NARRATIVE

Uncovering the Sociological Interpretation of Visual Impairment-Related Inequities and Their Social Determinants in India

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ABSTRACT

Introduction: Determinants of health are divided into four types, such as "Biological-Psychological-Environmental-Social Determinants". The social determinants of health include gender disparities, economic status, ethnicity, race, geographic isolation, or having a specific health condition. Moreover, the social determinants are interdependent and interrelated with one another. There can also be a primary determinant that affects the other determinants. For example, educational level of the patients is associated with knowledge and awareness of eye care and its conditions. However, education might have a different effect than income in should be access of eye care when needed.

Methodology: The study is mainly dependent on secondary data analysis.

Results: The primary objective of the study is to illustrate the sociological aspects of visual impairment-related inequities and to identify the social determinants of visual impairments and disparities in India. Another aim of the paper is to present a deeper understanding of how inequities impact the incidence of visual impairment and blindness based on the social determinants of health. The present study adopts the ecological and Commission on Social Determinants of Health (CSDH) framework 2008. We reaffirm the fact that inequities negatively affect the visual impairment and blindness conditions. The national health policies should take into account the social determinants of visual impairment in their policies relating to comprehensive eye care. Social and economic factors are connected with health and welfare; those socio-economic inequalities contribute to health inequalities. For reducing the health inequalities around the world, we need effective policy implementation and proper fund pools. Furthermore, committed action on societal determinants of health, sufficient human resources are also necessary to control the health disabilities, include visual impairment.

Key Words: Health inequalities, Social Determinant, Sociology of health, World Health Organisation, Visual Impairment

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INTRODUCTION

In 2008, the World Health Organization released a report for public health professionals and the general public on social determinants of health (SDH) and its recommendations to widen the concept of social determinants of health among the population. The importance of social determinants of health is advanced well by agencies like the Centres for Disease Control and Prevention, which defines health determinants as factors that contribute to a person's state of health, that include biological, social, economic, psycho-social, or behavioural elements. The social determinants of health are complex, interrelated with each other. Moreover, there is overlapping of social and economic determinants that are responsible for most health inequities. An initiative launched by the Department of Health and Human Services in the United States in 2010 called Healthy People 2020 envisioned objectives to eliminate health inequalities due to social determinants.[1] Marmot (2020) claimed that the real reasons why health has not really improved are social is supported by the growing disparities in health according to region and deprivation. There is a graded relationship between deprivation and health. (Marmot, 2020).[2]

Importance of Social Determinants in visual health

Understanding of the social determinants will improve visual health by predicting adverse outcomes caused by the determinants. We can achieve equity in health by addressing social determinants. Similarly, identifying vulnerable sections can help eye care providers ensure healthy vision. This can assist in social diagnosis and help with social prescribing by addressing the challenges of the group through numerous support services inside and outside the stakeholders in eye care. Social and structural determinants of health impact health outcomes, so eye care providers should be aware of these instead of only focusing on the biological factors. Addressing SDH can significantly affect visual health outcomes at the individual and community level and reduce health inequities at a more significant population level. According to World Health Organization (WHO), 50 % of inequalities are accounted for by social inequalities with the following risk factors: (1) relationships and social support on mental health; (2) trauma and adversity on cardio metabolic outcomes; (3) marriage history; (4) childhood maltreatment and brain development; (5) deprivation and obesity; (6) unemployment and depression.[1]

Health Policy: Equality, Disparities, Equities and Inequities:

The Human Rights Commission defines "equality as the distribution of the same resources and opportunities to every individual across a population; for instance, a primary care centres providing anyone with free treatment. Justice in health access means that everyone gets individualised treatment to get them to the same level of health. But equality of wellbeing is often not preferred. For example, if a hospital offers free eye examinations every morning, an individual who might work during the morning cannot access this service. Although the hospital provides check-ups on the same terms for everybody, specific individuals still cannot take advantage of the facility. Attaining health equity needs equitable valuation for all; the introduction and continuation of focused community measures to remedy and preventable inequality; and historical and current injustices. A difference in social circumstances leads to unfair and unjust health outcomes in social groups. Health inequality is an analytical notion that refers to differences between different classes in health status. It is a multifaceted term consisting of acceptable metrics in technological and normative decisions. Relative and absolute inequalities are apparent. Adequate baseline data is essential to better understanding health inequality. Information on the use of death, disease, wellbeing, and health care and how these health measures are patterned across various demographics or socioeconomic classes and different geographical areas helps identify suitable goals and strategies to minimise them. Inevitably, health inequalities are about variations in the health status of individuals. However, the term is often widely used to refer to differences in the care people receive and their options to lead healthier lives, which may contribute to their health status. Thus, health disparities can include differences in:

