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PUBLIC PERCEPTION OF EYE HEALTH CARE IN KENYA: A COMPARATIVE STUDY BETWEEN URBAN AND RURAL POPULATIONS IN ACESS TO EYE SERCIVES

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ABSTRACT

The paper will look at the ways the society has perceived ophthalmic services within Kenya with a comparison made between the urban and rural residents to explain how access, cultural beliefs and institutional structures influence the understanding of health seeking behaviors and ultimate outcomes. The analysis is conducted using a mixed-methods approach that combines quantitative data, qualitative interviews, and a desktop review and outlines eminent distinctions between the two milieus. City dwellers usually have better access to professional medical care, diagnostic supplies and facilities, which is directly converted into an increase in satisfaction and trust with the formal health system. Conversely, rural communities constituting nearly 70 % of Kenyans requiring eye care—encounter formidable barriers such as geographic remoteness, financial costs, inadequate infrastructure, a scarcity of specialists, and dependence on intermittent outreach programmes. The adoption of modern ophthalmic services is also hindered by the cultural bias on traditional medicine, which is supported by trust, familiarity and the historical mistrust of formal providers. National assessments, including MOH RAAB 2024 and ECSAT 2025, underscore the substantial prevalence of avoidable blindness in rural counties, the paucity of cataract surgical coverage, and persistent deficiencies in refractive services. Increasing primary eye care and enhancing awareness by the populace are key measures that cannot be done without in the reduction of preventable blindness and creation of parity in ocular health within the Kenyan population.

KEYWORDS: Refractive error coverage, cataract surgical coverage, health systems, eye care services, assessment of avoidable blindness, eye care situational analysis.

INTRODUCTION

The effect of vision loss is tremendous and has a significant influence not just on an individual but also on the entire society but there is little focus on ocular health care as a health priority by the population. Treatable and preventable conditions like cataracts and refractive errors are also a major part of the burden of blindness in Kenya, and their treatment is affordable (Achoki et al., 2019). The rise in non-communicable eye disorder is also an epidemiological transition in the country. Care barriers are multidimensional and include physical barriers, such as distance to the medical facility, and non-physical barriers, such as cultural and economic barriers and institutional barriers that exist within a cumbersome system of eye-health.

The Kenyan government has in turn incorporated eye care as primary health care and launched outreach programmes; but the rural-urban disparity still exists. The urban centers have better access to qualified staff, technology and infrastructures which means that the diagnosis and treatment can be timely done, but the rural areas have a problem of finding trained personnel and permanent facilities. As a result, many rural people turn to traditional medicine thus increasing the risks of blindness that can be avoided. Dibie (2025) points out that being blind is not only a dehumanizing physical health loss but also an economic and social loss, especially to the rural population whose economic existence is largely agricultural and informal. Here, the lack of proper eye care breeds more poverty and social marginalization and, therefore, the need to emphasize that the issue of ocular health exists beyond medical consideration and involves socio-economic aspects.

The paper will attempt to explain the perception of eye-care services in urban and rural Kenya. The study will help in informing more equal health policies by analyzing the factors which influence such perceptions, such as service availability, provider relationships, and cultural beliefs that would meet the needs of both urban and rural populations. Mailu et al. (2020) state that the level of knowledge on eye-health problems, as well as the dispelling of myths and misconceptions about treatment methods, are key determinants in increasing the use of eye-care services.

Theoretical and empirical foundations.

The conflict between the need and utilization of health services has been theorized as a public health discrepancy. Health attitudes have a significant impact on care-seeking behavior, claim adherence, and trust among providers. Abu et al. (2021) claim that perceptions are a socially constructed phenomenon, have a cultural context, and are influenced by the previous

experience of the individuals about the health system. Therefore, the social environment is behind the perceptions of health of people, which are shaped by the interactions between communities and the culture around health seeking behavior. Indicatively, in the example of a cultural belief, the populations that are used to the traditional remedies might be discouraged to access the modern medical services especially in the rural Kenyan areas (Baez-Camargo et al., 2020).

