



## Reducing gender inequity in eye care: translating our knowledge into action

March 11-13, 2010  
Moshi, Tanzania

### Background

The first International Gender and Blindness meeting was held in Moshi in 2002, co-hosted by the Kilimanjaro Centre for Community Ophthalmology (KCCO) and the British Columbia Centre for Epidemiologic & International Ophthalmology (BCEIO), and funded by various Canadian government agencies. There were policy, programme and research recommendations from the meeting; much has been accomplished in the intervening years. Considerable visibility has been created, research has led to a number of successful models, and many organizations have changed policies. IAPB and the WHO selected “Gender and Eye Health” as the theme for World Sight Day (WSD) 2009 and this led to creation of considerable advocacy materials, connections outside of eye care, good corporate support, strong interactions with WHO EMRO support, and mainstream and specialist media interest. WSD was the leverage to get the NGOs in the US to form themselves as a group (VISION 2020 USA). Building on successes, there was a need to outline the next phase of work.

### Meeting in Moshi

The meeting in Moshi brought together researchers, planners, NGO staff, WHO and others from Nepal, India, Tibet, Egypt, Kenya, Tanzania, Malawi, South Africa, Congo Republic, Guatemala, UK, USA, and Canada. The meeting reviewed the progress since 2002; individual researchers discussed their work and implications of their findings. Small group sessions focused on how to use the lessons learned to assist develop policies, revise programmes, and undertake new research.

### Key issues arising from the meeting

There were a number of key issues arising from the meeting. These are listed below:

- In the next phase of work researchers and others need to explore ways to link gender and blindness efforts into the broader health, equity, and poverty reduction strategies. This would help enable programmes to have a broader impact (beyond eye care and even beyond health care) in the long term.

- While the existing programmes have been successful there is a need to roll-out or scale up these efforts. Doing so requires us to better understand the key factors that have led to their success. In addition, there is a clear need to define how the existing programmes can be revised to become more embedded within existing initiatives (such as microfinance).
- Improving gender equity is a long term goal; getting there requires a long term partnership between a number of different groups, including NGOs and local women's groups. These partnerships will require time to build trust; trust is a crucial component to these relationships.
- The messages promoted through the gender and blindness work have not reached many groups and it is important to identify how to "get the word out" better. This will have to be done through many different networks, by many different groups, and to many different audiences.
- While the last 8 years has seen a significant growth of evidence, much of this evidence has yet to be widely available. Getting the evidence into the mainstream scientific literature, while essential, is still insufficient. Other ways to ensure that this evidence is widely disseminated is needed. Additional research is also required.
- There is a need to expand the current interest group, creating an Alliance in which all partners have a similar goal and mission. This would be a logical next step in the work of the informal group.

#### Brief reports from specific country presentations

##### Nepal

Colleagues from Lumbini Eye Institute first started to look at the data after their participation in the Moshi 2002 meeting. After much training of a wide variety of groups (traditional healers, pseudophakic motivators, school teachers, others) the female community health volunteers were identified to be the most effective in improving gender equity. Female community health volunteers (FCHV) are involved in eye care in order to increase utilization of available services, increase equity for women and girls, and integrate eye care into health care at the community level. A recent innovation is that patients who come as referral from FCHV get a 50% discount on cataract surgery.

##### Tibet

In the Tibetan areas of China, the Seva Tibet programme has assessed gender equity in the use of eye care services provided at various eye clinics. The programme staff in Tibet are exploring the best methods for addressing the disparity noted.

##### India

Colleagues at the Aravind Eye Institute started assessing gender equity in the past few years. The current work has included looking at gender differences among the three different admission streams (walk-in paying, walk-in free, free camp). Women account for more of free services while men account for more among paying. Based upon the findings, the Aravind team is looking for ways to modify their models.

##### Guatemala

Social status of women is lower in Guatemala compared to other Latin American countries. Recent research has shown that Guatemala has gender disparity in blindness and cataract

surgical coverage, however there is considerable variation according to the population (generally, urban populations have good equity). Indigenous populations (particularly women) lack social power and suffer from abuse. Social connections are important to urban women, assisting accompaniment; this need to be explored better with rural women.

#### Egypt

Gender equity work started in 1999 through trachoma control efforts (in particular, hygiene). Programme activities started from 2002 (after the Moshi meeting). A survey in Menia showed that women had higher blindness prevalence figures compared to men. Community education programmes led to increased use of services by women and reduction of blindness in women. Al Noor has prepared a “Gender and eye Health” training package for community health workers and they have strong links with partners outside of eye care activities.

#### Kenya

A study in Kwale sought to assess reasons why people did not come forward to accept free cataract surgery. Women have limited decision making capacity in this setting. Widows had much greater ability to make decisions than married women. Community based efforts are required for counseling.