i. State of health, for instance, lifespan and health condition prevalence.
ii. Accessibility to treatment, like the availability of services
iii. Quality of treatment and experience, such as levels of patient happiness
iv. Behavioural consequences to health, like smoking rates

Commission on Social Determinants of Health- 2008 describes that, "Health equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically". Living the healthiest life possible means growing opportunities for everyone, no matter who we are, where we live, or how much money we make. Attaining health equity, reducing inequalities, and improving all populations' health is an overarching aim for healthier people and a top priority for the Centres for Disease Control and Prevention (CDC). This includes eliminating health barriers such as poverty, inequality, and the effects of impotence as well as lack of access to decent, fair-paying jobs; quality education and housing; healthy environments; and health care. These solutions encourage equitable opportunity for health, which is the basis for a thriving, prosperous society, by making health equity a shared vision and value, growing community capacity to form outcomes, and encouraging multi-

sector collaboration", moreover; "health inequities as systematic differences in the health status of the population, health inequities are discrepancies between different demographic groups in health status or the distribution of health services resulting from the social circumstances in which individuals are born, develop, reside, function, and age. Health inequalities are unjust, and the correct government policies might reduce them. Health inequity arises from root causes that could be organised into two clusters: the unequal distribution of power and resources, including goods, services, and social attention, which are expressed in unequal social, economic, and environmental conditions, which are often referred to as health determinants.[3] In addition, "poor urban groups may experience increased vulnerability due to odd jobs, low access to equal credit and sanitation services, insecure tenure of land, denial of health care (particularly for migrants), high prevalence of disease (diarrhoea, fever, cough), alcoholism, etc. The government can reduce health inequity by ensuring the provision of essential services, redistributing resources, and protecting and promoting human rights such as health care, education, sanitation, safe water, and the right to a decent quality of life. Significant initiatives are required to support improving health services and poverty alleviation to minimise health inequality across the world".

As indicated by the Mackenbach and others, this is both helpful and basic to continue with the power to incorporate the social determinants of prosperity into preventive programming. This supplement means to advance consistent cognizance and show the way that overall prosperity experts can deal with SDH through various general prosperity practices that advance prosperity esteem among the most excessively influenced masses by overpowering and continuous ailments. Suitable movement on SDH requires a palatable cognizance of the components that influence prosperity lopsided characteristics and the execution of a sensible framework that makes sense of the association between cordial determinants and prosperity variations and helps with seeing mediation entry centres. It is essential to spread out targets that consolidate structure workforce capacity to make and execute a SDH plan. It's crucial to set goals that include building workforce capacity to create and execute an SDH agenda. It is also essential to promote and develop organisational frameworks and health systems (through legislation, studies, and partnerships) that emphasise health equity to act on the sources of health inequality effectively. To promote more significant action to eliminate health inequalities, identifying policy priorities to address SDH is crucial. Interventions at the policy level can immediately and sustain SDH. [4]

The primary objective of the study is to illustrate the sociological aspects of visual impairment-related inequities and to identify the social determinants of visual impairments and disparities in India. Another aim of the paper is to present a deeper understanding of how inequities impact the incidence of visual impairment and blindness based on the social determinants of health. The study is mainly dependent on secondary data analysis; the data was collected from various governmental and non-governmental organisations and reports published by eminent scholars in the field of health Sociology, Economics and Medical sciences.

