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Ensuring eye care access for women supports their work and well-being. INDIA

Eyes on equity: advancing eye health for women and girls

Addressing systemic barriers, promoting gender equity, and fostering women's leadership are crucial for achieving universal health coverage and improving high quality eye health outcomes.

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Achieving gender equity in eye health

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IAPB Gender Equity Toolkit
bit.ly/IAPBgender

To address the current imbalance in eye health between men and women, we need to do more, and do it better.

We are delighted to present this issue on eye health for women and girls. This is the first time since 2009 that the journal has focused on gender equity. Women and girls – and gender-diverse people – still experience worse access to good quality services, and therefore have a higher prevalence of vision impairment compared to men and boys. While the articles in the issue focus on women and girls as the largest group experiencing gender inequity, we recognise the amplified challenges faced by gender minorities, including transgender and non-binary people.

Women and girls make up 55% of the 1.1 billion people experiencing vision loss. The fact that women tend to live longer than men, and have higher rates of vision impairment due to age-related conditions, does not fully account for this difference in eye health outcomes between genders. The key cause is a lack of equitable access to high quality eye health care, due to both systemic barriers and social and cultural factors.

Eye care services are not reaching enough women. It was estimated in 2022 that effective cataract surgical coverage (eCSC) was 3.5% lower in women than men, while effective refractive error coverage (eREC) was 10.4% lower in women. In some regions this gap is even larger: for example, the eCSC gender gap in the Eastern Mediterranean region is more than twice the global average.

Women's higher prevalence of vision impairment means they disproportionately experience consequences to health, education, and economic stability, leading to reduced quality of life and increased mental health risks, contributing to a cycle of poverty and gender inequity.

The good news is that there are solutions to address gender inequity. A critical first step is to use gender-disaggregated data for advocacy at a policy level, as well as for planning more gender-responsive services.

Women make up 70% of the health workforce. INDIA

It is just as vital to listen to women. Their experiences are shaped not only by their gender, but also by factors such as their age, socioeconomic and disability status, and ethnicity; a concept known as intersectionality. Developing targeted strategies to overcome these diverse barriers is only possible through consultation with women and girls representing all of these groups.

Action at a programme management level includes educating health workers on gender biases, engaging men and boys as advocates and bringing eye care closer to communities. Actions at the clinic level includes introducing gender-specific waiting lines and accommodating childcare needs. Read more in this issue, and make use of the excellent guidance available in the IAPB Gender Equity Toolkit: **bit.ly/IAPBgender**

Part of the solution

Women make up over 70% of the global health workforce, but only hold 25% of leadership roles, creating a significant gender gap. Women leaders are well placed to understand the unique challenges faced by underserved women and girls, and there is substantial evidence (**bit.ly/WDEHfhf**) that having more women in leadership leads to better outcomes, innovation, productivity, retention, and financial performance. In health, this means more effective, inclusive, and sustainable health care systems.

We must actively cultivate strong female leadership at all levels of the eye health sector. This includes promoting mentorship and skills-building, and providing equal opportunities for women's advancement. A global monitoring project is the biennial survey implemented by the IAPB Gender Equity Work Group, which highlights best practices and areas for improvement – also available in the IAPB Gender Equity Toolkit (**bit.ly/IAPBgender**).

Achieving gender equity in eye health not only enhances women's own health and wellbeing, but also provides substantial societal and economic benefits.

We are grateful to the many contributors to this issue: the authors, who shared valuable experience and learning, the reviewers, who provided constructive comments and advice along the way, and the CEHJ editorial team.

Equality vs equity

Equality means providing everyone with the same resources and opportunities, aiming for uniform treatment regardless of individual circumstances.

Equity recognises that people have different needs and circumstances, and it involves offering varying levels of support to ensure fair outcomes. In essence, equality is about sameness, while equity focuses on fairness and accommodating diverse needs.

Equality

Equity

Preeti Dhingra
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Barriers preventing women and girls from accessing the eye care they need

To improve access, we must first understand the impact of social expectations on women and girls.

Seeing the World Clearly, Embracing Possibilities. INDIA

Barriers such as cost, distance, and the acceptability of eye care services prevent both women and men from receiving the eye care they need. However, these barriers are often more pronounced for women due to social or cultural expectations, and women also face additional, internalised barriers.[1,2]

Social and cultural barriers

- Almost everywhere around the world, women are expected to be the primary caregivers, doing unpaid domestic work and caring for children and elderly or vulnerable family members.
- Women tend to have less control over family finances as their caring or domestic work is unpaid and undervalued, and/or because they cannot undertake paid work outside the home (due to lack of support, or their domestic and caring responsibilities). As a result, women tend to have less decision-making power in the family, and less say in how money is spent.
- Women may be actively discouraged or even forbidden from travelling alone due to social and cultural expectations or safety concerns.
- In some cultures, women may not be allowed to speak to men, including health workers, without a male family member being present.

Distance and cost

Due to these social and cultural barriers, travelling long distances for eye care, and waiting in line for a long time, can be a major barrier. For example:

- Women may have to wait until a male family member can accompany them, and these men may lose wages if they take time away from work.
- Women either need to find someone to take on their caring responsibilities while they travel, or they need to bring their dependents (e.g., children) with them, increasing travel costs.
- Women's lack of financial independence, plus the attitudes of male heads of household, can either support or discourage women from seeking eye health care.[3] This is particularly challenging in countries without national health insurance or similar social safety nets.

Internalised and other barriers

- Social and cultural expectations of women can lead women to prioritise their family's needs over their own need for eye care. As a result, they experience higher rates of unemployment and dependency, perpetuating gender inequity.[4]
- Women with vision problems may feel that they are a burden. Social stigma about blindness or disability can be so deeply ingrained in the subconscious of women who are blind or have vision impairment that shame may prevent them from seeking help.[5,6]
- A decline in vision is often viewed as an inevitable consequence of ageing and women affected by vision loss are less likely to have social support in a family to seek care.[3]
- Women's rates of literacy are often lower than men's (because their education was not prioritised), especially among older people. Consequently, women can be unaware of information regarding vision loss or other eye health conditions and may be less likely to know about the possibility of treatment or where to receive it.

A case study from India[7] describes the different cultural reasons women required more preparation before accessing medical services, including: waiting for permission to travel, waiting for finances to be allocated, having an accompanying person, and preparing for time away from the household and child care tasks expected of them.

It is also important to understand barriers from the perspective of women who experience intersectional marginalisation (for instance, those who are also older, have a disability, live in rural areas, are socio-economically disadvantaged, and/or are members of an ethnic minority group).

