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THE ROLE OF CULTURAL BELIEFS ON EYE HEALTH PRACTICES ACROSS COMMUNITIES IN DISTRICT RAHIM YAR KHAN

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Abstract

Background: *Cultural attitudes significantly influence health behaviors, especially in under-resourced communities where home remedies are often preferred over professional medical care. Eye health practices in such settings are shaped by traditional beliefs and cultural norms, which can impact the timely adoption of professional eye care services.*

Objectives: *To examine the impact of cultural attitudes on eye health practices in communities of District Rahim Yar Khan. To explore health-seeking behaviors and dependence on traditional remedies.*

Method: *A purposive convenience sampling technique was employed to select 334 participants from various communities in District Rahim Yar Khan. Data were collected using a structured questionnaire and analyzed through SPSS version 27.*

Result: *Findings revealed that most participants had a reasonable to good understanding of eye conditions such as glaucoma, diabetic retinopathy, cataracts, and dry eye syndrome. However, only 50.8% had ever visited an eye specialist. Cultural practices such as using surma, honey, rose water, breast milk, and herbal mixtures were common for treating eye discomfort, vision enhancement, and cosmetic purposes. Approximately 36.2% of participants believed in myths, such as glasses weakening eyesight and eye surgery posing spiritual risks. Despite these beliefs, professional care was not entirely rejected. A generational shift was observed, with younger and more educated individuals showing skepticism toward traditional remedies. Cultural knowledge was strongly passed down among rural women.*

Conclusion: *The study highlights the significant role of cultural beliefs in shaping eye health behaviors in under-resourced communities. It underscores the need for culturally sensitive health education, improved accessibility to professional eye care, and targeted awareness programs that address both*

cultural values and medical risks. Incorporating these strategies could enhance acceptance of professional care and improve overall eye health outcomes.

INTRODUCTION

Culture affects mental discomfort, social problems, physical illness, and how emotions are perceived, experienced, and expressed. Cultural perspectives on what constitutes illness and how to treat it vary widely.[1] People from diverse cultural origins often assign illness, health, disease, symptoms, and therapy in different ways. Since the beginning, medical professionals have had to take cultural differences in health attributions into account. Over time, attributes play a critical role in the formation of concepts related to health and illness. This relationship then becomes reciprocal, and health beliefs influence how people ascribe things by forming a cognitive schema. For instance, African Americans in the US could be more likely to externally attribute illness to fate or God's will (equity attributions) and to believe in the curative power of prayer.[2]

"Culture" usually refers to the specific beliefs and behaviors that define a social or ethnic group. A strong deterministic force that shapes people's thoughts and actions is culture. When we visit to other countries, especially those that are outside of our own continent, the influence of culture becomes evident. When we observe cultural differences, we may experience confusion and anxiety in addition to surprise, curiosity, and delight. These intense feelings and emotions are a reflection of the wide range of cultural variation and the impact that culture has on people of all ages. The notion that culture affects behavior and thought is not controversial because, of course, such findings are not new. But more lately, a continuously expanding corpus of research has shown evidence that culture affects visual perception as well.[3]

In the study's context, culture refers to the common customs, values, and beliefs that are transmitted from one generation to the next and are impacted by social institutions, religion, and ethnicity.[4] The effectiveness of medical therapies and the degree to which patients adhere to their treatment programs can also be influenced by cultural norms and beliefs. However, in order to provide culturally sensitive care and improve patient outcomes and reliability, healthcare providers must understand how cultural beliefs impact the behavior of those seeking medical attention. By understanding cultural practices and beliefs, medical personnel can better tailor their treatment plans and communication to the patient's values and preferences. Better overall health outcomes, more therapy adherence, and higher patient satisfaction can result from this.[5]

Eye health and vision have a major impact on many aspects of life, health, sustainable development, and the economy. However, a lack of access to highquality, reasonably priced eye care still affects a large number of individuals, families, and populations today, resulting in blindness and visual impairment (VI).[6] With 2.2 billion people worldwide suffering from only vision impairment, more than half of which is treatable or preventable, eye health is an important but under-prioritized component of global public health. Because of socioeconomic and cultural constraints, health-seeking behavior is still low in developing regions, despite breakthroughs in eye care. Designing successful treatments requires an understanding of these elements.[7] Visual impairment (VI) and blindness affect over 4.2 million Americans over the age of 40. .[8] In the United States, blindness is defined as having a central visual field of ≤20 degrees in the better eye or a bestcorrected visual acuity of 20/200 or below. Although some studies use 20/40 or worse in the better eye, the accepted definition of visual impairment is bestcorrected visual acuity (VA) of 20/70 or worse in the better eye. By 2050, it is predicted that the overall number of blind and VI-affected people will more than triple to 6.95 million.[9]

