

Guest editorial

Rethinking eye care: from exclusion to equity

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Eye care services have expanded rapidly in Nepal from one eye department in Kathmandu with 16 eye beds, one eye department with 4 beds each in general hospitals of Biratnagar, Birganj and Pokhara in the late 1970s to a network of 20 eye hospitals, 18 eye departments of medical colleges/general hospitals, 54 primary and secondary eye care centers and over a hundred private clinics in 2008. The number of service users is close to 2 million every year. The number of cataract surgery has gone up to 60,000 reaching a cataract surgical rate (CSR) of 2,000 cases per million population per year (Nepali patients). The number of eye care providers has increased to 150 ophthalmologists (from 7 in the seventies), over 350 ophthalmic assistants and over 50 optometrists. National programs exist for control of Vitamin A deficiency, trachoma and for provision of low-vision services, some integrated with existing health infrastructure, others independent of it. Several NGOs and INGOs are working in the country bringing in technology and resources.

Although no national survey of blindness has been conducted in recent years, the data pooled from various sources indicate that the prevalence of blindness in Nepal has declined only marginally from 0.84 % in 1981 to a still high of 0.74 % and the number of blind persons has increased from 117,634 (for a population of 14 million) in 1981 to 210,000 in 2008 (for a population of 28 million).

We are now confronted with the challenge of addressing this paradox of an increasing number of blind persons in the country despite rapid expansion of services. A casual explanation of this could be that the facilities have not kept pace with increase in population hence resulting in inadequate access to eye care. We no doubt need to expand our eye care services several times more than the existing ones, but we also perhaps need to ask ourselves:

Is insufficiency of eye care infrastructure a sufficient reason to explain the almost static prevalence of blindness or are there other factors contributing to this state of affairs that we have overlooked?

The Study done by Nepal Gender and Eye Health Group (2009) has shed new lights with regards to the state of blindness and this work may hold some of the answers to the apparent paradox.

Nepal Gender and Eye Health Group reviewed data of 2,453,858 patients attending 16 eye hospitals of Nepal over a 3-year period (2006, 2007, 2008), 142,457 service users in eye camps in different parts of Nepal over a one-year period (2008) and data from a house to house survey of 28,640 individuals in systematically selected clusters in 11 of the 14 zones (2008-2009) of Nepal using WHO Rapid Assessment of Avoidable Blindness Protocol (RAAB) to provide population-based data.

Using this comprehensive, and probably the largest national database on gender and eye health, the Group concluded that the problem of gender inequity in eye care in Nepal is:

Profound, as one-third of the women who need services still fail to utilize them. Over a 3-year-period, 1.2 million men accessed eye care as did about the same number of women. However, given the fact that two-thirds of all blindness occur in females, it clearly emerges that 1.2 million fewer women accessed eye care services than needed to achieve gender parity.

There is a similar gap in access to surgery by women, which is also one-third less than needed to achieve gender parity (men-180,352, women - 181,711). Gender parity would require that there be at least 2 women for every man undergoing surgery. Additionally, women report late and with advanced degree of visual loss compared to the men. Slight improvement in utilization of services by women at eye camps is still far below the number required for achieving gender equity.

Persistent, as evidenced by the fact that the Nepal Blindness Survey of 1981 showed that of all the blind people at the time of the survey, 60 % were female. The more recent National Census of 2001 has shown that 67 % of blind persons in Nepal are women. This 2009 study also confirms that inequity has persisted over the last 28 years or even longer.

Pervasive, as it is there from the east to far west, from north to south and in adults and children. It is there in the mountains, the hills and the plains, only even worse in the plains.

Much to the surprise of the group, the study also found that of the 2,453,858 patients attending these 16 hospitals, there were only 326,841 children. This is less than 14 % of all service users although children constitute 40 % of Nepal's population. Looked at simplistically, one may be tempted to attribute this to a prevailing notion that the children have fewer eye problems. Available evidence, however, indicates otherwise. The Bhaktapur Eye Survey (1986-87) showed that 30 % of children have some or other eye problems at a given time. More recent studies on refractive status of school children¹² have shown that at least 15 % of school children have refractive errors. Available evidence therefore strongly indicates that a large number of children are currently being missed out by Nepal's eye care system. The march of time seems to have left many Nepalese women and children behind it so far as eye care is concerned.

We also have some information from other studies revealing inequity based on geography. The population based Rapid Assessment of Avoidable blindness survey of persons 50 years and older showed a very high prevalence of blindness in Narayani, Bheri and Karnali zones of Nepal. Performance indicators such as cataract surgical rates and cataract surgical coverage are also seen to vary greatly between the regions and the ecological terrains, with a CSR of 460 in the mountains; 1, 310 in the hills and 2,435 in Terai (Ruit S et al 2006).

In the absence of caste, ethnicity and level of income –disaggregated data, it is difficult to know what proportion of those utilizing services are women and children from lower castes, ethnic minorities, indigenous populations and other marginalized communities. **The full extent of inequity in eye care, therefore, remains undetermined and what we have come to know today may only be the proverbial “tip of the iceberg”.**

While a lot remains to be discovered, what we know already is sufficient to trigger action. **The process of exclusion needs to be corrected urgently. A twin track approach** may be our best bet-continued efforts to expand general eye care services to enable all to access services and a targeted eye care service focused specifically at the marginalized communities. This is perhaps the quickest way to address the problem of exclusion if we do not want to wait for the effects of non-inclusive development to trickle down.

References

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