It is vital that everyone involved in providing eye care understands that social and cultural expectations have an impact on the way women and girls are able to access to eye care. It is our responsibility to challenge our own perceptions and biases to ensure eye health information and services reach women and girls, especially those who experience intersecting forms of discrimination.

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Gender inequity in eye health: what is the impact?

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Equitable access to eye care benefits all of society, not just women and girls.

Eye health issues limit women's ability to work, which contributes to economic instability for them and their family. INDIA

Improving access to eye care is essential for enhancing women's overall health and wellbeing. Vision problems can profoundly impact daily life, diminishing quality of life[1] and increasing health risks, including those related to mental wellbeing.[2] Women often shoulder the dual responsibilities of paid work (employment) and unpaid work (household management, caregiving responsibilities, and the associated mental load). Untreated vision issues can impair their ability to perform essential tasks, manage their health effectively, and contribute to the wellbeing of their families and communities.

When women and girls have less awareness of, and access to, eye health services, this results in delayed diagnoses, higher preventable blindness rates, increased health care costs, and reduced quality of life. Long-term effects include lower educational attainment for girls, reduced productivity, poverty, and worse health outcomes - all of which deepens existing gender inequity.

Vision impairment can have profound effects on overall health, increasing the risk of accidents and falls, and complicating the management of chronic conditions like diabetes. Untreated eye conditions can worsen over time, leading to blindness, which further restricts women's mobility, financial authority, and independence, and increases their risk of other impairments. There are also wider impacts on communities and at national level. When women and girls do not have the eye care they need, this hinders socioeconomic development, raises national health care costs, and negatively impacts community wellbeing.

These effects have greater impact on women and girls as they already have worse access to health care. The financial costs to treat eye care are compounded as women and girls' needs may not be prioritised by families, health providers, and society. There is also evidence that women with vision impairment are highly vulnerable to violence, crime, and assaults in private and public spaces; they also face challenges accessing services and support as survivors of violence.[3]

> **"Women with vision impairment are highly vulnerable to violence, crime, and assaults in private and public spaces and face challenges accessing services and support as survivors of violence."**

Educational and economic impact

Vision loss poses significant challenges to girls' educational attainment, as any vision impairment can hinder their ability to read, write, and fully engage in their studies. Social stigma, discrimination, and cultural pressures often lead families to treat girls' education as less important or urgent, especially if they have vision impairment. In some countries, social expectations of how women and girls should look are reported to discourage many girls from wearing glasses, adding to the barriers they face in achieving academic success.

Vision loss also severely limits women's ability to find work and earn an income, contributing to economic instability for themselves and their families.[4] Vision impairment often increases women's dependence on others, adding strain to household resources. In addition, caregiving responsibilities, typically assigned to women, further restrict their economic participation. The financial burden of eye care and treatment, including travel costs, deepens this hardship, creating cycles of poverty that disproportionately impact women and their families.

Social and emotional consequences

The psychological impact of vision impairment on women can be profound, leading to increased feelings of isolation, anxiety, and depression. Vision loss often results in decreased social interactions, as women and girls may feel embarrassed or self-conscious about their condition and their appearance. This isolation can further diminish their quality of life and reduce

their participation in community activities. Additionally, the stigma associated with vision loss can deepen these challenges, making it harder to seek support.

Broader implications for society

Women's eye health issues have broader social consequences, particularly with regards to caregiving roles and community productivity. Vision impairment reduces women's capacity to care for children or ageing parents, often shifting caregiving responsibilities to other women or even girls, disrupting their education and opportunities. These structural dynamics perpetuate cycles of poor health and economic disadvantage, as systemic discrimination leaves women with fewer resources to address vision problems or access services. When women - who are vital contributors to households and the economy - are unable to fully participate because of vision impairment, it leads to lower productivity in the community as a whole and makes inequality between generations worse.

Conclusion

Addressing eye health disparities among women and girls is about social justice and equity, not just health care. According to global reports,[4,5] investing in eye care for women not only improves individual outcomes but also yields significant economic and societal returns by enhancing productivity and reducing the economic strain on families and communities.

Prioritising gender-sensitive strategies is essential to provide women and girls with life-changing care. Stakeholders must act now to implement policies and programmes that remove barriers and foster inclusion, ensuring that no woman or girl is left behind in the fight against avoidable blindness.

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The importance of gender equity in eye health leadership

Including women in eye health leadership improves health outcomes for everyone.

Despite making up over 70% of the global health workforce, women hold only 25% of leadership positions in health care worldwide.[1] This significant underrepresentation means that health initiatives are not yet fully benefiting from the diverse knowledge, perspectives, and expertise that women bring to leadership.[2]

Achieving gender equity in health leadership – i.e., including women at the decision-making level – improves health outcomes for everyone:

- As leaders, women understand the lived experience and challenges faced by women and girls in the community, who are often more underserved than their male counterparts.
- The insight and lived experience women bring to leadership can have a major impact on the productivity and retention of a predominantly female health workforce.
- As leaders, women often expand the health agenda, strengthening social inclusion and health for all.[1]

The impact of women in leadership: evidence from the COVID-19 pandemic

One compelling example of the benefits of female leadership can be seen in the global response to the COVID-19 pandemic. Countries led by women achieved lower COVID-19 mortality rates compared to those led by men.[3] For example, by June 2020, women-led countries like Germany and Aotearoa (New Zealand) reported fewer than 10 COVID-19 deaths per 100,000 people, whereas mortality in many other countries continued to increase at an alarming rate.[4]

Common characteristics of women leaders identified during the COVID-19 response were:

- **Their effective leadership and rapid response**, which helped to contain the virus.
- **Their emphasis on social inclusion.** Prioritising policies that addressed the social and economic impact of the pandemic helped to reduce the effect that COVID-19 had on vulnerable members of society.
- **Clear communication** from women leaders, as well as empathy where appropriate, allowed the public to understand the pandemic as well as the new policies.

These characteristics of women leaders are synonymous with the findings of an analysis that compared the key leadership capabilities of women and men, and found that women leaders excelled in taking initiative, acting with resilience, displaying integrity and honesty, inspiring and motivating others, and championing change.[5]

Women bringing care to the community

Women eye health leaders play a major role in providing equitable access to eye care for their communities. An example

A health worker engages community members during a health awareness session. SRI LANKA

of this is provided by Marnat Adugna, a health programme leader at Partners in Education Ethiopia, a charity organisation primarily engaged in improving access and quality of education and promoting health and well-being to disadvantaged communities in Ethiopia. Starting in 2019, Marnat led the development and implementation of successful community- and school-based eye health projects, including the establishment of six vision centres in primary health care facilities across Amhara region, outreach screenings and surgical campaigns in remote rural communities, and the training of hundreds of community health workers (CHWs) to integrate primary eye health services into the country's primary health care system.

