



Cataract surgical uptake synthesis review: executive summary

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Acknowledgements

Written by

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Images

Front cover: Kohinoor Begum has an eye exam after her bandage is removed at Jessore hospital February 28, 2017 in Khulna division, Bangladesh. © Sightsavers / Allison Joyce

On this page: A combined team of Sightsavers, hospital staff and medical personnel at Moroto Regional Referral Hospital in Moroto, Uganda. ©Jason J Mulikita / Sightsavers 2017

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A healthcare worker removes bandages from the eye of a patient who has recently undergone cataract surgery in Rawalpindi, Pakistan.
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Executive Summary

Background information

Sightsavers has thematic strategies for eye health and social inclusion. As the organisation aligns its programme work more closely with the central principle of the Sustainable Development Goals (SDGs) to leave no one behind (LNOB), it commissioned an in-depth interpretive synthesis of existing evidence relating to cataract surgical uptake for women and girls, with and without disabilities. As part of this body of work, Sightsavers was keen to review and assess relevant external evidence alongside internal evidence from Sightsavers' evaluations and inclusive data activities, which relates to access and uptake of cataract surgery by women and girls.

Purpose of review

The synthesis review aimed to answer the following questions:

- 1. What are the main barriers to access affecting women who seek to participate in Sightsavers eye health projects, a) at the point of screening and b) in the uptake of surgery?**
 - How do these barriers vary to those experienced by men?
 - Are there any common trends which affect both men and women?
- 2. What recommendations / trends commonly appear (regionally and overall) in evaluation reports from Sightsavers eye health projects which relate to cataract surgical access / uptake for women?**
 - Is there evidence that recommendations have been taken up?
- 3. Is there any emerging evidence of what has worked well for encouraging women to attend eye screening, both at static facilities and outreach camps?**
 - Are there any trends identifiable in the reference material regarding the ability of different groups of women being able to access eye screening outreach camps and subsequently cataract surgery? If so, what are they and why have they occurred?
- 4. What recommendations could be made for new and existing projects to a) adapt the delivery of cataract surgical components and b) measure if equitable access has been achieved?**

Review approach

The methodology involved a desk review of selected project reports and other organisational resource material. A secondary data collection methodology was used in this synthesis review. The resource material reviewed included evaluation reports from eleven projects, organisational research articles, population-based survey reports, inclusive data reports, project monitoring data, management responses, social behaviour change (SBC) formative analyses and selected academic articles.

Information from the desk review which was relevant and appropriate to the assignment objectives was synthesised and entered into knowledge matrices/frameworks developed for

this purpose. Thematic analysis and narrative synthesis were performed on the secondary data. Recommendations of the evaluations were also reviewed to assess the overall frequency of gender and disability related statements in the overall recommendations.

Discussion points and key learning

1. Barriers to access

Among the evaluations reviewed, in most cases projects achieved equal cataract surgical outputs for men and women, while in some projects there was progress towards equity, as surgical outputs for women exceeded those for men. Initially, equal proportions of cataract surgery were planned for men and women, but where Rapid Assessment of Avoidable Blindness (RAAB) data became available, the proportions were revised during the life of the project to better align with the proportions indicated by RAAB. This meant reducing the proportion of cataract surgeries for men and increasing them for women in respective proportions. Six out of eleven projects demonstrated a net average increase (average increase during the project life over the baseline) in cataract surgery for women; three projects exceeded a 5% average increase while one project achieved a net average increase of 10% for women. The other projects achieved close to equal proportions of cataract surgeries for men and women.

Six thematic factors were identified as having implications for access. Often, it was a combination of barriers which affected the uptake of cataract surgery by women. The main factors and barriers included:

- **Socio-cultural factors** – lower decision-making autonomy, cultural perceptions and expectations
- **Information and awareness factors** – fears, misinformation and misconceptions; disability misconceptions; low awareness and demand; level of education; and rumours and cultural beliefs relating to eye health
- **Health factors** – health seeking behaviour; negative experiences of cataract surgery being communicated to others; insecurity about loss of home or livestock if a person (especially elderly women in rural areas) went for treatment; and co-morbidities
- **Workforce factors** – trained human resources, staff retention and attitudes and behaviours
- **Access factors** – unmet demand, availability of medicines, geographically inaccessible services, cost, waiting time and accessibility of infrastructure
- **Policy and System factors** – low state investment in eye health, limited or no integration with other health programmes, inadequate working environment and limited or no service availability

Disability data from selected organisational studies in four countries indicated that the proportion of women with disabilities seen at eye health facilities ranged from about a fifth (19.5%) to over half (56.3%), while the proportion of women with non-visual disabilities seen at eye health facilities ranged from (13.2%) to just under a third (31.4%). Almost two-fifths of women with cataract (range 37.3% to 44.6%) had a non-visual disability.

