A Study on Gender and Eye Health Services - Singida Region

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Sightsavers

Gender Issues in Maono Project Areas

(Sightsavers Tanzania)

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Acronyms & Abbreviations

CBO	Community Based Organization
CSO	Civil Society Organization
DCR	Dacryocystorhinostomy
DHS	Demographic and Health Survey
DPs	Development Partners
FGD	Focused Group Discussion
GBV	Gender Based Violence
GDP	Gross Domestic Product
GEWE	Gender Equality and Women's Empowerment
HRD	Human Resource Development
LGA	Local Government Authority
M & E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
NBS	National Bureau of Statistics
NGO	Non-Governmental Organization
NPA	National Plan of Action
PAR	Participatory Action Research
PO-RALG	President Office-Regional Administration and Local Government
PWDs	People Living with Disabilities
PHWs	Public Health Workers
SP	Strategic Plan
SIGI	Social Inclusion & Gender Index
TAMISEMI	Tawala za Mikoa na Serikali Mitaa[1]
TGNP	Tanzania Gender Networking Program
TZS	Tanzanian Shillings
SACCOS	Savings and Credit Cooperative Society
TZS	Tanzania Shilling
UNFPA	United Nation Population Fund
URT	United Republic of Tanzania
VICOBA	Village Cooperative Banks
VHWs	Village Health Workers

[1] President Office-Regional Administration and Local Government

Acknowledgement

This Gender Study Report is an analysis on gender dynamics in Iramba and Manyoni Districts and to inform and guide **Sightsavers'** Maono Project program's future planning and implementation and to contribute to the broader dialogue on Tanzania's development initiatives. The Gender Study was commissioned by **Sightsavers Tanzania.** The study was performed through a field visit, review of various literatures and documents, with some obtained from the internet and as hard copies from the client.

We are grateful towards **Sightsavers'** for showing trust and confidence in **Tanzania Gender Networking Program**'s ability and competence to provide an upbeat Gender Study report on the topic and theme at hand. It is within such spirit that **TGNP's** consultant **Mr. Edward Hiza Mhina,** embarked on this job, and focused sight on combing various sources to unearth as many leads as possible relevant to the topic and theme at hand. We at TGNP hope that this Gender Study Report we composed shall bring forth a wealth of information to be shared with **Sightsavers** and their stakeholders.

Execution of this Gender Study was guided by **Ms. Magdalena Focus Shija** and **Mr. Edwin Maleko** from **Sightsavers**, and for valuable comments and insight reviews from other Sightsavers staff, namely, **Koronel Kema, Gosbert Katunzi, Yvonne Sawe,** and **Andrew Kilewela.** It is sincerely expected that the review report provides **Sightsavers** and other eye health care stakeholders with an authoritative analysis on situation as regards gender disparities in the access to eye health services by women and men in the world and Tanzania.

Mention needs also be made of Government officials and staff in Singida Region who were instrumental in providing tacit support and guidance while in the field. Mention is made on the following: **Ms. Shukurani Mmbaga** (Singida Region's RCDO Office), **Ms. Lilian Kidoleza** (PHO, Iramba District Hospital), **Ms. Melina Sabugo** (DCDO, Manyoni District Council), **Ms Queeni Mshumbula** (Iramba District Hospital), **Mr. Renatus S. Ngeze** (Manyoni District Hospital), plus the District Medical Officers in Iramba and Manyoni Districts, and the Regional Medical Officer in Singida Region. We equally acknowledge with gratitude the Sightsavers Drivers who safely transported the team members during the 2 weeks of fieldwork in Manyoni and Iramba Districts.

On the TGNP side, we acknowledge the administrative and logistics support from TGNP Program Officer **Ms. Clara Kalanga** [Program Officer in charge of consultancies]. Once more, we at TGNP anticipate that this Gender Study Report shall be useful and instrumental in providing more substance towards creation of practical and effective measures in addressing gender disparities in the health sector and do away with prejudice and dishonour against elderly women in accessing visual care in Tanzania.

1. Executive Summary

1. Sightsavers is a global organization working to ensure that avoidable blindness are eliminated and people with visual impairments and other disabilities have the same opportunities as everyone else. Sightsavers interventions include protecting sight by preventing sight loss and avoidable blindness in some of the poorest parts of the world including Tanzania by treating conditions such as cataracts and fighting debilitating eye diseases.

2. The Gender Study was initiated in order to better comprehend gender dynamics in Singida Region's Iramba and Manyoni Districts, and to inform and guide Sightsavers' Maono Project program's future planning and implementation and to contribute to the broader dialogue on Tanzania's development initiatives. On the whole, 14 FGDs sessions, with a total 126 stakeholders (67% were females and 33% males), were accomplished in Manyoni (61 persons, of who 69% were females) and Iramba (65 persons of who 67% were females) Districts.

Sightsavers' Maono Project

3. The Gender Study is partly a review of existing strategies and actions concerning gender and development which have been adapted by the Sight Savers. The review assesses consideration of gender aspects in Maono Project activities in Iramba and Manyoni District project areas. More closely, from a gender perspective, the review looks at whether Maono Project has rudiments of gender responsiveness in its project document, and more specifically in regards to strengthening of eye health systems to deliver eye health services targeting at men and women with visual impairment.

4. So far, the Maono Project document shows that the project contains elements of gender mainstreaming through the promotion of female role models through recruitment of female staff or trainers, and in indicating that all training packages shall be designed to include a gender training component. In addition it also shows gender responsiveness in stating that men and women with visual impairment shall access eye health services in all 6 districts, and in addition, community leaders, women groups, disabled peoples organizations, and community health workers were to be targeted with training and awareness raising on eye health. Furthermore, the Maono Project document also states that gender segmentation process shall be incorporated so as to identify specific women groups to target and follow-up.

5. Moreover, the project document also focuses at understanding barriers that targeted women groups undergo in accessing eye health services, and at operating a quality standard assessment process that also ensures "*sex disaggregated data will be collected at each screening, and analysed to ensure that targets are met"* and to ensure that more women are screened and treated. Likewise, as concerns gender responsiveness, the Maono Project aims at promoting learning opportunities which intended to make beneficiaries provide feedback, especially women and people with disabilities. Last but not least, the project document also noted that risks such as the limited number of available

female staff in the eye health services, and in regards to challenges involved in recruiting additional female staff, shall be addressed.

Women's Socio Cultural and Economic Influence in access to Eye Care Services

6. The Gender Study reveals that the Sightsavers Maono Project, faces similar type of gaps and shortcomings as has been observed in several other countries. Strictly speaking, the *gender division of labour and responsibilities* in women beneficiaries from households representing the 3 largest ethnic groups (Wanyiramba, Wagogo and Wasukuma), in Maono Project areas appear to be inundated with numerous domestic chores which deprive them of idle time for accessing eye health services.

7. Patriarchal attitudes and male determined *socio cultural and economic determinants* barred women in Maono Project areas access eye health services. Taking into consideration that most of the women beneficiaries are senior citizens, and more often dispossessed of literacy and other communication proficiencies, focus group discussants revealed that occasional limited support from family members, especially the male spouse, makes most women accept vision loss as an inevitable natural consequence. Added with the complexity in getting male family members to accompany them to health care facilities, and the fear for outcome of the surgery, women beneficiaries faced certain challenges in accessing eye health services.

8. The FGDs revealed that women and girls in Maono Project areas were allocated a myriad of household gender roles such as: child care, child rearing, tending children for school, preparation of meals, household laundry chores, and management of household energy requirements (firewood), accompanying husband to farms, caring for poultry, cooking, baking buns, water fetching, hewing of firewood, milking, and making small repairs on households. Altogether, women had their hands full with numerous daily chores and were literary constrained with chores.

9. Generally the focus group discussants argued that *women* are the ones caring for the families and the entire community, and are members in VICOBA groups. They take loans and start businesses and involve themselves in various businesses to earn an income. Moreover, even disabled members of the community were mentioned to partake in public activities.

10. Men on the other side were noted as avoiding community work, accused of being spoilt, busy with charcoal burning, sugarcane growing, cultivation of sweet potatoes, livestock keeping and selling, and spending most of their time on themselves than their families, and generally deemed as untrustworthy. In addition, they were also mentioned as having excessive authority in their households, sometimes expressing selfish habits by keeping most of the household income for themselves. It was also observed that most men forced ownership of all properties, even those belonging to their spouses. Overall, it was stated that men have failed to take on their responsibilities in community volunteer based public works, and most of them shun public or community volunteer based work.

11. By and large, *women* from the *Sukuma ethnic group* in Singida Region's Manyoni District were usually characterized as relatively more restricted to their households, and appeared to be under stricter proximity limitations from wandering away from home. They also appeared to have an increasingly more pronounced traditional distribution of gender roles and chores compared to say the women from the Wanyiramba and Gogo ethnic groups.

12. Most decision making at the household is dominated by the males, even the decision to accompany a sick person to hospital is made by men, but still very few men accompany women to hospitals. The problem is that men are too concerned with their activities and give scant priority to the health problems of women.

Barriers that affect Women's Access to Eye Care Services

13. Women are acknowledged as having slight problems in accessing eye health services for treatment of trachoma, and eye surgery. Challenges mentioned by focus group discussants were as follows hereunder:

    a) Surgery services and price tags on spectacles. The price tag on spectacles was mentioned as a barrier for women to accessing eye health services. Some discussants wondered if there was possibility for being provided with free spectacles by the project, since the costs force some elderly women to beg their children for contribution in order to afford such costs.

    b) Women who have a huge number of responsibilities at home view feel the days required for recuperating are too much to afford (e.g., they feel they cannot afford to stop hard work such as farming, fetching firewood, carrying water, etc., for 2 weeks).

    c) Furthermore, women were faced with problems in requesting permission from their spouses for additional visits to the eye health service facilities.

    d) Low overall knowledge on how to take care of their eyes and inaccurate information on the effects of wearing glasses?

    e) Overall, institutional barriers that were noted in the Gender Study included: proximity or location of health facilities, travel costs, service costs, service provider environment, staff, privacy, safety, and spouse support, etc.

    f) Money is a problem, as are costs for travel to service facilities, and the time or duration of the treatment.

    g) An additional factor is delayed relay of information to rural areas on where and when the eye care clinical services will be held.

14. Nevertheless, women are supposedly restricted by the long distances when eye health facilities are distantly located and late dispersal of information on where the mobile clinic is supposed to be held. Costs for travelling to the location where the eye health services are being held as another limitation to men too.

15. Other institutional factors are the travel costs for the PHWs, and poor knowledge among some of the service users. Referrals were likewise mentioned as adding to the costs in accessing eye health services, and the fact that some beneficiaries travel distances that cost up to TZS 10,000/= in one direction.

16. Persons with disability only accessed services when mobile clinic is conducted in the nearby health center. This was due to lack of person to facilitate transportation, communication barrier at the clinic, cost of treatment, awareness of the availability of eye health services in at the district hospital and few who get treatment fail to copy with post- surgery follow up and spectacle prices or availability.

17. All in all, financial issues mean that patients given referrals had to request additional funding from their families or male spouses, in order to return for additional referral services. Combined with long distances to eye health facilities, and the crowds of service users needing treatment, accessing the eye care services are spell trouble. Moreover, spectacles are provided later, and the prices are not deemed as user friendly.

18. On ***individual barriers*** regarding limited access to domestic resources, property and benefits, and limited decision-making within the household and at community level, these included:

    a) Surgery services and price tags on spectacles, whereas the price tag on spectacles was mentioned as a barrier for women to accessing eye care health services. Some discussants wondered if there was possibility for being provided with free spectacles by the project, since the costs force some elderly women to beg their children for contribution in order to afford such costs.

    b) Women who have a huge number of responsibilities at home view the days required for recuperating are too much to afford (e.g., they feel they cannot afford to stop hard work such as farming, fetching firewood, carrying water, etc., for 2 weeks).

    c) Women were faced with problems in requesting permission from their spouses for additional visits to the eye health service facilities.

    d) Low overall knowledge on how to take care of their eyes and inaccurate information on the effects of wearing glasses?

    e) Overall, institutional barriers that were noted in the Gender Study included proximity or location of health facilities, travel costs, service costs, service provider environment, staff, privacy, safety, and spouse support, etc.

    f) Money to cater for the costs of travel to service facilities, and the time or duration of the treatment.

Strategies for Addressing Gender Gaps in Eye Care Services and Service Delivery

19. Overall, it can be stated that social cultural structures are the bedrock of gender inequalities that persist in Tanzania. Traditionally, men enjoy better status as regards time use, access and control over family or common property resources, employment opportunities, private consumption, state provided commodities and services, as well as educational possibilities and income generating opportunities. Men in Tanzania have better access to private and or public assets, have higher cultural status or dignity, and enjoy extensive autonomy. However, although women are faced with unequal gender relations and unfavourable social statuses, they however have developed various means or ways to cope with these gender inequalities through complex tradeoffs that include maintain their role in caring for their families, as well as undertaking other community obligations as observed in the Manyoni District and Iramba District focus group discussions.