Marnat explains: "I was inspired by the urgent need to address gaps in equitable access to eye health services in disadvantaged communities. As a health programme lead, I saw the opportunity to integrate eye health into existing community health structures, like the community health workers programme. I wanted to ensure that even the most remote communities could access essential eye care, which I believe is critical for improving overall health and educational outcomes."

By the end of 2024, this work had resulted in eye screening for more than 90,000 students, teachers and community members, eye services for 32,000 people, and the distribution of over 3,500 pairs of spectacles.

"Women leaders excelled in taking initiative, acting with resilience, displaying integrity and honesty, inspiring and motivating others, and championing change."

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Improving access to eye care for women and girls: what are the key areas for action?

Action is needed in several areas to overcome the unique barriers faced by women and girls, and gender-diverse people.

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It is only by collaboratively addressing the systemic barriers that impede equity of access to eye care for women, girls, and gender-diverse people that we can foster a more equitable eye health environment. To do this we need to focus on several areas of action.

1. Data, monitoring, and evaluation

Accurate data collection, evidence, and research are crucial for shaping future eye care initiatives. Comprehensive data (including sex/gender disaggregation) allows for the identification of gaps and the evaluation of health care programmes and treatment effectiveness.[1]

Evaluating the effectiveness of eye care programmes requires robust key performance indicators (KPIs) to monitor impact. Knowledge, attitudes, and practices (KAPs) assessments can be carried out to gauge community awareness and behaviours regarding eye health. Gender indicators are essential for tracking disparities in access and outcomes between different genders and ensuring that programmes address specific needs effectively. Satisfaction surveys can help to measure the quality of care and identify areas for improvement based on patient feedback.

More research is needed to explore gender inequities in eye care access and to develop targeted solutions that address these disparities. By continuously gathering and analysing data, stakeholders can refine strategies, enhance programme design, and implement evidence-based practices to improve eye care services and ensure equitable access for all. Research and sex/gender disaggregated data showing eye health disparities, quality of care differences, and gender access inequities can make a compelling case for policies and other targeted interventions.

2. Policy interventions

Policies that prioritise women's eye health are crucial for addressing disparities and improving outcomes.

Policy interventions can range from integrating eye health into broader health services specifically provided for women, such as maternal and child health services and sexual and reproductive health services, to ensuring that gender-specific needs are considered in national health strategies. Effective policies should include regular screening, affordable treatment, and public education campaigns that highlight the importance of eye health for women and girls. Read more in the UN Women report: **bit.ly/UNwomeneye**
Engaging policymakers and stakeholders in discussions about the unique challenges women face can help to create targeted and effective policies – including policies to increase the proportion of women represented in decision-making bodies and organisations.

Taking services to the doorstep: Eye care camps held within communities help women overcome barriers to access. Health workers register and screen community members during the outreach event. INDIA

UN Women report
No Woman Left Behind: Closing the Gender Gap in Eye Health
bit.ly/UNWeye

From the field

Telemedicine in a woman-led vision centre

Tasmia Tasmin Tani is the allied ophthalmic practitioner in charge of Haimchar Vision Centre in Chandpur, Bangladesh. She is responsible for providing eye screening and primary eye care. "For patients requiring advanced consultation, we arrange tele-consultancy sessions with doctors at our base hospital." Patients with severe eye conditions are referred to the base hospital.

"Women-led vision centres are important because people in these rural areas are not comfortable speaking openly with a man. But they can say everything in detail to a woman. These open discussions help provide patients with proper treatment."

3. Interventions at the level of eye health programmes

Eye health programmes and initiatives that bring eye care closer to communities, especially rural communities, play a major role in improving access for women and girls, as transport and travel are significant barriers.

Vision centres are an example of a sustainable model of eye care provision for rural, underserved, and/or low-resource settings, particularly those that are densely populated, e.g. in South Asia.[2] Vision centres can provide primary care, screening, and referral to a local hospital when needed. Vision centres staffed by women have been found to encourage greater uptake of eye health services among women.[3]

In many regions, **community health workers** have been trained to conduct eye screening and provide basic eye care, or to refer people to local hospitals or **outreach camps**, which significantly improves access to services for women and girls in remote areas. Examples are the National Lady Health Worker Programme in Pakistan and the female Community Health Workers in Ethiopia.

Training health workers in gender equality and equity, and in how to investigate inequities in access and decision-making locally, can also help to ensure cultural and gender barriers are overcome.[4] These initiatives not only enhance access to care but also empower local communities to take ownership of their health.[5]

4. Collaboration and partnerships

Effectively addressing the eye health of women and girls requires collaboration. Multi-sectoral partnerships involving health care providers, NGOs, and community-led organisations (including women's or gender equity organisations) are essential for creating a comprehensive and inclusive approach. Such collaborations can lead to the development of innovative solutions and a more efficient use of resources.

Linking eye care with broader health and education initiatives ensures better integration and scalability. Collaborating with school health programmes and educational campaigns raises awareness and promotes early detection of vision problems. Aligning eye care with general health programmes supports a comprehensive approach to wellbeing, addressing immediate needs and fostering long-term improvements in eye health. For example, eye care can be provided in conjunction with other essential health services, such as maternal and child health, sexual and reproductive health, and child immunisations. This can be delivered via mobile or outreach services, or at community health centres.

5. Awareness and education

Engaging men and boys as advocates for women's eye health is also crucial. By involving them in awareness raising campaigns and educational programmes, eye care teams can challenge and change cultural norms that may undermine women and girl's health. Awareness campaigns and educational programmes can also address issues facing women and girls as patients, such as stigma, bias, lack of access, or discrimination.

Educational campaigns are also needed to address the challenges facing women as health professionals, such as burnout, lack of supervision or adequate support, and pay gaps – while also considering their roles as care providers. This is vital for ensuring equitable and effective health care delivery.[6]

6. Technology

Telemedicine is revolutionising access to eye care, particularly for historically underserved populations. The vision centre model uses telemedicine to connect remote communities with specialised eye care through virtual consultations and remote diagnostics.[2] This approach bridges geographical gaps and enhances the efficiency of services.