Theoretical Framework:

The present study adopts the ecological and Commission on Social Determinants of Health (CSDH) models as the theoretical framework of the study. It studies the health seeking behaviours of the individuals in the community, and how they are influenced by the inter-personal, socio-cultural, and public policy factors.[5] As per Marshall (2012), "the ecological model helps public health practitioners explain the impact of attitudes, culture, and social structures on the individual's health. Thus, interventions are necessary to be focused on the causal factors at the multiple levels of society. Moreover, the social-ecological paradigm is based on the core principles of the interrelationships between environmental conditions, human behaviour, and wellbeing. The (socio) ecological model enables public health professionals to speak about the influence of attitudes, community, and social structures on health and its use as a theoretical guide to collaborate with a community-based coalition.[6] According to the World Health Organisation, throughout the ecological model, the SDH is responsible for health inequities, which are unfair and avoidable health status differences seen within and between countries.[3] Health's social determinants are shaped by the distribution of money, power, and resources across local communities, nations, and the world. The W.H.O and CDC's definition of "Social Determinants of Health-(SDH) provides a global and regional perspective. Understanding the social determinants and their health effects is at the socio-ecological model's heart. The Commission on Social Determinants of Health (CSDH) framework- 2008 is mainly based on three social concepts, such as (1) psycho-social, (2) social production of disease, and (3) eco-social/multilevel approaches. For example, in the income-health relationship, psycho-social theorists emphasise how social status influences people's views, leading to stress and poor health. The lack of material resources that leads to ill health is interpreted by social production of disease theorists, while eco-social theorists attribute it to biological conditions throughout life. However; the theories are complementary, they differ in related policy recommendations, which are essential given the action lens present in health determinant discussions.[5] Conversely, demographic research suggests that the main factors that affect health are: wages and social standing; community support networks; education; employment/working environment; social setting; surrounding environment; physical health and coping strategies; healthy child development; genetic factors and genetic endowment; healthcare services;

gender; and culture. People's health can be examined by age, gender, and location, so the SDH is considered preventive and curative of health issues.[7]

The World Health Organization's CSDH framework (2008) also recognised the weak social policies and services, unequal economic conditions, and destructive policies that caused ill health in 2008.[5] For instance, the overall clinical benefits structure in India over the latest seventy years has prepared a couple of public prosperity programs zeroing in on enormous prosperity related issues, provoking improvement in prosperity markers like future that has extended from 32 years at the hour of opportunity to 65 years in 2012; the maternal mortality extent has lessened from 398/lakh live births in 1991 to 167/lakh live births in 2013, and the infant youngster demise rate has dropped from 140/1000 live births in 1976 to 40/1000 of each 2013.[8] But some indicators where the development was quite fast have now slowed down and are further expected to decline. For example, undernourishment in below five years of age children, were shown a minimal reduction in National Family Health Survey reports, it is from 43 % in NFHS-2 (1998-99) to 40 % in NFHS-3 (2005-06). But still in the states like Tamil Nadu, the proportion of underweight under-5 children went down marginally from 31.5 to 29.8 to 23.8 during the second, third, and fourth rounds of NFHS-3. The public health system's gains are because the focus has always been on improving people's accessibility to medical knowledge and technology, in terms of preventative and therapeutic medication. The community plays a critical role here to help improve the utilisation of these services. The failure to make communities self-reliant and empowered to take care of their health has always been reflected in the overall public health system. However, regional, and population-level disparities in health are still seen in public health. The degree of underweight among under-five children was represented to be practically on numerous occasions higher, i.e., 56.6 % among the most diminished overflow quintiles appeared differently in relation to 19.7 % among the most extravagant quintiles during 2005-2006 (NFHS 3); among youths in natural locales, it was 45.6 % versus 32.7 % in the metropolitan districts.[9]

Conversely, to decrease these intergroup and provincial contrasts in medical services and advance value in wellbeing, the current government drafted an adjustment of strategy in the Public Wellbeing Confirmation Mission through Universal Health Care-(UHC) Program. To address value, simply giving clinical consideration won't do the trick. Likewise, social change is the need of great importance to give relationship-building abilities to expand their command over their well-being determinants, in this way working on their general wellbeing. Indeed, W.H.O is additionally thinking about this sort of well-being advancement. The Ottawa Contract characterizes well-being advancement as a thorough social and political cycle, not just embracing activities coordinated at reinforcing the abilities and capacities of people yet in addition activities coordinated toward evolving social, ecological, and financial circumstances to mitigate their effect on open and individual wellbeing. Hindered individuals additionally should be empowered with abilities, not recently engaged. This strengthening would prompt orientation uniformity in assets, status, and authority, and the lopsided conveyance of such figures in society is known as the Social Determinants of Wellbeing. As per W.H.O; promotion of the health and well-being is, also promoting the societal determinants of health in the society.[5,10]