#### Tanzania

The Tanzania project aimed to decrease gender inequity in use of eye care services. Sentinels were trained on counseling, community mobilization, awareness creation, and data collection. While there were significant changes in the use of services there has not been a significant impact on acceptance of cataract surgery. This may be due to a number of factors, including different ethnic and tribal groups. There is a need for further data analysis and research. The group is keen to explore how to work with micro-finance programmes.

#### Malawi (childhood)

The team in Malawi has been testing the ability of HSAs (primary health workers) compared to key informants to find kids with vision loss. Similar numbers of male and female health workers and key informants were trained. About 35% of childhood cataract surgical cases are in girls. In Malawi the uncle is the person who makes the decision regarding use of services.

#### Tanzania (childhood)

There has been a large increase in the number of children receiving surgery but still gender inequity persists in use of services, with about two times as many boys as girls. Follow up used to be less for girls compared for boys. After interventions were put into place to address the problem; gender inequity in follow up was eliminated. These lessons learned have led KCCO to apply these strategies in other settings.

### **Recommendations and action plans**

Based upon the findings from the meeting, the group has created a number of recommendations. For each recommendation, there is a specific action plan which members have agreed to undertake.

#### **1. There is a need to link the gender and eye care activities to the broader health, education, equity, and poverty reduction initiatives**

Actions to be taken:

- Update the IAPB Blindness, Poverty and Development document (Abi)
- All members of the Alliance will frame documents in terms of equity

- There is a WHO meeting on chronic diseases in October 2010: blindness (and gender equity) should be included in these discussions (no individual identified to carry this forward)
- Explore how the Alliance can interact with the Global Forum for Women's Health and identify all of the global women's health movements to see what are the opportunities to link eye care and gender (Gamal and Lene)
- Prepare two page document that can be used to include gender and eye care gets into the broader gender, health, education, and equity discussions (Penny/Abi/Gamal)
- Explore how to include the issues of blindness prevention and gender and blindness onto the agenda of regional forums such as SADC (Lene)

**2. Gender equity needs to be included in national blindness prevention strategic plans**

Actions to be taken:

- Prepare fact sheet template that can be adapted for use at the national level (Suzanne)
- Interact with the Evidence Informed Policy Network (at WHO) to develop policy briefs. REACH (eastern Africa) (Robert)

**3. Partnership between eye care programmes and local women's groups needs to be fostered and strengthened**

- Identify prospective partnerships within countries (a person from each country will be responsible to identifying the potential partnerships)
- Create a formal structure for the gender group: Gender & Eye Health Alliance GEHA)—single voice, identity (Penny to draft the mission statement, objectives, etc.)

**4. Multi-audience publications and training packages need to be developed and disseminated (community, programme level, training institutions, global, donors/funders)**

Actions to be taken:

- Prepare one page rationale on global gender equity and eye health (Abi/Penny)
- Prepare Gender Equity Check List that can be used by NGOs, WHO, IAPB, etc. (Suzanne)
- Develop Wiki based website on gender equity and eye health (Abi)
- Prepare case studies (impact on patient lives, on community, on eye care service delivery programme) and send to Abi (all members of the Alliance)
- Prepare training packages or modules on gender equity and eye health for eye care training programmes, public health training programmes, etc. (Paul)

**5. There is a need to link the gender and eye care activities with the various approaches to strengthening health systems (monitoring, human resource development, etc.)**

Actions to be taken:

- Identify opportunities for linking the Alliance with other (non-eye care) funding opportunities (Robert)

- Carry out situation analysis of monitoring gender and eye care reporting (work with Erlene and others to find out which countries report data disaggregated by sex (Paul for Africa, Kandel for Asia)
- Create a job description of a gender and blindness coordinator and encourage its adoption (Herieth)

**6. All eye care NGOs need to include gender sensitive reporting within their programmes**

Actions to be taken:

- Carry out a situation analysis of eye care NGOs reporting on gender disaggregation of data (and programme activities) (Lene)
- Prepare some “best practice” models which can be communicated to all through forums (Suzanne/Paul)
- Publications on gender and blindness will be compiled into a central site where people can request. A periodic service of notifying people of new articles will be developed. (Paul)

**7. Operational research is needed to further elaborate successful programmes , the benefits of gender sensitive approaches to eye care service delivery and other health and social development, etc.**

Actions to be taken:

- Document what has been accomplished to date, particularly the women to women activities. Prepare a proposal for carrying out a multi-country assessment. This would include having research teams visit other programmes to build capacity. (Ken/Kandel)
- Explore potential funding sources for additional research (Robert)