Innovations in eye care technology can help to improve early detection and treatment at the primary care level. Mobile apps such as Peek Acuity (**bit.ly/41iFFL8**) can enable anyone to check visual acuity. AI-powered tools can analyse retinal images for conditions like diabetic retinopathy and glaucoma, enhancing early intervention and care[7] for female patients, who may face barriers to accessing traditional services.

In conclusion, it is imperative for everyone – including governments, health organisations, NGOs, and community leaders – to prioritise initiatives that directly address gender inequities. By investing in community health worker programmes, enhancing education about eye health, collecting sex disaggregated data, and expanding service availability through technology innovations, eye care teams can bridge the gap in eye care access and address gender inequities. Best practices also demonstrate that using gender equity tools, such as those shared in the IAPB Gender Equity Toolkit (**bit.ly/IAPBgender**), allow relevant stakeholders to effectively integrate gender into eye health planning and programming.

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Improving access to eye care for women and girls: practical steps

There is much that eye health professionals and managers can do to improve access to eye care for women and girls in their clinics or eye health programmes.

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Initiatives that make eye care services more affordable and bring them closer to communities can help to overcome several of the barriers faced by women, as described elsewhere in this issue (see page 4). By specifically targeting women and girls, these initiatives can be improved; for example, by working with local women's groups or carrying out eye screening in workplaces dominated by women such as hospitals, health centres, and garment factories.

However, if we are to provide access to eye care for **all** the women and girls who need it, we need to do more. In this article, we look specifically what else health care workers and managers can do in their health facility or eye health programme.

Step 1. Data collection

You cannot start to solve a problem without knowing it exists – or how big it is. Gathering and analysing data by gender is necessary so that we can see if there are any differences between women and men's (or girls and boys') access to eye care services, such as cataract surgery or refractive error screening, and how great those differences are.

To find out if women and men are receiving eye care in proportion to their needs, calculate the percentage of women and men accessing eye services at your facility or in your eye programme, and compare this to what is known about the percentage of women and men with eye care needs in the community.

To carry out a very broad gender analysis across all age groups and eye conditions, you can take the following steps:

1 Analyse the eye health department or eye programme records by gender: divide the total number of female patients by the total number of patients of all genders, and multiply this by 100. This gives you the overall percentage of female patients accessing the service.
2 Compare this to the percentage of women and girls in the community or country who are known to have eye conditions. You can use local rapid assessment of avoidable blindness (RAAB) data, if available for your country (available at **www.raab.world**). Or, if no national or local data is available, we know from global data that approximately 55% of those who are blind or who have vision impairment are female.

If you have access to eye service/facility and national data for different eye conditions and/or age groups you can make similar comparisons to gain a more detailed understanding of any gender differences (disparities) in access, e.g. amongst people over the age of 60 years coming for cataract surgery, or in school-age children receiving refractive error screening. It may also be useful to gather data on other characteristics, such as disability status, or urban vs rural location, in order to identify which women and girls face additional barriers to accessing services.

A young girl undergoes a vision screening during a community eye health camp, helping detect issues early and improve access to care, especially in rural areas. INDIA

Read more
How to measure inequality in eye care: the first step towards change
bit.ly/4knisQD

TIP: Keep on collecting data
Data collection isn't a one-time activity. As you work to improve women and girls' access to eye services, continuously monitor the gender of people using the service. This will allow you to track the success of each new initiative you try. This feedback is important as it tells you how well you are doing, and may highlight new areas that need improvement.

Step 2. Consult with key groups

The data analysis in Step 1 will show you whether disparities exist, and where they are. To understand what is preventing women and girls from accessing eye health services, and how to overcome these barriers, you will need to speak with them. You can do this either individually, through conversations, or collectively, through focus group discussions – for example, with women who are members of local community groups. You could also speak with groups such as community leaders and community health workers who work closely with women. Ask these groups why they think women are not accessing eye health services, and what they think will make things easier or better. Please note that this should be done with each group separately, and where possible with women and men separately too. Women may feel scared or unwilling to discuss sensitive issues when male community members are present.

The 2012 *Community Eye Health Journal* issue 'Putting patients at the centre of eye services' includes practical suggestions on finding out what patients think. Visit **https://cehjournal.org/38/volume/25/issue/78** to read more.

Case study: Ethiopia

One example of tailored programming from Ethiopia showed that establishing two waiting lines during outreach programmes – one for women and one for men – increased access to eye health for women. This is because, due to women's household and caring responsibilities, they may not be able to show up early to stand in long lines and could miss out on a consultation or operation otherwise (Figure 1).

Figure 1 Establishing a separate waiting line for women increased their access to eye care. **ETHIOPIA**

Case study: Malawi

Health care workers at eight district hospitals received gender training in 2020 and 2021, which helped them to better understand the different barriers that women face in trying to access eye care. For example, they realised that the distance people needed to travel, and the cost of this, was keeping women from coming for cataract surgery, Opthalmologist Dr Moira Chinthambi explains: "The team now sends vehicles to the remotest of areas to look for women and girls and make sure they're included. Sometimes people would have to walk to go and look for patients and pick them up and bring them to the nearest health facility. That also helped with the economic challenges, because now there's no need for transport money."

Dr Moira Chinthambi. **MALAWI**

TIP: Consider all women and girls
When consulting with different groups, consider women and girls in all their diversity. Women and girls with different characteristics, such as age, disability, income levels, or membership of indigenous or specific ethnic groups, will face multiple, compounding barriers that hinder their access. For example, women who live in poverty, women with disabilities, and indigenous women all have additional barriers to overcome in accessing health care. Understanding and addressing these 'intersectional' barriers is only possible through consultation with women and girls from all of these groups.

Step 3: Finding solutions

Specific barriers will need specific solutions, which should be developed in conjunction with the communities involved. Women – and women leaders – must be at the heart of these discussions, but we also need to involve cultural and religious leaders to ensure that actions taken are appropriate and acceptable to everyone in the community. This step could be taken in conjunction with the above consultation process.

"Engaging women in identifying challenges and co-designing practical, culturally appropriate strategies will lead to more effective and sustainable change."

Ensure that women's voices shape the solutions. Engaging them in identifying challenges and co-designing practical, culturally appropriate strategies will lead to more effective

and sustainable change. These insights can then be brought to eye care management, not just as problems, but as collaboratively developed solutions that reflect the real needs and priorities of the women affected.

