Improving gender equity in eye care: advocating for the needs of women


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Of the people who are blind in the world today, 64% are female.[1] There are three main reasons for this:

- in many countries, women live longer than men and are at greater risk of blindness from causes related to age (such as glaucoma and age-related macular degeneration)
- some blinding conditions, such as trachoma and cataract, are more likely to affect women than men, whatever their age
- women and girls do not access eye care services as often as men and boys.[2,3,4]

There have been efforts in some countries, such as Pakistan[5] and Tanzania,[6,7] which have been effective in increasing the use of services by women. However, most communities, political leaders, and even some eye care workers are not aware of this problem.

Ensuring equal access to eye care services for women will require advocacy at all levels: national, district, and community.

Although it is beyond the scope of eye care programmes to change gender roles and expectations, gender issues that affect VISION 2020 goals need to be addressed.

National level

At the national level, for example national government or the national department of health (where policy and overall strategy are developed and agreed upon), advocacy should be focused on the following:

- getting decision makers to acknowledge that there are gender differences in access to eye care
- persuading decision makers to commit to finding ways to increase access to eye care for women of all ages.

Although data from local clinics, districts, and individual countries would be very useful to demonstrate the magnitude of the gender imbalance, these are often not available. However, you can still use global data, such as reports from the World Health Organization (WHO),8 to inform people in government and in other organisations of the situation, the needs, and the potential solutions. Many organisations and governments have departments devoted to gender issues; it is helpful to contact key people in these departments and work with them at the national level.

Advocacy should also be focused on the monitoring of VISION 2020 data by sex. Although the sex of patients accessing eye health services is often routinely recorded and reported at the district VISION 2020 level, this information usually isn't passed on and reported at the national level. In most settings, any change to the reporting format will be quite simple; the major challenge will be to convince decision makers that they should ensure this is routinely done. WHO, IAPB, and VISION 2020 could support this by changing existing reporting formats and requiring that data reporting at all levels be done by sex. Non-governmental organisations (NGOs) should also routinely collect data by sex.

District level

As a first step, it is extremely helpful to generate local evidence; this can be done by collecting data from the reports of clinics and surgical services (cataract, glaucoma, and childhood cataract) and by collecting data about spectacle sales. In-depth interviews with both men and women can highlight the factors that limit the use of services by women and girls. This evidence can inform district health authorities and NGOs about the importance of being sensitive to the needs of women; such evidence can also be used to design programmes in a way that will allow and encourage women to access them.

> **'Some communities don't appreciate that women need eye care services just as much as men do'**

Community level

At the community level, advocacy needs to be targeted at both community members and eye care service providers. In our experience, some of the main messages at this level are:

Restoring vision restores contribution to the household and community

In many communities in developing countries, it is often not recognised that women need eye care services – including sight-restoring operations – just as much as men do. Poor families need to make difficult decisions about how to use their scarce resources, based on complex considerations of costs and perceived benefits; they may not realise the value or benefits of sight-restoring surgery for women. Therefore, it is important to help families recognise that cataract or trichiasis operations can restore sight and enable women to contribute to the family once again.

Cataract surgery should be done when vision loss interferes with the activities of daily living

Due to well-known factors that make women less likely to access eye care services, women are generally more likely than men to be blind before they make use of eye care services.[9] Once women become blind, additional barriers (whether imposed by the society or by the individual) make it even more difficult for them to use eye care services.[10] It is better to promote the concept that eye care should be sought as soon as decreased vision starts to limit activities that are important to the person and to the family.

This problem can be made worse by programmes that have rigid visual acuity cutoff points for cataract surgery (for example, only operating on people with visual acuity <6/60 or <3/60). There is evidence that, once a patient is told, "your cataract is not mature, come back later," many come back only much later, or they do not come back at all.[11] Rigid visual acuity cutoff points for surgery seem to be most common in settings where there is no counselling provided and where the potential benefits of cataract operations are not discussed with the individuals and their families. Operating on patients with moderate visual impairment, in addition to those with severe visual impairment or blindness, is strongly recommended. It should also be combined with a good quality counselling service whenever possible.

Even older people can have eye operations

Advocacy is frequently needed to help communities understand that even older people can have eye operations. Many negative perceptions exist, for example: "Hospitals are places to go and die", "I am too old for an operation", or "There is no one to take care of me while I'm in hospital". Elderly residents often do need assistance to access services. As transportation is probably the most significant barrier for this group, it is essential to work with communities and hospitals to ensure that elderly residents, particularly women, can get to the services. Women often have little experience travelling outside the

A counselling coordinator speaks to a son about his mother's need for cataract surgery. TANZANIA

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community. Experience suggests that, if key members in the community (e.g. religious leaders) understand the relative ease (and benefits) of cataract or trichiasis surgery, they can play a significant role in ensuring that everyone understands the value of eye care, even for the most elderly.

Approaches to community advocacy

Getting these three basic messages into communities will require multiple approaches; there is no one way to do it. Some things to keep in mind are:

To reach women, you need to reach men

Since men often have better access to a family's financial resources and make the financial decisions, advocacy and counselling should be directed at them as well: the husband, if the woman is married, or an eldest son, if the woman is widowed. In some settings, village leaders or religious leaders may have influence over family decisions. Health care workers should be comfortable speaking to these individuals and groups and raising awareness about the needs of women. It may be helpful to involve men whose wives have had eye operations (and who have recognised the value of this) in advocacy activities.

Widows require a special approach

In most developing countries, a large proportion of elderly women are widows. In some settings, widows are shunned, stigmatised, and neglected. Reaching widows can therefore be particularly challenging as their children may live elsewhere and may have minimal contact with their mother. Eye care services such as operations often require the consent of a family member, and eye care workers should use whatever means available to contact the children of widows – whether through community structures or via cellphones/mobile phones. Community women's groups, where they exist, are most likely to know of widows needing eye care services and may be valuable in helping to encourage women to use these services.

Religious organisations can be powerful allies

In most settings in developing countries, religious organisations can be extremely helpful partners in reaching people, women in particular. Religious groups may also be able to assist people who are unable to afford eye care services. The credibility of religious groups comes from within the community and women, although usually not in key leadership positions, often have their own special groups within these organisations.

Conclusion

Achieving equal access to eye care services for both men and women is a long-term goal, and ongoing advocacy at all levels is essential if VISION 2020 is going to reach women.

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