Dialogue not monologue: preventative eye care and research in Vanuatu

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Abstract

A basic premise of this research is that people can bring about changes in their lifestyle. As individual ni-Vanuatu develop greater insight into the current state of their eye health and are stimulated to act on it, change in their lives is facilitated. An attempt is made, not only to bring about changes at the "grass roots" level, in the people themselves, but to establish some means for the ni-Vanuatu to influence policy to ensure sustainability of these changes. I suggest that if people recognise their ability to change their world through thinking critically about their circumstances, imagining and devising other ways of understanding and behaving, and co-operate together, they can in fact achieve desired goals no matter how oppressive their social structures appear or are perceived to be[1]. This paper examines the role of the health researcher, and calls for real "dialogue" as the key to opening doors to health programmes which are more successful in their outcomes and more satisfying for those implementing and using the services.

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Introduction

In 1995, I commenced research into primary eye health in Vanuatu. The central problem of the research is to both isolate the issues related to ni-Vanuatu wearing sunglasses and to determine how these issues can be addressed in order to ensure a promotive / preventive eye care programme which is culturally sustainable and effective. The motive behind the research is to support the development of an effective eye health programme through the wearing of sunglasses.

Education of the people in the scientific causes of their eye problems might encourage their seeking solutions to their eye health problems. If chiefs, villages leaders and elders were made aware of the benefits to peoples' eye health in wearing sunglasses, perhaps a means could be found of incorporating them into village life and culture. Further, if ni-Vanuatu came to associate the wearing of sunglasses with protection and health, rather than "colonial" fashion and status, they would be more widely worn and accepted. In this paper the importance of personal values is emphasised, although the ability to "step-back" and critically view the outcomes is acknowledged[2]. As I reflected critically, I began to see that inequalities and injustices within their society meant that many people, particularly women, felt unable to take measures to improve their eye health.

Meaning, purpose and a sense of wholeness are central to many indigenous cultures; therefore the importance of understanding the cultural framework of illness and health as cultural factors is essential. Research needs to be undertaken to gain insight into ni-Vanuatu pre-existing conceptions about eye disease and treatment. In order to discover more about the nature of these factors the researcher needs to engage in dialogue with the people.

The dialogue: primary eye care

Primary eye care is a new concept in health. The need for imaginative programmes which incorporates clinical, preventative and promotive activities, are flexible and tailored to the needs of the community is emphasised[3]. Eye diseases in tropical and developing countries, such as Vanuatu will differ from that of other countries in four particular ways[4].

The number of blind or partially blind is high. A population based survey conducted in 1989 found that the overall

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prevalence of bilateral (both eyes blind) blindness was 0.4%. There was a much greater prevelance 1.6% of monocular blindness. In addition to monocular and binocular blindness, 3.55% had impaired vision (Va <6/18) in one eye.

As the majority of the population of Vanuatu live in rural areas in small localities of less than 50 people, and blindness or visual impairment significantly reduces the ability of a person to function within or contribute to networks within the household/village unit, the loss of one member's contribution through loss of vision is a significant loss to the whole group. In some instances two people may be "lost" to the group as one assumes the role of carer for the blind person.

Most of the blindness in Vanuatu is preventable or treatable. Cataract, trauma and pteryigium have been found to be major causes of visual impairment in Vanuatu. Trauma was not uncommon amongst small children. Pterygium was common in most school age children and adults. Cataract was the leading cause of blindness in adults. These are all either treatable or preventable.

Vanuatu's medical resources are inadequate to meet demand. The hospitals, health centres and aid posts, often experience shortages of funds, for supplies and infrastructure, staff turnover and lack of training, distance and isolation from villages and Vila central supplies.

Vanuatu does not have a resident ophthalmologist and only one resident optometrist in Port Vila who caters largely for the expatriate population. It relies on visiting surgical teams sponsored by foreign aid. As part of its Second National Development Plan (1987), the Government of Vanuatu expressed the desire to meet the need for primary eye care services. As yet this need has not been addressed except for spasmodic foreign aid, and some efforts on behalf of non-government organisations. These factors, supported by dialogue with many of our patients, led me to focus on promotive and preventative aspects of primary eye care.