20. The 2019 **Social Institutions & Gender Index Report** (SIGI Report), places the gender index in Tanzania at 46%, which implies the country has high gender inequality as concerns discrimination in the family (treatment between boys and girls, or men and women), and especially in regards to legal aspects around inheritance issues (disregard for women rights in case of a marriage unraveling), legal framework around child marriage (inadequate protection of underage girls from early marriage), and household responsibilities (women’s and girl’s workload or burden in comparison to men or boys). This means the report identifies these as the areas where Tanzania is faring the worst in regards to gender equality. The report also notes that women in Tanzania have encounter high inequality in relation to ownership of agricultural farmlands, in ownership of households, in physical integrity, reproductive rights, in legal framework towards violence against women, and in justification of domestic violence against women.[2]

21. It is in this light, and the various findings included in the Gender Study report, that the recommendations hereunder are tabled:

Recommendations and Way Forward

22. Recommendations as concerns ***eye care project design and execution***:

    a) It was mentioned by focus group discussants that **eye health services should be consolidated at *Division or Health Center level***, and eye screening moved closer to *Village level*. **The services should also be targeted at or *prioritize the areas or locations with higher intensity* of eye health issues, such as Kinangali ya Chumvi, Kintinku and Makanga in Manyoni District.**

    b) Since knowledge on eye care health and services lags far behind compared to knowledge on other disorders, **it was proposed that *sensitization seminars* should be more frequently provided, and be given at least 3 or 4 days,**

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[2] Edward H. Mhina & Fortunata M. Temu. **Tanzania SIGI 2019 Background Paper.** OECD Development Center. November 2019. Pg 16-17.

and reach up to Hamlet level in all villages. Houses of worship were mentioned as an opportune location for sensitization seminars.

c) Focus group discussants also suggested the c**reation of a *continuous chain of communication and linkage* from the District Hospital all the way to the Dispensary level**, which should involve *Village leaders such as Hamlet Chairpersons, Village Chairpersons* and Ward Councillors in order to make the campaign sustainable.

d) Eye health services sometimes are held in the sight of youths and civil servants, but do not target them. **It was therefore suggested by** focus group discussants **that these services should target the screening of youth and people with disabilities.**

23. Recommendations on ***Services delivery process*** which in turn affect women's accessibility to eye care services:

a) The number of would be eye health service users is huge, and most get discouraged with referrals or the long waiting hours due to congestions. At the moment *outreach clinics* are placed too far from rural villages. Also, most women usually have few substitutes to take their tasks and responsibilities at home, so they require their treatment to be fast tracked. **It is therefore suggested that outreach services should *reach remote locations* such as Mahaka, London, Simbanguru, Mafulungu, Manguli and Kahama 3 in Manyoni District, Ndago and Kinampanda in Iramba District**.

a) The focus group discussants similarly suggested that the **number of *health personnel* for eye health services should be increased so as to manage the crowds that come for treatment**. They **suggested that *outreach teams* should be composed of at least 2 female and 1 male health personnel. Moreover, eye surgeons should also organize themselves to be part of the outreach team.**

b) **In addition, outreach services should concentrate more during the dry season instead of the farming season when most people are busy farming.** In addition, *transportation* is required for service users coming from remote areas in order to reach the clinic location and be able to manage the doctor instructions.

c) It is further suggested from the study that **the number of *outreach days* for eye care treatment of beneficiaries should be increased**, to enable all patients get treated. It was suggested at least 4 days would do.

d) Moreover, the **Maono Project needs to *detect eye problems much earlier* before the surgery clinics. Similarly, there is a need to have *proper and regular schedule* for eye clinics, and laboratory for eye screening.**

e) ***Older women and men, lactating or breastfeeding women*, and women with toddlers should be given priority and treated first**.

24. Recommendations on eye health ***staff preparations***:

a) Presence of *eye health personnel* at the village or ward level was noted as essential.

b) Health personnel should come with all necessary equipment and *complete all treatment procedures* in the field. **Moreover, eye health *equipment should be available* at the *Dispensary level. Spectacles* should also be available at the Dispensary level. Eye *health* care *education* should be delivered to PHWs at Dispensary level, and retraining provided regularly**.

2. Introduction

25. Sightsavers works on promoting equal opportunities for people with disabilities, and campaign for disability rights so everyone will have the chance to receive an education, earn a living and be happy. Sightsavers works with governments around the world to tackle the problems at the root of avoidable blindness, as well as working with local communities to support people. In 2015 Sightsavers secured funds from seeing is believing to implement a four years' project named Maono Project in six districts of Ikungi, Iramba, Manyoni, Mkalama, Singida Rural and Singida Urban in Singida region. The objective of the project was to:

    - Strengthen eye health systems to deliver eye health services in all six districts of the Singida region;
    - Enable women and men with visual impairment access eye health services in the six districts of Singida; and,
    - Increase support and commitment to eye health from local and central government.

26. The project focuses on ensuring both women and men are benefiting from it; and since women are adversely affected by blindness, the focus stressed on ensuring that a higher number of women are screened and treated. However, reports received from some of the project districts indicated that a big number of women usually shows up for screening but do not appear for surgery.

27. It is from this background that Sightsavers approached Tanzania Gender Networking Program to conduct Gender Study to identify a root cause the problem. The study was conducted in Singida Region's Manyoni and Iramba districts. Based upon the Sightsavers' Maono Project lessons learned and observations from field

experience up till now, there is inequitable division and deployment of labour and resources between women and men within Iramba and Manyoni Districts. Sightsavers' Maono Project aims to better understand and address gender dynamics in these two Districts, and beyond.

2.2. Rationale of the Assignment

28. The Gender Study was therefore initiated in order to better comprehend gender dynamics in Singida Region's Iramba and Manyoni Districts and to inform and guide Sightsavers' Maono Project program's future planning and implementation and to contribute to the broader dialogue on Tanzania's development initiatives. Information, specific to Sightsavers' Maono Project, was particularly sought in the following areas:

a) Socio-cultural and economic influence that prevents women's equitable access into eye care services (e.g., access to resources for rural livelihoods, gender differences in access to resources such as land, finance and markets and income generating crops, etc).

b) Institutional barriers that affect women's access to eye care services, needs and interest in seeking health services (e.g. women's participation, engagement and decision making in domestic households decision making and at the community level; and barriers and opportunities for female participation and decision making on health issues at the household and community level).

c) Gaps in Singida Region's Maono Project service delivery process (e.g., project design gaps that make the project eye care services delivery process difficult for some women and men to access equitably; health staff gender awareness gaps; project design gaps on how to enable disadvantage women to utilize eye care services more effectively, etc).

d) Gaps in Singida Region's Maono Project's existing and future gender equitable strategy and advocacy mechanisms or activities with potential for promoting gender equitable health service delivery and uptake through Sightsavers' Maono Project.

2.1. Objectives of the Assignment

29. The main objectives of the Gender Study were to: First objective is conducting a gender analysis of Singida Region's Maono Project areas which will in turn inform Sightsavers planning to ensure that men, women and vulnerable groups benefit equitably from Sightsavers' project initiatives in Singida Region. Iramba and Manyoni Districts were selected as sample districts to represent other districts in Singida Region.

30. It is anticipated that the findings from these districts shall be rolled out in the remianing districts and in other areas in the Tanzania where Sightsavers is engaged. Secondly, another objective of this Gender Study is developing program tools and materials for gender mainstreaming, training, monitoring and an advocacy strategy based on research findings. Thirdly, is the objective of

disseminating report findings through presentation to Sightsavers and Singida's Maono Project staff and other stakeholders on gender related issues in Singida Region's Iramba and Manyoni Districts.

2.2. Expected Deliverables

31. The main output of this Gender Study is an analytical report consisting of a comprehensive scrutiny on how gender roles and household tasks of women, men, youths, elderly and marginalized groups in Singida Region's Maono Project areas create barriers and opportunities regarding women's full participation in eye care services.

32. The Gender Study noted barriers that women and men encountered (e.g., household and community level participation, engagement and decision making, access issues to resources and benefits) in taking advantage of the opportunities provided in eye health services. In addition, the Gender Study examines how Sightsavers' Maono Project interventions are accessed and or influenced women and men differently in the program areas and assessed vulnerability and adaptation for women in Singida Region's Maono Project areas from a gender perspective.

2.3. Limitations

33. This gender study was applied in accordance to standard qualitative research protocols. The findings in this study can be extrapolated with knowledge that the inference, extension or extrapolation of the findings cannot be wholly applicable to the entire Singida Region. Any larger inference to ethnic groups not mentioned in this study would therefore require a more comprehensive and structured research which should include more quantitative research methods and instruments. The present study was limited to an extensive literature review and a set of 12 purposive qualitative consultations through focus group methodology.

34. In addition the overall research time frame of 2 weeks limits the findings to the context pertaining in the observed Districts, and more specifically, to the relatively larger or more prominent ethnic groups (e.g., the Wanyiramba, the Wasukuma, and the Wagogo) in Iramba and Manyoni Districts. In case we want to extend these findings to the remaining Districts in Singida Region, we need ensure that the ethnic content in those Districts is largely similar to that in Iramba and Manyoni Districts. On a more scientific note, we could sum the gender study is contextual to the ethnic groups mentioned, and more accurately associated to the predominant ethnic groups in the 2 Districts as noted.

35. Nevertheless, after saying the above, by and large, we can still conclude that the gender study report provides a picture of gender relations in parts of Singida Region Maono Project areas and its impact on access to eye health services in Iramba and Manyoni Districts. Lastly, through inference, the findings and information thereof, can play an instrumental part in informing the designing of a more gender responsive 2nd phase of the Maono Project in Singida Region and beyond.

3. Documentation Review: Gender Relations and Eye Health

36. Sightsavers' Maono Project works on strengthening eye health systems in delivery of eye health services in 6 Districts (e.g., Singida Rural, Singida Urban, Iramba, Mkalama, Manyoni and Ikungi) with Singida Region.[3] The project targets at undertake the screening of more than 86,000 people directly, and benefit significant others indirectly through reduction of care burdens at the household level, and opportunity for pursuance of livelihoods.[4]

37. The project document ***"Maono Project: November 2015",*** states that the project shall *"address the needs of predominantly poor and rural communities, particularly women with visual impairment who head up the household,"* and furthermore *"other vulnerable women who would otherwise not have access to eye health services."*[5] In regards to statistics, the project aimed at reaching a total 141,013 beneficiaries, through undertaking 7,000 cataract surgeries and providing treatment for 25,800 other ocular morbidities in Singida Region.[6] The project was also to execute

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3 ***"Maono Project: November 2015",*** Sightsavers. pg 8

4 Ibid., pg 11

5 Ibid., pg 11

6 Ibid., pg 6-7

examination on 13,438 patients, and moreover, issue 7,000 spectacles to those with refractive errors.[7]

38. More closely, from a gender perspective, the Maono Project has rudiments of gender responsiveness in its design document, more specifically in regards to noting that the strengthening of eye health systems to deliver eye health services shall target "men and women with visual impairment access eye health services in the six districts of Singida."[8] In addition it also requires the promotion of female role models through recruitment of female staff or trainers.[9] Secondly, indicating that all training packages shall be designed to include a gender training component.[10] Thirdly, stating that men and women with visual impairment shall access eye health services in all 6 districts, and in addition, community leaders, women groups, disabled peoples organizations, and community health workers were to be targeted with training and awareness raising on eye health.[11] Fourthly, the project categorically states that gender segmentation process shall be incorporated so as to identify specific women groups to target and follow-up.[12] Fifth, the project focused at understanding barriers that targeted women groups undergo in accessing eye health services.[13] Last but not least, the project also aimed at operating a quality standard assessment process that also ensuring that "*sex disaggregated data will be collected at each screening, and analysed to ensure that targets are met"* and to ensure that more women are screened and treated.[14]

39. Moreover, as concerns gender responsiveness, the Maono Project aimed at promoting learning opportunities which intend to make beneficiaries provide feedback, especially women and people with disabilities.[15] It also noted that risks include a limited number of available female staff in the eye health services, and in regards to challenges involved in recruiting additional female staff.[16]

40. However, a range of questions are also noted in the project document as regards how the Maono Project had intended to ensure its activities and approach was delivered equitably and by gender?[17] The questions were: How would it ensure that women and men were involved in the design, implementation and monitoring of the project?[18] How would the planned research and observational studies identify barriers that women faced in accessing eye health services in regards to affordability, time and comfortability?[19] How would the gender segmentation

7 Ibid., pg 11
8 Ibid., pg 12
9 Ibid., pg 11
10 Ibid., pg 11
11 Ibid., pg 12
12 Ibid., pg 12
13 Ibid., pg 12
14 Ibid., pg 12
15 ***"Maono Project: November 2015",*** Sightsavers. pg 8 pg 16
16 Ibid., pg 11
17 Ibid., pg 18
18 Ibid., pg 11
19 Ibid., pg 11

process enable narrowing down to specific women groups?[20] Would its purpose be to understand barriers that women encounter in accessing eye health services? Will the approaches target groups improve their access to eye health services?[21] Would Maono Project ensure that barriers that women encounter in accessing eye health services be removed and so enable both men and women access services equitably?[22] Finally, the Maono Project document also possess the question whether its impact would ensure that the implementation process has gender needs mainstreamed in human resources for eye care?[23]

41. The Gender Study exercise expected to *increase our understanding of the actual situation that women and men* in Singida Region's Maono Project areas, encounter in uptake of eye care services. Furthermore, it reveals how women and male beneficiaries accomplish their eye care requirements and expectations as per existing gender relations, their division of labour, distribution of resources, and the actual needs that are met and extent of needs going unmet. It was expected that the Gender Study will *enable a feasible integration of gender issues or preferences* into Singida Region's Maono Project areas. This Gender Study is projected to be applied by Sightsavers program planners, stakeholders, regional level policy makers, in appreciating the situation of women and men and their gender relations within project areas.