Attitudes of the population towards eye health, in particular, the role of cataracts and refractive errors, are deeply affected. These diseases are chronic; some of them remain untreated either due to ignorance about the severity of the diseases or lack of awareness about therapies that exist (Mailu et al., 2020). Therefore, people tend to get services when blindness or permanent impairment of vision has taken place. The health-behaviour theory suggests that people will approach health-care when they feel that the benefits will exceed the perceived barriers. When there is no sufficient information or confidence in the system, perceived benefits are not translated into action. Health outcomes are a serious issue in low- and middle-income countries like Kenya that will have to grapple with the existing perceptions of the populace. The gap between the perceived needs and actual utilisation may be increased by barriers such as low access, lack of services or skilled personnel and social or cultural factors.

Kenya Health System Decentralization.

In addition, in the decentralized health system in Kenya, eye care services have not been equally provided and available in rural and urban settings. Cities like Nairobi and Mombasa have better health care facilities and a greater and much more accessible number of trained professionals, which leads to greater satisfaction of clients and more chances to receive care in time. However, issues of costs and long queues even in such metropolitan regions remain (Gai et al., 2024). These barriers are also reinforced by income inequality since comparatively cheap services might not be accessible to large groups of people. The case is even more disadvantaged among rural populations in Kenya. Most of these regions do not have permanent facilities and trained eye care personnel hence producing little or no access to any eye care interventions. The outreach efforts have been introduced by state and non-governmental organization (NGO) actors but their implementation and effectiveness have been illustrated by occasional deployment and poor effects of providing long term care (Palmer et al., 2014). In this regard therefore because of the lack of a steady, reliable model of service delivery in rural Kenya, the quality of care suffers, creating a vicious circle of

service avoidance. People in these locations tend to postpone care, use alternative solutions or access inaccessible or prohibitively priced care**.**

Cultural Beliefs and Health Seeking Behavior.

Cultural beliefs and health-seeking behavior are among the determinants of low uptake of formal care on the part of rural residents. According to empirical findings, traditional healers are the initial approach in most cases of people with ocular health issues (Baez et al., 2020). This is especially high in societies where traditionalism has been ingrained in the everyday existence of people. An example is the situation in which some rural communities view modern medicine as alien and they, as a result, shun it to adopt practitioners that are consistent with the cultural beliefs of the community. A rural interviewee expressed this point of view when he explained that he goes to the local herbalist when he has issues with his eyes since the herbalist knows our culture and has methods of healing that are effective in us. On the community level, the preference of traditional medicine to the available and affordable health services creates a mistrust attitude in the general sense of the official health systems. Earlier negative experiences, misinformation, and lack of culturally competent communication in the formal health care environment have developed distrust in these populations (Mailu et al., 2020). This distrust can be the catalyst behind the treatment delays or worsening of the health conditions that would otherwise be alleviated had the patient sought timely treatment.

Health Service Use Theories.

Perceived need is one of the variables that is critical in all theories of health care utilization. Both the Health Belief Model and the Theory of Planned Behavior emphasize on individual perception about the severity of the disease, as well as the assessment of costs and benefits of seeking care. As an example, a person who considers the ocular afflictions insignificant or sees no much gain in the case of medical intervention is less likely to seek treatment. On the other hand, eye care users who consider it as a necessity and achievable are more likely to utilize accessible services. The theoretical viewpoints are especially relevant to the Kenyan situation, in which the obstacles to eye care include both logistical issues, including distance to services and access to facilities, and cultural factors and distrust of the formal health system. As a result, patients can delay the need to receive formal treatment of a curable eye disease until permanently blind. To deal with this problem, in addition to improving physical

service accessibility, there should be an active concerted effort to improve the general knowledge of eye health as well as promote an earlier onset of treatment-seeking behavior.

METHODOLOGY

In the current study, the mixed-methods design was used, which entailed the combination of desk-based literature review, as well as qualitative and quantitative data collection to explain the perceptions of the populace towards eye health care in Kenya. This combination in a methodology helped the capture of general and statistically sound observations in large samples and, at the same time, offered a detailed insight into the divergent eye health experiences in the rural and urban environment.

Findings

The MOH-National Eye Health Strategic Plan 2020-2025

The report strategic plan indicates that the rural population in Kenya is 32,732,596 (68.8%) and urban population is 14,831,017 (31.2%). Rural areas host 68.8% of the population but often experience limited access to specialized eye care compared to urban centers. Urban regions benefit from higher population density, better-equipped facilities, and greater availability of ophthalmologists and optometrists. Rural areas rely heavily on primary health workers and community volunteers for early detection and referral, which may delay timely diagnosis and treatment.