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Dialogue includes learning to listen: mobile eye clinics and initial data collection

In August-October 1995, my optometrist husband and I commenced mobile eye clinics in rural and urban areas of Vanuatu. These clinics would form the vehicle for data collection as they gave us opportunity to visit villages, speak with the ni-Vanuatu people and experience ourselves, some of the difficulties facing this nation, especially in relation to provision of eye health services. A specially designed optometric stand, based on a golf buggy, enabled a refractor head[5] to be used rather than trial frame refraction's. This was important as in trial frame refraction's, a heavy, cumbersome spectacle frame (trial frame) is fitted to the patients face and the lenses are inserted one at a time from a large case of lenses. As the trial frame is sitting on the face, the patient can experience some discomfort as the lenses are inserted, rotated and changed. This is especially so when they are embarrassed by wearing the frame and by having someone, especially strangers touch them. Further, it is easy to lose lenses from the case when operating mobile clinics. The unit was on wheels, and thus the clinics were mobile, enabling access to villages by foot where necessary.

We examined over 1000 people and dispensed spectacles and sunglasses. Examinations were conducted in Bislama, the national language of Vanuatu. Referrals of patients requiring surgical assessment by visiting surgical eye teams from Australia and Japan were made to the appropriate hospitals. Patient histories were collected together with their perceptions of aetiology of eye health. Although the recorders of the information varied from place to place, they were working from a printed questionnaire, which formed our patient histories. After some time it was decided to amend the questionnaires. Initial sampling showed they were not producing adequate information for the study. The lists of questions were seemingly viewed with suspicion by some of the patients. Further, with the set questions the ni-Vanuatu recorders would prompt the answers they had decided were correct! The information collected was not the opinion of the patient but that which the recorder had decided was the one we wanted to hear.

The revised questionnaire contained one leading question in each category and then asked the patient to "Storian" that is, "tell me about it". The resulting data often included vivid, detailed descriptions of incidents, illness episodes and glimpses into their life. Further questioning by the optometrist or myself would often result in lengthy conversations. As we showed a genuine desire to listen and learn so the people showed a genuine desire to share their health experiences. Dialogue was the key!

Primary data gathered from ni-Vanuatu patients attending our clinics confirmed that they perceived eye problems to be related to the factors noted in Table 1.

Table 1. Eye problems as perceived by patients

Environmental Factors	The sun is strong.	*"Sun i strong tumas"*	"The sun is too bright."
	Smoke from fires.	*"Smok blong faea"*	"The smoke from the fire"
	Poor lighting when reading.	*"Lukluk tumas buk long laet we i no gud."*	"Reading too many books when the light is not good"
	Work related.	*"Oli stap karem kaekae long hed oltaem"*	Carrying heavy things on my head all the time
		"Wevem tumas basket mo pen daon tumas"	"Weaving too many baskets or bending down too much"
	Trauma related.	*"Man blong mi i kilim mi long raet ae blong mi wetem wan wud"*	My husband hit me in the right eye with a piece of wood"
		"Long bifo was pis iron i hitim ae blong mi.	"Long ago a piece of iron hit my eye..."
	Wrong food.		
Biological Factors	Bad Teeth.	*"Taem man we ol tut oli kamaot nao ae i no gud"*	"Your eyes are bad because you have lost your teeth"
	Age.	*"Mi kam olfala nao"*	"I am old now"
	Inherited Factors.	*"Laen blong olgeta, oli gat gud blad".*	"Our family line has good blood"
		"A ting i folem blad long famili"	"I think it follows family blood lines."
Spiritual Factors	Sorcery.	*"Ol kastom, oli kaekae long ples no gud, mo man I mekem long kastom"*	"All custom magic. If you eat food in a place associated with evil spirits or if a witchdoctor casts a spell on you eyesight can be affected."
		"Sam fala man long saed blong kastom oli spoelem"	"Some people associated with custom magic can spoil your eyes."