In India, we have regional and state-level classifications based on caste, gender, and socioeconomic status. To achieve equity, gaps in the health system need to be reduced in the different sections of society. The newborn child death rate during the third round of NFHS was 55.7/1000, and live births were among the upper-castes. Whereas it is in the backward-castes 61.1/1000, and in scheduled tribes it is 63.9/1000, and scheduled castes it is 71/1000. Such disparities are due to disadvantaged groups' poor accessibility and affordability of health services, including scheduled castes and other backward sections of society. According to the NFHS-3 report; when comparison the institutional delivery services, it is varied between social groups. As per above said report; in upper-caste community, 51% of the mothers are having delivered in health care institutes, and in backward communities it is 38% only. Moreover, in scheduled castes the institutional deliveries are 33%, in scheduled tribes the institutional deliveries are nearly 18% only.[9]

As per Sarkar (2016), owing to the minor importance of SDH and that UHC could not be attained without SDH, the group added SDH in a report of the Planning Commission in 2011. Thus, the report recommends setting up SDH committees at various geographical levels, i.e., district, state, and national. Also, SDH is to be added to the proposed National Health Promotion and Protection Trust. The policy identifies priority areas in sanitation, diet, substance abuse, rail and road safety, gender violence, workplace safety, and air pollution. But the vision to enable and empower people to take control of their health has been missing in this document because it is believed that most of the illiterate rural population is incapable of deciding their health and welfare independently".[10] Michael Marmot (2014) noted that; inequalities are the social determinants of health are the circumstances of daily life as well as the factors that contribute to the causes of illness. Furthermore, Fair Society, Safe Lives, a systemic analysis of health inequalities in England since 2010, headed by Sir Michael Marmot, provided the latest findings on inequality in social determinants and the connection to health outcomes. The November 2010 Public Health White Paper, Safe Lives, Safe People, responded to the analysis by introducing a long-term plan to combat SDH. The early years of a child's life lay the basis for their experi-

ences for the remainder of their lives. For example, early childhood development, including pre-birth, directly affects their ability to sustain healthy relationships, develop skills, and create the capacity and resilience required to manage their lives. These then affect their educational attainment, jobs, and health. Giving each child the best possible start to life would reduce health inequality and improve the population's health during their lifetime.[11]

DISCUSSION

Visual Impairment in the World: According to the International Agency for the Prevention of Blindness (IAPB), and the Global Burden of Disease-2010 (GBD-2010); two-thirds of the world's blind are women suffering with visual impairment. Moreover, the global prevalence of blindness (age-standardized) has declined from 0.60 % in 1990 to 0.47 % in 2010. Even after this steady decline, not much has improved across national and international boundaries. Inequality in blindness is also presented as a gender disparity, with 60 % of blindness worldwide among women.[12,13,14] However; Rius and others (2014) told that, it is estimated that worldwide, 32.4 million people are blind and another 191 million people have moderate and severe visual impairment, besides that, around the world up to 80% of blindness and 85% of visual impairment are preventable.[15] According to a World Report on Disability-2011; jointly published by W.H.O and World Bank said that, people's main hurdles to accessing health services are affordability and transportation to health services.[16] A study in Sudan revealed that blindness is strongly correlated with socioeconomic position in terms of income, occupation, and place of residence, and most of the blind people who participated are unemployed, reside in rural locations, and have meagre monthly income.[17]