42. In accordance with a guide titled ***"Eye Health for Women and Girls: A Guide to Gender Responsive Eye Health Programming"*** it is believed that there are more than 36 million persons globally, are blind, of who 20 million are women. More than 80% of these blind persons live in low income countries. In addition, out of 1.4 million children suffering from visual impairment, 2 out of 3 blind children are girls. All told, women and girls are more likely to be blind than men and boys. The leading causes of blindness for these women and girls are cataracts, trachoma and retinal diseases. On why more women and girls are blind contrasted to men and boys, it is suggested they lack awareness or information and resources, they face inability to travel to health facilities, and they lack financial decision making capacity.[24] Furthermore, it is due to fear of a poor outcome, and some of the girls, being too young to speak for themselves. Nevertheless, 80% of blindness is apparently avoidable through prevention or treatment, and around 4 out of 5 blind persons

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20 Ibid., pg 11

21 Ibid., pg 11

22 Ibid., pg 11

23 Ibid., pg 19

24 **Eye Health for Women and Girls: A Guide to Gender Responsive Eye Health Programming**. Gender & Eye Health Network. The Fred Hollows Foundation. Pg 8

could have avoided being blind. Surgery to treat blindness, medication for prevention of blindness, spectacles to correct refractive errors, and strategies that bridge or connect women and girls to eye health services are among measures that help in preventing blindness.[25]

43. Inequalities in gender relations often lead to discrepancies in the willingness and ability of women and men to utilize eye health services as well as other social services. These inequalities could also lead to disparities on the quality of services provided to men as compared to those provided to women in the same community or facility. At the *individual level*, personal consciousness, self esteem, cultural stereotypes and other personal beliefs might cause women to forfeit her right to eye cares services. Regrettable cultural or social barriers originating from women's gender roles plus biased cultural norms or assumptions discourage or impinge women not to worry about their eye health. On the *community side,* collective cultural attitudes, gender roles, norms and values, also influence how women attend to their health needs or access eye health services.[26]

44. More to the point, *structurally*, women more often are denied access to and control of domestic resources, power, skills or opportunities to capitalize on public services abounding in their midst. Such gender based differentials on access to and control over resources at the household and institutional levels, or the extent of involvement in decision making between men and women, add up to form inopportune socio-cultural norms in regards to or the physical and social mobility of women. Each of the above factors, or their combination, usually compound and aggravate the ability and willingness of both women and men to use eye health services.[27]

45. On the *institutional side*, areas of gender differentials in terms of access to services or their provision include financial barriers to access eye health services (affordability of eye health services between men and women), a gender bias or focus on access to eye health services for women, male and female differentials in access to eye health services such as eye surgery, low social value placed on women and therefore them being treated with less respect by some health staff, women being less able to demand better attitudes and services, inadequate privacy and confidentiality for women, insufficient space within facilities for women who are accompanied by minders and lengthy waiting times for women.[28]

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25 Ibid., Pg 9

26 Ibid., Pg 15

27 Mwakyusa, N; Katunzi, G; Shilio, B et al. Pg 15

28 Adrienne Brown "**Current Issues in Sector Wide Approaches for Health Development: *Tanzania Case Study"*** Pp 6-7

46. In a paper titled ***"Gender and Use of Cataract Surgical Services in Developing Countries"*** by Susan Lewallen & Paul Courtright, notes that cataract surgical coverage was 1.2 to 1.7 times higher for men than women, and that for women the odds on having surgery were 67% compared to males. What this says is, although women constitute the larger proportion of cataract cases that require surgery, fewer get the treatment. If women were enabled to receive cataract surgery at par with men, the prevalence of blindness caused by cataracts would be reduced by an average 12.5%. Introducing gender sensitive programming in cataract treatment could close the gender gap and therefore appreciably do away with cataract blindness among women and men.[29]

47. The paper also discusses the following aspects: cost of cataract surgery could be considered as prohibitive by some of the beneficiaries especially since these costs include transportation to hospital, loss of work time for the patient and her accompany partner, and living expenses while away from home. In addition if cataract surgery requires women to travel to hospital or far removed treatment facility, women might be restricted to access such services. Thirdly, the perceived value of the cataract surgery is usually determined by the status and age of the beneficiary, whereas single, divorced or widowed women might be more able to get treated, as are women with older working children. In sum, the paper concludes that *"cataract programs should assume that women have equal access to cataract surgery compared to men, and women receive just 50% of the surgery performed."*[30]

48. In another paper titled ***"Interventions to improve Gender Equity in Eye Care in Low-middle Income Countries: A Systematic Review"*** it is noted that gender is an important determinant in eye health, especially noting that gender differences exist in risk of moderate to severe visual impairment or getting blind, and that uncorrected refractive errors and cataract are more pronounced in women, or that women experience higher risks of blindness from cataract, uncorrected refractive errors and trachoma than men. The paper categorically mentions that in Tanzania women are denied financial resources by their male partners for cataract surgery, and a societal perception exists which gives men significant community influence. Women in Tanzania are supposed to accept their visual impairment because they face barriers in accessing eye health care. Policy makers and program planners were urged to recognize these challenges.[31]

49. One of the central elements in development of the situation of women and men is their access to and control over productive resources or factors of production. Access to or control over resources such as land, energy, credit, seeds, markets

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[29] Susan Lewallen & Paul Courtright. **"Gender and Use of Cataract Surgical Services in Developing Countries"** Bulletin of the World Health Organization 2002. Pg 300

[30] Ibid., Pg 301

[31] Gareth D Mercer, Penny Lyons & Ken Bassett. Pg 1-2

and extension, determines the level of equality or empowerment achievable by an individual within their community. Access to eye health services is undeniably about increasing people's capacity and participation in productive activities and enabling them take charge of their own lives. Therefore it is imperative to find out whether women have an equal place with men through access to and or control over factors of production in order to access eye health services.

50. It is a well-known discernible fact that men dominate positions of medical officer and medical assistants. What's more, it is an established practice that the majority of nursing staff are female, or that local skills upgrading training is attended mostly by female staff while degree based career training possibilities are dominated by male staff (e.g., female students make a third of all students enrolled at Muhimbili University of Health and Allied Sciences).

51. Sightsavers' report titled ***"Eye Health System Assessment: Mainland Tanzania"***[32] shows that eye health staff are few and unevenly distributed within the country, and they face lack of space, equipment and medicines, as well as limited sponsorships for training, demotivated to perform eye care work due to their qualifications being unrecognized in the current government scheme of service in the health sector.[33]

52. What's more, a paper titled *"**Skills of general Health Workers in Primary Eye Care in Kenya, Malawi and Tanzania**"*[34] reveals that primary eye care services in Africa is mainly supposed to include diagnosis, treatment, and referral of eye conditions by a PHW. However, these PWHs have limited and basic training in eye care with limited knowledge. The paper shows that a partly 8.2% of PHWs displayed competence in measuring visual acuity, which places the level of skills among PHWs for undertaking primary eye care service as very low, and therefore raising a need for reconsidering their training content to include more content on measuring visual acuity and therefore be more able to reduce avoidable blindness and visual impairment. Moreover, the study also reveals that male workers were

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32 **"Eye Health System Assessment: Mainland Tanzania."** Mwakyusa, N; Katunzi, G; Shilio, B et al. 2017. Government of Tanzania & Sightsavers May 2017

33 Mwakyusa, N; Katunzi, G; Shilio, B et al., Pg 53

34 Khumbo Kalua, Michael Gichangi, Ernest Barassa, Edson Eliah, Susan Lewallen & Paul Courtright. Biomed Central. 2014. Human Resources for Health.

generally assumed or viewed more as doctors and female workers as nurses or assistants.[35]

53. Moreover, a paper titled ***"Gender-based Distributional Skewness of the URT Health Workforce Cadres: A Cross Sectional Health Facility Survey."***[36] Argues that the distribution of health staff in Tanzania is largely skewed from a gender perspective, and reflects gender inequality in career choices. With over 75% of health workers in Tanzania being women, nursing and midwifery are careers dominated by females, while Clinical Officers and Medical Doctors are dominated by males. Representation of women in highly trained health personnel cadres should look at increasing proportions of female health personnel in order to limit service user preferences regarding the sex of service providers.

54. As talked about elsewhere in this report, the aim of any gender mainstreaming process is to integrate a gender focus into the aim, strategies and implementation plans of eye health services. Any discussion of gender issues in regards to eye care health status and disease patterns between women and men in their respective communities, and the socio-cultural and economic factors underlying these relations help reveal how gender inequalities are related to the health provision, access, efficiency and partnership in the existing program.

55. Cataract surgery is an area which requires clear pricing policy for its beneficiaries, especially when considering that most of them are elderly. In Tanzania, it has been observed that nearly ¾ of beneficiaries can afford to pay for some of the cataract surgery expenses, but also a ¼ other beneficiaries cannot afford at all and therefore would require free services. Affordability has to be linked to the capacity and willingness to pay and it is necessary to have procedures and mechanisms in place to screen and identify the poorest that want cataract surgery but cannot actually afford to pay. According to Dr. Susan Lewallen, et al., in a study titled ***"Willingness and Ability to Pay for Cataract Surgery: A Study in Tanzania"***[37] considering that the region's per capita income places Singida Region at the lower rungs in Tanzania, eye surgery should be judged against economic benefits of sight restoration, as well as purchasing power parity.

56. It is in this light essential that the Maono Project establishes clear and uniform pricing policies for its services and or a package that is known to all in its project

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35 Khumbo Kalua, Michael Gichangi, Ernest Barassa, Edson Eliah, Susan Lewallen & Paul Courtright. Pg 5-6

36 Amon Exavery, Angelina M. Lutambi, Neema Wilson, Godfrey M. Mubyazi & Senga Pemba. Human Resources for Health. 2013.

37 Draft Report. Kilimanjaro Center for Community Ophthalmology. Sightsavers International.

areas. Similarly, health personnel working in the eye health services need be trained on the charges and costs recovery aspects and how to avoid confusion caused by multiple small charges.

57. A research report titled ***"Gender in Eye Care in Bangladesh: Breaking the Silence, Speaking the Unspoken"*** listed a series of barriers for women in seeking eye health care services, these included: costs of surgery (e.g., whereas women were supposedly less able to access family financial resources for either transport or surgery costs); inability to travel to a surgical facility (e.g., women have less alternatives for travelling and require assistance to do so); differences in the perceived value of surgery (e.g., most women had limited support and are discouraged from seeking eye health care); low access to information and resources (e.g., women had lower literacy and less able to get informed on eye health care clinic schedules and locations); and fear of poor outcome of surgery (e.g., most societies discourage women from wearing glasses, and also scare them about going blind if operated).[38]

58. Moreover, the above mentioned Bangladesh research report also noted that gender based problems that health care institutions that faced in treating women for eye heath issues were inclusive of: women seeking services later that what is appropriate; most women patients needing ample consultation for persuading to get treated; medical personnel facing difficulties in convincing women patients to complete their entire treatment schedule; female patients being less aware of their eye health condition; women eye health care beneficiaries neglecting treatment even when they have glaucoma, DCR or cataract; and lastly, older women, pregnant or lactating women requiring safer medication and careful treatment due to their biological state.[39]

59. Furthermore, the Bangladesh research report summarized the institutional conditions that create a gender friendly eye health care facility environment should consist of: a suitable location; low or subsidized costs; special arrangements for women; female doctor for female patients; separate eye tests or screening for women; and priority services for women. What's more, female patients suggested for the eye health services to be located near their homes so they attend without accompaniment; lowering of service costs; and less time requirements due to proximity issues?[40]

60. In a paper titled ***"A Review of Factors Influencing the Utilization of Eye Care Services"***, by M.D. Ntsoane and O.A. Oduntan, it is noted that there are three main or primary factors or barriers, these being: availability of eye health services,

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[38] Mshuda Khatun Shefali. December 2014. ORBIS International Asian Regional Program. Pg 29-30

[39] Ibid. Pg 59

[40] Ibid. Pg 62

the affordability of the eye care services, and thirdly, the accessibility of the facilities that provide the eye care services. Moreover, the paper similarly notes that additional factors are inclusive of inadequate knowledge on the existence of such services, insufficient knowledge as concerns the impact of eye disease to the afflicted, and thirdly, limited information on who to consult once one is afflicted with eye impairment.[41]

61. Other additional **secondary factors** include demographic (e.g., there is close association between age and vision impairment, race, gender and level of education also influence, and women are more likely to seek eye care services than men), personal (e.g., level of education, knowledge of eye diseases and eye care services, and psychological factors), social (e.g., socioeconomic status influences use of eye care services whereby those with higher incomes or insurance have more frequent eye examinations) and cultural issues. Taken as a whole, individual factors, the need, enabling factors (e.g. family and community resources, health insurance, family resources,) and predisposing factors (e.g., illnesses, age, gender, race, marital status, ethnicity, occupation, beliefs, knowledge about the disease, and attitudes towards health services), and the probability of a person to use health care services), all interrelate and sway the probability of a person to make use of eye health services.[42]