Although many factors were listed as connected with eye health, the sun emerged as a factor in the majority of cases. The ni-Vanuatu perceived aetiology was borne out by epidemiological data gathered at our mobile clinics. There was a high incidence of impaired vision related to exposure to ultra violet radiation. Short term exposure to UV radiation can damage the conjunctiva, while long-term exposure can cause it to thicken, forming a fleshy growth known as a pterygium[6]. The incidence of cataract was also high amongst those attending our clinics[7].

The survey conducted by Newland et al (1992) also found

use of impaired vision was cataract.
into the causes of cataract has
a great deal of literature which,
f cataracts is related to the exposure
these patient histories, optometric
e would be to encourage the patient to reduce their
re to UV light through the wearing of sunglasses or a
nglasses provide better UV protection as they screen
t reflected from surfaces below the eye, as well as light
bove.

In Vanuatu, where people spend a significant amount of time on the water, or on beaches consisting of highly reflective white coral, reflected light is a significant factor in UV damage. Further, sunglasses also provide a barrier between the eye and the general environment. They offer protection against other irritants to the eye. Insects, dust, wind an other airborne particles, as well as dense foliage both overhead and alongside paths pose a constant risk to the eyes of ni-Vanuatu because of their lifestyle and climate. Injuries to the eyes had occurred in the course of work, recreation, and in travelling in open transport through the dense bush of Vanuatu. Newland et al (1992) found that 11% of monocular blindness was due to trauma. The high incidence of trauma related visual impairment was borne out in data collected through our clinics[9].

At Valesdir we were met by a mother and a young boy whose head was wrapped in cloth. He had been shooting pigeons, a source of food, with a slingshot when the rubber on the sling shot broke and rebounded into his eye. The eye was swollen and shut. Without correct medication the eye would have been permanently damaged and vision lost or

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severely impaired. I was to see many more young people who had suffered vision loss due to slingshot injuries in the course of my work in Vanuatu. Encouraging the wearing of sunglasses in daily tasks, could reduce the incidence of trauma related visual impairment.

Of the patients visiting our clinics who had been seen by an ophthalmologist or optometrist previously, some had been issued with and told to wear sunglasses but had not followed this advice. I wanted to know why. Thus before prescribing the wearing of sunglasses, a seemingly simple means of reducing UV light and lifestyle related damage, complex issues must be researched in depth, in order to develop promotive and preventative eye care programmes which can address these needs, make the necessary changes and provide appropriate, equitable eye health services to ni-Vanuatu.

Dialogue means exchanging ideas

Interpretative theory, if not carefully constructed, can be prone to distortions, which arise from a number of factors[10]. A researcher's biases and prejudices, anxieties, and pressures both internal and external, can affect their ability to listen. We need to discuss what we think we've heard, clarify our understanding, Confirm it by repeating it back and have our understanding confirmed by the people who shared the knowledge with us. The issue of "knowing" also must confront the importance of personal knowledge and choice in health development decisions.[11]

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Further, the process of knowing involves a "passionate contribution" (Polanyi; 1958) of the person knowing what is known. The addition of this "passionate contribution" by the researcher does not make the perception or knowledge "imperfect" but is rather a vital component of knowledge. Commitment to the ideal which inspired the research can lead to researchers not noticing inadequacies.

Commitment to the ideal, which inspired the research, can lead to researchers not noticing inadequacies. The research experience is part of them now, they have lived through it and therefore it is difficult to stand back from the research. Hence, it is necessary to enhance the validity of the research by moving to and fro between reflection (standing back) and experience (acting) and by finding a balance between these two phases[12]. Reason, (1988, p 23) writes:

"Finally, what is important is that human inquiry is a process of human experience and of human judgement. There are no procedures that will guarantee valid knowing or accuracy or truth. There are simply human beings in a certain place and time, working away more or less honestly, more or less systematically, more or less collaboratively, more or less self-awarely to seize the opportunities of their lives, solve the problems which beset them, and to understand the things that intrigue them. It is on the basis of this that they should be judged."