The global estimate before the launch of Vision 2020 was 38 million blind people, which has increased to 76 million in the year 2020. There has been a transition from infectious diseases in younger people to non-communicable disorders in adults and the elderly, this transition has strongly influenced the health patterns in developing countries, increasing the burden of blindness. In developing countries like India, lack of eye care and malnutrition result in an increasing prevalence of blindness, which is 10–40 times higher than in the developed world, where it is due to degeneration and metabolic disorders. However, after cataract diseases, childhood blindness is the second biggest problem in the world, nearly 70 million blind people are suffering with disease globally, moreover; globally the visual impairment was increasing over the years, for instance in 1990, about 148 million people had Visual Impairment (VI), including 38 million blind people. But it is; in the year of 2022, it is 161 million VI's, along with 37 million blind people.[18] According to the World Health Organization (WHO), 285 million people were visually impaired in 2014; 39 million were blind, and 246 million had low vision, with developing countries accounting for 90% of visually impaired people. The right of sight VISION 2020 was launched by the World Health Organization (WHO) and the International Agency for the Prevention of Blindness (IAPB). Its goal is to eliminate the causes of blindness and guarantee the right to sight to people worldwide, particularly to the millions who suffer from blindness. It aimed to eliminate the main reasons for blindness by 2020 with the help of governments, eye professionals, and non-governmental agencies to facilitate the planning and implementation of sustainable eye care programs. Global data on blindness prevalence; are shows that, developing nations have a higher incidence of blindness than developed countries, the people from high socio-economic strata, having a low prevalence rate of blindness, due to intake of well-nourished food and sufficient level of vitamin-A.[19]

In recent study reported (Lancet Glob Health 2017) about 36 million individuals were projected to be blind in 2015 (visual acuity of worse than 3/60), 217 million had moderate to severe vision impairment (visual acuity of worse than 6/18 but 3/60 or better), and 188 million had mild vision impairment (visual acuity of less than 6/12 but 6/18 or higher). While the age-standardised prevalence of blindness was highest in western sub-Saharan Africa, eastern sub-Saharan Africa, and south Asia, the majority of those who were blind or had moderate to severe vision impairment lived in south Asia, east Asia, and southeast Asia.[20] In such a circumstance, worldwide endeavours to dispense with avoidable visual deficiency have promised help for techniques to limit the visual impairment by utilizing the Vision-2020 right to sight drive. However, the removal of cataract blindness, is increases the quality of life of the elderly in India.[21] Besides, the socioeconomic condition and political context were also seen as necessary. The psycho-social outcomes of financial imbalance are a significant determinant. The connection between financial status and well-being starts with the primary reasons for imbalances. A more prominent comprehension of orientation disparity in ways of behaving may make sense of errors in people's well-being results.

Likewise, orientation dissimilarity influences the dynamic body, influencing admittance to administrations and contrasts in psycho-social and natural gamble openness. Explicit medical problems connected with pressure impact the gamble of diabetic retinopathy, glaucoma, and cataract. Because of pathologies like organ transfers, coronary issues, catastrophe medication, and drug expenses, ladies don't look for treatment. More exploration is expected to distinguish whether saw orientation separation, dynamic power, and working time are related to orientation imbalances in visual impairment and permanent blindness.

Visual Impairment in India:

India, home to almost 1.3 billion inhabitants, has blindness as an important public health problem. According to a 2010 study in Gujarat, India, in the elders the cataract disease is one of the main reasons for visual impairment, blindness. After recognising this issue, the Government of India started a fully funded programme for controlling of blindness and visual impairment. The inimitability of the programme is evidence-based inception, identification, and implementation guided by data collected. Moreover, the world-bank conducted national-wide survey on cataract blindness and visual impairment project for evaluation of the development process of the cataract project from last thirty years, moreover the survey report said that the cataract blindness is reducing some extent.[22] As per the W.H.O standards, the incidences of blindness are 5.34 %, and low vision was 23.85 %. Moreover, this prevalence was related with the demographic indicators, like with age, sex, residence, educational levels, occupational status and others. When compared with age group of 50-59 years of patients, the 70+ years of aged people are at high risk with visual impairment. Same way the illiterates are more menace, than educated people in the community. Besides that; the unemployed were at two time's higher risk than those actively involved in the occupation, moreover, the rural women have also at higher risk.[21] Despite approximately 6.5 million cataract surgeries performed in India and an average cataract surgical rate of nearly 5000 per million people each year, untreated cataract still ranks as the most common cause of blindness and VI in persons aged 50 or older.[23] The incidence of blindness has risen from 2.06% in 2010 to 2.4% in 2020, with a higher age-specific blindness trend persisting as the elderly population has grown over the last ten years.[24]