Rapid Assessment of Avoidable Blindness (RAAB) 2024

The survey on RAAB was carried out in 15 out of 47 counties in Kenya. Similar counties in terms of demographics and geography were combined to create one survey unit and ten survey units were created. The counties that were surveyed included Vihiga, Bomet, Nakuru, Kajiado, Kiambu/Meru/Tharaka Nithi, Kakamega/Busia, Kwale, Turkana, and Homabay/Migori. The general purpose of this survey was to produce evidence-based information that can be used to inform the policy, allocation of resources and improvement of services related to the eye health.

It is estimated that 15.5 0 percent of Kenyans (7.5 million people) have eye ailments that require eye health services to avoid sight impairment (Estimated Needs Survey -2013). Only 0.5% of the Kenyan population is estimated to be blind (5 persons/ 1,000) as of 2005. Out of the 7.5million people in need of eye care services, 68.8% are in rural regions as compared to 31.2% based in urban regions. Therefore, an estimated person in every three Kenyans whose eyes need attention is in an urban setting, and one in every three is in rural setting where the

provision of eye care services is generally less than the national data on services provision and access issues.

The rural counties, including Turkana, had much higher rates of blindness (6.2 per cent) and visual impairment (3038 per cent) along with very minimal rates of cataract surgical coverage and refractive error correction as reported by the RAAB report. In contrast, urban and peri-urban counties such as Nakuru demonstrated markedly lower blindness prevalence (0.8 %) and superior access to cataract and refractive services. Such differences indicate the availability of workforce, density of facilities, socioeconomic indicators, and infrastructure. Such obstacles as the expense of the surgery and spectacles, perceived insufficiency especially in rural communities, lack of awareness, long distances to eye-care centers, ophthalmologists, optometrists and diagnostic tools necessary to assess the eye conditions such as biometry devices are the key barriers. Urban areas still experience restrictions in terms of refractive coverage of services but overall fare better in terms of indicators of access.

Eyecare Situational Analysis in Kenya 2025-ECSAT Report.

According to the report by the World Health Organization, the situation with rural territories is the shortage of facilities, a long journey, and a shortage of specialists, and urban areas have more facilities capacity but still face the issue of personnel such as the perception of lack of need and affordability problems. The report also states that 46 percent of the patients, who are referred to the rural areas, get taken care of, with the adult population of less age of males being the least probable to be taken care of. Outreach services and teleophthalmology also have an advantage over the rural population, whereas the mechanisms of financing and digital technologies influence them unevenly. The access is still limited due to the geographic and financial factors, such as the travel time and cost. It is also found that there are significantly different perceptions of eye health care among urban and rural people.

The level of satisfaction with care, the degree of trust in health care providers and access to better services are usually higher in urban populations, which might be explained by the proximity to better health facilities and professional staff, however, the cost factor cannot be considered the full explanation of the presence of long waiting lines even in urban areas. The wider picture scenario, according to Gai et al. (2024), partly exacerbates these difficulties, in that people in certain layers of society cannot use the existing, albeit unavailable, services. This is even worse in the rural regions, where the respondents often mention the unavailability of information regarding services, distance, and cost, as among the obstacles to accessing eye care. Without professional personnel and eye premises, over 50 percent of the

rural population uses informal or traditional modes of attendance. The reliance on traditional practices of treatment is also an additional cultural obstacle to formal access to eye care, with the qualitative interviewing showing that a significant percentage of interviewees in the rural areas would choose the local methods of administering herbal remedies rather than a doctor administering treatments. These remarks agree with Mailu et al. (2020), who state that the primary solutions to these problems are the attitudinal change among the general population and increased awareness of the necessity of paying more attention to the health of the eye. Cultural beliefs and distrust of the formal health sector will prove to be the key barriers to eye-care seeking among the rural populations. Baez-Camargo et al. (2020) claim that this type of mistrust prevents the trust in getting quality health care and proper treatment. In Kenya, the formally integrated indigenous medicine with mainstream health system is culturally accepted and theoretically, it could eradicate disparities and improve access to the eye care services. The possible integration tools are to train community health workers to work with modern and traditional providers and refer patients to more formal care when needed. Dibie (2025) argues that cultural practices can either be used as a complement to the formal system hence promoting the uptake and use of modern medicine.

