GENDER DIFFERENCES IN AVAILING NGO BASED EYE CARE SERVICES IN NORTH –WEST PARTS OF PUNE DISTRICT, MAHARASHTRA, INDIA.

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Abstracts:

The health NGO working in the study area, organizes free eye screening camps for last 30 years, observes gender differences in availing operative treatment for cataract as well as probable socio economic factors responsible for it, in the north-west parts of Pune district, Maharashtra.

Key Words: *Ophthalmic, glaucoma, NPCB, Vision—2020, Cataract*

Vision-2020, the program launched for blindness eradication is estimated that about 314 million people are visually impaired worldwide and 45 million of them are blind. Most people with visual impairment are older, and females are more at risk at every age, in every part of the world. About 87% of the worlds visually impaired live in developing countries. The number of people blinded by infectious diseases has been greatly reduced, but age-related impairment is increasing. With increasing life span senile or old age blindness is a major challenge Worldwide. Its more severe for women population as their longevity is more than men. Cataract remains the leading cause of blindness globally, except in the most developed countries. Correction of refractive errors could give normal vision to more than 12 million children (ages five to 15).About 85% of all visual impairment is avoidable globally.

1.Indian Challenges for blindness eradication

Prevalence and controlling blindness is one of the major ophthalmic health challenges in India. The national record of average blindness is 1% of 122 crore people of India. India accounts for 20% of the global blind population, having 7.8 million blinds, out of 39 million across the globe.[1] 62% blindness in India is on account of cataract, 19.7% refractive error, 5.8% glaucoma and 1% corneal blindness. Prevalence of childhood blindness is 0.8 per thousand children with a total of 300000 blind children in the country. The blind population in India is estimated to rise to 15 million by the year 2020. There will be a huge burden of vision impairment, particularly in rural India. Medically, it has been proved that cataract surgery is an acceptable intervention to the age-related blindness, but the levels of acceptance nationally for this intervention are extremely poor.

Majority of population in India still resides in rural areas where as medical facilities are concentrated in urban pockets. Thus a large proportion of patients in rural India continue to remain blind. India is a vast country with geographical, linguistic and cultural diversities and a complicated socio-economic structure. Any one model of blindness control does not suit the entire nation. Installation of eye care medical units is not the only solution towards eradication of blindness in India. The important challenges are confidence building; awareness and psychological acceptance towards eye care among the patients. Advancement in technology & medical facilities are meaningless unless they are accepted by the society. No wonder India accounts for one of every three cases of blindness caused by cataract in the world. Thus with high population and increase in life expectancy, ophthalmic problems are also enhancing. Women are biologically blessed by larger life span, hence old age group outnumber females as well as ophthalmic problems like cataract and blindness.

The major issues in the expansion of eye care services in India are acceptability, accessibility and affordability. Gender equality and providing proper medical help to women can reduce blindness burden in the country.

This paper focuses on the gender based ophthalmic problems, acceptance level for available medical services and socio-economic factors responsible for it.

2. "National Program for control of blindness" (N.P.C.B)

India is the first country to launch a "National Program for control of blindness" (N.P.C.B) in the year 1994. It has been well received by the government as well as various organizations. Now India has committed itself for "vision 2020: the right to sight" initiative launched by the World Health Organization to reduce avoidable blindness worldwide. While implementing this ambitious program one has to consider the gender inequality in Indian society, gender difference in blindness prevalence and its impact on acceptance for eye care treatment. In spite of the effort from all the sectors there is a huge backlog of avoidable blindness. The role of health NGOs is crucial in making the N.P.C.B. program successful.

The Study Area

North-West part of Pune district, Maharashtra, comprises mainly Junnar ,Ambegaon&Shirurtahasils. Local NGO in the eye care sector has been rendering free services to rural poor's & people residing in inaccessible mountain areas.There are 185 villages in Junnar,143 in Ambegaon& 116 in Shirurtalukas. In Junnar&Ambegaon average 20% villages are located in hilly areas of Western Ghat. Shirur is a drought prone area of Deccan Plateau. Rampant poverty, illiteracy & low economic strata are the main features of the study areas. The hilly area is predominated by schedule casts, schedule tribes &adivasis. Comparatively better development is seen along to Pune-Nasik highway passing through the study region.