The prevalence of VI and other eye problems may differ by sex and gender, race and ethnicity, socioeconomic status (SES), and geographic region, and they may also increase with age. Chronic diseases were also shown to be more common in older persons with VI than in those without VI.[10] Understanding the causes of VI and blindness is

essential to addressing ocular health disparities and enhancing health equity for all groups. Vision impairment is still a major worldwide health concern in developing nations, despite the fact that 80% of cases are believed to be treatable and reversible.[11]

Millions of children worldwide suffer from visual impairment, which can have a long-lasting effect on their quality of life and academic performance. Refractive error, the most prevalent cause of visual impairment in children, can be addressed with affordable interventions including the use of spectacles and school-based eye screening programs. Parental awareness and understanding (parents not knowing their children need eye exams), cultural beliefs (reliance on traditional medicine, stigma of spectacles), lack of government support (lack of funding and policy), affordability (cost of examinations and spectacles), and limited access (limited number of specialists and clinics) were the main barriers to receiving eye care.[12] Globally, it is estimated that over 285 million people suffer from visual impairment, with 246 million having poor vision and 39 million being blind.[13] Untreated refractive errors and cataracts are the two main causes of blindness and visual impairment worldwide.[14]

In certain societies, particularly those with strong religious beliefs, cataracts are seen as a divine punishment or design. As people mature, this opinion could become more pronounced. For example, there is a superstition in Taiwan that during the lunar ghost month, surgery—especially cataract surgery—is unfortunate. Consequently, fewer procedures are carried out during that period.[5] Millions of people's lives could be significantly improved by effective and affordable eye care, since most causes of visual impairment are avoidable or treatable. According to the World Health Organization (WHO), eye care is a worldwide health priority. The WHO World Report on Vision provides information on the worldwide obstacles to eye care. Lack of qualified eye care providers, inadequate integration of eye care services into health systems, and disparities in the caliber and availability of treatments for prevention, treatment, and rehabilitation are some of these issues. These challenges are more acute in countries with lower and moderate incomes.[15]

A significant determinant of eye health outcomes is eye health literacy. A number of factors related to the aging population and other significant health determinants, including socioeconomic status, environmental, cultural, individual, behavioral, and biological factors, are contributing to the rise in ocular illnesses. Thus, it is crucial to comprehend the role that health literacy plays in encouraging preventative measures, early detection, and timely treatment of eye disorders. The main causes of permanent vision impairment at the moment are age-related macular degeneration, diabetic retinopathy, and glaucoma.

Nevertheless, not enough research has been done on how improved eye health literacy affects these conditions.[16]

Cultural background influences health beliefs and behaviors and, as is increasingly acknowledged, can influence how a patient and a practitioner interact. However, little is known about how cultural diversity affects clinical judgment and how optometrists react to culturally based ideas of health in the context of optometry. Patients' and optometrists' clinical relations might be influenced by culture. Differences in health practices and attitudes that are driven by culture might negatively impact clinical interactions. Clinical encounters may suffer as a result of culturally based variations in health practices and attitudes. It might be challenging to negotiate culturally based disparities, attitudes, and values (pertaining to eye health).[17]

Traditional and folkloric traditions for eye care are strongly ingrained in many cultures.[18] Numerous physical and psychological problems, as well as disasters, have been linked to the effects of the evil eye.[19] Belief in the evil eye itself may be considered a cultural practice, but actions against it may be viewed as culturally hostile. The phenomena of evil eye is not limited to culture. Both a cultural practice and a cultural-opponent act comprise a cultural case. Many cultural anti-evil-eye customs exist all throughout the world. But some amulets and rituals are unique to the region.[20]

In Yemen, a nation with a sizable Muslim population, research has shown that reciting passages from the Quran and praying duas have been used to treat glaucoma and retinal eye problems. Many rural

cultures worldwide hold the belief that disabilities, including vision impairment, are the result of witchcraft or are retribution for past actions by a member of the disabled person's family.[18]

