Gender and Blindness

Initiatives to address inequity

A REPORT BY SEVA

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Federal ID # 38-2231279

Published August 2008

Cover photograph: Women cataract patients at Chitrakoot Hospital, India. Photo by Brian Harris.

INTRODUCTION

Seva believes that, to achieve VISION 2020 goals, eye care programs must develop explicit strategies to reach the most vulnerable populations, particularly women and girls. We encourage our program partners to disaggregate data by sex, determine gender-specific barriers to uptake of services and to study strategies to increase utilization by women. More generally, Seva looks forward to collaborating with all international eye care providers to eliminate all forms of inequities in eye care.

2. HISTORY

In 2000, the British Columbia Centre for Epidemiologic & International Ophthalmology (BCEIO), located at the University of British Columbia, began a Gender and Blindness Initiative. Through a meta-analysis of population-based prevalence studies, researchers at the Centre found that approximately two out of every three blind people in the world were women, most of who were over age 50 years, and ninety percent of who lived in poverty.[1] Furthermore, the researchers found that the sex ratio held true for most population-based blindness prevalence surveys from 'Western industrialized' and economically poorer countries. This sex ratio also held true, albeit for different reasons, for virtually all the preventable and treatable blinding conditions in the world, including cataract, glaucoma, and trachoma. The sex ratio only approached *one* for age-adjusted rates of less treatable conditions such as macular degeneration.

In no instances did biological differences explain the increased prevalence of vision loss among women. Instead, women of all ages (including children) were more frequently exposed to causative factors, such as infectious diseases and malnutrition, and utilised eye care services less frequently than men. Based on these findings, in 2001, BCEIO prepared a WHO Fact Sheet for the WHO Gender and Women's Health Unit.[2]

A Canadian Federal Partnership for Global Health Equity Program funded an initial Gender and Blindness meeting in Moshi, Tanzania from 17-21 June 2002, among women's health researchers, policy makers and

programme staff. Organized by the BCEIO and hosted by the Kilimanjaro Centre for Community Ophthalmology, the participants identified key research, policy and programme priorities.[3,4]

Following on the theme of gender and blindness, in 2003, the Canadian Global Health Research Initiative provided pilot funding to initiate an international collaboration among epidemiologists, anthropologists and ophthalmologists in four countries:

i. Community Ophthalmology Program, Lumbini Eye Hospital, Bhairahawa, Nepal
ii. Lions Aravind Institute for Community Ophthalmology, Madurai, India.
iii. Kilimanjaro Centre for Community Ophthalmology, Moshi, Tanzania
iv. Al Noor Magrabi Foundation, Cairo, Egypt

Gender inequity has been reduced in these eye care programs through local public health initiatives as well as community-based service development (i.e. improved water supply).

The collaborative approach has augmented individual countries' ability to design and conduct applied anthropologic and epidemiologic research. This 'south-south' collaboration greatly exceeds the 'north-south' collaboration with Canadian partners.

The primary finding from this Gender and Blindness Initiative is that utilization of eye care services is strongly associated with socioeconomic status of women and female literacy[5,6] (as a surrogate for

educational attainment).[7] Female literacy remains the strongest independent predictor of health service utilization by women themselves and of an overall population, across all socio-economic levels.[8] Indeed, examples from Southern India show that an indirect investment in female education improves all aspects of public health, through increased use of already available health services, without any additions to the health services themselves.[9]

The Global Health Research Initiative funds for gender and blindness were followed by sustained local program funding in each of the original members of the network. Interest continues from non-government organizations such as Seva[10] and within allied organizations such as the Boston-based Women's Eye Health Task Force.[11]

In the past year, the Gender and Blindness Initiative has attracted new funding to expand the network in Asia from southern India to northern India, as well as central Nepal and Tibetan regions of China; and in Africa to expand from Tanzania to Uganda and Madagascar. The following sections outline the Gender and Blindness Initiative, 'ongoing programs' and 'future expansion', respectively.