Moving to and fro between Vanuatu and Australia, between two cultures, but at the same time engaging in the same field of work, primary eye care, gave me time and the distance, to reflect, compare, contrast and stand back. Reflecting on my time there, as a health worker, I was challenged to think critically about the practice of health work and in particular, the way I practised; the eye health solutions offered; the way the people perceived us. How could the visual and health needs they expressed to us best be met? How could I facilitate the changes these people were requesting?

As I was living and working with the researched, I found I was often in a state of conflict as to whether I should be "reporting" (thinking) or "living" (acting and feeling) the moment. I had to constantly weigh the appropriateness of my actions. What were the boundaries of privacy? When I was struggling with personal issues were they research or personal growth? What was "privileged" information?

Developing "Cognitive respect"(Berger, 1975) enables the establishment of rapport and trust, which are necessary for dialogue and sharing of knowledge and out of this dialogue emerges a participative inquiry process which embraces a genuine commitment to work with democratic values and to honour the wisdom of the people. As is often the case, the process of participation and dialogue began with an intervention that had a formal objective of development of health care and grew into a project which encompasses far more, including self- determination of primary eye health choices.

I have a double objective. One aim is the production of knowledge and action that is directly useful to ni-Vanuatu. This may be achieved through research, adult education, and socio-political action. The second aim is to enable the ni-Vanuatu to take control at a deeper level through the process of constructing and using their own knowledge. Both objectives involve action. True dialogue is active. It involves feeling responding, body positions, actions as well as language. It results in changes in behaviour of both people engaged in the dialogue.

Participant Action Research emphasises the role of participation and self-direction in development, and is radically

egalitarian in approach, however, I was faced with the dilemma of knowing that without the initiative of someone like me, from a privileged and educated group, who has some skill, commitment and finances, this project of preventative eye care would, most likely, not occur. Certainly, in an ideal world, Participatory Action Research would always be initiated by the groups the research is meant to benefit. The great majority of rural ni-Vanuatu have problems with limited literacy and although they possess complex bodies of informally learned skills and practices, their ability to evaluate long held practices and beliefs are also limited[13]. How do I resolve this dilemma? Dialogue once again holds the key.

I came to the field as instigator and facilitator. I did not come believing that I had "all the answers" or with a "hidden agenda" of which I was aware. I came seeking truth through dialogue. Not so pre-occupied with myself that I sought an audience for my monologue! *"In a sense the process of dialogue which attempts to integrate is the closest approximation of truth we can achieve.*
(Romm et al, 1986; in McIntyre, 1995; p42)

Initially this dialogue took place in mobile eye clinics held in local villages. The people who came to our clinics sought to improve or check on their eyesight.

"Mi mi kam long klinik blong jekem ae blong mi nomo."
"I have come to have a check-up on my eyes that's all."

When we explained some of the measures they could take to achieve relieve their discomfort, symptoms or improve their vision, many of them felt powerless to do so.

"Mi mi gat fraet tumas"
"I am too frightened (embarrassed)"

If people perceived themselves as "powerless", nothing could be achieved by leaving them just with information in their "powerless" state, nor by having them ostracised for speaking out or in this case acting out,"too soon"; that is prior, to enough people having time to evaluate the information presented and deciding that they too would like to bring about change. In fact, frustration and anger could result from offering what were seen to be inappropriate solutions.