Preventive eye care is highly valued in Japan starting at a young age. Children are taught the value of good posture, sufficient lighting, and consistent eye workouts in order to avoid myopia and eye strain. The Japanese are dedicated to preserving their best vision throughout their lives, which is shown in this proactive attitude to eye health. Traditional healers are important contributors to the provision of eye care in many African societies. In order to cure a variety of eye diseases, these healers frequently combine traditional beliefs with contemporary medical procedures, using medicinal herbs and spiritual rites. In African communities, the interdependence of physical, emotional, and spiritual well-being is highlighted by this holistic approach.[21]

Herbal plants have been utilized in traditional medicine for a long time to cure a variety of human illnesses in different parts of the world. The most common disorders that impact the eyes include inflammation, allergies, glaucoma, cataracts, and conjunctivitis. Nowadays, the usage of herbal medicines to cure eye illnesses has expanded due to the issue of current pharmaceuticals' negative side effects.[22] Herbal medicines and superstitions are common in eye care procedures throughout Latin America, especially in nations like Mexico and Guatemala. Many herbal medications are commonly used to improve and strengthen vision. Known for their antioxidant properties and ability to improve ocular circulation, they include bilberry, triphala, and ginkgo biloba. Foods like leafy greens, carrots, and omega-3-rich fish are also beneficial for overall eye health.[23]

Retinal ganglion cells (RGCs) and their axons degenerate in glaucoma, causing a restructuring of the tissue that impacts the retina and the optic nerve head. Lowering intraocular pressure, a major risk factor for progressive visual nerve injury, is a special emphasis of glaucoma treatment. Nowadays, more and more people are turning to natural remedies including vitamins, minerals, and plants. Even though plants are a great source of new physiologically active substances, only few of them have undergone phytochemical analysis and been assessed for possible medical uses. Because herbal medications are so widely utilized, eye care providers must educate their glaucoma patients about their effectiveness, safety, and treatment options.[24]

Caffeine, which is found in coffee and tea, inhibits adenosine receptors and influences choroidal thickness, intraocular pressure, tear production, and macular perfusion, among other aspects of eye health. There is also conflicting information about its impact on myopia/hyperopia, diabetic retinopathy (DR), retinopathy of prematurity (ROP), central serous retinopathy (CSR), dry eye (DE), and macular degeneration (MD). Caffeine does not seem to be a risk factor for dry eye, despite research suggesting that it may offer protection against wet age-related macular degeneration (ARMD). Alternatively, a more promising treatment for myopia might be the metabolite 7-methylxanthine.[25]

Chamomile tea is believed to have soothing properties for tired eyes, while placing a piece of potato over the eyelids is thought to reduce puffiness. These cultural rituals reflect a deep-seated belief in the power of nature to heal and protect vision. Even in Western cultures, where modern medicine prevails, there's a growing appreciation for holistic approaches to eye care. Practices like yoga and meditation are increasingly recognized for their benefits in promoting overall eye health and reducing eye strain caused by digital screens. Traditional eye medication (TEM) use has long been associated with detrimental consequences on eye health. In order to treat TEM, many hazardous treatments are applied to the eye. Traditional eye practices are defined as activities that include the use of TEM, performing sacred rituals and prayers, or ophthalmic self-medication to cure an ocular ailment.[26]

Ayurveda, an ancient medical system, places a strong emphasis on holistic methods of preserving eye health in Indian culture. The use of herbal eye drops and eye exercises like Trataka (gazing at a fixed spot) are only two examples of the many natural therapies for eyesight care that Indians have long practiced.[27] With an estimated one million suffering from corneal blindness, India likely has

the highest number of affected individuals globally. (10)

Hen's blood, plant extracts, castor oil, and human breast milk were the most often utilized medications. Human breast milk accounted for almost 45% of all of these, making it the most widely utilized medication.[28] Practices include applying materials or mechanical or thermal devices on the surfaces ofthe eyes.[29] Seawater, polluted water, dry gin, extracts of roots, leaves, or trees, herbs, vegetables, powdered charcoal, breast milk, human urine and saliva, cattle and lizard excrement, kerosene, gasoline, and other hydrocarbons are typical examples of such things.[30] Depending on whether they are alkaline or acidic, these compounds are either hazardous to tissues or polluted as a result of improper handling or application. Poisonous materials can cause the ocular tissues to deteriorate, even while exposure exposes them to highly contagious microorganisms that can have disastrous effects. Unlike conventional or orthodox medicine, alternative medicine (TEM) is the primary line of therapy in most developing countries, including Nigeria. This tendency leads to dissatisfaction with natural treatment, and the main drivers of this tendency are the belief that TEM is natural and hence better than conventional treatment, accessibility, cost, and ignorance of alternative options. These methods frequently result in preventable blindness since these illnesses may have been readily handled without complications or ocular morbidities.[31]