Another common challenge is when women do not feel comfortable seeing a male professional. This could be overcome with women-specific clinics or specific scheduling of female eye care practitioners. In Sierra Leone, for example, some women refused to be treated by male professionals due to their religious beliefs and because they did not feel comfortable around men. Setting up specific clinics for women, with female eye care practitioners, helped them to feel comfortable to seek care.

Something as simple as allowing women to bring their children to the eye clinic can also help, as women are often the default child care provider and would otherwise need to find someone to look after their children.

TIP: Remember that eye care is part of health care

Reach out to other health professionals to explore how you can work together to improve access for women. For example, you can agree to offer eye health services near and/or on the same days as other health services commonly used by women, such as maternal and child health clinics. This will reduce the number of trips and the associated costs.

Step 4. Educate health workers

Many of your colleagues may not grasp the depth of inequities in health care or how these can affect access to health care. You can:

1 Host an information session highlighting these inequities, share real world examples, and brainstorm actionable solutions.
2 Conduct training to create awareness of traditional gender roles and expectations. This can include training on gender biases and how we, as health care workers, can challenge our own assumptions or biases, such as assuming that children need to be looked after by women, when in reality men are equally capable of doing so.
3 Present ideas to management or co-create solutions to the barriers you have identified.

Step 5. Address cultural and gender expectations in the community

Ingrained cultural and gender expectations can be more complex to address, but eye care professionals are trusted members of the community and can speak with community and religious leaders about the need for women to have eye care. It can be helpful to work together with other health professionals, e.g. maternal and child health workers.

Simple health promotion messages can be very useful. One of the barriers highlighted in this issue is that women may prioritise their family's eye care needs over their own. Light for the World addressed this in Ethiopa by creating posters and billboards encouraging women to prioritise their own eye health (Figure 2) as part of a wider project supported by the Austrian Ministry of Social Affairs, Health, and Consumer Protection.

TIP: include men

Messages aimed at men – about the importance of women's access to eye care, and the benefits of this – are needed to challenge patriarchal norms in some societies. This can include messages about the need to provide money and other support for female family members to access eye care services, particularly when they have to travel to secondary facilities after being identified at a screening or outreach programme, and messages about the need for men to perform domestic duties and take over caring responsibilities so that women can travel to receive eye care and have time to recover after surgery.

Case study: Involving men to improve access for women

Edwin Maleko
TANZANIA

In a Sightsavers- and UK Aid-funded programme in Tanzania, the team improved access to eye care for women by working directly with men to challenge attitudes and change their behaviour.

Programme manager Edwin Maleko explained: "Around 56% of the people who benefited from the programme are women, but in terms of cataract surgery, the number in our previous project was just 36%. Why? Because if a woman accepts cataract surgery, she may need around two weeks to recover. Who will take care of the children? That is the challenge. To tackle it, we needed to challenge community attitudes and behaviour, so that men can be more responsible in taking care of their children and doing domestic work."

The team designed a set of messages aimed at making men more supportive of their spouses attending health care services and clinics (known as a **sensitisation approach**). The team also **engaged with religious leaders** and asked them to encourage men to support women.

In addition, the team worked in partnership with the Tanzania Gender Network to provide training, develop training manuals, and liaise with social welfare officers working at district and regional levels.

"While there is still work to do in this area, it was encouraging to see that during the programme, the number of women who accepted cataract surgery is now 46%. We can see the benefit of all these efforts."

Reference

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Overcoming the barriers to women's leadership in eye health

The shortage of female leaders in eye health is a matter of opportunity, not competence.

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What is holding women back from leadership positions in eye health is the lack of opportunity, not competence. There is evidence showing that, if women get the opportunity to lead, they excel in bringing change at global, national, and community levels.

However, there are many barriers that prohibit women from advancing to leadership positions, including:

- Systematic disadvantages, gender biases and stereotypes being perpetuated by society
- The inflexible nature of health system structures
- Economic disparities and inequitable access to professional development opportunities for women and girls, such as mentoring and skills development
- Discrimination, workplace bullying, and sexual harassment
- Lack of recognition and respect
- The gender pay gap – i.e., fewer women in high-paying jobs – which contributes to women becoming demotivated.

Lessons from other sectors

Addressing these barriers requires long-term commitment, collaboration, effective and evidence-based strategies, and innovative and intentional interventions to bring a transformative change. A recent report[1] identified the following lessons from other sectors on how to boost women's leadership in eye health.

Deliberately create opportunities for leadership

Develop gender equity policies that encourage the involvement of women in leadership positions. For example, set up policies of equal representation of men and women on boards, as board chairs, on decision-making committees, and on recruitment panels.

Monitor progress

Be clear about the change you are trying to make – i.e., set explicit targets. Then set up the right mechanisms to measure, monitor and communicate progress. The IAPB Gender Equity in Eye Health survey tracks a number of metrics, and might be a useful place to start (see the IAPB Gender Equity toolkit at **bit.ly/IAPBgender**).

Provide support

Set up mentorship and sponsorship programmes specifically designed for aspiring women leaders, from an early career stage.

- **Mentorship** from a more senior colleague can provide women with career guidance, networking opportunities, and feedback and support to take on new roles and greater levels of responsibility.
- **Sponsorship** goes beyond the usual role of a mentor. Sponsors are senior colleagues who can use their position and influence to proactively advocate for women's advancement, for example, nominating them for positions in leadership groups. This will help women to advance their leadership career and be at the head of the table when the time is right.[2]

Fix the problem, not women

Building the capacity of women as leaders is insufficient if systems aren't changed, as women themselves are not the limiting factor. Even women

Deliberately create leadership opportunities for women working in eye health. INDIA

in leadership positions cannot change the system independently, as evidenced by research and case studies that consistently highlight the need to address institutional and structural barriers.[3]

Removing structural barriers that may hold women back from achieving their leadership potential could include progressive organisational policies like flexible working (e.g., having flexible start and end times to the working day, and/or working from home some of the time), and forums for women to share their lived experiences. Supporting women to balance their paid work and unpaid parenting or caring roles could involve offering shared parental leave, childcare support, and women's health benefits.

Note that women may face additional disadvantages related to age, disability, or ethnic group; additional supportive policies should be developed in collaboration with these groups.

Encourage men to support gender equity

Men in positions of power and influence should be fully involved as strong allies in the development of women and fill the development gap by offering opportunities, mentorship, and sponsorship.

Men can help to bring about cultural change by breaking and challenging systemic and cultural biases toward women and contributing to a gender-inclusive environment.