According to the Nasrin (2016); one of the studies conducted in India showed that almost 96 % of females and 88 % of males were aware of the social and economic effects of blindness and visual impairment. People were mindful of the cause of blindness and that treatment was available free of cost under the National Program for the Control of Blindness. This suggests that there has been a general improvement in the level of awareness about one's health amongst community members. However, the difference in knowledge and health-seeking behaviour was due to inaccessibility. The reputation of a facility, the competence of its staff, and free services were the primary reasons patients cited for the utilisation of services. Given that community eye health education is an essential component of India's national control of blindness program, a large gap is observed in understanding blindness and control. This indicates that to minimise the burden of visual impairment in society, there is an immediate need to enhance community behavioural health services, particularly addressing gender discrimination issues.[18] On account of a visual disability, clarifications for not looking for eye care have shown different orientation patterns; men made sense of not looking for care as 'compelling reason need'. Attitudinal aberrations in looking for medical care have additionally been proposed to make sense of gender differences in admittance to eye care and well-being administrations. In one of the examinations, low wages or pay was related to a visual deficiency in India. Likewise, the commonness of visual impairment and visual hindrance was higher in developing nations contrasted with developed nations. There was likewise a distinction between the nation's Gross domestic product-(GDP) and the predominance of visual impairment.[18] As per Anna, Van and others; nevertheless, there is a lack of evidence whether the lack of information in obtaining eye care services is rooted in socioeconomic determinants. Although some studies have indicated that access to eye care is a significant barrier even in health centres, it suggests that a lack of awareness and education about eye diseases could be the reason. Moreover, poverty makes the situation even worse, along with this education factors and social deprivation are other problems that contribute to blindness.[25]

Social Determinants of Visual Impairment:

Clear relation was observed between social determinants of health and patient outcomes in eye care. As social determinants are intricately linked with each patient's clinical course, increased understanding of these structural and social contexts is essential for ophthalmologists to provide the best care possible for patients. Ophthalmologists must intervene to address social factors of vision health if they are to deliver the best care possible. According to Rius and others (2014) socioeconomic status is an indirect cause of visual impairments and blindness. In Europe, visual impairment has been associated with not having a paid job, having a permanent disability, and manual social class, and in India, it is associated with unemployment. But this trend was not found in the United States.[14] In addition; in nations like the US, India, China, Australia, and Taiwan, lower levels of schooling were related with higher visual disability and blindness are more common. In India, the low wage and non-working people were related to visual impairment, and individuals without work were at major risk of visual impedance.

Many kinds of research have shown that 87% of the outwardly hindered and 90 % of the visually impaired live in the least income nations. In any case, differences in predominance existed between nations in a similar locale and were contrarily connected with the Gross domestic product per capita in every country. So much exploration concentrates on figuring out that, the three principal reasons, for example, (1) women were more probable than men to have a visual disability or visual impairment. (2) The pervasiveness of visual impairment or visual disability was viewed as conversely connected with higher pay, higher instructive status, and non-manual word-related social class. (3) Visual impedance has been

connected to ethnic, racial, and geographic inconsistencies". As per Alma MA, Van der and others (2012); studies on the participation of visually impaired older adults, suggest that reduced vision restricts social interactions, daily activities, recreational activities, and other work. In addition to the presence of a cardiac disorder, the perceived vision distance and using special devices (e.g., cane, tablet dispenser) is related to decreased involvement in self-care, household and physical activities, and limitations in mobility. Also, physical and mental fitness affect participation. Only a few studies deal with the determinants of visually impaired older adults' participation, suggesting that 4 % of people with decreased vision did not participate in any of the four domestic existence activities, whereas 23 % participated in all activities.[26] While; "older adults still have a certain amount of visual capacity, significant personal and social changes are essential for learning to live with gradual vision loss. Visual impairment is a self-determining interpreter of useful impairment for elders in both compulsory Activities of Daily Living-(ADL) and Instrumental activities of daily living-(IADL). In a small-form, the high-rates of misery and functional impairment amongst elders, visually impaired adults should have a more study. Moreover, the continuous adaptation method to vision impairment increases crucial challenges in friendships and family relationships. Friends of older adults provide emotional support and help adapt to vision loss. It has been found that interaction with friends reduces the risk of disability, fewer depressive symptoms, and greater satisfaction. Friendships may mitigate the loss of formerly valued activities. Also, age-associated loss in vision in older adults poses unique obstacles to the family and friends' network. There is evidence that vision loss is one of the most dreaded medical circumstances. Including multiple continuous diseases, age-related vision loss is expected to raise serious questions about self-reliance and dependency on other day-to-day behaviours. People's interaction with their family, friends, and co-workers can have a big impact on their health, especially when racism and racial issues are involved. Black race has been linked to vision impairment in the UK Biobank and eye loss in all of Us programme.[27]