Following further dialogue, I was made aware that there was a need for me to become the "conduit" (Denzin and Lincoln,1994, p15) for making their voices heard. I had already become this, in one sense, in the talks with some non-government organisations and other government departments about the project. The question then arises of how I become their voice . How does a researcher gain the "right" to speak for others? How can someone from the "outside" speak for those on the "inside"? The key again is authentic dialogue, where the others' knowledge and experience is directly honoured and valued. Friere (1982), emphasises the value of knowledge of language and perceptions in enhances the researcher's ability to view the social world and its structures with new understanding, and as a result of this learning process to plan social and political action. The professional and personal experience of delivering primary eye care services in Vanuatu has provided me with essential theoretical sensitivity to the phenomena being researched[14] and theoretical sensitivity enables good interpretation. But what can be said to constitute good interpretation? Geertz,(1975) states that:

"a good interpretation of anything- a poem, a person, a history, a ritual, an institution, a society- takes us into the heart of that of which it is the interpretation."

For me that implies "getting to the heart" of what it means to be ni- Vanuatu and what it means to wear sunglasses in ni-Vanuatu society. Active dialogue helped me "get to the heart" as I collected ethnographic data in the process of living and working as an optometric assistant in Vanuatu.

My initial dialogue with ni-Vanuatu patients, revealed a reluctance to wear sunglasses, especially amongst women in rural areas. Through further dialogue with ni-Vanuatu, a number of issues emerged .

- Wearing any spectacles, but particularly sunglasses causes embarrassment as it is seen as an attempt to raise your status.
  "Hem i flas tumas!"
  "It is too flash!"

- For women particularly, being "flash" poses problems as the men ridicule them. They expressed this as
  "Mi mi gat fraet tumas".
  "I am too frightened/embarrassed."

- The wearing of sunglasses is associated with lack of respect for authority. Sunglasses are often worn by young people who have left the villages, gone to Port Vila, lived outside the traditional authority, then been sent home to the village, and now cause concern as they don't respect the authority of the chiefs or participate in village life. In some cases the men had forbidden women to wear sunglasses.

- Ni-Vanuatu rely to a great extent on facial gestures and eye contact when communicating with each other. They do not like not being able to see the person's eyes. Dark lenses such as those common in European sunglasses are therefore not acceptable. Having "dark" eyes may also be associated with illness as it is a commonly used phrase to designate illness.

- Patients attending our clinics often claimed that the children had broken their spectacles and sunglasses.

- Issue of ownership of small property. If a ni-Vanuatu is wearing sunglasses and someone related to them admires,

they may feel "obliged" to make a gift of them. Alternatively the person may ask to try them, and later walk off with them. There would be a reluctance to ask for them back.

- The sunglasses made for Europeans do not fit Melanesians. Their skeletal structure is markedly different. Models are too narrow in the bridge and sit up too high on the face covering their eyebrows or sit too low, resting on their cheeks. Larger bridges, longer temples and shallower lens shapes are required to obtain correct fit and maximum protection.

- There is the perception that if you wear glasses they will cause more damage to your eyes.

- Patient education needs to be addressed. People were unaware of the health reasons for wearing sunglasses, even if they had been seen by an optometrist or ophthalmologist. Dissemination of information to villages is difficult.

- Obtaining access to sunglasses is a problem both financially and geographically in rural areas.

Many programmes have been undertaken with the "best of intentions" and have resulted in the exploitation of people and a host of unexpected, and possible unwanted outcomes. To fail to look for the "downsides" is a common fault in health programmes and can be problematic[15]. Failure to recognise that the act of helping to improve health is often not free of exploitation and political implications can result in "downsides" as can lack of consultation and participation of those for whom the programme is being established. I was aware that there could be unforeseen consequences of introducing an artefact into a culture. It was necessary to consider many aspects of ni-Vanuatu culture in order to assess the impact wearing sunglasses could have on it.

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Although sunglasses had been available in Vanuatu for some time and as such I was not "introducing" the artefact; I was for the first time advocating everyone wearing sunglasses, and as such advocating a new use for the sunglasses. Previously sunglasses had largely been worn by people

"blong mekem flas nomo"
"to make themselves look "cool (radical, wicked)"

or by some people, mainly men, to cut glare
"from sun I strong tumas"
"because the sun is too bright". Or to conceal the effects of "partying", Kava makes the eyes very red. During one of my visits one of the women on the advisory committee commented:

"I always thought the men work dark glasses so they could perve on other women without their wives knowing (where their eyes were looking)!"