Men can also help to break the 'maternal wall' of workplace discrimination against working mothers by eliminating the assumption that working mothers are less motivated to be involved in leadership positions than men,[3] and advocating for a flexible and supportive working environment.[4]

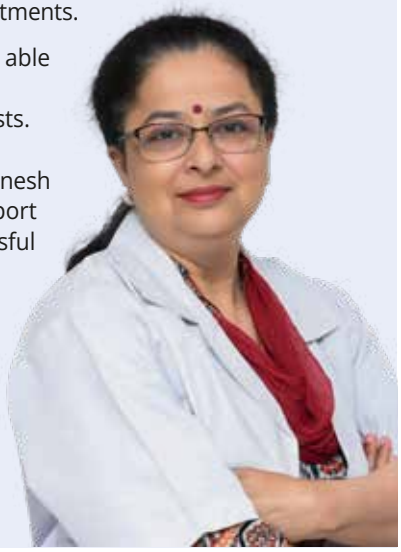
> **"Men can help to bring about cultural change by breaking and challenging the systemic and cultural biases toward women."**

Getting men in leadership positions onboard, however, requires strong advocacy and training on gender equity issues. A study showed that trained male executives were more likely to speak about gender inequity than their female counterparts.[5]

In conclusion, there are clear steps organisations and individuals can take to increase the proportion of women in eye health leadership positions. What we need most are people and organisations willing to take these steps.

Suma Ganesh

Suma Ganesh is Director, Paediatric Ophthalmology at Dr Schroff's Charity Eye Hospital, New Delhi, India. She championed the creation of a flexible paediatric ophthalmology fellowship that allowed women to develop a specialty without compromising their family commitments.



As a result, the hospital has been able to recruit and train two full-time female paediatric ophthalmologists. "We need to be flexible with the training we offer," she says. Dr Ganesh believes that women should support each other: "Behind every successful woman is another successful woman," she says. "When an opportunity comes our way, we need to grab it and not let it go. We need to focus on our career growth and work together to remove any obstacles."

Wanjiku Mathenge

Wanjiku Mathenge is the Co-founder and Director of the Rwanda International Institute of Ophthalmology and was recently appointed President of the African Ophthalmology Council.

In 2003, while working as an ophthalmologist in Nakuru Eye Clinic in Rwanda, Wanjiku noticed that her surgical lists always had men first, then women. Because of shortages of supplies, a lot of the time the surgeons didn't get to the women.

"I thought, 'Why is it like this?' What finally triggered me into action was a couple who came together; both were blind. The man, of course, was on the list – and we didn't get to the woman. The next day, the man was expecting his blind wife to still look after him. He didn't want to be discharged without his wife, even though the wife was still blind. He said, 'Who's going to cook for me when I get home?'"

"After that, I said that all men must bring their wives for a checkup before I do any surgery on the men. And my surgical list must always start with women." This flipped the data for this district: the rapid assessment of avoidable blindness (RAAB) survey for Nakuru, conducted two years later, found lower point prevalence estimates of blindness and moderate to severe visual impairment in women than in men.

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Empowering professional women in eye health: how to get involved

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Engaging with organisations that improve gender equity is a helpful first step.

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A panel of eye health leaders at a United Nations Commission for the Status of Women event in 2024, New York. USA

The field of eye health presents numerous opportunities for collaboration toward gender equity. Many organisations are focused on promoting gender equity and enhancing women's roles in ophthalmology, health care, and leadership. This article highlights meaningful ways to get involved.

Joining local and regional organisations

In your community, you can enhance eye health activities by focusing on prioritising gender equity. Start by gathering evidence for advocacy, such as asking female colleagues about workplace barriers. Promote positive messages about female eye health workers in campaigns, and review policies and recruitment practices to ensure inclusivity and equity for all genders, while actively addressing any potential biases.

Local and regional women's organisations, such as **Women in Ophthalmology South Africa** (WOSA), play a vital role in advocating and supporting female eye health professionals. These organisations can connect women with mentors and sponsors who can support them to navigate career challenges. Building such a network of trusted individuals is invaluable for career advice and opportunities, and for personal growth. If there is not a local organisation or society focusing on gender equity in eye health in your region, consider working with colleagues or peers to form one.

Knowledge sharing and volunteering within global organisations

Several key organisations actively promote gender equity in eye health, collaborating across regions through global consortia and workgroups. Notable examples include:

- IAPB's Gender Equity Workgroup (**www.iapb.org/connect/work-groups/gender-equity/**)
- Women Leaders in Eye Health (**bit.ly/3E9tEzJ**)
- Women Ophthalmologists Worldwide (**wowophthalmology.org/**)

Joining these initiatives and knowledge-sharing efforts can help women in eye health to connect with like-minded individuals and build impactful relationships. These collaborations enhance personal and professional development while enhancing global advocacy for female eye care workers.

Looking beyond eye health, organisations like **Women in Global Health**, **Women Lift Health**, and **Global Health 50/50** focus on gender equity in public health and support female leaders worldwide. They also offer valuable resources and training opportunities.

Within the wider gender space, there are also several major organisations such as **Women for Women International**, **Global Fund for Women**, **UN Women**, **Vital Voices**, **Purposeful**, and more that advocate for gender equity across all sectors.

Global collaboration and leadership opportunities

Global organisations in ophthalmology, like the **Asia Pacific Academy of Ophthalmology (APAO)** and the **American Academy of Ophthalmology (AAO)**, offer numerous leadership opportunities. Women interested in leadership roles can actively seek involvement in committees or start new chapters, advocating for the strategic support needed by their female colleagues. Other impactful organisations to connect with and learn more about include **Women Deliver** and **Women in Ophthalmology**.

A call to action

Gender equity is not solely the responsibility of women: men who are in positions of power and influence can play a vital role in supporting women to take up leadership positions. As women in eye health, working with male allies, we can shape the future of our field. Let's step forward with confidence, engage with key organisations, and take on leadership roles.

Everyone can advocate for more data on gender disparities in eye health leadership. If your organisation is a member of the International Agency for the Prevention of Blindness (IAPB), take part in the IAPB Gender Equity Workgroup's Gender Survey. At the community level, assess existing policies and conduct surveys to identify issues affecting women in eye health. Engage key stakeholders in decision-making and collaborate on gender equity initiatives. Support best practices and policies that promote gender equity, advocate for women's leadership, and create environments where they can thrive.

We encourage everyone to reach out to organisations and initiatives that focus on the intersection of eye health and gender equity, and to get involved in events to women and the wider eye health community.

