

Barriers to the uptake of cataract surgery for women in urban Cape Town

Aditi Shah

University of Birmingham Medical School, UK.

Groote Schuur Hospital (GSH) is a mainly state-funded hospital in the southern suburbs of Cape Town, South Africa. The majority of patients presenting to the Department of Ophthalmology cannot afford private medical care.

According to the most recent WHO data on blindness, women are 1.5 to 2.2 times more likely to be blind than men (WHO Bulletin Nov 2004). In 2004, a qualitative study was conducted in the Department of Ophthalmology to identify and understand the barriers that women face in accessing cataract surgery in and around Cape Town. Eighteen female cataract patients (14 pre-operative and four post-operative) were interviewed. Two focus groups were conducted, one with doctors and the other with nurses. Interviews with healthcare professionals and paramedical staff were also performed.

The study identified ten major barriers (Figure 1). Whilst the barriers were applicable to both men and women, they were often exacerbated for women.

Transport was identified as a major problem by both health care professionals and women. Whilst the State paid for cataract surgery, the socio-economic costs of surgery such as taking time off work and leaving daily responsibilities, acted as important barriers for women as well as their carers.

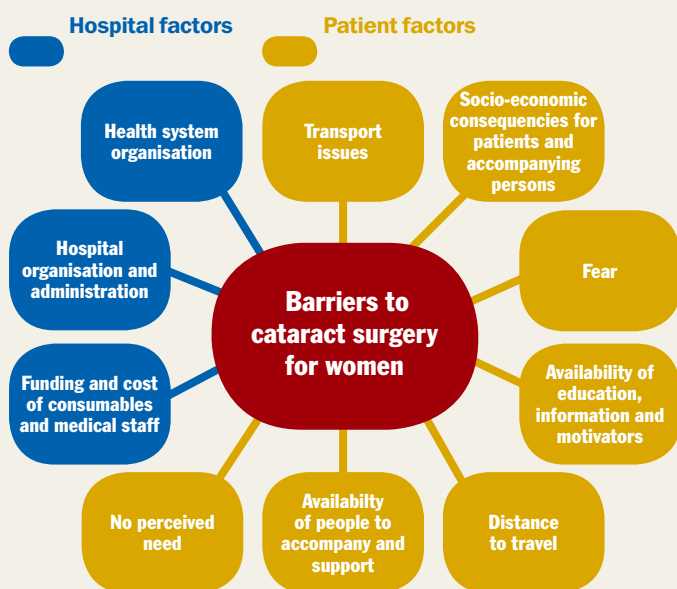
Stated barriers for women at the individual level included fear and lack of education. However healthcare professionals felt that barriers at the institutional and organisational level were more significant. These included availability of funding and the cost of consumables, medical staff and equipment, hospital organisation and administration (waiting times in the day hospitals, patient pathway at GSH, waiting lists for surgery) and health system organisation (lack of resources to conduct cataract surgery at the secondary district level hospitals so the tertiary level was saturated with cataract patients).

Strategies needed to overcome the barriers include:

- Community education
- Increasing the capacity for cataract surgery
- Fast-tracking patients to reduce waiting lists
- Decentralisation of ophthalmic care
- Increased Government and NGO funding for staff and resources
- Intersectoral collaboration (government, NGOs and corporate organisations).

Before these strategies can be implemented, increased resources and funding for the hospital and health-system are needed to increase the capacity for cataract surgery.

Fig. 1. Barriers preventing women from accessing cataract surgery in Urban Cape Town, South Africa



Enhancing the SAFE strategy through collaboration, participation, accountability and sustainability

William Astle, Boateng Wiafe, April Ingram, Mike Mwanga, Colin Glassco

Alberta Children's Hospital, Canada in collaboration with Lusaka Eye Hospital, Zambia.

The purpose of our project was to determine the prevalence of trachoma, and to measure the impact of implementing the SAFE strategy for controlling trachoma in the Gwembe District of southern Zambia. Implementation of the strategy was enhanced by ensuring local input and cooperation at every stage of development. Direct involvement at the village, community and government levels strengthened the commitment to the project, thereby promoting accountability and responsibility for its success.

New, clean water wells were drilled under local supervision for each identified village. All levels of government were aware of the project and approved each well and drilling location. All people living near the wells were screened for trachoma, and then treated with antibiotic if required. Education on personal and environmental hygiene was provided by trained volunteers. Patients affected by significant trichiasis and corneal scarring received surgery, locally if possible. Attempts were made to control fly populations by cleaning villages, penning livestock and digging latrines; this was done in consultation with local villagers and government officials. Data was collected on all variables normally associated with trachoma as well as variables relating to demographics, water quality, environment and hygiene.

In total, 26 wells throughout the valley were drilled. While the total population of the valley area is approximately 60,000 people in an area of 3,600 km², the total sample population totalled 3,892 people, with 54% under 16 years of age. The overall prevalence of trachoma in the area was 45% in 2001; however, prevalence was 52% within the subset of children under 16 years. Two years of intervention has reduced the overall prevalence of trachoma to 6.5%, representing 9% in the child subset, and 3.8% among adults. The drop in prevalence is likely to be due to the interventions but there could also be other explanations.

Problems identified from baseline were: lack of water wells close to the communities; poor personal and environmental hygiene; and lack of awareness of the potential dangers of trachoma infection. It is common in trachoma projects to encounter a high number of patients who do not return for follow-up, yet we had only 4% lost to follow-up in our study, due to the diligence of our staff. This loss percentage is considered quite low in studies of this magnitude.

Continued monitoring will be required for long-term sustainability of our trachoma control project in this area of Zambia. While it is possible to control trachoma if the appropriate risk factors are addressed, an approach including collaboration and active participation at both local and federal levels will increase the long-term success of such a project.

Trachoma prevalence in southern Zambia