TEM may damage the cornea by introducing bacteria that cause primary or secondary infections or by its own toxic effects. Microorganisms can thrive when certain TEMs are used as culture media. As an illustration, human milk has a substantially higher lactose content [32] superior to cow's milk, and this could potentially promote the proliferation of microbes.[33]

AIM AND OBJECTIVES

The aim of this study was to explore and understand how cultural beliefs influence eye health practices among different communities, with the goal of identifying culturally-driven behaviors, perceptions, and barriers that impact eye care-seeking behavior, prevention, and treatment of eye conditions.

METHODOLOGY

The research was conducted in the outpatient departments of Sheikh Zayed Medical College and Hospital, where data were collected through a structured and pre-tested questionnaire. A total of 334 participants aged 18 years and above were recruited using a non-probability purposive convenience sampling technique, with the sample size calculated at a 95% confidence level and 5% margin of error. Inclusion criteria allowed adults with awareness or adherence to cultural eye health beliefs, while individuals with cognitive impairments, language barriers, or other ocular disorders were excluded. Ethical approval was obtained from the relevant committee, and informed consent was taken from all participants, ensuring privacy, anonymity, and voluntary participation. Data collection involved assessing participants' demographics, knowledge of common eye diseases, cultural practices, and healthseeking behaviors, and responses were recorded on structured forms. Statistical analysis was conducted using SPSS version 27, applying descriptive statistics, chi-square tests, independent t-tests, and logistic regression to examine patterns, relationships, and the influence of cultural beliefs on eye health practices.

RESULTS

A total of 334 participants were included in the study, with a relatively balanced gender distribution: 179 males (53.6%) and 155 females (46.4%). The mean age of participants was 43.2 years (SD = 15.1; range = 18–75 years).

Table 1. Gender distribution of participants

Participants were asked to self-rate their knowledge of common eye diseases (cataract, glaucoma, diabetic retinopathy, dry eye). The majority rated their knowledge as either "Fair" (36.5%) or "Good" (36.8%), while 26.6% reported "Poor" knowledge, indicating notable gaps in eye health literacy.

Table 2. Self-rated knowledge of eye diseases

Just over half of respondents (50.8%) reported having visited an eye specialist (ophthalmologist or optometrist), while 49.2% had never consulted one.

Table 3. Visit to an eye specialist

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Independent samples t-tests were conducted to explore whether knowledge levels varied by gender. No significant differences were found between males (Mean = 1.53, SD = 1.13) and females (Mean = 1.53, SD = 1.08), $t(332) = 0.014$, $p = 0.989$.

Table 4. Gender differences in knowledge of eye diseases

To examine whether knowledge of eye diseases influenced cultural perceptions, participants were divided into Poor Knowledge and Good Knowledge groups. Across all cultural belief items, differences were statistically non-significant ($p > 0.05$), suggesting that cultural perceptions were prevalent regardless of knowledge level.

Table 5. Cultural beliefs by knowledge level

A binary logistic regression model was applied to identify predictors of consulting an eye specialist. Predictor variables included knowledge, gender, age, and cultural beliefs. None emerged as statistically significant predictors of specialist visitation.

Table 6. Logistic regression results

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Age	0.086	0.769	1.059
Gender	0.314	0.575	0.981

The most common symptoms reported were blurred vision (31.4%), headaches (25.7%), and eye pain. The most reported eye conditions included myopia (19.2%), hyperopia (14.4%), cataracts (14.1%), and dry eye syndrome (12.3%). (Fig. 1)