62. Interdependence between the above named factors (e.g., availability, accessibility and affordability), has to be recognized as a vital element in provision of eye health services. For instance, availability of eye health services would be affected by practitioner to patient ratios, absence of eye health services personnel, inadequate health care facilities, insufficient state support or funding, and the disproportionate distribution of optometry and ophthalmological personnel and services in rural or urban areas. Absence of low cost and good quality vision care services and the absence of professionals or training to support eye health services is yet another hindrance.[43]

63. With regard to **accessibility** to eye health services, the paper notes that people living in rural areas are still dependent on alternative sources of treatment such as traditional healers and medicine vendors. Inaccessible roads, difficulties in getting a family member to accompany the patient, proximity to a health facility, and costs of transportation, all act to impede accessibility to eye health services.[44]

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[41] "***A Review of Factors Influencing the Utilization of Eye Care Services"***, by M.D. Ntsoane and O.A. Oduntan. Pg 182

[42] Ibid., pg 183

[43] Ibid., pg 184

[44] Ibid., pg 185

Concerning **affordability**, it is mainly in the form of whether the patients' income levels can accommodate the costs of eye health services.[45] Costs involved here are such as surgery, transportation to health facilities, and loss of paid work hours by the patient or caregiver, living expenses at the health care facility, and price tag on the spectacles. There may also exist indirect costs such as the possibility of the patient having to return to the health facility another time in order to pick up their spectacles.[46]

64. Finally, we might conclude with a paper titled ***"Cataract Services are Leaving Widows Behind: Examples from National Cross Sectional Surveys in Nigeria and Sri Lanka"***, policy makers, health services providers, and families have to identify new solutions that ensure good quality eye health services are provided nearer to where older women live, transportation is provided to and from hospital, surgical costs are eliminated, and motivators are engaged to urge patients to use eye care services.[47]

4. Gender Relations in Sightsavers' Maono Project Areas

65. It is universally accepted that gender relations are socially constructed relations between women and men. Gender roles describe how women and men engage in or connect with domestic and public activities in a certain community. They are context specific, meaning that they cannot be generalized. Thus gender division of labour in an urban setting like Singida Region's Manyoni District may not necessarily be completely similar to those in a more rural context such as Iramba District. Gender relations are always specific to a particular place, a particular time; reflect social norms or behaviors, levels of poverty, religious beliefs, and other social factors within the community at the observed time. Considering that gender roles are socially constructed roles, they're dynamic. Gender division of labour does, and can, change. Social factors, economic factors and political factors all have a continuous impact on gender relations, whether this is intended or not. However, gender relations are normally prone to resisting changes.

66. Focus Group Discussions were used in this Gender Study in order to access to a larger body of knowledge of general gender relations and women empowerment issues or information from a spectrum of stakeholders in Singida Region's Maono Project areas in Manyoni and Iramba Districts. The FGDs involved approximately

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[45] Ibid., pg 185

[46] Ibid., pg 185

[47] ***"Cataract Services are Leaving Widows Behind: Examples from National Cross Sectional Surveys in Nigeria and Sri Lanka"***, pg8

10 representatives or stakeholders from the designated group. The FGDs were facilitated through group semi structured questions which allowed discussions are as informal as necessary. The FGD technique provided information and relatively in-depth discussions on how communities in Singida Region's Maono Project areas were composed, and which gender relations issues dominated. Moreover, the discussions provided room for clarification on perceptions and opinions regarding vulnerability of women or girls, and reasons for the skewed gender relations as per observed perspectives in the respective communities.

67. Altogether 14 FGDs sessions, with a total 126 stakeholders (67% were females and 33% males), were accomplished in Manyoni (61 persons, of who 69% were females) and Iramba (65 persons of who 67% were females) Districts. The stakeholders performed relatively in-depth discussions and scrutiny on current prevailing forms and types of gender inequities as well as the status of women and girls compared to men and boys.

68. The FGDs further highlighted underlying causes and factors which contributed to achievements or failure in attaining gender equality and equity in development in Iramba and Manyoni District project areas. The FGDs also studied effectiveness of measures and interventions applied in addressing the gender equality and equity problem. Last of all, the FDGs solicited recommendations on effective strategies and interventions to be implemented in order to eliminate existing gender inequities in regards to accessing eye health services for women, men, girls and boys.

4.1. Socio Cultural Factors in access to Eye Care Services

69. On the whole, the Gender Study observed that gender roles distribution between women and men, girls and boys in households within Singida Region's Maono

Project areas in Manyoni and Iramba District was dissected through lively and engaged focus group discussions. The discussions started by requesting the focus group discussants determining which ethnic group they would focus on in their gender roles assessment. *Wanyiramba, Wagogo and Wasukuma ethnic groups* were selected in Manyoni District.

70. The FGDs revealed that women and girls in Singida Region's Maono Project areas in Manyoni were allocated a myriad of household gender roles such as: child care, child rearing, tending children for school, preparation of meals, household laundry chores, and management of household energy requirements (firewood), accompanying husband to farms, caring for poultry, cooking, baking buns, water fetching, hewing of firewood, milking, and making small repairs on households. Altogether, women in Singida Region's Maono Project areas in Manyoni District had their hands full with numerous daily chores and were literary constrained with chores.

71. With reference to *women* from the *Wanyiramba ethnic group* in Singida Region's Maono Project areas in Manyoni and Iramba Districts, these were generally characterized as relatively more restricted to their households, and appeared to be under stricter proximity limitations from wandering away from home. They also appeared to have an increasingly more pronounced traditional distribution of gender roles and chores compared to say the women from the Wanyiramba and Wagogo ethnic groups.

72. *Wanyiramba women* in Singida Region's Maono Project areas were also noted as being engaged in productive roles such as farming of vegetables (their vegetables feed Manyoni Township), food vendoring, sale of tomatoes, vegetables, and fish, and engaging in small food based businesses, tailoring, pottery, selling bananas, brewing of local brew, takes produce to neighbouring Districts such as Igunga and Mkalama, and are very knowledgeable of different markets in the immediate Districts. The women were supposedly very industrious such that it was difficult to find any Wanyiramba women who were purely housewives.

> *"Siku hizi hakuna mwanamke wa nyumbani, wote hujituma" (These days there are no women who are housewives only, they are all busy in seeking a living.) – Male Beneficiaries, Iramba District Council.*

73. They engage in VICOBA and SACCOS and take loans to develop their families, and are very supportive towards each others. Women were termed as the household financial managers and were more adept at saving household financial resources than their male partners. In fact they also claimed that income from males was not reliable, and were sometimes even lazy.

> *"Pesa ya Baba siyo ya kutegemea" na pia "Baba wa Kinyiramba ni wavivu"(Men's money is undependable, especially when Wanyiramba men are lazy.) – Female Beneficiaries, Iramba District Council.*

74. Women in Singida Region's Maono Project areas are characterized as avid *community volunteers*, industrious, and widely involved in VICOBA and religious activities.

> *"Wanawake hujiwekea malengo ya kufanya kwenye VICOBA au SACCOS"(Most women have targets on what they want to achieve in their VICOBA or SACCOS) – Women Group representatives, Iramba District Council.*

75. They were similarly very responsive to community works, and stated as dominating community works. Normally they composed of up to ¾ of community members who turn up for community works ("matoleo"). *Wanyiramba women* are noted as being strong implementers rather than leaders, and hard working with numerous responsibilities.

> *"Wanawake wa Kinyiramba ni wepesi kupokea ujumbe na kuufanyia kazi. Ukitaka kumshirikisha Baba katika kazi inakuwa kelele na fujo, hawataki kushiriki kazi." (Wanyiramba women are fast in receiving messages and implementing them. But if you engage men in any work, they create problems because men do not want to be involved in any work) – PHWs, Manyoni District Council.*

76. In regards to ability to sell any items when in need, *Wanyiramba women* in Singida Region's Maono Project areas were said to need permission from their spouses, even if the property belong to them. They also required permission from their spouses in order to do business. In case they cultivated vegetables, it was the husband who markets the produce. By and large, *Wanyiramba women* dwelling in villages required permission from their husbands even for taking sick family members to health facilities. On the other hand, there was mention that increasingly rural women were taking part in leadership roles and were contesting for leadership positions. In the main it was narrated in the focus group discussions that:

> *"Wanawake wako kwenye uongozi wa Vitongoji, Kijiji, na Vikundi. Wanawake wana umakini zaidi kwenye utendaji na usimamizi wa kazi." (Women are leaders at Hamlet level, Village level and in groups. Women are careful in executing their obligations and in oversight) – Women Groups representatives, Manyoni District Council.*

77. *Wanyiramba women* in Singida Region's Maono Project areas were observed being denied possession of household materials, and other possessions such as her clothes or animals, even if the property was from the beginning belonging to the spouse, the husband would still claim it as his. It is therefore a struggle for women to claim ownership of internal household possessions without permission from the male spouse.

> *"Ni shida Mama kumiliki hadi amwambie Baba." (It is difficult for a female spouse to own anything unless she has informed and received permission from her male spouse) – Women Groups representatives, Manyoni District Council.*

78. Nevertheless, being matrilineal, the *Wanyiramba women* in Singida Region's Maono Project areas enjoy more support and influence from their brothers, and hence the uncles have more influence over the family than the husbands

> *"Kwa Mjomba ndiko kwenye nguvu zaidi kuliko kwa Shangazi. Zamani Kaka au Mjomba ndiye aliyekuwa analea watoto wa Dada, lakini sasa wameipoteza hiyo mila."(The matrilineal uncle's side is the relatively stronger or more influential side in Wanyiramba tribe, and children were brought up at their maternal uncle's home. But this tradition or custom has subsided now) – Bomani Health Center staff, Iramba District Council.*

79. *Wanyiramba men* in Singida Region's Maono Project areas in Manyoni and Iramba Districts were characterized as essentially responsible for considerably less chores within their households, compared to women. Their domestic chores were limited to such household tasks as providing general protection, giving supervisory guidance on daily chores for household members, caring for medium and large livestock, doing farm work, engaging in activities that earned them incomes. Repeatedly, the focus group discussants associated *Wanyiramba men* with extended drinking forays and regular adventurism with temporary suitors, and indulging women to provide them with money for drinking the local brew called *"mtukulu"* - resistance to part with such money would break the household's fragile peace. In fact *Wanyiramba* women claim that if they involve their men in their businesses there is a risk they steal from you.

> *"Ukimshirikisha sana Baba anaweza kukuibia. Kaya mbili kati ya kumi zinakuwa na tatizo hilo." (If you involve men in all your activities, they steal from you. Almost two out of every ten households have this problem) – Women Groups representatives, Iramba District Council.*

80. Focus group discussants in Iramba District claimed that around 20% of *Wanyiramba* families in the District experienced problems with alcoholic males. Men were seen as contributing to poor utilization of family financial resources, and were being accused of undermining families through unproductive use of family resources without consulting other family members.

81. Alcoholism was noted as a pronounced time passing attribute of the *Wanyiramba* men in Singida Region's Maono Project areas in both Manyoni and Iramba Districts.

> *"Wanaume wengi wakirudi jioni wanakwenda kilabuni." (Most men go to their beer clubs in the evenning) – Women Groups representatives, Iramba District Council.*

82. In addition it was mentioned that in Singida Region's Maono Project areas within Iramba District, an average 30% of male headed households had no women, and were thus single parent households. Some of the focus group discussants noted

that some of the *Wanyiramba women* preferred to be single because they view married life as similar to being in slavery.

> *"Baadhi ya wanawake wanajiona ni bora kuishi bila ya ndoa au hudhani ndoa ni utumwa." (Some women have decided that being married is equal to slavery, so they prefer to live single)* – *Male & Female Leaders, Iramba District Council.*

83. Moreover, men were accused of poor support and responsibility on their child caring obligations, and were pushing all family care responsibilities to their wives.

> *"Wakitakiwa kutoa hela wanasema hawana hela na kwamba si watoto wako, hivyo wanunulie mwenyewe" (When requested to pay contributions to the upkeep of the household, men answer that since the children belong to the women, they should care for them on their own)* – *Women Groups representatives, Iramba District Council.*

84. Women focus group discussants noted that men held all family funds, and were reluctant to share the funds without a shakedown, and see family funds as their own individual resources. *Wanyiramba men* were noted as avoiding community work, and more liable to pay contribution rather than work. The men were accused of being spoilt and exaggerated any sickness so that women care for them more closely. *Wanyiramba men* were busy with charcoal burning, sugarcane growing, cultivation of sweet potatoes, livestock keeping and selling, and spending most of their time on themselves than their families, and generally deemed as untrustworthy. They were also mentioned as having excessive authority in their

households, sometimes expressing selfish habits by keeping most of the household income for themselves.

85. Although some of the male discussants claimed that women do not have any decision making power in all tribes, it was nevertheless, also noted that most *Wanyiramba* women want to take control of their families and lead them.

