

Gender and Blindness: Eye Disease and the Use of Eye Care Services

Summary and Recommendations from a meeting at the Kilimanjaro Centre for Community Ophthalmology, Moshi, Tanzania, June 17–21, 2002

Blindness is an increasing global health problem that afflicts approximately 50 million people, two-thirds of whom are women, and ninety per cent of whom live in poorer countries. Much world blindness is due to cataract, routinely curable through surgery, or due to chronic trachoma infection, preventable through clean water and improved sanitation. The Vision 2020 initiative of the World Health Organization is addressing this problem through advocacy, planning and programming.

In poorer countries, women of all ages utilise eye care services much less than men. As a result, more women than men are blind or visually impaired from cataract, trachomatous trichiasis and angle closure glaucoma. To date, however, Vision 2020 programmes have not incorporated gender issues into evaluation, planning, or treatment efforts. Little applied research is available to help guide decisions in service provision.

Ophthalmic and women's health researchers, policy makers and programme staff held a meeting in Moshi, Tanzania from 17–21 June, 2002 to discuss gender and blindness. The Kilimanjaro Centre for Community Ophthalmology (KCCO) at KCMC (Tumaini University) and the British Columbia Centre for Epidemiologic & International Ophthalmology (University of British Columbia) organised the conference, while a consortium of Canadian public health agencies sponsored the meeting. The participants identified key research, policy, and programme priorities listed below. A full report is available.

The participants agreed upon the following recommendations:

Policy Issues

1. Programme managers in all national and local blindness prevention programmes need to assess gender equity of service utilisation. This means separately assessing the potential barriers to use of services by men and women, throughout the life span.
2. Eye care agencies should follow WHO policy and critically evaluate gender roles within their own organisations,

developing strategies to improve gender equity in the work environment.

3. Programme monitors need to incorporate sex specific indicators used for all eye care programme activities (e.g., cataract surgical rate, trichiasis surgical coverage). Leprosy control programmes should also monitor lagophthalmos and cataract surgical rates by sex.
4. Eye care service providers should encourage collaboration with non-health care programmes (e.g., water and sanitation) to improve environmental factors influencing women's health.

Programme Issues

1. Eye care programme planners should direct most attention to the community level in order to gain long term trust and to involve community members in planning and providing prevention and treatment strategies. Programme planners should especially encourage women's representation. This is a difficult and sensitive process requiring an understanding of local social, political and economic issues in their historical context.
2. Programme planners need to be aware that women often do not have decision-making power within communities. Programmes designed to increase utilisation of services by women, therefore, must include the people (often husbands or male community elders) who have decision-making authority. The goal is to empower communities to meet their eye care needs, not to achieve gender equity in the decision making process.
3. All cataract surgery facilities should have designated personnel (preferably, male and female) to provide good quality education for cataract surgery patients.
4. Eye care programme planners need to be aware of many different approaches to promote health education in a gender sensitive fashion within communities (e.g., school child health programmes, collaboration with traditional healers, women's groups, local service groups).
5. Trachoma control activities need to emphasise facial cleanliness and environmental hygiene improvements (known as the 'F and E' components of the SAFE strategy), because these will be the most effective in long-term control of this disease, which affects primarily women.

Research Issues

General

1. In each context (society/culture/religion) researchers need to:
 - Clarify decision-making roles for accessing eye care
 - Identify existing or potential social networks which support women needing eye care
 - Define barriers and enabling factors to increase the use of eye care services by women and men
 - Determine effective gender-sensitive methods to provide health information (regarding existing perceptions of surgery, primarily fatalistic attitudes and fear of surgery).
2. Researchers need to determine if the excess burden of blindness rates for women found in Africa, Asia and in industrialised countries is also found in Latin America and Eastern Europe/Russia. In addition, researchers need to determine the specific causes of this excess blindness. Do these causes vary between the industrialised and non-industrialised countries?

Cataract

1. Epidemiologists and anthropologists need to clarify the factors that influence acceptance of cataract surgery by women. For example, do women accept cataract surgery more readily if counselled by female health workers, by other women who have had surgery, or by other community based groups?
2. Health services researchers need to determine how health sector reform and cost recovery affects service utilisation by men and women. What is the effect of marital status, education, family size, or other factors? What mechanisms can be put into place to ensure equity in utilisation?
3. Basic science researchers needed to understand better why women have a higher risk of developing cataract than men of a similar age.

