compounded when a foreign surgical team arrives, provides free surgery and undermines the trust being gradually built up by the local eye doctors. Ogoshi also refers to the problems that arise from free eye camps threatening the sustainability of permanent eye hospital services.

## Increasing the motivation to take up cataract services

Addressing the barriers to uptake of surgery is crucial, but still may not be enough. People need to be motivated to act. Motives or reasons for changing behaviour or spending money and energy on acquiring something, are described in marketing terms as 'consumer drives'. This concept captures the notion of internal tension between the desired ideal state (sightedness for oneself or a family member) and the actual state (diminishing or lost sight). This arouses motivation, propelling the individual and 'close ones' to seek solutions. The information that cataract is curable might not arouse sufficient drive to take up the services. However, the value placed on sight throughout the life span might provide the motivation to act. Every context is different, and this is why qualitative methods are becoming more widely valued as a way to understand the mindset and motivations of users.

## Increasing accountability

The value of involving satisfied patients is well recognised. Perhaps there is also a role to be played by the less satisfied patients. This is potentially sensitive, but in-depth understanding of their experiences, and reasons for dissatisfaction, might provide insights to help providers make services more responsive to patients. It is interesting to note in the article by Kuper *et al.* that the Rapid Assessement of Avoidable Blindness (RAAB) methodology includes a question to those who have undergone cataract surgery, to find out details of their operation, including satisfaction.

## Conclusion

Much has been written about increasing uptake of cataract services. In this issue of the *CEHJ*, we present recent experiences and case studies on increasing the use and demand for cataract services amongst specific groups (women) and populations in China, Mexico, Nigeria and Cambodia.


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# Increasing uptake of eye services by women


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## Is there a problem for women?

It often surprises people, but it's no secret to eye health workers in poor countries, that patients who live with blindness and low vision in these countries often do not make use of existing services. Many programmes, particularly in Africa, struggle to get patients in for surgery. How many eye health workers also know that the problems of access and acceptance are generally worse for women than for men and that women comprise a disproportionate number of the world's blind?

Figure 1 shows the proportion of blind who are female in Asia and Africa.[1] Why does this imbalance occur?

It is well established that the major cause of blindness in poor countries is cataract. Figure 2 is derived from population-based surveys in several countries and shows that 60 to 65 per cent of those blind from cataract are female. This is partly because women live longer than men and thus are more likely to develop cataract. In addition, women have been shown to have a slightly increased age-adjusted risk of cataract.[2] Cataract blindness, however, can be cured, or even prevented if the operation is done early enough, and herein lies the crucial imbalance: women do not receive cataract surgery at the same rate as men. Figure 3 shows the cataract surgical coverage (which measures the proportion of the need for cataract surgery in the community that is being met) reported in a number of studies. These coverage figures are higher for men.[3-5]

This inequity is often overlooked because

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***Figure 1. Gender differences in the burden of blindness in the population***

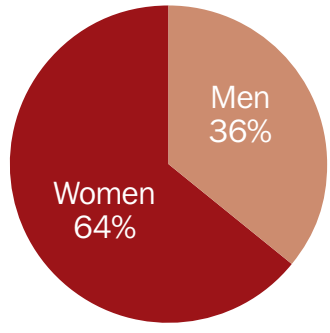



***Figure 2. Estimated percentage of people with cataract who are female***

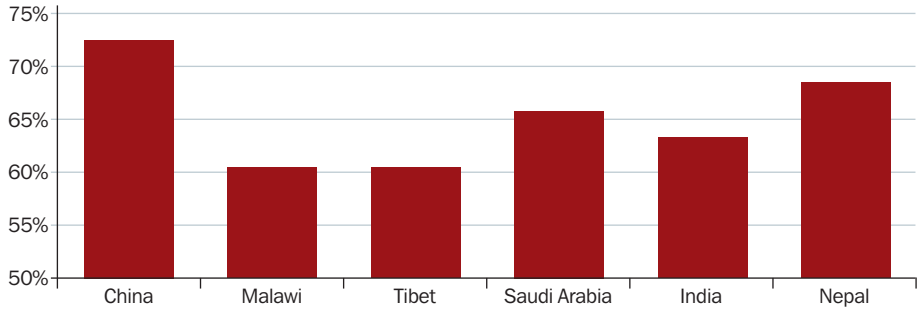
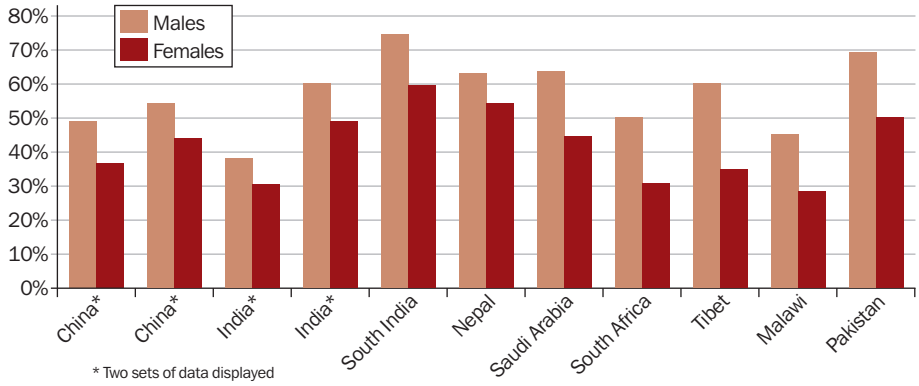