> *"Wanawake wengi wa Kinyiramba hutaka kuitawala familia na hutaka kushika Uongozi."(Most Wanyiramba women want to dominate their families and want to become leaders)* – *Male & Female Leaders, Iramba District Council.*

86. *Wanyiramba men* in Singida Region's Maono Project areas in Manyoni District were termed as laying claim on all household possessions as theirs, even material goods that were bequeathed to the wife from her family *"ukisema kitu ni chako inakuwa shida".* It was concluded that most men forced ownership of all properties, even those belonging to their spouses.

> *"Wababa wengi hulazimisha kumiliki mali za wake zao." (Most men force to become owners or controllers of their wives' property)* - *Women Groups representatives, Manyoni District Council.*

87. Example was shared that even if a *Wanyiramba woman* sold her chicken for say TZS 5,000/= she was allowed to keep only TZS 2,000/=. *"Mama huyu ana maisha ya woga."* However, focus group discussants in Iramba District noted that *Wanyiramba women* had constructive fear and did so for defensive and protective reasons; they did not want their children to be disturbed.

> *"Hofu chanya, hapendi kusumbuliwa na kwamba wanaofaidika ni watoto wake." (This is positive fear because she does not want to be disturbed, and her children benefit more without the presence of a father)* – *Women Groups representatives, Iramba District Council.*

88. By and large, it was concluded that women's claim to ownership raised questions and problems from their male partners *"umiliki wa wanawake huleta maswali kutoka kwa wanaume."* It was concluded that most families had poor family relations between the spouses.

> *"Kwenye familia nyingi hakuna mfumo rafiki kwa upande wa Baba",* na pia *"Baba ndiye mwenye maamuzi ya lazima au kulazimisha."(In most families there are no friendly relationships between the parents and the male partners or spouses want to impose their decisions on all matters)* – *Male & Female Beneficiaries, Manyoni District Council.*

89. Male children in Singida Region's Maono Project areas in Manyoni District were mentioned as heirs to family properties, with the father controlling all possessions within and outside the household. What's more, men were also said to marry other wives without consulting their current spouse(s). Interestingly, it was noted in

Manyoni's focus group discussions that more and more *Wanyiramba women* were nowadays reverting to living alone as single parents as a way to avoiding unnecessary disturbance from males. They argued that living as a single parent enabled most women to progress much faster than under the dominant partnership of a male spouse.

> *"Wanawake wengi hupenda kuishi pekee bila ya Baba. Hili huwawezesha kupata maendeleo ya haraka zaidi. Mfumo dume wa kibano ndiyo sababisho la maamuzi hayo." (Most women prefer to live without husbands, and this enables them to progress faster. Patriarchy chokes women and makes them opt for living single)* – *Women Groups representatives, Iramba District Council*.

90. Basically it can be concluded that *women* in Singida Region's Maono Project areas *in Manyoni District* are the first to wake up and the last to sleep *"huamka saa 10 alfajiri na kufika kwenye kibanda chake saa 11 asubuhi."* They are responsible for a long list of domestic chores, caring for family members, carry the burden of caring for their families and are busy bodies. *Women* are responsible for providing household needs, and work vegetable stalls in the markets, cultivate vegetables, engage in entrepreneurial activities, raise chickens, and vend food. Some single women engage in serious enterprises such as raising of cows, goats, and chickens. They also manage food kiosks where they sell various fast foods such as *"rojo"*, *"rosti"* and *"madikodiko".* Girls were mentioned as very helpful for women and were great at assisting their families,

91. In a good number of ethnic groups or tribes, girls are under the care of mothers. Generally it was argued that *women* are the ones caring for the families and the entire community, and are members in VICOBA groups. They take loans and start businesses and involve themselves in various businesses to earn an income. Women are strong and dominant volunteers in public works such as vegetation control, construction of school buildings, clearing grass at the village cemetery, and other works. Some women managed to be elected or got appointed as "Balozi" or ten cell leaders, and in some villages up to 20% of ten cell leaders are women.

92. However, it was noted that marriage or the presence of a male partner was generally a stumbling block to women's involvement in public leadership positions, and literally marriage was termed as a stumbling block for most women to pursue leadership roles in their communities.

93. *Wanyiramba women* in Singida Region's Maono Project areas are now awakening to leadership roles, and are said to be steady, measured, and balanced. Moreover, even disabled members of the community were mentioned to partake in public activities. Although doubters existed who mentioned that women were insecure, non daring, afraid to fail, and have a hard time expressing themselves so as to gain votes.

> *"Wanawake hawajiamini, hawajiwezeshi kushika Uongozi, huogopa kufeli na hawawezi kujieleza ili wapewe kura."* (Women do not have courage, cannot take leadership roles, and cannot

campaign or express themselves in order to be elected) – *Women Groups representatives, Iramba District Council.*

94. *Male partners* in Singida Region's Maono Project areas are mainly responsible for safety of the family, providing money for purchasing vital needs, farming and other engagements. Young *Wanyiramba males* are involved in the *"bodaboda"* business, while young *Wasukuma males* are into charcoal making and cultivation. Men mainly engage in public activities which were remunerated, and little in volunteer based works such as construction of school buildings, or roads. If called to public voluntary work, the *Wanyiramba* men are noted as being finicky and eager to upsetting the work.

> *"Wakipangiwa shughuli za kufanya wana vikwazo vingi sana."* (When given functions or duties, women encounter numerous obstacles) – *Male & Female Leaders, Iramba District Council.*

95. It was mentioned that they sometimes have time to sit and pass time, and sometimes neglect caring for their children. Men were said to fail in caring for their families, and instead were more prone to entertaining themselves with extramarital affairs.

> *"Baba wengi wana tatizo la nyumba ndogo, kati ya kaya 10 utakuta katika kaya 6 ni za Wababa wenye nyumba ndogo" (Most men have problems with extra marital affairs, in fact in six out of every 10 households the husbands have extra marital affairs) – Male & Female Beneficiaries, Iramba District Council.*

96. Some men deprive their families of their care, whereas, up to 50% of men in households within some villages in Iramba District experience problems with alcoholism. It was mentioned that's why up to 60% of households are women headed, widowers, divorcees or spinsters.

> *"Kaya nyingi siku hizi zina wanawake kuliko wanaume, 6/10, ambao ni wajane, waliotalakishwa na "masela" (Most households, 6 out of 10, have widowers, divorcees and unmarried single women) – Male Beneficiaries, Iramba District Council.*

97. Overall, it was stated that men in Singida Region's Maono Project areas have failed to take on their responsibilities in community volunteer based public works, and are full of disrespect and are prejudiced with political affiliations which make most of them shun public or community volunteer based works. Men were associated mostly with money matters and liked taking leadership roles where there is money or resources. Men were stated as poor in following up on decisions.

98. *Women* in the *Wagogo ethnic group* were characterized as engaged in household cleanliness, garden farming, caring for children, and health care of family members, fetching firewood, and small businesses. *Wagogo women* were also mentioned as being involved with VICOBA for *Wagogo women*, and various crop based businesses. *Wagogo women* sell milk, cultivate paddy, prepare local brews, work as labourers, weave baskets and mats, and sell tamarind or *ukwaju* and baobab fruits or *ubuyu*. They also play a small role in financial matters and have a limited role in sharing their views at public meetings.

> *"Maamuzi kwa sehemu kubwa hufanywa na Baba zaidi, wanawake hawana maamuzi kwenye makabila yote tu!"(Most decisions are made by men, and women do not have any decision in nearly all tribes)* – *PHWs, Manyoni District Council.*

99. *Wagogo women* in Singida Region's Maono Project areas were similarly mentioned as involved in community activities such as those involving education facilities, health and other public amenities. But they are at the same time alleged as inadequate volunteers. Their male partners come out in small numbers. *Wagogo women* are denied a voice at public assemblies, even though they are the main keepers of their households.

100. With regards to *Wagogo men in* Singida Region's Maono Project areas, these were characterized as engaged in farming, and generally responsible for taking care of the family. They engage in fishing and selling of fish, and rice farming. *Wagogo men* are mentioned as hard to involve in public or community activities, and are correspondingly accused of spending family resources on drinking, and engage in extra marital affairs. They are also responsible for taking their sons for circumcision or *"jando".* Men are said to spend most of family finances on themselves or through individual decisions. *Wagogo men* are supposedly quarrelsome and bothersome when drunk. *Wagogo men* take most leadership positions, and women are mainly left with being followers. More vocal women are silenced or dealt with by their male spouses. Men are said to be sole decision makers in their families, are listened to, and respected in their communities.

> *"Mwanaume ni mtoa maamuzi katika ngazi ya familia, anasikilizwa na kuaminika katika jamii." (Men are the decision makers in their families, and they are listened to and trusted in their communities)* - *PHWs & Health Center Staff at Kintinku, Manyoni District Council.*

101. Women leaders are supposedly less respected. Moreover, women who run for elected offices have a hard time winning support, even from fellow women.

> *“Mama akitaka kugombea uongozi wa aina yeyote hapewi au haungwi mkono hata na wanawake wenzake.” (If a woman wants to contest or run for any leadership position, she is not supported even by her fellow women)* – *PHWs & Health Center Staff at Kintinku, Manyoni District Council.*

102. Educated *Wagogo men* are suggested to involve their female spouses in decision making within household matters.

> *“Familia iliyoelimika Baba anaweza kumshirikisha mkewe au familia katika maamuzi.” (In educated families, the father might involve his spouse and family members in decisions)* – *PHWs & Health Center Staff at Kintinku, Manyoni District Council.*

103. As concerns the *Wasukuma ethnic group* in Singida Region’s Maono Project areas in Manyoni District, the women were noted as engaging in strenuous household domestic chores relating to cooking, milking, cleaning, herding, cultivation, and caring for children. They also engaged in small income generating activities based on crops, and sale of milk. *Wasukuma women* are good at volunteer work in public works, especially in chores such as fetching water, sand and other construction materials. As concerns decision making, they are involved in decisions over child care issues, especially on girl child’s behavior and general upbringing. They are given space to contribute their ideas on various issues in public, and are allowed involvement in leadership positions.

104. By and large, *women* from the *Sukuma ethnic group* in Singida Region’s Maono Project areas in Manyoni District were usually characterized as relatively more restricted to their households, and appeared to be under stricter proximity limitations from wandering away from home. They also appeared to have an increasingly more pronounced traditional distribution of gender roles and chores compared to say the women from the Wanyiramba and Gogo ethnic groups. In other words, women and girls from the *Sukuma ethnic group* were supposedly living in polygamous relationships, with huge populations of offspring. It was noted they would belong to households with several wives and with dozens of children at a time.

105. *Wasukuma men* in Singida Region’s Maono Project areas also engaged in milking, cultivation, herding, and some household chores as their spouses. In addition they sought earning incomes; involved themselves in livestock businesses, vegetable gardening, and fishing. *Wasukuma men* engage in volunteer activities in community works, volunteer as “*sungusungu”* or local militia guards. Inside their households, *Sukuma men* perceived themselves are custodians and main bread earners. In their communities, they view themselves as leaders and responsible for giving advice and guidance.

4.1. Access to Eye Health Care Services

106. In relation to access and control over resources, the Gender Study focus group discussions in Manyoni District stated women as having limited accessibility, ownership and control of household resources like land, capital, raw materials, credit, technology between women and men in Singida Region's Iramba and Manyoni Districts. Even when they owned a kiosk and all the utensils or furniture in the kiosk, the men would claim it as theirs, or owned jointly at best. However women could claim owning their clothes, and kitchen or household utensils. It was distressing hearing that women could not have 100% ownership of gadgets they buy for their family, such as TVs.

107. In order to avoid unwanted violence, women would resort to stating that all property was jointly owned, but yet they would still be forced to abandon the same in case of divorce or separation. Moreover, it was stated that increasingly different actors were supporting and advocating for women's legal rights and this enabled more women to reaffirm their ownership statuses, plus more women were practicing joint ownership of family properties with their children. Joint ownership was said to work where there are enlightened men. Still men voiced their dominance in ownership of landed properties houses, and other possessions.

108. On the other hand it was also acknowledged in some focus groups that men shall be men, unless they give up and die.

> *"Baba ni Baba tu, ila akijikatia tamaa hujimaliza, na wanaume wengi hufa kwenye vitongoji."(A father is a father, but if he gives up he loses. Most men die in their localities) – Male & Female Leaders, Iramba District Council.*

109. Above all, women in Singida Region's Maono Project areas accessed eye care services and it was acknowledged that these services do not have lengthy processes.

> *"Huduma za macho hazina mizunguko mirefu kama kwenye huduma nyingine. Hazina figisu figisu wala kona." (Eye care*

services have less bureaucracy unlike other health services. They do not have corners nor hidden agendas) – *Male & Female Beneficiaries, Manyoni District Council.*

110. The services were stated as easily accessible and were provided after public announcements were made on the date and location of the mobile services. The few challenges were surgery services, price tags on spectacles (e.g., spectacles were charged at between TZS 15,000/= and 18,000/=, while TZS 5,000/= was mentioned as the more affordable price tag) Money is a problem, as are costs for travel to service facilities, and the time or duration of the treatment.