Several measures can be taken to tackle health inequalities. The quality of the eye health services should be equally available for everyone, according to their socio-demographic factors, like age, gender, ethnicity, economic-status, place of residence, education, or disability status. More awareness training camps for staff members and a quality monitoring checklist for regular updates. Eye care providers should hire people and employees by supporting to their staff without any discrimination. However, to reduce inequity, every individual would have to contribute their bit by adopting a new perspective. Improvement in accessibility, affordability, and eye care availability is the key and the first step to promoting health equality and equity. Another side: community-level engagement is required to address ignorance, cultural traditions, and lack of awareness at individual, family, and community levels. Eye health services need to be addressed as general overall health in partnership and collaboration with other community-based services. A robust policy framework to address such issues is required. Eye health care policies need to be strengthened so that they serve as a means to tackle significant issues involving a lack of services, lack of awareness, and issues of costs regarding health care. Universal health coverage and health insurance schemes are followed in many countries to cover healthcare costs. These schemes must be put in place to cater to the disadvantaged and lower sections. The availability of transport for these poor populations must be ensured.

Way Forward:

These studies highlight the significance of social factors in the development of blindness and visual impairment. They underline the necessity for appropriate community eye health initiatives to be developed and put into place in order to alleviate health inequities, which must be coordinated with other social and educational policies. Access to eye care and the risk of vision impairment are influenced by social determinants of health. Patients' environments must be considered while we treat their eye conditions. Ophthalmologists can play a significant role in addressing the underlying societal variables that have an impact on visual health by working together to develop effective change-making initiatives. A study in Sudan (2019) Blindness is strongly correlated with socioeconomic position in terms of income, occupation, and place of residence. The big chunk of the blind participants is unemployed, reside in rural locations, and have meagre monthly incomes.[17]

Income, educational, and social classes measure an individual's socioeconomic status, which affects producing visual impairment and blindness. Furthermore, an overview of the context will provide the path required for improvements related to social norms, systemic barriers, and cultural barriers. One of the critical concerns in eye care is those with a lower socioeconomic status, who are targeted using population-based prevention strategies provided by IAPB and CSDH. There should be a solution to who are with of ocular impairment. Moreover, it is crucial to provide a policy that includes all the social determinants of ocular patients and their risk factors. Primary care tends to be the most effective entry point for healthcare programmes known for addressing equity issues. According to the M Marmot achieving health equity requires mutual responsibility, social support, and attachment from all sections of society. This can be done by providing special provisions to the most disadvantaged and vulnerable areas, with the basic needs to maintain health. Furthermore, empowering the population involves involving the affected in the decision-making process and recognising their fundamental human rights. More excellent synchronisation at every geographical and political level must provide universal health

coverage and expand these main phenomena across national and international boundaries. Majority of the research are recommending, the health seeking behaviour is more useful to prevent the visual impairments, it is better than the treatment after the disease. Moreover, timely monitoring and evaluation of the programs on health inequalities and implementing measures to reducing the stress of societal determinants on wellbeing, it is very important to controlling the blindness in India, and the world. Though health inequalities have multiplier and multi-layer consequences the study is largely limited to the impacts of health inequalities on visual impairment. Moreover, this paper is primarily based on secondary data sources. The assessment of the first-hand data collected from visually impaired people could have provided more evidence to the claims made in the previous discussion section.

Conclusion

Social and economic factors are connected with health and welfare; those socio-economic inequalities contribute to health inequalities. For reducing the health inequalities around the world, we need effective policy implementation and proper fund pools. Furthermore, committed action on societal determinants of health, sufficient human resources are also necessary to control the health disabilities, include visual impairment. Further investigation is essential to evaluate how income, education, and social class measure an individual's socioeconomic status, which affects producing visual impairment and blindness.

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