***Figure 3. Data on cataract surgical coverage from various studies***




* Two sets of data displayed

most programmes report about the same number of cataract operations performed in women as in men. The chances are, if you look at the records of your hospital, you will find a 50/50 split by gender in the number of cataract operations. However, since women have more cataract to begin with, we should perform about 60-65 per cent of our cataract surgery in women, if we are to achieve equality in cataract surgical coverage for men and women. We find similar inequity in glaucoma. Chronic open-angle glaucoma (COAG) is the second leading cause of blindness in sub-Saharan Africa. It occurs equally often in males and females, yet males comprise around 70 per cent of new COAG patients at the two largest referral eye clinics in Tanzania[6] (also authors' own data).

Hospitals and clinics are not deliberately discriminating against women, but women face special problems in accessing services. We need to consider these in order to plan solutions.

## What special problems do women face?

The *Community Eye Health Journal* has published articles discussing barriers that prevent patients from accessing services. We like to think of barriers occurring at three levels: lack of awareness of services, lack of access to services, and reluctance to accept services. All three of these types of barriers tend to affect women more than men. Consider the following:

### Awareness

Women are less likely to be educated than men. They are therefore less likely to be aware that some blindness can be cured, to know where to go, and to know how to get there. Elderly women, with little or no formal education or exposure to hospital settings, may have more concerns and questions than men regarding surgery. Language barriers or unfamiliarity with the health system can lead to decreased awareness of health care services by some women.

### Access

Travelling away from home for surgery is hard for all old people, but it is often more difficult for women. In many cultures, women have little money or control over how money is spent. Many elderly people depend mostly on their children to cover the costs of cataract surgery. We found in Tanzania that young heads of households are less likely to encourage and support old women to go for surgery than old men. In many cultures women cannot travel unless accompanied by a male, and the lack of someone to accompany them can also be a barrier.

### Acceptance

Quality of life expectations in old age are gender-specific in some cultures and the perceived 'benefit' of cataract surgery may be gender-dependent. For instance, elderly men expect and are expected to participate in community meetings; their involvement requires mobility. Women, on the other hand, may be more confined to the house.

In summary, men and women all face the same barriers, but many of these are more difficult for women to overcome.

## How do we help women have access to services?

Our experience in developing and studying VISION 2020 programmes in eastern Africa indicates that several essential components must be in place if a 'community' is to have access to an eye care service. These are shown in Figure 4. We have found two specific components to be especially important to ensure care for women: transportation and counselling. Both can be built into whatever strategy the programme uses to establish a 'bridge' between the hospital services and the community.

### Transportation

Hospitals are still widely scattered in resource-poor countries and patients often cite distance as a barrier. Either the surgical team has to go to the patients or the patients must come to the surgical team. We have found that females are significantly more likely than males to access services through programmes that provide transport from rural areas; they are less likely to come to the hospital on their own.

### Counselling

This task is often assumed to be done by nurses. Sometimes it is, but more often it is neglected or given little attention in a busy clinic or screening session, where a nurse has other duties to perform. It is preferable to have one person solely dedicated to the counselling task during the clinic or screening session; this ensures that patients and their families really have a chance to have their questions answered. Accepting surgery is a family decision and engaging the family through good quality counselling is essential. The counsellor needs to be very familiar with all aspects of the process. What will happen in the hospital? Will the patient be alone? Is surgery painful? How long is the hospital stay? How will the patient get back home? How much will it cost for surgery and 'extras'? What if the patient wants to wait until next month? Patients need answers to these questions before they can agree to surgery.

In addition, there are other ways in which programmes can target women. Special educational programmes with women's groups help to raise awareness among women about eye health. When women meet other women who have had successful surgery, they are more likely to accept surgery themselves. And let us not forget that men – husbands, brothers, and sons of visually impaired women – are always part of the decision-making process. They need to know that women have the same 'right to sight' as men do.

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***Figure 4. The bridging strategy***