> *"Usafiri hususan kwa wanaokaa maporini, na kubanwa muda kwa ajili ya shughuli mbalimbali".(Transportation, especially for those living in most remote areas, and lack of time for managing other obligations is a constraint)* - *Women Group representatives, Manyoni District Council.*

111. Another shortcoming was scant awareness raising information among community members. In particular the fact that a significant proportion of the service users were noted as harbouring a dislike for referrals, but are forced to accept them because they require the treatment. A large proportion of the service users were poorly informed on the effects of neglecting eye health issues or delaying treatment.

> *"Uelewa hafifu jinsi huduma itakavyomsaidia au athari za kuchelewa kupata matibabu"(Poor understanding on how the eye health care service is going to help them and also poor understanding how delayed treatment affects their recovery)* – *Women Group representatives, Manyoni District Council.*

112. Congestion at treatment facilities were another challenge during the mobile treatment outreach services. Since most female and male service users are senior seniors or adults, they resist additional referral treatment especially to the regional facilities.

> *"Watumia huduma wengi ni wenye umri mkubwa na hivyo hukataa tiba za nyongeza."(Most service users are elderly and therefore less tolerant for additional treatment)* – *Women & Male Beneficiaries, Manyoni District Council.*

113. Focus group discussants in Singida Region's Maono Project areas in Manyoni and Iramba Districts referred the eye care services that the *Wanyiramba women* accessed easily as namely: screening of their eyes, especially those with hypertension or allergies, and corrective surgery. In 2019, women were in the forefront in uptake of eye care services in Manyoni District, and they were provided with transportation and surgery. As regards *Wanyiramba men*, screening of their eyes for eye defects, and provision of eye glasses or spectacles were pointed out as the eye care services they easily accessed. They have access to all referrals and can access eye care services with comparative ease in contrast to women.

114. If at all, *Wanyiramba women* in Singida Region's Maono Project areas delayed getting treatment it is mainly caused by their being delayed by their husbands.

> *"Ucheleweshaji wa Mama kupata huduma hutokea kwa ajili ya ubishi wa Baba"(Delayed treatment for most women occurs because of male stubbornness) – Women Groups representatives, Iramba District Council.*

115. Most decision making at the household in Singida Region's Maono Project areas is dominated by the males, even the decision to accompany a sick person to hospital is made by men, but still very few men accompany women to hospitals. The problem is that men are too concerned with their activities and give scant priority to the health problems of women.

> *"Wanaume wachache husindikiza wake zao hospitali, na wanaume hujikita zaidi kwenye shughuli zao bila ya kujali afya ya Mama"* (Few males accompany their spouses to hospital, and they instead engage themselves in their businesses instead of caring for the health of their wives) *– District Hospital Health Staff, Iramba District Council.*

116. Nonetheless, Kiomboi District Hospital have a "male friendly corner" for counseling men on the importance of supporting their spouses, and also seminars to persuade more men to support the health of their spouses.

117. On the other side, *Wanyiramba women* in Singida Region's Maono Project areas were said to be experiencing complexity when given new appointments to return after 3 months for additional treatment or surgery. These complications were for the most part due to intricacies faced in managing transportation costs due to proximity issues:

> *"Uwezo duni hususan pale huduma zinapopatikana Mjini Manyoni" (Poverty, or low affordability especially when services are available in Manyoni Township, and service users are required to travel there) – Women Groups representatives, Manyoni District Council.*

118. Secondly, they were faced with problems in requesting permission from their spouses for additional visits to the eye care health service facilities. Thirdly, is the low overall knowledge on how to take care of their eyes.

> *"Taarifa zisizo sahihi kwamba ukivaa miwani macho hufa" (Inaccurate information on the effects of wearing glasses) – Male & Female Leaders, Iramba District Council.*

119. Another factor is delayed relay of information to rural areas on where and when the eye care clinical services will be held.

120. Individually, the barriers for *Wanyiramba women* in Singida Region's Maono Project areas in accessing eye care treatment were inclusive of poor economic status to manage treatment costs, due to belong to low income households. There is a registration fee of TZS 5,000/= at the eye health care facility, which most women do not have means to pay

> *"Kunakuwa na gharama ya usajili ya TZS 5,000/= ambayo wanawake wengi hawaimudu, pia dawa wanashindwa kuchangia hata kidogo, wachache ndiyo wenye uwezo wa kulipia, yaani watatu kati ya kila 10." (There is a registration fee of 5,000/= which most women cannot afford. Also they cannot afford the medicines, and a few can afford, actually perhaps only 3 in every 10 women) - District Health Staff, Iramba District Council.*

121. Price tag on medicines was pointed out as another such barrier for most individual women, including doctor's consultation fees, and overall living costs.

122. The price tag on spectacles was similarly mentioned as a barrier for women to accessing eye health services. It was suggested that spectacles could be priced affordably at TZS 20,000/= in urban locations and TZS 5,000/= in rural locations. Some discussants wondered if there was possibility for being provided with free spectacles by the project since some of the costs were up to TZS 40,000/= to 60,000/= and it forces some elderly women to beg their children for contribution in order to afford such costs

> *"Gharama za miwani ni kubwa sana, na inabidi ubembeleze watoto ndipo upate huduma, watoto nao wana majukumu yao na shughuli zao" (Costs for spectacles are too high and some women have to beg their children to assist them. But most children also do have other obligations and commitments) – Male Beneficiaries, Iramba District Council.*

123. The focus group discussants mentioned that a maximum price tag of TZS 10,000/= for the eye treatment would be more affordable for most rural based beneficiaries because this was similar to the cost of a chicken.

> *"Elfu kumi ingekuwa ni bei nzuri kwa sababu ni sawa na bei ya kuku mmoja." (Ten thousand shillings is a reasonable price tag for spectacles because it is similar to the cost of one chicken) - Women Groups Representatives, Iramba District Council.*

124. What's more the price tag on medicines should not resemble that in commercial pharmacies, but be much less

> *"Bei ya dawa isiwe sawa na ile ya wafanyabiashara wa mitaani au dukani" (The prices for Maono Project medicines should not be similar to commercial process in private shops) – Female Beneficiaries, Iramba District Council.*

125. *Wanyiramba men* in Singida Region's Maono Project areas can access eye health care with ease because they have financial and other resources. Nevertheless, they are supposedly restricted by the long distances when eye health care facilities are distantly located and late dispersal of information on where the mobile clinic is supposed to be held. Costs for travelling to the location where the eye health care services are being held was mentioned as an individual limitation to men too.

126. *Wagogo women* in Singida Region's Maono Project areas in Manyoni District faced eye injuries due to risks involved in using firewood. However, they accessed eye care services relating to screening, medication, and surgery, although male spouses were noted as failing to accompany their wives to service facilities. They are however, limited from enjoying the services which involve a slightly high cost, such as surgery and eye glasses. *Wagogo women* are faced with long distances to service facilities, poor knowledge on how to care for their eyes, and misinformation on how eye problems come about. They are in addition also affected by low staffing numbers in eye care facilities.

127. With regard to men from the *Wagogo ethnic group* in Singida Region's Maono Project areas also faced risks to eye injuries from chopping firewood, but generally had comparatively easier access to eye care services than women, mainly because they have the means to pay for the costs and have authority over their movement. They similarly have easier access to eye care referrals, and information on preventive eye care. Interestingly, but in a disappointing way, *Wagogo men* were noted as having financial resources, and furthermore possessed misguided faith that traditional medicine could treat eye health problems.

128. *Wasukuma women* in Singida Region's Maono Project areas were revealed having access to eye screening, treatment of *"mtoto wa jicho",* surgery, and optometric services. Women are acknowledged as having slight problems in accessing eye health services for treatment of trachoma, and eye surgery. Some *Wasukuma women* also experienced problems in accessing medication for eye problems. Main individual barriers for *Wasukuma women* include blind trust for traditional eye treatment medicine, insufficient access to information on eye care health clinics, and long distances to eye health services. Additional individual barriers for *Wasukuma women* include excessive burdens in domestic chores.

129. Men from *Wasukuma ethnic group*, correspondingly had access to eye screening, fitting of eye glasses, and eye surgery. Beliefs in traditional medicine, poor knowledge for eye health care, and general ignorance. Nevertheless, men constitute a smaller proportion of eye care service users.

4.2. Institutional Barriers that affect Women's Needs and Interests in Eye Care Services

130. Overall, institutional barriers that were noted in the Gender Study included: proximity or location of health facilities, travel costs, service costs, service provider environment, staff, privacy, safety, and spouse support, etc. More closely, some of the focus group discussants noted that some health staff in hospitals used harsh language in the maternity wards:

"Wahudumu wana maneno makali sana hususan upande wa wodi za wazazi - e.g., "kukwangua jicho" (Some Health staff have inappropriate or poor language, especially in maternity wards) - Women Groups representatives, Manyoni District Council.

131. Another institution based barrier was the use of chilling vocabulary in regards to the eye treatment regime was considered unethical, together with the congestion during the clinic days was mentioned as another institutional challenge, and the time required to get treated.

132. It was therefore suggested that the number of days for treatment be increased, and time be sufficient in order to treat more service users, and the mobile outreach services be rolled out to each Ward. This was argued through the point that most eye problems were to be found among villagers dwelling in remote rural locations, whereby even children have eye infections.

"Uono hafifu mwingi uko vijijini na mabondeni ambako kuna watoto wadogo walio na uono hafifu. Huduma zote ziende huko kwenye ngazi ya Zahanati na kwenye Kata." (Problems in regards to weak eye sight prevail among children living in villages and valleys. Eye care services) – Male & Female Beneficiaries, Manyoni District Council.

133. There are challenges for persons with disability to access eye care services. These challenges included: language or communication barriers (especially if they had speech or hearing and sight impairment), accessibility (especially for paraplegics), distance and cost. Beneficiaries with disabilities accessed eye care services mainly when the outreach services were moved to their neighborhood health facility, or when they had someone to accompany them to the District Hospital.

134. Generally it was noted that *women from the Wanyiramba ethnic groups* in Singida Region's Maono Project areas faced poor reception as concerns information on

outreach through mobile clinics which was not issued in good time, and this delayed the sensitization of villagers by PHWs.

> *"Iwapo taarifa zimetoka mapema, na ratiba ndipo PHWs wanahamsisha wanakijiji, na wanapoweza kupita na kuwatayarisha wananchi mapema" (If information for an outreach session is relayed earlier plus the schedule, then PHWs can mobilize community members earlier too) – Male & Female VHWs & Health Staff, Manyoni District Council.*

135. An additional institutional factor was the travel costs for the PHWs, and poor knowledge among some of the service users. Referrals were likewise mentioned as adding to the costs in accessing eye health care services, and the fact that some beneficiaries travel distances that cost up to TZS 10,000/= in one direction. Villages located in hilly or mountainous areas experienced the most difficulties in accessing the eye health care services, especially villages such as Tulya, Kidawi and Kela.

136. Women who had infants and were breastfeeding mentioned experiencing hardship in accessing services.

> *"Wanawake wanaonyonyesha hupata shida sana kusubiri muda mrefu kupewa huduma" (Lactating mothers cannot wait for long hours) – Women Groups representatives, Manyoni District Council.*

137. Sometimes service providers were absent from their facilities when patients arrived for treatment due to poor information on their whereabouts. Women who have a huge number of responsibilities at home view feel the days required for recuperating are too much to afford (e.g., they feel they cannot afford to stop hard work such as farming, fetching firewood, carrying water, etc., for 2 weeks). Multitudes of potential service users and scarcity of service providers doubled up to create long waiting times for getting treatment.

> *"Wingi wa wahitaji wa huduma na uchache wa watoa huduma husababisha mrundikano vituoni"(Multitudes of service users and the deficit in service providers causes longer waiting hours during outreach sessions) – Male & Female Leaders, Iramba District Council.*

138. The old and infirm in Singida Region's Maono Project areas also experienced problems in accessing eye health services due to being poor, having to travel too far, and having to queue for long hours when they reach the service location. Misinformation also existed with the sensitization or advocacy teams announcing that treatment is free, but when actually some services are paid for (e.g., the health insurance card costs 30,000/=, the spectacles cost 15,000/= and upwards, medication costs 5,000/=, surgery costs 10,000/=). It was suggested that maybe some of the above factors made older women reluctant to attend eye health care services earlier until their eyes reached a more serious state.

> *"Wagumu kwenda hospitalini hadi wafikie mwisho na wanapokuwa hawana msaada wowote tena" (Most beneficiaries are stubborn in going for treatment at eye care services facilities until it is too late)* – *Women Group representatives, Iramba District Council.*

139. Distances to some of the remote locations such as Majili, Mahaka, Maika and Masigati were formidable and a huge stumbling block for VHWs to reach all people in need of services. Eye health care outreach locations were too few, and information on their presence did not reach the potential users on time, especially for those located in remote villages. Moreover, there was poor priority for treatment of eye defects in most of the existing health facilities. Financial issues mean that patients given referrals had to request additional funding from their families or male spouses, in order to return for additional referral services. Combined with long distances to eye health care facilities, and the crowds of service users needing treatment, accessing the eye care services are spell trouble. Moreover, spectacles are provided later, and the prices are not deemed as user friendly.