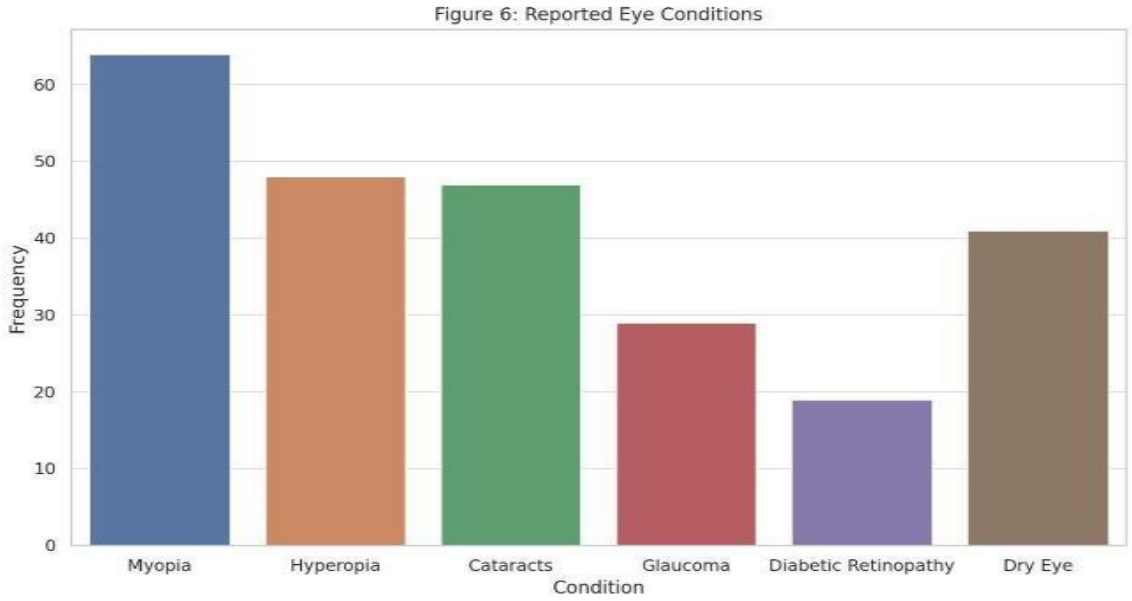


Figure 1. Reported Eye Conditions

Chi-square analysis revealed significant associations:

- Blurred vision with myopia ($p < .001$)
- Headaches with glaucoma ($p = .002$)
- Eye pain with dry eye syndrome ($p = .036$)
- Blurred vision inversely associated with diabetic retinopathy ($p = .026$)

Approximately 36.2% of participants endorsed all three common myths: (1) glasses weaken vision, (2) eye surgery is culturally risky, and (3) vision loss is caused by spiritual forces. However, these beliefs did not significantly affect actual care-seeking behavior. 36.5% of participants reported using prescription glasses regularly. 34.1% reported no use of visual aids. Only 23.1% underwent annual eye checkups. 61% delayed care until symptoms worsened. Among children, 27.2% reported <1 hour/day of screen time, while 21.9% reported >4 hours/day.

Table 7. shows that there is a strong cultural reliance on home remedies and traditional eye medicines (TEMs) across communities in District Rahim Yar Khan. Remedies were commonly used for four major purposes: relieving eye irritation and discomfort, treating newborn eye infections, enhancing or sharpening vision, and improving beauty or appearance.

For eye irritation and discomfort, participants frequently used rose water, honey, alum water, boric acid wash, chilled water, and surma (black and white). These remedies were believed to soothe redness, burning, itching, swelling, and discharge. Rose water was most commonly applied with cotton pads, while chilled water or ice was used to relieve tired eyes, especially in hot weather. Surma held cultural importance: white surma was thought to provide a cooling effect, while black surma was used to reduce burning and minor eye injuries.

For newborns, breast milk and diluted goat's milk were widely used as natural antibacterial remedies to treat red or infected eyes. Caregivers considered these practices safe and effective for infants.

To enhance or sharpen vision, foods such as almonds, fennel seeds, mishri, 4 maghaz, carrots, and fish head marrow were commonly consumed, often with milk or honey. Black pepper with water and exposure to greenery were also cited as practices believed to strengthen eyesight and reduce eye strain.

For beauty and appearance, black surma was applied to define and beautify the eyes, while honey and olive oil were used to promote healthy eyelash growth.

These practices reflected both health-related beliefs

and cultural values attached to aesthetics and eye care within the community.

