiological profile of cataract burden in India. Despite the availability of free surgery and logistical support, the unwillingness rate reflects deep-rooted challenges not easily overcome by clinical offerings alone.

The most frequently reported reason for refusal was lack of accompaniment (14.6%), followed by need for family consent (12.5%), and fear of surgery (10.4%). These findings highlight a major gap in functional support systems and indicate that even patients residing in nuclear families (77%) may not receive adequate care during their treatment journey. A similar pattern was observed in a study by Briesen et al. (2010) in Kenya, where 40% of cataract-eligible patients refused surgery due to fear and absence of escorts.

Economic barriers also significantly influenced decision-making. In this study, 56% were daily wage workers, and 75% earned daily incomes, with over 79% earning less than ₹10,000 per month. These indirect costs (loss of daily income, household disruption) were cited in over 22.6% of refusal cases. Gupta et al. (2009) also noted similar findings in Bihar, India, where even free services were refused due to financial insecurity and the perception of hidden expenses.

Illiteracy (67%) was associated with misunderstanding or underestimating the necessity of surgery. Patients who believed their condition was “not serious” or “could be managed without surgery” often lacked basic awareness about cataract progression and outcomes. This is consistent with findings from Brilliant et al. (1991), who identified poor literacy as a key factor in refusal decisions in South India.

Furthermore, cultural and situational reasons—such as family functions, religious obligations, and caregiving for grandchildren—were also reported, mirroring findings from Chan et al. (2012) in Nepal and Lindfield et al. (2008) in Tanzania, where social expectations delayed or prevented surgical uptake.

Table - 5.1 Comparison with Other Studies

Study	Finding
Briesen et al. (2010) – Kenya	Escort unavailability and fear caused 40% refusal
Gupta et al. (2009) – Bihar	Daily wage loss and poor literacy led to refusal
Brilliant et al. (1991) – Andhra	Illiteracy strongly correlated with belief that surgery was unnecessary
Chan et al. (2012) – Nepal	Religious/cultural priorities interfered with surgery acceptance
Lindfield et al. (2008) – Tanzania	Fear, transport issues, and caregiving responsibilities blocked participation

This comparison confirms that the barriers identified in this study are not unique to Tamil Nadu or Sankara Eye Foundation, but part of a broader pattern of behavioral and socio-cultural resistance seen across low-resource settings globally.

5.3 Strengths of the Study

- ❖ **Focused Population:** This study exclusively examined patients who were eligible but unwilling, offering deep insights into last-mile barriers.
- ❖ **Mixed-Methods Approach:** The combination of quantitative and qualitative data allowed for both statistical patterns and contextual interpretation.

- ❖ **Real-World Setting:** Conducted during live outreach camps, the study reflects ground-level realities.
- ❖ **Comprehensive Dataset:** Socioeconomic, educational and psychological dimensions were all covered.

5.4 Limitations of the Study

- ❖ **Sample Size:** With only 48 unwilling patients, generalizability is limited.
- ❖ **Purposive Sampling:** The non-random sampling may introduce selection bias.
- ❖ **Self-Reported Data:** Responses are subject to recall bias or social desirability bias.
- ❖ **Geographic Scope:** Restricted to a single hospital network in Tamil Nadu, the findings may not apply to other regions or healthcare models.

5.5 Recommendations

Engagement and Counseling

1. Since lack of accompaniment and family consent are key barriers, implement pre-surgery counseling sessions involving patients and their family members, especially spouses and children, to address fears and clarify benefits and post-operative care requirements.
2. Use community health workers to facilitate family meetings to increase support and reduce refusal rates.

Address Psychological Barriers and Fear of Surgery

1. Conduct awareness campaigns using local languages and culturally appropriate messaging to demystify eye surgery.
2. Share testimonials of successful surgeries by local patients to build trust and reduce anxiety.

CHAPTER 6

CONCULSION

6.1 Conclusion for Objective 1: To assess the psychological, socio-cultural, and economic barriers

The study confirms that clinical eligibility and free services alone are not sufficient to ensure the uptake of cataract surgery in rural outreach settings. A significant proportion of patients refused surgery due to a complex interplay of psychological fears, socio-cultural norms, economic constraints, and logistical challenges.

The most prominent barriers included:

1. Lack of escorts and post-surgical caregivers, even among those in nuclear families.
2. Fear of surgery, often stemming from misinformation and low literacy.
3. Economic insecurity among daily wage earners, who feared income loss despite free treatment.
4. Cultural obligations such as religious events, family ceremonies, and caregiving duties, which were prioritized over surgery.

These findings align with national and international research, confirming that patient behavior is influenced by deep-rooted, context-specific factors—many of which are not visible during the screening process. The barriers are behavioral and social in nature, requiring a broader lens than just medical access.

6.2 Conclusion for Objective 2: To provide evidence-based recommendations for improving patient counseling, education, and support mechanisms

Given the multidimensional nature of refusal, the study proposes targeted, community-sensitive strategies to improve surgical acceptance among rural populations:

1. Family-inclusive counseling to involve spouses and key decision-makers.
2. Use of visual and verbal awareness tools—like storytelling, local testimonials, and simplified education materials in regional languages—to overcome illiteracy and fear.

3. Creation of escort and caregiver support systems, possibly through trained community volunteers or health workers.
4. Alignment of surgical camps with cultural calendars to minimize scheduling conflicts with local events.

These interventions go beyond traditional awareness models and address practical and emotional needs of patients. If implemented, such strategies can significantly improve patient confidence and support, bridging the gap between diagnosis and treatment in rural cataract programs.

Furthermore, the study identified the role of cultural and social obligations in shaping healthcare decisions. Events like temple festivals, funerals, family naming ceremonies, or the illness of a relative often took precedence over medical treatment. These findings highlight that healthcare behaviors are deeply embedded in the social fabric and cannot be addressed by clinical solutions alone.

When compared to other studies conducted in India and abroad, the results resonate strongly with existing global evidence—particularly from regions like Kenya, Nepal, and Tanzania—where fear, misinformation, gender roles, and logistical hurdles continue to impede surgical uptake. The similarity of barriers across different countries and cultures emphasizes the need for context-sensitive, community-based approaches that go beyond simply increasing the number of surgeries or outreach events.

By bringing these nuanced barriers to light, the study contributes valuable insights for improving the effectiveness of rural outreach programs like those run by Sankara Eye Foundation. The ultimate goal is not just to diagnose cataracts but to ensure that every eligible patient feels empowered, supported, and motivated to take the next step toward restoring their vision.

CHAPTER 7
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