Global evidence on barriers in access to healthcare for women with disabilities indicates that they not only experience financial and physical barriers in access to healthcare, but they also face discriminatory and disrespectful behaviours from health professionals¹. Many of the sociocultural, financial and structural factors/barriers highlighted in available evidence were also noted in the barriers found in the eleven projects.

2. Trends in recommendations from evaluations

Four main trends were noted in the recommendations presented in the evaluation reports reviewed as part of this synthesis. These included:

Planning and design

- Initially, target setting for cataract surgeries in men and women was a challenge. However, it was recommended that project targets for cataract surgery in women could be rationalised based on evidence stemming from RAABs.
- The project monitoring evaluation and learning (MEL) frameworks were not designed for the integration and disaggregation of disability data and there was a need to restructure and revise MEL frameworks for disability data disaggregation and measure outcomes and impact of accessibility interventions introduced in the projects.
- The evaluations also noted that the scope of the eye health projects (to increase access for women with and without disabilities) could be enhanced through cross-sectoral collaboration and linkages with other health programmes e.g. non-communicable diseases (NCDs), neglected tropical diseases (NTDs) and maternal and child health (MCH)

Workforce preparedness

- ‘Disability’ was a new programme area for partners who faced challenges in implementing an inclusive approach. This underscored a need for strengthening the capacity of partner staff and the participating eye health workforce through disability awareness, and inclusion training

Health seeking behaviour and demand

- The project evaluations noted that patient confidence in the eye health services (health seeking behaviour for taking up referrals) could be enhanced through
 - improved patient counselling,
 - referral completion training for community-based eye health workers,
 - improved reception at the point of referral,
 - prioritisation of referrals for surgery
- Some projects indicated that sensitising traditional healers could help with the diagnosis of eye health conditions and promote attendance at a recognised eye health facility

¹ Matin, B.K., Williamson, H.J., Karyani, A.K. et al. Barriers in access to healthcare for women with disabilities: a systematic review in qualitative studies. BMC Women's Health 21, 44 (2021). <https://doi.org/10.1186/s12905-021-01189-5> Accessed on 11th February 2022

Evidence generation and learning

- This was a general theme noted in most projects, emphasising the need for more evidence on gender and disability through qualitative, formative and operational research on cataract screening, referral and treatment, especially for women and other marginalised groups such as people with disabilities.
- There was great merit in enhancing organisational learning of programme teams through documentation of case studies and cross-country learning, for example, using Bajenu Gox in Senegal, engagement of organisations of people with disabilities (OPDs) in Mozambique and gender organisations in Tanzania

3. Emerging evidence

Five main trends were noted in the projects demonstrating what worked well to increase the uptake of surgery by women at the points of screening and referral. Screening and referral uptake need to be viewed as parts of the continuum of care with inter-connected activities. For instance, social mobilisation, prioritisation of female patients, influencers and trained eye health personnel contribute to both screening and referral uptake. On the other hand, accessibility, affordability (cost of treatment and transport), availability (trained ophthalmic personnel, infrastructure, ophthalmic equipment), acceptability (attitudes of eye health staff) are more germane to the point of referral uptake (the point at which cataract surgery is performed).

These five main trends were:

Social behaviour change (SBC)

- This was one of the highlights of the projects. By actively collaborating with disability and gender focussed organisations, women's groups, older people monitoring groups and traditional healers, the projects were able to work alongside the networks of these organisations to enhance uptake of screening and cataract surgery by women.
- Extending the reach of eye health services was achieved through working with community health workers (CHWs) or village health workers (VHWs), merging screening interventions and mobilising local government officials. Positive motivation by champions (who had previously undergone cataract surgery) was an excellent example of social behavioural change

Services

- Uptake of screening and surgical services by women was enhanced through the prioritisation of women at screening camps and at the point of surgery.
- Access factors were addressed by reducing treatment costs, arranging for someone to accompany groups of women who attend surgery, improved patient counselling (especially counselling sessions for women with cataract and their husband or partner) and reduced waiting time for treatment.
- Post-operative visits were scheduled to provide more convenience to patients and selected health facilities were made more accessible for patients with disabilities

Human resource development

- This was an important capacity building component of the projects. Human resource factors often contributed to improved access and uptake of surgical services for women. This included providing adequate staffing at eye care facilities; developing a critical mass of influencers for social mobilisation; training community health workers to screen and refer women for surgery; and strengthening capacities of the programme teams through gender mainstreaming workshops