Table 7. Common traditional remedies and associated cultural beliefs

	Breast milk, goat's milk

DISCUSSION

An in-depth investigation of how indigenous health practices and culturally ingrained beliefs influence eye care behaviors among the people in District Rahim Yar Khan is provided by the current study. According to the findings, traditional eye remedies (TEMs), which have been used for many generations, are still the main treatment for a wide range of ocular conditions. These include broad discomfort, burning, itching, drainage, and redness. The results show how perceived efficacy, cultural tradition, limited access to professional healthcare, and the significant influence of community elders in making health decisions overlap.

One of the most noteworthy results of this study is the widespread usage of surma (kohl), in both its black and white forms, for cosmetic, therapeutic, and preventative purposes. Surma was the most often mentioned cure, as it was thought to improve eyesight, ease irritation, and make the eyes seem better. This customary behavior is strongly ingrained in the community as a ritual, supported not only by cultural conventions but also by religious supports. In various South Asian and Middle Eastern contexts, where surma has spiritual, artistic, and therapeutic value, comparable findings have been reported.[52, 53] However, the medical literature expresses concerns regarding the possible toxicity hazards associated with adulterating surma with lead. Even though most participants were unaware of this, their perception of surma's safety—especially when made locally—reflects a high level of cultural trust and rejection to biomedical caution. The extensive usage of natural remedies like cold compresses, boric acid, alum, honey, and rose water further demonstrates the public's preference for easily accessible, reasonably priced, and nonpharmaceutical treatments. According to the participants, these therapies had calming, cleaning, and anti-inflammatory effects. Notably, honey was utilized for suspected illnesses, often in its undiluted form, and rose water was frequently administered to soothe irritation and watering. The usage of honey medicinally is consistent with recent studies showing that it has antibacterial and wound-healing properties for eye diseases.[54] However, although being thought to be beneficial locally, treatments like boric acid and alum should be used with caution because they may cause irritation or be abused. In situations when access to healthcare is limited, these results demonstrate how traditional treatments frequently serve as alternatives to contemporary medication rather than just complements. One noteworthy finding was the use of these medicines on newborns and young children, especially when it came to treating ocular discharge, redness, or possible infections. Because of its natural healing andantibacterial qualities, breast milk in particular has been frequently documented as a traditional treatment for newborn eye disorders. Although some scientific research indicates that breast milk has immune-boosting properties, improper usage of it when applied unsupervised can be dangerous.[55] Similarly, cleansing baby eyes with diluted goat's milk is a deeply culturally rooted practice that has no scientific support. The importance of women as keepers of traditional health practices is emphasized by these activities, which also emphasize the dependence on mother and family knowledge in early child health decisions.

The study also found support for nutritional therapy to maintain and improve vision in addition to topical treatments. Foods including carrots, black pepper, almonds, fennel seeds, mishri, 4 maghaz, and fish

head marrow (gudda) were cited by participants as being essential for preserving eye health. These ideas align with cultural narratives that attribute better vision to particular diets. However, some foods, including beta-carotene-rich carrots, have been shown to improve vision and prevent night blindness.[56] The study's other cited chemicals have scant or anecdotal evidence. However, by integrating home remedy, spiritual belief, and diet, the community's holistic approach demonstrates a culturally cohesive approach to eye health that incorporates tradition, healing, and prevention. Additionally, the results show that many medicines, especially among women, are utilized for aesthetic or cosmetic motives. Black surma was frequently used to adorn the eyes, and eyelash development was said to be boosted by honey and olive oil. These behaviors were seen as a component of cultural grooming customs and everyday self-care rather than as medical. A cautious shift in attitudes, probably brought about by formal education or exposure to public health messages, was seen in certain situations when women voiced reservations about the safety of using surma on children. Future health initiatives may benefit from this dichotomy, which implies a shift in health ideas between appreciating heritage and doubting safety.