3. The action plan was framed to reach to every needy patient consist of the following steps-

- To reach inaccessible remote mountains areas towards needy and tribal people.
- Planned free eye-camps at specific intervals.
- Building confidence with head of village, villagers, particularly women and convince localities through teacher/counselor.
- Announcement of free eye-camps, well in advance, through vehicle with loud speakers.
- Visit the village as per the schedule with well-equipped mobile van and team of staff.

- After investigation selection send cataract patients to hospital van.
- Arrangement of free stay, food, medicines, check-up and pathological test of patients.
- Perform operations, post-operative care like giving protective goggles, etc.
- A gift of new clothes as an additional incentive.
- After discharge, take back patients to the door-steps/homes.
- The hospital builds local capacity by accommodating local health works like general practitioners, paramedical, local leaders.
- Exhibition, posters and film screening during public gathering, fairs and festivals.
- Propaganda for IOL as pointless and safe eye surgery.
- Operated/satisfied patient's presence as a motivator in eye camps.
- Follow up of patients by the team of doctors.
- Develop a community research center under which collect long duration statistical data for better planning.
- Partnership in National Program for Blindness Control (NPBC).

Methodology

The health NGO working in the study area, at Narayangaon, talukaJunnar, for last 32 years in the ophthalmic field has authentic primary data. It runs well-equipped eye hospital on charitable basis. The hospital is authorized center for Government induced NPBC Program me. Free eye screening camps has been organized regularly in the study area. On an average thirty eye screening camps are organized in a month. Patients selected for cataract are treated at the base hospital.

The charitable eye hospital data of last five years through light on the fact that out of the total patients operated for cataract, female number is always more. Primary data of this hospital,year 2010 to 2014 is used for the analysis.

4. Socio-Economic factors responsible for fewer acceptances for availing cataract treatment in the study areas

People in the study area are involved in primary occupations like farming and forest collection etc. So poverty is rampant among people. Western part of the study area is covered with mountains known as Western Ghats, which is remote and inaccessible area with less transport and communication facilities. This is the reason for not accessing general medical and even ophthalmic facilities provided by the charitable eye hospital. There is a lack of awareness about eye diseases and treatment due illiteracy and ignorance. People are busy in farms, thus blind people are ignored as they are of no use. They have joint family system in which any blind person can be accommodated easily. Old age blinds can fulfill basic requirements in joint family so getting eye care treatment is not an urgency for physically fitblindor family members. Blind patients need companion otherwise there is no way for them to get to the hospital. Being a backward area, people have insufficient knowledge about cataract and are ignorant to the eye problems until they are completely blind.

Poor access to information regarding the treatment is also the reason for not availing the treatment. Due to ignorance, many people come late. This leads to glaucoma, which is seen mostly among women. Female patients are ignored as they possess low status in the society.

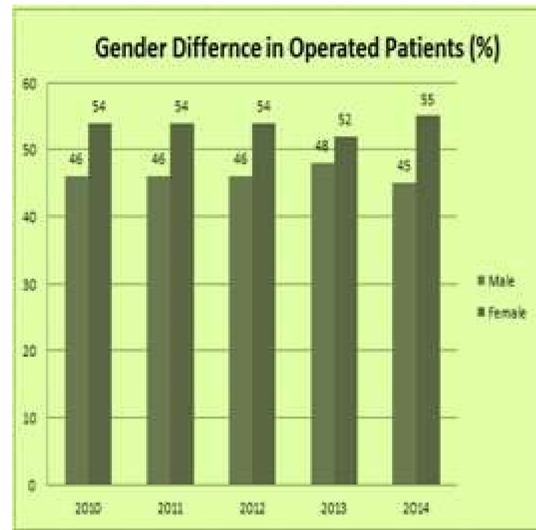
Gender difference in availing ophthalmic treatment in the study area

Cataract blindness in in India is considerably very high (62%) and it is easily curable hence unnecessary. In rural India proportion of age related (senile) cataract is more whereas epidemiological transition is the major cause for non-communicable blindness in urban India. It has been observed that eye care treatment is reaching to the needy people through Primary Health Centers & mainly efforts of NGOs. Organization of free eye camps is the most influential positive determinant for acceptance of eye treatment.50% of the patients only could accept the treatment through eye camps; however, 50% are yet to accept.