Improving gender equity in access and leadership: regional priorities for change


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We invited women from several world regions to share the key priorities to achieve gender equity in eye health in their region.

Sub-Saharan Africa

Women and girls in Africa experience disproportionately low access to eye health services due to a range of social, cultural, and economic barriers. Gender-related barriers, such as prioritising caregiving roles, further hinder women from addressing their eye health needs. To ultimately improve eye care outcomes and foster lasting change, we need to **i**nvest in empowering women and girls through gender-transformative approaches.

Experience shows that bridging the gap in access to eye health for women and girls in this region requires meaningful engagement with women, girls and their representative organisations at all levels to ensure that eye health-related interventions reflect their needs and interests. We need policies promoting gender inclusion in eye care programmes and tailored financing options to make eye care more affordable for women. There also needs to be more training opportunities, and an enabling work environment, for female eye care professionals.

South-East Asia

To promote more female leaders in eye health in Southeast Asia, a multi-pronged approach is needed. In Vietnam, structural challenges like the earlier retirement age (60 years for women versus 65 for men) and extended maternity leave impact career growth. Gender-specific research is also crucial to identify and address gaps in access to services and leadership roles.

In Cambodia, and many other South-East Asian countries, despite an increase in female ophthalmologists, optometrists and eye health workers, sociocultural barriers persist. Family responsibilities often take priority over professional development, especially in rural areas.

More efforts are needed to incorporate gender equality into policies and raise women's visibility in leadership. Strategies required to build a supportive environment, which will increase female leadership in eye health across the region include harmonised policies which provide flexible work, awareness campaigns to change cultural norms, and expanded mentorship and training programmes to ensure women are prepared for leadership roles.

Middle East and North Africa

Priorities that can improve eye health for women and girls vary across countries in the Middle East and North Africa region due to sociodemographic and cultural diversity. In lower-income countries, increasing access to eye care is the main priority. Low family incomes lead to allocating the family budget to basic needs and life-threatening health issues. Improvement is needed in the physical accessibility of affordable and sustainable eye care services for women and girls.

In high- and higher-middle-income countries in this region, community-based awareness and empowerment campaigns focused on women and girls' eye health is needed to place eye health higher on the priority list for women, their families, and other stakeholders. These should focus on the importance of women's eye health in enhancing the individual and family's quality of life and productivity.

Latin America

In Latin America, a deeply entrenched culture of 'machismo' and systemic inequality exacerbate existing barriers. Women from rural, indigenous, and Afro-descendant communities encounter complex challenges stemming from historical marginalisation, language barriers, and geographic isolation. The region also grapples with one of the highest rates of gender-based violence, including femicide, which jeopardises women's safety and constrains public engagement. Although laws promoting gender equality exist, their enforcement remains weak due to political instability and corruption. Economic disparities, more pronounced than in many other regions, further hinder women's access to resources and opportunities.

Nevertheless, Latin America demonstrates remarkable resilience through grassroots feminist movements like "Ni Una Menos," (Not One Woman Less) which advocates for policy changes such as the legalisation of abortion in Argentina. To tackle these challenges, culturally tailored solutions are crucial. By harnessing its activist strength and confronting systemic barriers, Latin America can potentially lead significant advancements in gender equity.

South Asia

Although the region has made significant economic strides, within the predominantly patriarchal societies, progress on gender equity continues to be inadequate. Consequently, girls and women commonly experience stigma and discrimination, with lower access to health, education, employment, and political participation.

A multifaceted, integrated approach is needed to address cultural barriers, promote female leadership, harness innovation, and ensure inclusivity. For example, more supportive workplace policies are required that address the unique challenges women face. Fortunately, within the region we have successful gender-focused models that could be replicated, including the higher uptake of services by women when care is provided by female health workers. Our region also has extensive technological capacity, with telemedicine and mobile health applications offering promising strategies to address some of the barriers experienced by women and girls. Finally, a key priority is to involve communities in discussions about gender equity and health, ensuring that the voices of women and girls are heard and prioritised in the development of health programmes.

Addressing gender disparities in eye health services among school-age girls in India

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By emphasising community engagement and gender inclusivity, a school eye programme was able to improve access to eye care for girls.

Sitara, a 12-year-old girl from an intervention district in Madhya Pradesh, struggled academically due to undiagnosed vision problems, which affected her ability to see the blackboard and read textbooks. During a school eye screening camp, her impairment was identified, and she was referred for a comprehensive eye examination. With her new glasses, Sitara's confidence and academic performance improved. INDIA

With nearly 29% of its population under the age of 15, India is home to an estimated 33.4 million children who require spectacles for vision correction. However, many children, particularly girls, remain underserved.[1,2] A study conducted in Telangana, India found that girls are at greater risk of developing myopia, with an adjusted odds ratio of 1.30 compared to boys. Effective refractive error coverage for girls (39.1%) lags behind that of boys (47.0%).[3,4] India's National Programme for Control of Blindness and Visual Impairment (NPCBVI) has made significant strides in addressing childhood vision impairment through initiatives such as the School Eye Screening Programme, which trains teachers to carry out preliminary vision screening and referrals.[5,6] However, challenges remain, including limited reach, inadequate follow-up, and a lack of gender-sensitive strategies, disproportionately affecting girls in underserved areas.

The Vidyajyoti School Eye Health Programme, by Sightsavers India, seeks to bridge the gap in eye health services for children in government schools by conducting comprehensive screenings, implementing preventive strategies, and adopting an inclusive approach focused on equity and accessibility..

Strategies

The programme strategies are as follows:

- **Awareness campaigns.** Raising community awareness about the importance of eye health; educating students, particularly girls, about the benefits of wearing spectacles and dispelling myths associated with vision correction
- **Parental engagement.** Encouraging mothers' involvement in eye health discussions, as maternal literacy plays a crucial role in ensuring girls' compliance with wearing spectacles
- **Peer support groups.** Facilitating groups where girls can share experiences and encourage each other to wear spectacles, reducing stigma and fostering compliance
- **Addressing operational challenges.** Tackling systemic issues such as school absenteeism, inadequate infrastructure, and delays in delivery of spectacles
- **Gender- and culture-sensitivity training.** Training teachers and health educators to address gender gaps, harmful gender norms and roles, and socio-cultural barriers
- **Improving infrastructure.** Enhancing school infrastructure to support effective screening
- **Community-based outreach programmes.** Provision of eye care services, particularly in rural areas, which indirectly benefits women and girls by enhancing overall access to eye health services
- **Collaboration with NGOs and the private sector.** Improving resource availability and support for eye health initiatives, thus creating an inclusive environment for women and girls.