140. As regards women from the *Wagogo ethnic groups* in Singida Region's Maono Project areas, the absence of eye treatment experts at most health facilities was the overall challenge, including the shortage of eye treatment medication.

> *"Kutokuwa na wataalam wa macho, na upungufu wa dawa mchanganyiko za tiba" (The absence of eye specialists and scarcity of various medication for treatment of eye problems)* – *Kintinku PHW & Health Staff, Manyoni District Council.*

141. It was furthermore suggested that some of the eye health care service providers were not adequately trained or informed on eye ailments and treatment. Shortage

of equipment was noted, as was outreach services being spaced out too infrequent.

142. As for women in the *Wasukuma* in Singida Region's Maono Project areas, at the Health Center level there was no presence of eye health care personnel. Eye care clinics were few, and information for mobile clinics was late in reaching the service users, especially those living farther away from the District center. Treatment equipment and medication was also in low quantities, and the absence of a proper unit for eye health care services was an issue. All in all the eye care clinics were too few and too far in-between.

5. Concluding Remarks and Way Forward

143. This Gender Study on Sightsavers' Maono Project was set up in order to assess the *gender division of labour and responsibilities* in beneficiary households in Singida Region's Maono Project areas in Iramba and Manyoni Districts. Secondly, it also aimed at looking into *socio cultural and economic differences or influences* that prevent women's equitable access to eye care services. Thirdly, it was projected to assess *institutional barriers* (e.g., access to resources and benefits, community engagement and household and community level decision-making) that affect women in accessing or seeking eye health services.

144. Fourthly, it was to *examine gaps* in the Sightsavers Maono Project intervention in eye health *services delivery process* which in turn affect women's accessibility to eye health services in are accessed and/or influencing women and men differently in the program areas. Basing on findings, the Gender Study was anticipated to provide specific recommendations on how to improve Sightsavers' Maono Project programming and measurement of the same. The recommendations are also expected to identify both opportunities and or constraints in incorporating the same.

145. This Gender Study in Singida Region's Maono Project areas, probed information on level of access that women and men had towards various domestic and community level assets, goods and services, such as: farmland, gardens, building plots, firewood, charcoal, formal credit, informal credit, livestock, markets,

appropriate technology, extension agents, eye care and health staff, community meetings, leadership positions, and decision making. Other items were knitting, weaving of mats or hair, salons, poultry keeping, food vendoring, piggeries, brewing of local brews, kiosks, retailing of firewood, pottery, stone crushing, tree planting, etc

5.1. Findings and Recommendations

146. To cut a long story short, the Gender Study in Singida Region's Maono Project areas, reveals that the Sightsavers Maono Project, faces similar type of gaps and shortcomings as has been observed in several other countries. Strictly speaking, the *gender division of labour and responsibilities* in women beneficiaries from households representing the 3 largest ethnic groups (Wanyiramba, Wagogo and Wasukuma), in Maono Project areas appear to be inundated with numerous domestic chores which deprive them of idle time for accessing eye health services.

147. Patriarchal attitudes and male determined *socio cultural and economic determinants* barred women in Singida Region's Maono Project areas access eye health services. Taking into consideration that most of the women beneficiaries are senior citizens, and more often dispossessed of literacy and other communication proficiencies, focus group discussants revealed that occasional limited support from family members, especially the male spouse, makes most women accept vision loss as an inevitable natural consequence. Added with the complexity in getting male family members to accompany them to health care facilities, and the fear for outcome of the surgery, women beneficiaries faced certain challenges in accessing eye health services.

148. As regards ***Individual barriers*** regarding limited access to domestic resources, property and benefits, and limited decision-making within the household and at community level it was observed that even though Wanyiramba in Singida Region's Maono Project areas are matrilineal, and whereas their women enjoyed relatively more support and influence from their brothers, with the uncles having more influence over their sister's family than the husbands, this was progressively disappearing at the moment. This demise has reduced more Wanyiramba families into a chaotic vacuum where social order appear to be disbanding. Although Wanyiramba *women* are the ones caring for the families and the entire community, and are members in VICOBA groups. They take loans and start businesses and involve themselves in various businesses to earn an income.

149. Recommendations as concerns ***individual barriers to accessing eye health services***:

    a) Most *Wanyiramba women* in Singida Region's Maono Project areas are denied the ability to sell any items they own even when in need, and require permission from their spouses, even if the property belongs to them. They also required permission from their spouses in order to do business. This prevents them from managing their immediate financial requirements at ease. **This is obviously an opportunity for promoting creation of women support groups as a platform for building their confidence.**

b) In addition, it was noted that marriage or the presence of a male partner for the *Wanyiramba women* in Singida Region's Maono Project areas was generally a stumbling block to the women's involvement in public leadership position. **In order to assist *Wanyiramba women* take more leadership roles, it was suggested to support their ambitions through *linking them with NGOs or CSO* that provide leadership seminars.**

c) Some of the *Wanyiramba women* in Singida Region's Maono Project areas engage in VICOBA and SACCOS and take loans to develop their families, and are very supportive towards each others. They are termed as their household's financial managers and were more adept at saving household financial resources than their male partners. Membership to micro credit institutions facilitates most women to afford their immediate and intermediate financial responsibilities, including health costs. **It would be opportune to *locate microcredit NGOs or CSOs* which would promote more of the women with eye health problems to join or become members in micro credit groups in their localities.**

d) Overall, it was stated that *Wanyiramba men* in Singida Region's Maono Project areas held all family funds, and were reluctant to share the funds without a shakedown, and see family funds as their own individual resources, and failed to take on their responsibilities in community volunteer based public works, and are full of disrespect and are prejudiced with political affiliations which make most of them shun community volunteer based works. **It is thus requisite to *engage the national NGO called MenEngage* to promote positive masculinities among men in Maono Project areas.**

e) *Women* in the *Sukuma ethnic group* in Singida Region's Maono Project areas in Manyoni District are characterized as relatively more restricted to their households, under stricter proximity limitations and with an increasingly more pronounced traditional distribution of gender roles and chores compared to say the women from the Wanyiramba and Gogo ethnic groups. **This therefore calls for a Maono Project *sensitization approach which packages a set of messages targeted at making Sukuma men more supportive of their spouses* in attending health care services or clinics. The *sensitization package* should include promoting more women involvement in decision making forums, provision of more space to women and girls to contribute their ideas on various issues in public, and their elevated involvement in leadership positions.**

f) *Wagogo men* in Singida Region's Maono Project areas, were characterized as generally responsible for taking care of the family, and mentioned as hard to involve in public or community activities, and are correspondingly accused of spending family resources on drinking, and engage in extra marital affairs. They are said to spend most of family finances on themselves or through individual decisions as was the case above for Sukuma men, it was thus proposed by the Gender Study consultant **that Maono Project *engage the national NGO called MenEngage* to promote positive masculinities among the Wagogo men living in Maono Project areas.**

150. Recommendations as concerns ***eye care project design and execution***:

a) It was mentioned by the Gender Study focus group discussants that eye health services should be consolidated at *Division or Health Center level*, and eye screening moved closer to *Village level*. **The services should also be targeted at or *prioritize the areas or locations with higher intensity* of eye health issues, such as Kinangali ya Chumvi, Kintinku and Makanga in Manyoni District.**

b) It is similarly suggested by the Gender Study focus group discussants that **additional funding should be sought in order to accommodate the cost for sensitization of communities in more remote locations**, so as to reach families that cannot be reached by vehicles equipped with public announcement systems.

c) Due to the absence of quality health facilities to support eye care procedures, e.g., absence of operating theatres – the Gender Study focus group discussants recommended **increased utilization of screening materials in remote locations is required** so as to facilitate beneficiaries who fail to travel to facilities with proper operating theatre.

d) Since knowledge on eye health and services lags far behind compared to knowledge on other disorders, **it was proposed** by the Gender Study focus group discussants **that *sensitization seminars* should be more frequently provided, and be given at least 3 or 4 days, and reach up to Hamlet level in all villages. Houses of worship were mentioned as an opportune location for sensitization seminars.**

e) It was suggested by the Gender Study focus group discussants **to create a *continuous chain of communication and linkage* from the District Hospital all the way to the Dispensary level, which should involve *Village leaders such as Hamlet Chairpersons, Village Chairpersons* and Ward Councillors in order to make the campaign sustainable.**

f) Eye health services in Singida Region's Maono Project areas were sometimes held in the sight of youths and civil servants, but some felt they were not directly targeted by the same. **It was therefore suggested** by the Gender Study focus group discussants **that these services should target the screening of youth and people with disabilities.**

151. Recommendations on ***Services delivery process*** which in turn affect women's accessibility to eye health services:

f) The number of would be eye health service users is huge, and most get discouraged with referrals or the long waiting hours due to congestions. At the moment *outreach clinics* are placed too far from rural villages. Also, most women usually have few substitutes to take their tasks and responsibilities at home, so they require their treatment to be fast tracked. **It is therefore suggested** by the Gender Study focus group discussants **that outreach**

services should *reach remote locations* such as Mahaka, London, Simbanguru, Mafulungu, Manguli and Kahama 3 in Manyoni District, Ndago and Kinampanda in Iramba District.

g) It is proposed by the Gender Study focus group discussants **to sensitize community members or beneficiaries to understand that cataract surgeries cannot be performed anywhere**.

h) In addition, the Gender Study focus group discussants also requested that **outreach services should concentrate more during the dry season instead of the farming season when most people are busy farming. In addition, *transportation* is required for service users coming from remote areas in order to reach the clinic location and be able to manage the doctor instructions.**

i) **It is further suggested** by the Gender Study focus group discussants **that the number of *outreach days* for eye health treatment of beneficiaries should be increased, to enable all patients get treated.** It was furthermore **suggested to revisit the number of days that would be affordable to both, the service provider and service users.**

j) Moreover, the Gender Study focus group discussants suggested the **need to *detect eye problems much earlier* before the surgery clinics.** Similarly, there **the need to have *proper and regular schedule* for eye clinics, and laboratory for eye screening by PHWs, or other relevant medical staff.**

k) ***It was suggested* by the focus group discussants that *older women and men, lactating or breastfeeding women*, and women with toddlers should be given priority and treated first.**

l) ***On referrals*** some of the beneficiaries noted these have a cost bearing on service users in regards to transportation and other logistical aspects**, it was thus suggested by the focus group discussants to keep referrals at a minimum rate of recurrence.**

m) Surgery costs of TZS 45,000/= per eye, were deemed as too high for poor elderly women. It was argued that eye health services should be provided at *affordable prices*, and cost for spectacles brought down from the current price tags of TZS 50,000/= to 25,000/=. **It was furthermore suggested by the focus group discussants that spectacles price tags in urban areas could be priced at TZS 10,000/= on the low end and TZS 20,000/= on the higher end. While in rural areas the price tags could range between TZS 5,000/= and 20,000/=.**

n) MSD have no spectacles in their inventory, therefore procurement and provision of spectacles depends on private vendors. In order to appropriately deal with this cost issue, it was there**by** underscored by **focus group discussants** that **Maono Project and District Health managers needed to conduct a study on costs in order to map and chart the affordable levels for purchasing spectacles from various suppliers before determining the**

price range or the practical reasonably priced cost to be paid by eventual beneficiaries or patients.

152. Recommendations on eye health ***staff preparations***:

a) Presence of *eye health personnel* at the village or ward level was noted as essential. **The focus group discussants suggested that *outreach teams* should be composed of at least 2 female and 1 male health personnel. Moreover, eye surgeons should also organize themselves to be part of the team.**

b) It similarly suggested that the number of *health personnel* for eye health services should be increased so as to manage the crowds that come for treatment, perhaps only 40% of potential beneficiaries were eventually reached by the outreach services.

c) The focus group discussants also **proposed that the registration of eye health service beneficiaries should be handled by the eye unit or department instead of the general registry.**

d) Health personnel should come with all necessary equipment and *complete all treatment procedures* in the field. Moreover, eye health *equipment should be available* at the *Dispensary level.* ***Spectacles* should also be available at the Dispensary level.**

e) On eye *health education* focus group discussants **proposed that should be delivered to PHWs at Dispensary level, and retraining provided regularly.**

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TIME FRAME AND DURATION

WORK SCHEDULE FOR IMPLEMENTATION OF THE CONTRACT

ITEM	ACTIVITY DETAILS	SUGGESTED DATE FOR IMPLEMENTING THE ACTIVITY	DELIVERABLES
1	**Work with the Sightsavers Maono Project staff in Dar Es Salaam:** Working meetings **with the Sightsavers and Singida's Maono Project** staff on finalizing details and schedule of work and possible instruments. [**0.5 work day**].	Thursday, 13th February 2020	Mutual understanding and consensus on Schedule of Work and planned activities
2	**Literature Review:** Review of relevant documents including gender study and reports conducted in, Tanzania Mainland, on emerging gender relations in health care services within and outside the country. [**3.5 work days**].	Tuesday, 18th to Friday, 21st February 2020	
3	**Designing Field Instruments:** Designing of Focus Group Discussion instruments for various respondent groups. [**1.5 work days**].	Monday, 24th & Tuesday, 25th February 2020	
4	**Travel to Manyoni District in Singida Region:** Travel from Dar Es Salaam to Manyoni District in Singida [One night Stopover in Dodoma].	Saturday, 29th February 2020	