Trachoma

1. Researchers need to clarify what the impacts of F and E will be on the roles and activities (e.g., use of time) of women?

2. Researchers need to determine if girls are re-infected more readily than boys following antibiotic distribution.
3. Researchers must determine which local community-based approaches best improve uptake (and equity in uptake by men and women) of trichiasis surgical services before vision loss occurs. Researchers must also examine whether women have a higher rate of recurrence of trichiasis following surgery and what can be done to reduce recurrence.

Childhood eye diseases

1. In each context, researchers need to determine what prompts parents to bring their children for surgery and when. Do mothers and fathers have different perceptions of the need of eye care for children and does this depend on the household structure or economic

status? How do these perceptions affect utilisation of services?

2. Researchers need to explore why, in most settings, parents bring more boys for juvenile (non-traumatic) cataract surgery than girls. They must also study long-term follow up of children receiving surgery to assess utilisation and benefit of low vision services.

Other conditions

1. For glaucoma and other major causes of blindness, researchers need to clarify the utilisation of services and outcomes of service by men and women. Very little information exists to date on screening, medical and surgical services. In many settings there are more men than women receiving surgery.
2. For leprosy, researchers need to determine if the burden is similar for men

and women and if more cosmetically appealing lagophthalmos surgery (compared to tarsorrhaphy) can improve socio-economic status or quality of life. Lagophthalmos is a significant cause of vision loss and disability in leprosy patients and is a burden on quality of life because of its stigmatising qualities.

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Report

Training Principles for Ophthalmic Care in Developing Countries

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Introduction

Over the past few decades the authors have visited a number of developing countries in Africa, Asia and the Americas, providing both general ophthalmology care and specialised consultation, teaching and service. The programmes initially were largely oriented towards cataract surgery and glaucoma care in more rural areas, then towards teaching in the field of paediatric ophthalmology and strabismus in large city hospitals. There seems to be a never-ending amount of service needed in these countries, although, over time, the ability of colleagues to provide service to their own people has increased. However, as the cataract backlog is reduced, there develops an interest in learning specialised ophthalmic concepts and surgery techniques.

Volunteers visiting a developing country should not make assumptions based on previous visits because perceptions and conditions in the country vary. It is essential to have good communications with colleagues in the country visited.

The recognition and application of three major principles should be observed on medical mission trips:

1. **Appropriate technology** based on the existing infrastructure and the needs determined at both local and national level.
2. **'Empowerment' of the physicians and paramedical personnel** in the country. This should include informal teaching in the clinic, working together with colleagues in the operating room, as well as formal lectures and courses at centres of medical education.
3. **Project sustainability.** Equipment should be donated to local organisations, such as Lions Clubs or Rotary Clubs with support organisations placed in those Clubs so that return trips can be organised more effectively. There is a need, also, for colleagues in these countries to come for further training in more developed countries. This provides the greatest amount of 'multiplier effect', as then a person can return to his or her own country and devote his or her career to service in ophthalmology – particularly paediatric ophthalmology and strabismus, the specialty interest of the authors.

Appropriate Technology

Supporting the improvement in technology in a developing country should be 'step by

step', rather than by introducing the latest technology, which may remain unused. For example, phakoemulsifiers at small hospitals in the poorly served periphery (e.g., rural areas) may be used by the visiting specialist, after which it may be placed under a dust cover for years. In countries where the water supply is not clean, sediment in the water supply typically contaminates the lenses of lasers, reducing effectiveness and ultimately the use of the laser. It is best to work with colleagues in these countries to select what is appropriate. Surgical instruments are most commonly needed.

Empowerment of Physicians and Paramedical Personnel

Most people in the developing world, including physicians, are so used to diminishing resources and an unresponsive government that they may have given up trying to establish new programmes. It is, therefore, important to empower the physicians and other personnel to improve this situation. Service programmes can bring in visiting specialists with expensive equipment and highly trained technicians to do a large number of operations or procedures in a short period of time. These programmes leave a clear and inappropriate message that visiting doctors can carry out various procedures and the local doctors cannot. Should this type of visit continue as the developing country progresses, the