
Roundup

An Illustrative Roundup of Public Health “Subsystems”: Introduction

Corinne Kirchner

This section brings together brief articles on a highly diverse selection of topics illustrative of resources in the public health system relevant to the health-related needs of people with vision loss. The areas covered are specialized fields in which resources should be, but generally are not, adequately available to people who are blind or visually impaired. Each of the six subjects addressed—physical activity, emergency preparedness, diabetes management, mental health, services for the elderly, and programs for Native Americans—merits much fuller development.

If this Roundup appears to be something of a hodgepodge, that reflects the reality out there in the field. Public health, over its long history, has developed in a somewhat haphazard way. Except for the comparatively centralized structure of the federal, state, and local levels of CDC, public health is delivered within and through an array of service bureaucracies, some of which are not primarily health-oriented, reflecting various “special” populations. Some of these groups, such as school children or Native Americans, represent health care services of long standing. School-based health care, for example, is a vast system that is no more centralized than the public education system within which it operates. Nevertheless, we can refer to a school health “system,” in an informal sense, because the field of school health services does have professional associations and other identifiable organizational nodes that people in the vision rehabilitation field must understand if they seek to improve school health services provided to blind and visually impaired children.

Health services for Native Americans, on the other hand, are delivered through a more centralized structure, the Indian Health Service, which affords those in the vision rehabilitation field a clearer focus for advocacy and program collaboration. In this case, the system has a centralized data bank, which could be enlisted in helping to assess the health-care needs of Native Americans with vision loss.

Similarly, there are specialized organizations, professional subspecialties, legislative mandates, and funding streams that have specific application to the public health systems in the area of emergency preparedness and the self-management of diabetes. Both of these are public health subsystems of quite recent vintage, which can be expected to expand in the near future. Thus, it is particularly timely to examine their policies and practices with respect to serving individuals with vision loss.

For all of these segments of the public health system—those represented in the articles that follow and those that may be the subject of forthcoming reports—the questions of interest start with assessing the adequacy of accommodations, so that people with vision loss are able to receive optimal, or at least equitable, services, and move on to identifying the power centers and funding sources that could bring about the needed improvements in policies and practices.

We hope that these brief pieces will serve as a stimulus to readers working in these areas to develop and submit articles that do greater justice to multiple aspects of the subjects. Explorations of data sources on prevalence and subpopulation characteristics; the nature and challenges of providing services for people with visual impairments in these specific arenas; the body of research-based evidence on interventions; and related themes will be especially welcome. As is the case with this entire Supplement, the pieces that make up this Roundup section are intended not as the last word on their respective subjects, but as the start of a continuing thread in *JVIB* on public health in relation to vision (re)habilitation services.

Taken together, these pieces identify opportunities for collaboration with regard to the ways in which services are structured organizationally at a national level, which federal agencies are relevant for setting policy and funding, and how those system components relate (or fail to relate) to the vision rehabilitation system. Also relevant is the structure of third-party payment for services, especially if there may be special inclusionary or exclusionary aspects for people with vision loss.

Many other important systems could have been included here that deliver health services as part of their mission (the schools and the prison system, for example) or deliver health to a population subgroup (such as military veterans), or deliver services defined by health conditions (for example, dental health). Regrettably, the authors we contacted to write those pieces were unavailable within the time frame of this special supplement. Again, perhaps informed readers with something to say about themes and topics not addressed here will be moved to contribute to future issues of the journal.

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Building Inclusive Physical Activity Communities for People with Vision Loss

James H. Rimmer

Physical activity is universally recommended for the maintenance of good health. Unfortunately, for people with disabilities, including those with vision loss, options for exercise may be limited by the built environment, as well as by inaccessibility of programs, equipment, and services offered in community recreation facilities (Rimmer, Riley, Wang, Rauworth, & Jurkowski, 2004).

Indoor and outdoor structures have a major effect on participation in physical activity among people with vision loss (North Carolina

Office on Disability and Health, 2001; Rimmer, Riley, Wang, & Rauworth, 2004). Structures such as gyms, fitness centers, outdoor trails, parks, and swimming pools often have poor signage, lack detail on how to use the equipment or participate in a program, or provide poorly delineated access routes to and from the facility or program. These issues can have a major effect on whether or not a person with vision loss chooses to be physically active. A brief overview of the major areas that should be addressed in order to improve access to various physical activity venues follows.

PHYSICAL (BUILT) ENVIRONMENT

One of the primary approaches being undertaken today in land development is the creation of more healthful, "livable" communities, which offer, for example, increased access to walking and cycling paths (Brownson, Baker, Housemann, Brennan, & Bacak, 2003). For people with vision loss, creating communities that are fully accessible requires greater attention to the safety of the outdoor environment. Walking paths should be well lit; curb cuts should have visible or high-color contrast and palpable (for a white cane user) warning textures (for example, truncated domes) to alert the individual that he or is approaching a street or an intersection; travel paths should be free of temporary obstructions (for example, snow, garden materials, bicycles); new construction should avoid placing objects (fire hydrants or bike racks, for example) in travel paths; and stop lights should include audible signals that provide an adequate period of time for individuals with vision loss to cross the street. On paths or trails, benches should be located along the trail at points suitable for someone needing frequent rest periods. Paths and trails should also be clear of natural debris (for example, fallen branches) and should include adequate signage so that individuals can determine their exact location.

Indoor environments of many fitness and recreation facilities also need to become more accessible than they currently are for people