Dialogue and action

In putting the findings of the dialogue into action, I set about designing a programme with a group of advisers. It requires commitment from people who see the importance of the prevention of disabilities, diseases and eye problems. It is proposed that, in the first instance, this is a joint venture between interested government and non-government organisations. The formation of a sub-committee responsible for Preventative Eye Care, would allow all organisations to be represented without the burden of the extra administrative work falling on one group alone yet all groups having their interests represented. It is important to note that the responsibilities of the NGO's and Government Departments should be made very clear by the committee at the early meetings, when choosing their agenda. The group will share, and assign the responsibility for each of the chosen tasks to its various members, in such a way no one body is left with the full workload.

At a meeting in March 1996, representatives from the Department of Health, Department of Women's Affairs, The Vanuatu Society for Disabled People, Vanuatu Family Health Association, The Foundation for South Pacific People's and the National Council for Women all expressed interest in this project. An application for funding has been made, at the suggestion of the Department of Health in Vanuatu, to an international service organisation. Should they decide to assist in funding this proposal it would also be appropriate for them to be represented on the committee. This committee would also be responsible for the ongoing evaluation of the project both in urban and rural areas.

The Department of Health has an important role in the provision of community health services. Their nurses are currently involved in visual screening . Their involvement in the distribution of educational material through their hospitals, health centres and Aid Posts is critical, as one key to changing community attitudes towards sunglasses, is the association of sunglasses with health, not fashion.

The distribution of the sunglasses poses more of a logistic problem. For the system to be self -sustaining it would be more appropriate for the joint administrative committee to accept the responsibility for maintenance of a supply of sunglasses. The Health Department is already pressed to meet its patient's needs due to the high demands already placed on the health services. Sunglasses could be made available for sale through the various pharmacy outlets at Hospitals, Health Centres, and Aid Posts. However, as their budget would not allow large purchases at a time, it is more economic for them to purchase the sunglasses from the joint committee who would be purchasing large quantities to service other agencies in Vanuatu as well as the Health Department. In such a way the same quality sunglasses can be purchased from a variety of sources, thus making them more accessible to all people.

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In March 1996, with assistance from the Department of Women's' Affairs, I conducted a number of lectures on eye health with community groups. The focus of these lectures was to introduce to people the association of sunglasses with eye protection. It also gave me the opportunity to confirm much of the data I had previously collected and to draft an educational pamphlet, which was subsequently distributed as part of our clinics. It has been very well received and is currently being reproduced for wider distribution.

A number of health oriented radio programmes have begun the task of community education. It is important that the momentum that has begun be continued through the media, especially radio as it reaches a large number of people in outer islands. I have talked with a number of people about the possibility of having a string band compose a song encouraging wearing of sunglasses. Some groups have done this in the past with other health-related issues including nutrition and AIDS. In order for this to occur the joint committee proposes to conduct a "sunglass song" competition. Now that Vanuatu has its own television station it would also be appropriate to use this media as a means of getting the message across.

A poster competition was conducted in the high schools of Vanuatu, in May-June, 1996. Schools were asked to include in their curricula eye health and to assist students to produce a poster encouraging the wearing of sunglasses. The response was excellent. A poster and slogan have been selected and are being prepared for printing.

Conclusion

The ni-Vanuatu people have responded to the challenge to improve their eye health. The pamphlets have been read and people have sought further information and assistance. Many have taken the step of purchasing the sunglasses. Armed with their new knowledge, they now need to keep the dialogue going. Through increased understanding and the resulting action their voices may grow stronger and loud so that they can influence the socio-political structures which dictate their health and work programmes.

