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Short Communication

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Engendering Eye Care

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Women have made strides in traditional metrics of professional achievement including ophthalmology. We see them as an integral part of all aspects of service delivery from ophthalmic assistants, doctors, to being a part of the administrative and leadership management team.

While this is a general trend the percentage of women pursuing these subspecialties still remains lower than that of men [1] and make up a minority of ophthalmologists with professional industry relationships [2]. As per a study conducted, female ophthalmologists provided 35% fewer services per ophthalmologist per year (2834 vs 4328) than male ophthalmologists [3]. An interplay of work-life balance that is expected of women, a prioritization of her personal over professional life and at times gender bias at workplace impacts the work satisfaction & potential of ophthalmology workforce [4].

When we look at the beneficiaries, two thirds of adults over the age of 40 in rural Indian population with low vision secondary to cataracts, glaucoma, and refractive error had never sought eye care [5]. Women account for 67% of all individuals with visual problems, adjusted for age and irrespective of any biological attribute. Also, women were found to utilize eye care services 40% less than men. Another finding reveals that approximately two out of every three blind people in the world were women, most of who were over the age of 50 years [6]. In no instances did biological differences explain these gender disparities. Instead, "women of all ages (including children) were more frequently exposed to causative factors, such as infectious diseases and malnutrition, and utilized eye care services less frequently than men" [7]. While higher life expectancy, lower levels of education, literacy, and income are proximate reasons for gender disparities in eye health, the root cause can probably be attributed to the low social status of women in much of the developing world.

It has been seen that female subjects refused rehabilitative services due to the lack of a female health worker or doctor available to assist them. This was, in part, because of difficulties encountered in retaining female health workers, as they were more likely to drop out of the programme due to the inconvenience of traveling to villages outside their own [8]. For female specific health conditions, there has been difference in preference of specific gender for providing care. For rural female patients, this might be one of the reasons for the hesitation of women patients coming to the hospital. Such traditional expectations might impact eye health considerably [9].

FCHVs (Female Community Health Volunteers) raise the awareness of eye care in their communities and increased utilization of eye care services by women and children. The outreach activities typically serve more adult women (54 - 55%) versus men (45 - 46%), which is closer to equitable, given that women carry a disproportionate burden of eye health issues globally [10]. It is important to have more number of female workers in eye health at both

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local and national levels and hence, have led to a greater number of women patients accessing eye health services nationally. In order to improve the eye health of children, it is important to understand the influence women and mothers have over children's eye health and the eye health of the community as a whole [11].

At Sankara Eye Foundation India, one of the largest community eye care providers in the world, female patients accounted for 53% of the beneficiaries, while male patients accounted for 47% of the beneficiaries. With more than 70% of total staff being women, the fact that Sankara routinely treats more women than men indicates that they are fulfilling their mission to provide equitable care to a group that is frequently marginalized. Though Sankara seeks to make eye care a reality for all, the emphasis on equality is especially evident in its treatment of women.

The current COVID19 pandemic has been a roadblock in community eye care also created challenges to women in healthcare. We have seen many of them having to take a sabbatical to care for those at home with comorbidities or isolate at home because children have tested positive. Traditional outreach models where large number of patients from the community were brought in together giving a sense of security are no longer valid.

While ophthalmology has helped enhance the role of women, future research needs to explore cross industry best practices and maybe incorporate gender sensitization as part of the formal training at the undergraduate and postgraduate training that could allow a level ground for women in eye care.

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