Recommendations

Enhance Rural Health Infrastructure Investments: Governments are encouraged to invest more in long-term permanent eye-care in rural health facilities so as to have the supply of well-trained ophthalmologists and optometrists. Comprehensive, integrated care that reaches underserved populations should be included in the outreach programs. To resolve the reliance on transitory outreach programs, in effect, one will have to create permanent eye-care facilities in the villages as suggested by Palmer et al. (2014). Low-priced Services: Eye care is expensive especially in the rural regions. The government would provide financial support or allow the involvement of a public-private partnership to make service provision a financially sustainable one. Joint partnerships with banks and NGOs to offer low-interest loans to the eye treatment can also be established. Achoki et al. (2019) go ahead and note that improving financial accessibility is an important first step in increasing uptake, and it is particularly relevant among low-income populations. Education and Awareness Programs: Due to the lack of awareness about the possibility and quality of the services provided by eye-care to the rural population, special educational programs are required. The public cognition could be redefined by providing public awareness campaigns, which would be conducted by reliable local staff, like community health workers, and in turn increase the

demand towards the eye care. Include Traditional Medicine: Due to the rich culture attached towards traditional medicine in rural areas, it may be necessary to incorporate the same into the mainstream health care system, as it would be a means of gaining better acceptance and encouraging rural populations to accept eye-care services. This could involve training community health workers in both traditional and modern medicine or collaborating with local herbalists to refer patients to formal eye-care services when necessary. Assimilation into culture can also help to implement new treatment methods and improve health (Dibie, 2025). Develop Trust in the Healthcare System: To increase the use of eye-care services, there is a need to build back the social trust in the health care system. Providers and government should focus on the quality of the services, dump unnecessary waste, and increase transparency in health-care delivery. Baez -Camargo et al. (2020) outline the provisions on accountability and good governance as essential factors to attain restoration of public confidence in the health system. Growing Digital Health: mHealth and telemedicine platforms have the potential to make a significant addition to the access to eye care in remote areas. Mobile health programmes can also support follow-up and consultations and check-up reminders and thus provide better access to eye-health services in rural situations. The solutions demand the support of government and the private sector in order to be scaled as promoted by Rono et al. (2021).

The 2024 report, Rapid Assessment of Avoidable Blindness (RAAB) and the 2025 report, Eye Care Situational Analysis (ESAT) propose the incorporation of eye care in the primary health care systems to expand the coverage especially in rural and remote counties. They suggest the development of the workforce in the eye-health sector with the help of training and placing ophthalmologists, Ophthalmic Clinical Officers (OCOs), and optometrists and creating clear staffing standards. It is proposed to improve finances, such as special county-level funding of eye health, which would decrease out of pocket costs on cataract surgery and spectacles. There should be the growth of community awareness programs that would cater to the needs that are not met, fears of surgery, and the misconception about cataract and refractive errors. The reports endorse hub-and-spoke delivery models linking county referral hospitals to sub-county facilities to enhance continuity of care and recommend augmenting diagnostic capacity and postoperative quality via investments in biometry, refraction services, and standardized surgical audits.

CONCLUSIONS

The purpose of the study was to have a refined insight into the perceptions of eye-health service among urban and rural Kenyan people. The results suggest a significant difference in service availability, access, trust in providers, and satisfaction with care among urban and rural respondents. Although the urban population had rather positive rates of trust and access, there was a strong distance problem, costs, and cultural aspect, which affected rural populations, thus justifying the reduced use of formal eye-care services and higher rates of traditional medicine use in rural areas. These findings support the findings of the studies conducted by Achoki et al. (2019) and Palmer et al. (2014), who reported the lack of adequately trained professionals and eye-care centers in rural Kenya. The paper also confirms the need to provide eye-care services to the rural population and change attitudes toward the importance of professional treatment. Additionally, the National Eye Health Strategic Plan 2020-2025 underscores the need to strengthen primary eye care, promote equitable specialist distribution, enhance referral systems, and invest in county-level infrastructure to mitigate preventable blindness.

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