5	**Planning Session with Sightsaver' s Maono Project Singida Representative and Maono's Manyoni District Team:** Familiarization and planning meeting with Sightsaver's Manyoni Maono Project Team lead and Singida Region Representative:	Sunday, 1st March 2020	Brief on process and intent of the gender study
6	**Courtesy Call at Manyoni District Office:** Courtesy call to Iramba District Council Offices: ▪ District Commissioner/District Development Director ▪ District Medical Officer ▪ District Community Development Officer Working session with Maono Project staff in Manyoni District [**0.5 work day**].	Monday, 2nd March 2020	Brief on process and intent of the gender study. [08:00 to 10:30]
7	**Gender Study Field Work in Manyoni District:** Conduction of gender study field work for collection of information for utilization in the engendering of **Sightsavers and Singida's Maono Project**, project, policies and strategies. (Manyoni District) **[4.5 work days].**	Monday, 2nd March 2020	▪ FGD with District Council Health representatives (DMO & Team) [11:00 to 14:00]
		Tuesday, 3rd March 2020	▪ FGD with Community Leaders. [09:00 to 12:30] ▪ FGD with Women's Group Representatives. [13:30 to 16:30]
		Wednesday, 4th March 2020	▪ FGD with Women Eye Care Beneficiaries. [09:00 to 12:30] ▪ FGD with Male Eye Care Beneficiaries. [13:30 to 16:30]
		Thursday, 5th March 2020	▪ FGD with Women's Group Representatives. [09:00 to 12:30] ▪ FGD with VHWs and PHC Workers. [13:30 to 16:30]
		Friday, 6th March 2020	▪ Debriefing Workshop. [08:30 to 12:00]
		Saturday, 7th March 2020	Travel to Singida Township
		Sunday, 8th March 2020	Travel from Singida Township to Iramba District
	Gender Study Field Work in Iramba District:	Monday, 9th March 2020	Courtesy call to Manyoni District Council Offices:

8	Conduction of gender study field work for collection of information for utilization in the engendering of **Sightsavers and Singida's Maono Project**, project, policies and strategies. (Iramba District) . (Iramba District) **[4.5 work days].**		▪ District Commissioner/District Development Director ▪ District Medical Officer ▪ District Community Development Officer [09:00 to 10:30]
		Monday, 9th March 2020	▪ FGD with District Council Health representatives (DMO & Team) [12:30 to 15:30]
		Tuesday, 10th March 2020	▪ FGD with Community Leaders. [09:00 to 12:30] ▪ FGD with Women's Group Representatives. [13:30 to 16:30]
		Wednesday, 11th March 2020	▪ FGD with Women Eye Care Beneficiaries. [09:00 to 12:30] ▪ FGD with Male Eye Care Beneficiaries. [13:30 to 16:30]
		Thursday, 12th March 2020	▪ FGD with Women's Group Representatives. [09:00 to 12:30] ▪ FGD with VHWs and PHC Workers. [13:30 to 16:30]
		Friday, 13th March 2020	▪ Debriefing Workshop. [08:30 to 12:00] ▪ Travel to Singida Town. to Debrief Regional Officers.
		Saturday, 14th March 2020	▪ Debrief Regional Officers. [08:30 to 12:00]
9	**Travel back to Dar Es Salaam:** Travel back to Dar Es Salaam from Singida Region.	Sunday, 15th March 2020	
10	**Writing of the draft Gender Study Report:** Drafting of the preliminary findings from the gender analysis study [**4 work days**].	Monday, 16th to Friday, 20th March 2020	Drafting of 1st version of Gender Analysis or Profile for Singida Region [1st Draft]

11	**Submission of Draft Gender Study Report.**	**Monday, 23rd March 2020**	

12	**Refinement and Finalization Draft Gender Study Report:** Completion of the Draft Gender Study Findings or Profile through incorporation of observations from the workshop, regional and district staff, **Sightsavers and Singida's Maono Project** staff, and other views or comments from other stakeholders. [**1 work day**].	Friday, 27th March 2020	**Amended Draft Gender Study for Singida Region [1st Draft]**
13	Submission to the **Gender Analysis Findings or Profile, Awareness Materials, and Advocacy Strategy** Hard and Soft Copies to **Sightsavers and Singida's Maono Project**.	3rd April 2020	**Final** Gender Study Report for Singida Region

Activities Duration: **19 work days**

FOCUS GROUP DISCUSSANTS – MANYONI DISTRICT

Focus Group Discussion: **District Health Staff** ***Date:*** **2nd March 2020** ***Venue:*** **Eye Department at Manyoni District Hospital**		
Serial Number	**Name of FGD Participant**	**Sex**
1.	Dr. Shadrack MUNISI	**Male**
2.	Juster SYIKILILI	**Female**
3.	Makoye BUKUMBI	**Male**
4.	Dr. Tembu SENZOTA	**Male**
5.	Renatus S. NGEZE	Male
6.	Melina SABUGO	**Female**
7.	Merry MUHANGO	Female
8.	Monica HUZI	**Female**
9.	Lilian KIDOLEZI	Female
10.	Shukurani MMBAGA	Female

Focus Group Discussion: **PHWs** ***Date:*** **2nd March 2020** ***Venue:*** **Kintinku Health Center**		
Serial Number	**Name of FGD Participant**	**Sex**
1.	Aphise Wanky LUPOGO	Female
2.	**Mwanaidi Masalu RAMADHANI**	**Female**
3.	Philis Arthur MARITA	Female
4.	**Anthony Ghoda NDOGWE**	**Male**
5.	Edward KANONI	Male
6.	**Ally Haji HAMISI**	**Male**
7.	Limbu MONDOKA	Male
8.	**Joyce Joseph MATONYA**	**Female**
9.	Neema Wadea ELIAS	Female
10.	**Kalisati Ernest KALISATI**	Male

Focus Group Discussion: **Women Groups Representatives - Sorya** ***Date:*** **3rd March 2020** ***Venue:*** **Sorya Village Office**		
Serial Number	**Name of FGD Participant**	**Sex**
1.	Jelly MTANGO	Male
2.	Victoria ADAM	**Female**
3.	Margareth MAGHENO	Female
4.	Dorica MAGENI	**Female**
5.	Shukuru KATUNGU	Female
6.	Esther JOACKIM	**Female**
7.	Betty KINGU	Female
8.	Rebecca S. SILLAH	**Female**

Focus Group Discussion: **PHWs** ***Date:*** **4th March 2020** ***Venue:*** **Manyoni District Hospital**		
Serial Number	**Name of FGD Participant**	**Sex**

1.	Amina SELEMANI	Female
2.	**Hassan Abdul HILLA**	**Male**
3.	Chuki M. KAVULA	Female
4.	**Editha E. WILLIAM**	**Female**
5.	Saimon M. MTEMI	Male
6.	**Bertha I. MAGOHO**	**Female**
7.	Nuru N. NSALAMBA	Male
8.	**Martha AKATEMA**	**Female**

***Focus Group Discussion:* Beneficiaries Representatives** ***Date:* 5th March 2020 *Venue:* Eye Department at Manyoni District Hospital**		
Serial Number	**Name of FGD Participant**	**Sex**
1.	Beatrice Leonard NYAULINGO	Female
2.	Happy George PETER	**Female**
3.	Aneth Jaero YUSUPHU	Female
4.	Baraka JUMA	**Male**
5.	Yusuphu Hassani SAIDI	Male
6.	Jasintha TIBAKANYA	**Female**

***Focus Group Discussion:* Women Group Representatives** ***Date:* 5th March 2020 *Venue:* Eye Department at Manyoni District Hospital**		
Serial Number	**Name of FGD Participant**	**Sex**
1.	Vaileth H. LUNYUNGU	Female
2.	**Jane M. NGAHILA**	**Female**
3.	Victoria EDWARD	Female
4.	**Sarah LEMELO**	Female
5.	Mercy N. SAMU	Female
6.	**Fatuma S. KUNDYA**	Female
7.	Celina M. LECHIPIYA	Female
8.	**Magdalena MATEWA**	**Female**
9.	Betiwela MACHASA	Female
10.	**Judith MADANYA**	Female

***Focus Group Discussion:* Beneficiaries** ***Date:* 6th March 2020 *Venue:* Eye Department at Manyoni District Hospital**		
Serial Number	**Name of FGD Participant**	**Sex**
1.	Rhoda ANDREW	Female

2.	**Neema SALUM**	**Female**
3.	Elizabeth HOZZA	Female
4.	**John NYANGE**	**Male**
5.	Abdallah LUHANDWE	Male
6.	**Isaya MOHAMMED**	**Male**
7.	Hosea MLULE	Male
8.	**Luvela BONIPHASI**	**Female**
9.	Dora Jacob KINSHAGA	Female

FOCUS GROUP DISCUSSANTS – IRAMBA DISTRICT

Focus Group Discussion: **District Health Staff** ***Date:*** **9th March 2020** ***Venue:*** **Eye Department at Kiomboi District Hospital**		
Serial Number	**Name of FGD Participant**	**Sex**

1.	Dr. Abel MAFURU	**Male**
2.	Noel K. VICENT	**Male**
3.	Leah SAMWELI	**Male**
4.	Esther P. TUMBO	**Male**
5.	Jacqueline GABRIEL	Male
6.	Happy S. PATRICK	**Female**
7.	Stephen T. OYUGI	Male
8.	Azimael MDUMA	**Female**
9.	Queeni MSHUMBULA	Female
10.	Emmanuel GABRIEL	Male

***Focus Group Discussion:* Women Group Representatives** ***Date:* 10th March 2020 *Venue:* Kiomboi Health Center**		
Serial Number	**Name of FGD Participant**	**Sex**
1.	Gladness S. TYEAH	Female
2.	**Edina GODFREY**	**Female**
3.	Happyness MICHAEL	Female
4.	**Maria MPINGA**	Female
5.	Jacquline YONA	Female
6.	**Pendo S. ISAACK**	Female
7.	Josephina Muna SHILA	Female
8.	**Anna FABIANO**	**Female**
9.	Joyce AYUBU	Female

***Focus Group Discussion:* Community Leaders** ***Date:* 10th March 2020 *Venue:* Storage Facility Offices - Kiomboi Market**		
Serial Number	**Name of FGD Participant**	**Sex**
1.	Elikana Enos SHIBIRITI	Male
2.	Rahel Enock DUKE	**Female**
3.	Subira BURETTA	Female
4.	Anthony LISAKAFU	**Male**
5.	Vailet MSENGI	Female
6.	Huruma DICKSON	**Female**
7.	Omari Hassan LIKUMBWE	Male
8.	Jackson Ibrahim GIMBI	**Male**
9.	Flora J. NSHANGA	Female
10.	Faraja KIJANGA	Female

***Focus Group Discussion:* Beneficiaries - Males** ***Date:* 11th March 2020 *Venue:* Kiomboi District Hospital**		
Serial Number	**Name of FGD Participant**	**Sex**
1.	Mathayo Zakaria YANDA	Male

2.	**Lutha Esmail NDIGI**	**Male**
3.	Paulo DAUDI	Male
4.	**Agustino Daniel NITWA**	**Male**
5.	Gerald Nagwa SHAMKUMBO	Male
6.	**Richard Gunda MSENGI**	**Male**
7.	Hamisi Mbutta MBOGO	Male
8.	**Mussa Msengi KIVUMBI**	**Female**
9.	Josephat PYUTTA	Male

***Focus Group Discussion:* Women Group Representatives *Date:* 12th March 2020 *Venue:* Eye Department at Kiomboi District Hospital**		
Serial Number	**Name of FGD Participant**	**Sex**
1.	Veronica FRANSISCO	Female
2.	Dorotea MSENGI	**Female**
3.	Nuru MAGANGA	Female
4.	Vivian NGULI	Female
5.	Vaileti MBIGU	Female
6.	Bertha EDWARD	**Female**
7.	Margareth EDSON	Female

***Focus Group Discussion:* Beneficiaries *Date:* 11th March 2020 *Venue:* Eye Department at Manyoni District Hospital**		
Serial Number	**Name of FGD Participant**	**Sex**
1.	Evaline SPIRIANI	Female
2.	**Gladness JUMANNE**	**Female**
3.	Janeti SHILAH	Female
4.	**Amina STEPHANO**	Female
5.	Elizabeth MSENGI	Female
6.	**Veronica MATHAYO**	Female
7.	Mwajuma RUGAMBWA	Female
8.	**Christina DANIEL**	**Female**
9.	Mwandawa M. HUSSEIN	Female

***Focus Group Discussion:* Beneficiaries *Date:* 12th March 2020 *Venue:* Eye Department at Manyoni District Hospital**

Serial Number	Name of FGD Participant	Sex
1.	Rivnus PROTAS	Male
2.	**Ulumbi MGANDI**	**Male**
3.	Henry JUMANNE	Male
4.	**Mariam SALUMU**	Female
5.	Robert NYAGWASWA	Male
6.	**Neema GIDION**	Female
7.	Hellen HANGU	Female
8.	**Bahati DICKSON**	**Female**
9.	Anna STEER	Female
10.	**Martha KITUNDU**	Female
11.	Anna KIMUMBI	Female

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