2. INITIAL PROGRAM PARTNERS

2.1 TANZANIA:

Kilimanjaro Centre for Community Ophthalmology

www.kcco.net

The Kilimanjaro Centre for Community Ophthalmology (KCCO), established in 2001 under the Good Samaritan Foundation, operates in close partnership with the Kilimanjaro Christian Medical College (Tumaini University) and KCMC Hospital, a tertiary referral hospital for 12 million people, based in Moshi, Tanzania. KCCO's mission is to: "eliminate avoidable blindness through the integration of programmes, training, and research, focusing on the delivery of sustainable and replicable community ophthalmology services."

KCCO helped establish the Kilimanjaro Regional VISION 2020 Task Force to strengthen the effectiveness and efficiency of community-based programs; these activities were subsequently adopted in three other regions (Singida, Tanga, and Mara; total population 5

million) and two regions in Uganda (Masaka and Lira).

With assistance from Seva Canada, KCCO worked to overcome the particular challenges faced by women. KCCO provided better female and family counselling at the 'time of recognition', transporting patients to hospital, and having local field assistants and Ministry of Health staff help identify people in need of care. As a result, utilization of services increased and gender issues became central to eye care program development and staff training at all levels. This effort is best reflected in the community outreach programs where the male:female ratio is 1.3:1. In contrast, the population that approaches the hospital directly for cataract surgery had a male:female ratio of 2.6:1.

With support from funds from the Canadian government and Seva Canada, the KCCO hired a "Gender and Blindness Coordinator" in early 2008. This person will supervise gender and blindness research and be a resource for national and "district" personnel to include gender strategies in their VISION 2020 plans.

2.2 NEPAL:
Lumbini Eye Institute
www.seva.org

The Lumbini Eye Institute (Shree Rana Ambika Shah Eye Hospital) in Siddharthanagar is the main Gender and Blindness Initiative partner in Nepal. This tertiary care hospital and training institute has acted as the focal point for several initiatives to improve community access to services both in the lowland and hill regions.

Lumbini hospital provides a comprehensive outreach program to the Nepali population in Lumbini Zone, including general and school vision screening as well as diagnostic and treatment camps.

Lumbini Eye Institute, as well as its satellite clinics and outreach activities, serves more adult women (54-55%) versus men (45-46%) as outpatients. The ratio is reversed for male versus female children.

Lumbini Eye Institute is linked with secondary eye care facilities, staffed by ophthalmologists, that provide full cataract surgical services, in Tansen, Palpa, a hill district north of Lumbini, and in Bharatpur, Chitwan District.

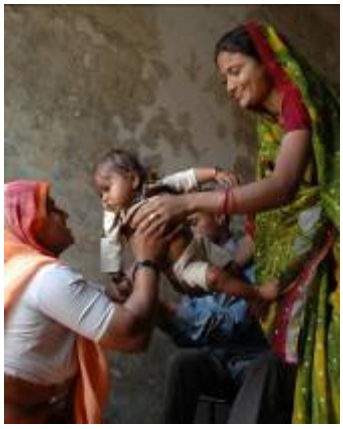
The project based at the King Mahendra Memorial Eye Hospital (Bharatpur, Chitwan District) continues to test and refine strategies to reduce gender bias against women in poor and remote regions. The program intensified community services and surgical referral throughout the zone.

2.3 INDIA:
Aravind Eye Care System
www.aravind.org

The Aravind Eye Care System has acted as one of the principle partners and primary promoters of the Gender and Blindness Initiative, particularly in India. Aravind Eye System acts as the primary training and consulting resource for the affiliated eye care programs in the Indian subcontinent.

The Gender and Blindness Initiative has been incorporated into a new model of community care focused on Vision Centres. The overall objective is to offer primary eye care services to the targeted rural population. Each Vision Centre is designed to provide the primary eye care needs for a population of about 50,000 people. Vision Centres are comprehensive because services are provided to all the age groups at any time.

The Gender and Blindness Initiative supports the gathering and analysis of utilization data from all community ophthalmology programs. The main finding to date is that the uptake of services for cataract surgery is much less than expected, by both men and women. As a result, Aravind staff plan a study of "barriers" to the utilization of cataract surgery.