The formation of the committee to continue the supply of protective eyewear is a challenge not just to the organisations represented but to all the people of Vanuatu. The need for them to express the desire for them to be active participants in maintaining their eye-health , not just recipients of curative aid, is still paramount. Dialogue, filled with respect, started this. Dialogue , filled with self-respect, can continue this. Sometimes we have to hear things we don't want to. Sometimes we have to say things we don't want to. Dialogue is not always easy, but it can be the key to health's door.

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2. Edwards and Talbot (1994) *The Hard-pressed Researcher: A Research Handbook for Caring Professions.* Essex: Longman describe personal values as a "distinguishing feature" of action action research and "Without attention to personal values action research becomes a different and less transforming exercise" (p 67).
3. See Sanford-Smith, J (1986) *Eye Diseases in Hot Climates.* Wright: Bristol and Schwab, L (1990) *Eye Care in Developing Nations.* 2nd Edition Oxford University Press : New York.

4. See Sandford-Smith, J (1986) *Eye Diseases in Hot Climates.* Wright: Bristol.

5. A refractor head is a piece of optometric equipment containing a number of lenses. The casing has two holes through which the patient looks by resting their forehead against the refractor. The optometrist can quickly rotate the lenses inside the equipment to bring up a new lens each time seeking to make the image clearer. Refractor Head examinations enabled more efficient use of our time and better patient comfort.

6. Progress of this condition is usually slow, growing until it starts to cover part of the cornea when it can interfere with vision and become unsightly. The only treatment is surgical removal. The incidence of pterygium was widespread and affected young and old people alike. In many cases pterygia had grown to a size where vision was significantly impaired, and surgical removal was urgently required.

7. A change in the lens of the eye from transparent to opaque is known as cataract. The light is thus prevented from reaching the back of the eye an vision is reduced accordingly. The changes in the lens can also cause a myopic shift and a person suffering from cataracts can experience difficulty in seeing objects in the distance. It is a relatively simple operation, to remove the lens and replace it with an artificial lens, known as an Intra Ocular Lens implant In many cases this will restore the sight to the person previous rendered blind or severely impared by the cataract.

8. The issue of the relationship between sunlight and cataracts is far from settled, given the high rate of cataract in Vanuatu and the extended hours spent outside in sunlight and on the water, where reflected light compounds the exposure of the eyes to UV light, until conclusive evidence to the contrary, it seems prudent to advocate UV protection for the eyes. (Hiller et al, 1977; Kahn et al; Zigman et al, 1979; Taylor, 1980; Hollows and Moran, 1981; Hiller et al, 1983; Leske and Sperduto, 1983; Brilliant et al, 1983 (Pitts, D in Cronly-Dillon (1986) Hazards of Light Myth and Realities; Eye and Skin Oxford: Pergamon p 202.

9. Domestic Violence is a large problem in Vanuatu. It was not unusual to have women with vision impairment as a result of being hit. *"Man blong mi I long raet ae blong mi wetem wan wud"* "My husband hit me in the right eye with a piece of wood" Children also had lost vision due to being hit by batteries, stones or other objects thrown by parents or siblings. The problem is currently being addressed by women's groups and government through education campaigns being conducted in the schools with young girls, counselling and poster promotion through health clinics and aid posts.

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12. See Reason, P (editor) (1988) *Human Inquiry in Action: Developments in New Paradigm Research.* London : SAGE p12.

13. Maclure, R and Bassey M (1991) *Participatory Action Research in Togo: An Inquiry into Maize Storage Systems.* P190-209 in *Participatory Action Research* Whyte, W.F ed SAGE: 1991 p202.

14. See Strauss, A and Corbin J (1990) *Basics of Qualitative Research: Grounded Theory, Procedures and Techniques.* SAGE.

15. See Geddes, B, Hughes, J. *Anthropology and Third World Development.* Remenyi, J (editor) (1994) Deakin. Uni Press: Victoria. □

Only the mediocre are always at their best

A sign at a business in Parnell, Auckland, New Zealand