Limited use of formal eye care services was one of the key themes that surfaced. Only when symptoms worsened or continued did most individuals seek medical help, preferring more conventional methods. Financial difficulty, remote location, inadequate health literacy, and skepticism of allopathic practices are some of the major obstacles to receiving professional care that are revealed by this pattern. It echoes larger structural issues that have been reported in comparable resource-constrained areas, where traditional practices frequently cover the gaps created by inadequately funded health institutions.[57] Early identification and prompt treatment may be further discouraged by the cultural framing of eye problems, such as concepts of spiritual causation or the idea that some symptoms don't need medical attention. Throughout the investigation, there was a noticeable transfer of information between generations, especially in rural areas. Homebased cures were promoted and administered by elder women, particularly mothers and grandparents. Younger family members' health decisions, including those regarding kid eye care, were influenced by their experiences and views. Traditional customs endure because of this cultural hierarchy and reverence for age based knowledge. However, there was evidence of growing skepticism toward some therapies, especially those viewed as hazardous or unsanitary, among individuals who were younger or better educated. This generational divide presents a chance for culturally relevant public health education that honors customs while presenting evidence-based substitutes. These discoveries have a wide range of consequences. They first emphasize the significance of culturally sensitive public health initiatives. Healthcare professionals must interact with community views and offer specialized education that combines scientific understanding with cultural values, rather than discounting traditional methods. Communities canbe urged, for instance, to use certified, lead-free surma products and to seek expert advice when symptoms last longer than a short while. Communication and trust between traditional households and formal healthcare systems can be enhanced by training community health professionals to serve as cultural mediators. Second, the findings support the inclusion of eye health education in the current community, school, and maternity health platforms. Language and cultural accessibility are essential, and educational tools should clear such misunderstandings without compromising conventional wisdom. Eye health screening programs can reduce avoidable visual impairment and offer early detection of curable disorders, particularly in schools and maternal health clinics.

Third, the results emphasize how important it is to make formal eye care more accessible, particularly in underprivileged and rural areas. The existing gap might be closed with the use of mobile eye clinics, government-subsidized treatment choices, and awareness initiatives. Crucially, include local influencers in health promotion initiatives, such as elder women, hakeems, and religious leaders, may boost community acceptability and involvement.

This study offers important proof of how customs and at-home eye care routines still significantly influence the health-related behaviors of communities in District Rahim Yar Khan. For some of these behaviors to be safe, effective, and used appropriately, contextualized public health participation is necessary, even if many of them are harmless or even advantageous. Improving ocular health outcomes in these groups requires acknowledging the importance of cultural identity while advocating for precise, prompt, and expert eye treatment.

CONCLUSIONS

This study demonstrated how deeply ingrained cultural attitudes are in the practices of eye health among the people in District Rahim Yar Khan. Even with the availability of contemporary eye care services, many people still favor traditional treatments for ocular discomfort, vision improvement, and beauty, such as surma, rose water, honey, breast milk, and herbal mixes. These customs, which frequently result in a delayed use of professional medical services, are maintained by enduring cultural traditions, information transfer between generations, and spiritual beliefs. Nonetheless, a growing trend was observed, especially among younger and better educated people, who showed heightened risk awareness and were more receptive to expert advice. Despite being widespread, cultural misconceptions such as "glasses weaken vision" and "surgery is spiritually harmful" did not statistically stop people from seeking medical attention. This suggests that although cultural attitudes continue to have an impact, they do not completely discourage medical involvement. In the end, enhancing eye health outcomes in these communities necessitates a balanced strategy that upholds traditional values while encouraging truthful, empirically supported practices using culturally aware tactics.

LIMITATIONS

Despite the depth of community insights, this study has several limitations. The study's focus on a specific geographic district may have limited the results' applicability to other areas with different sociocultural or healthcare circumstances. The reliability of participant replies is impacted by the possibility of recollection or social desirability bias introduced by the use of self-reported data. Furthermore, the study's ability to gather systemic and interdisciplinary insights is constrained by the lack of viewpoints from official healthcare professionals and traditional healers. Furthermore, the study limited findings regarding the claimed traditional treatments' medical relevance by failing to conduct a clinical evaluation of their safety or efficacy. Finally, a longitudinal evaluation of changing cultural practices is not possible due to the cross-sectional character of the research, which restricts the capacity to track changes in attitudes or actions over time.

RECOMMENDATIONS

To enhance culturally sensitive eye care in marginalized groups, this study makes a number of significant recommendations. The creation of culturally sensitive educational activities that dispel harmful stereotypes and advance evidence-based practices should be a top priority for public health campaigns. These ought to be disseminated via dependable local sources including community health workers, teachers, elder women, and religious leaders. Educating healthcare professionals to act as cultural mediators may improve professional care acceptance and communication. To capture geographical differences and temporal changes in health behavior, future research should use multicenter and longitudinal methods. Integrating school-based eye screenings and maternal health education with culturally adapted materials would support early detection and prevention. The safety and effectiveness of popular traditional eye cures need to be clinically assessed, and the possibility of incorporating proven methods into official health systems for safer and more efficient care delivery has to be investigated.

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