Monitoring and evaluation

- Disaggregating data by gender helped the projects to monitor the gender balance of patients reached. Regular gender disaggregated output reporting during the project life was beneficial in identifying gender-related service gaps

Research and evidence

Four main areas of research and evidence were fundamental to programme strategy. These included:

- RAABs, which underscored the need for “gender-sensitive awareness programmes regarding cataract surgery and provision of refractive services at primary levels” of the health system²
- A gender analysis study undertaken in Zambia during the project revealed gender imbalances in awareness, access to and utilisation of eye care services in the project area – this informed development of appropriate programme strategies.
- Equity measurement in RAABs which was useful for planning and implementation to ensure that the poorest were reached by the services offered.
- In addition, Sightsavers conducted three country studies on the key factors influencing the uptake of cataract surgery which identified key surgery motivators - family responsibilities; improved livelihood and independence; family support; positive experiences of others; provision of free services; and positive attitudes of healthcare staff

² End Term Evaluation Report. A new vision for eye health in Pakistan’s Khyber Pakhtunkhwa province. Sightsavers, July 2020

4. Conclusions

Some of the key conclusions noted are:

- Overall, the projects demonstrated a positive trend towards equality of access to cataract surgical services for women. In some projects, there are good examples of moving towards equitable access with a higher proportion of women operated
- Disability interventions are at an early stage as both partners and programme teams need to build their understanding of disabilities and social inclusion approaches
- Programme and MEL capacities need to be enhanced in relation to gender-responsive action so that programmes are more gender-responsive and evaluations are appropriately designed with a gender-lens
- Various common barriers were observed in the projects, which if compiled as a checklist or menu, could be used by programme teams to review existing interventions to make improvements or applied to new projects during the design phase
- Many good practices are presented in this review which need to be internalised and adapted to local contexts thereby improving programme strategy, design and implementation
- Achieving the aim to 'Leave no one behind' will require greater investment in social behavioural change
- Global evidence indicates a paucity of well-designed randomised controlled trials (RCTs) to assess the uptake of cataract surgical services in women - the systematic review conducted by the organisation is an excellent starting point for planning and conducting a multi-country RCT on uptake of cataract surgical services in women

5. Recommendations for new and existing projects

Evidence - RAAB findings can be used to update gender proportions for cataract surgery and revise strategies to reach vulnerable population groups (poor, people with disabilities). Recent good organisational examples of the use of these components include the 'Five multi-country and rural-urban RAABs in three countries' and the 'RAAB report of Kogi State, Nigeria'

Data disaggregation - Data disaggregation for women and especially people with disabilities should be internalised in project MEL frameworks. This should now be made essential for the point of screening and point of referral (including cataract surgical statistics)

Target setting - this was one of the challenges that was observed across the eleven projects. A simple to use Excel based 'Cataract Burden Estimation Tool' can be applied to determine targets. However, this requires RAAB or equivalent population-based data. It is important to note that the setting of targets derived from RAAB figures may also need to be informed by other factors like barriers and the limited capacity of the services to deliver on outputs. Other access/workforce issues need investments to be made to a reasonable level to meet that demand.

MEL frameworks need to be able to disaggregate data not only by gender but also by age (women aged 50 years and above at a minimum). The MEL frameworks used by the projects did not provide sufficient disaggregation by age

Checklist for new projects - a checklist of barriers and motivators/enablers can be developed for the programme teams as a quick reference guide for project conceptualisation, planning and design. It can be used when developing new projects or when reviewing and revising existing ones

Poverty mapping - while the use of an equity tool in RAABs is useful, equity information can be enhanced by the use of poverty maps which are now becoming increasingly available and often produced by national bureaus/institutes of statistics in most countries

Formative analysis - the formative analysis study in Malawi identified enablers and barriers to women's uptake of cataract treatment and access to eye health services among people with different forms of disabilities. It also determined behavioural change pathways to enable the target groups access cataract treatment and eye health services. The study design can be adapted to different country and project contexts to provide useful insight for improved planning and design of projects to enhance uptake for women and people with disabilities

Gender-responsive programme planning - in order to develop projects and programmes to demonstrate and enhance the uptake of cataract surgical services by women, the organisation can build on the capacity building process following the gender synthesis review, gender mainstreaming workshop and this synthesis review e.g. by taking proactive steps to train programme teams in gender-responsive action

Integrating geospatial data to assess inequalities - geospatial mapping can be integrated where eye health surveys are planned to highlight blocks where a higher prevalence of visual impairment is identified. This helps in measuring eye health inequalities and identifying population groups and locations that are at risk of being left behind



We work with partners in low
and middle income countries to
eliminate avoidable blindness
and promote equal opportunities
for people with disabilities.

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