Male and female free cataract operations carried in the charitable hospital

Year	Male%	Female%
2010	46	54
2011	46	54
2012	46	54
2013	48	52
2014	45	55

On an average 4000 cataract operations are done in the hospital, in which females are seen more in numbers. 52% to 55% women get operated in the free camp surgery whereas male number is restricted to 45 to 48%. The NGO has sophisticated paid hospital in the same area has more male response from the surrounding region. The average percent availing paid treatment is 63% for male to 37% for females. It shows gender inequality in the study area.

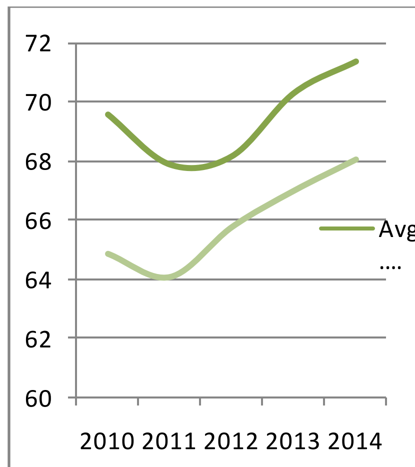


Women's cataract surgery in free camps significantly higher than males due to the following reasons:

Statistics reflect the fact that life span of women in India is more than men resulting more number of women in old age group, and prevalence rate of cataract blindness is more among women for all ages.

The cataract prevalence rate is higher among women due to hardship and low level of nutrients and low status in society. Generally women work in the farms as well as her involvement in domestic work. Rural women cook on fire wood hence ling time eye contact with smoke released from chulha causing more frequent & early age cataract.

Low literacy, lack of information about eye care services and less freedom in decision making process for women are some other reasons



Graph showing Average age for Cataract Operations

There is remarkable age difference in the age of onset of cataract among male and female population. Females suffer from cataract, on an average 4 to 5 years earlier than males.

Important factors responsible for high prevalence & early onset of cataract among females.

More life span hence more old women & prevalence of blindness

low levels of nutrients and low status in society.

Hardship in farms & at home

Smoke from chullha causing more frequent & early age cataract

Low literacy, lack of information about eye care services and less freedom in decision making process

Social-economic implications of blindness

We lose a valuable manpower due to blindness it is not only the loss of family but nation as a whole. It reduces productivity of the nation. Blind people lose their connectivity from family, relatives and society. Patients become dependent and lose their confidence due to visual impairment. It affects the wellbeing of the family as well as society. Patient may go through severe depression and become psychologically weak. A blind person healthy yet without some usefulness feels a burden on family and society. The patient is forced to lead a lonely life, being completely isolated from the community. There are certain examples of remarriage by men because of blindness in first wife. They have to suffer from the taunts and ignorance of the society. This loses their desire to live. The effects are more in women as they are given a lower status in the family. Blindness is a disease which has severe social and economic repercussions. It adversely affects the productivity of the country. It has been estimated that the maintenance cost of a blind person is rupees 300 per month while the loss of production is calculated to be rupees 600 per month.

5. Conclusion

Various factors contributing to increasing levels of blindness have been identified. These include geometric increase in life expectancy, lack of adequate surgical facilities, increased demand for improved vision and problems in decision making and gender inequality.

Thus the acceptability, accessibility, and affordability of cataract surgical services need to be carefully addressed in the light of gender equality, to improve visual efficiency. Senile cataract or age-related cataract is responsible for the largest number of blind people in the country. Socially backward, economically weak and female populations have a much higher prevalence of this disease. In a developing country like India, the prevalence is believed to be much greater and the onset earlier among women. The case study through light on the fact that free of cost cataract treatment is given to large number of women whereas more number of men prefers paid treatment which they feel better than free services. If more women in old age group are facilitated with cataract surgeries, it would certainly reduce blindness burden in the country.

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