2.4 EGYPT:
Al Noor Magrabi Foundation
www.alnoor.org.eg

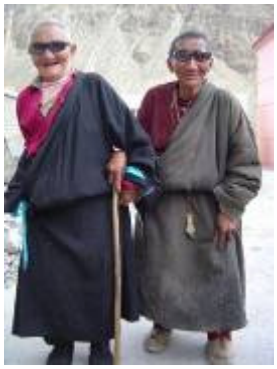
Al Noor Magrabi Foundation provides the only active community outreach activities in Egypt. Their interventions are aimed at increasing the volume of cataract surgery through the outreach caravans and a charity hospital.

National policies have begun to recognize the unnecessary burden of blindness, particularly due to cataract. This recognition has, to a large extent, been dictated by the population-based epidemiological studies conducted by Al Noor Magrabi Foundation in Menofyia (1999)[12] Menia (2002)[13] and Fayoum (2003)[14] Governorates.

The three studies conducted by Al Noor documented the high prevalence of low vision and blindness, under-utilization of eye care services, and barriers to access to eye care. Women with visual problems account for around 67% of the total, adjusted for age, and irrespective of any biological attribute. Women were found to utilize eye care services 40% less than men due to gender-specific and socioeconomic barriers.

Al Noor found the prevalence of low vision in adults exceeded 20%, the critical threshold set by the WHO, while the prevalence of blindness is 10% in rural areas.





3. FUTURE EXPANSION

3.1 Tibetan regions of China

A population-based survey found that the prevalence of cataract blindness in the Tibet Autonomous Region of China is one of the highest in the world.[15] Cataract surgical coverage (vision <6/60) for people age 50 and older (85-90% of cataract blind) was 56% overall, 70% for men and 47% for women.[16] The most common barriers to use of cataract surgical services were distance to eye care services and cost.

Eye Health Education

A project has begun to establish an outreach program in the Tibetan Autonomous Region. The objectives of the project are to plan, conduct and evaluate Primary Eye Care Training Workshops for rural health workers. The participants of these workshops included doctors of traditional Tibetan Medicine, county and village level health workers, and a few nurses with Western medical training.

3.2 Africa

Spreading the Gender & Blindness messages

The Kilimanjaro Center for Community Ophthalmology (KCCO) has facilitated VISION 2020 national and district planning workshops in Egypt, Uganda, Rwanda, Ethiopia, Tanzania, and Malawi which included gender specific programs and planning. At an African international – non-governmental organization meeting in Ethiopia in 2005, KCCO agreed to design a district-level VISION 2020 "dream team" and to compile information on training programs throughout Africa.[17,18] ; this was presented and adopted at a follow up meeting in Ghana in 2006.

Uganda and Madagascar: VISION 2020 planning

At the request of local colleagues and donors KCCO is assisting the Uganda and the Madagascar National Prevention of Blindness Programmes to develop a number of initiatives. These initiatives include addressing the gender gap through developing and

implementing practical plans that will address gender inequity.

4. NEXT STEPS

Gender and Blindness partners will continue to advocate through email, website development, and resource materials locally and with the IAPB. As programs develop the Network partners will provide them electronically for eye care professionals and program planners.

The Network will also continue to advocate for creation of "Gender & Blindness" program staff for key international regional development: Tanzania for eastern and sub-Saharan African region, Egypt for the eastern Mediterranean region, India in itself, and Nepal for the Himalayan region.

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TWO-THIRDS OF ALL BLIND PEOPLE ARE WOMEN, primarily because they are treated less than half as often as men. This disparity is even more pronounced between girls and boys.

Seva has taken explicit leadership in the gender and blindness global initiative. All Seva-led projects work towards achieving gender equity by focusing on overcoming traditional barriers to women's and girls' access. The barriers that prevent women and girls from receiving surgery vary locally and can include:

- *Cost of surgery*
- *Inability to travel to a surgical facility*
- *Differences in the perceived value of surgery*
- *Lack of access to information and resources*
- *Fear of a poor outcome*

Awareness of the problem is not enough. Political will and social action are needed to address gender inequities in use of eye care services. It is our belief that in order to achieve the goals of VISION 2020, gender inequities in eye care must be a priority for all organizations.

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