Sustainable change requires integrating strategies into broader policies, embedding gender equity in programmes like NPCBVI, and ensuring funding and accountability. Using sex-disaggregated data to understand the gender gap and forming deliberate collaborations among educators, health care educators, and community organisations can help close the gender gap in refractive error coverage. This will empower children—especially girls—to excel academically and socially, ensuring a healthier future in alignment with the Sustainable Development Goals.

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Bridging the gender gap in eye health by training allied ophthalmic personnel

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Young women trained as eye care professionals are serving as role models and increasing the likelihood that other women will seek eye care.

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Women from disadvantaged backgrounds are trained to become allied ophthalmic personnel. INDIA

In India, women, especially from marginalised communities, are disproportionately affected by blindness. They are 1.4 times more likely to be affected by vision impairment than men.[1] Traditional gender roles that prioritise men's health, financial limitations, and a lack of female eye care professionals remain significant challenges for women.

The Mission Saksham initiative in India was established to train young women from disadvantaged backgrounds who have completed Grade 12 to become allied ophthalmic personnel (AOPs) in the eye care sector. India requires over 98,000 AOPs to meet basic eye care needs and achieve good universal eye health coverage.[2] Mission Saksham addresses this shortage by training AOPs to provide essential eye care services and take on leadership roles within their communities. As of 2024, 92% of participants are women, with over 500 AOPs trained to lead vision centres, manage clinics, and assist during surgery.

The female AOPs act as role models and change agents, driving equity and better health outcomes in their communities. For example, two women from the first cohort of trainees, who completed their training at the LV Prasad Eye Institute (LVPEI) in 2017, are now managing a vision centre in their hometown in the state of Meghalaya. They are not only providing essential eye care but also leading their community's eye care services. One of them, Marbalin Wanniang, said: "On average, I attend to between 10 and 25 patients on market days, with 60% of these being women and girls. Female patients tend to feel more comfortable with a female eye health professional, even if they haven't explicitly mentioned it."

Research has shown that women in leadership roles in health care not only improve access to services but also enhance the quality of care, particularly for women and children.[1]

Saniya's Journey

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Saniya conducting a refraction test at the vision centre in Kothakota, Telangana. INDIA

Saniya grew up in a single-parent household, with her mother working as a tailor to support her and her brother. After completing the Mission Saksham allied ophthalmic personnel course at the LV Prasad Eye Institute, Saniya was appointed as a vision technician at the vision centre in Kothakota, in the state of Telangana. Between January and September 2024, Saniya examined 2,328 patients, 48% of whom were women. She dispensed spectacles to 483 patients, 55% of whom were women.

Of the 258 patients she referred, 212 underwent surgery; 53% were women. Many patients, especially elderly women from marginalised backgrounds, were reluctant to see male professionals. Since Saniya started working at the vision centre, the women began to seek treatment for themselves and to refer other women. Saniya says: "Before I became a vision technician, many women in my community were reluctant to visit male eye care professionals. Now, they trust me to help them with their eye health."

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Developing female optometrists while challenging gender norms

Girls in rural Bihar are empowered through football and optometry training.

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The Akhand Jyoti football team. INDIA

The Football to Eyeball Girls Education Programme, a sports-based education and career-development programme, was launched in 2009 by Akhand Jyoti, a non-profit organisation in Mastichak in the state of Bihar, for schoolgirls from rural, economically disadvantaged backgrounds.

The inspiration behind the programme was an incident involving a 15-year-old girl in rural Bihar who was sold by her parents to work as a domestic labourer.

The programme was initiated as a way to build confidence in girls through football, a sport traditionally played by boys and men, and to challenge stereotypical gender norms. It has now grown into a structured initiative that trains young girls in football and in optometry, equipping them with skills for a career in either the eye health sector or professional football.

Girls aged 12–16 years are recruited into the sport and study programme through a network of 44 vision centres and 1,500 outreach volunteers spread across Bihar. The volunteers assess the financial situation of the applicant's family, and give priority to girls from financially disadvantaged backgrounds. The parents of enrolled girls subsequently act as 'brand ambassadors', helping to promote the programme.

"The programme has now grown into a structured initiative that trains young girls football and in optometry and eye care."

There is an entrance examination for applicants, to test their proficiency in primary-level English language and O-level science, followed by a personal interview with both the applicant and her parents. Currently, the programme receives around 1,000 applications, from which cohorts of 150 to 200 applicants are selected. All girls are taught life skills in the foundation year. Thereafter, they are trained in their chosen careers: optometry (roughly two-thirds of the cohort) or professional football (with the aim of securing a place in state and national teams). They can also choose to pursue a dual role – as an optometrist and as a footballer. Students have the opportunity to pursue a business management course after completing the bachelor's degree in optometry.

The Football to Eyeball Girls Education Programme has transformed the lives of the girls involved, their families, and the wider community – both socially and economically. They have pursued higher education, secured stable employment, and even taken on leadership roles. Currently, graduates from this programme account for more than 60% of all leadership positions at Akhand Jyoti Eye Hospitals.

Graduates are employed as qualified optometrists in Akhand Jyoti Eye Hospitals or elsewhere, earning between Rs 20,000 (roughly US $230) and Rs 40,000 (roughly US $460) per month. Delaying the age of marriage and motherhood has improved their health and well-being, and they are inspiring other girls to follow a similar path. Importantly, men in the community have begun recognising the value of education and financial independence for girls.

Challenges

There was significant initial resistance to the programme in the deeply patriarchal environment of rural Bihar. Families were unwilling to let their daughters step outside their homes, let alone play football. Gradually, mindsets changed, as the tangible benefits of education for girls, their financial independence, and secure employment became evident. Success stories, such as that of Manishe Dwivedi, have inspired more families to support their daughters' education and career aspirations. Hailing from a low-income, disadvantaged family in Siwan, Bihar, Manisha joined the programme at the age of 14. She completed her bachelor's degree in optometry, followed by a degree in management. Today, she leads the Football to Eyeball Girls Education Programme, mentoring young girls to follow in her footsteps.

To date, 725 girls have been enrolled in the programme. A total of 485 have been trained as optometrists, and 15 have successfully qualified to play football for the Indian national and Bihar State Teams. The programme aims to empower 1,500 girls by 2030. By extending this innovative model to other underserved regions, it aims to replicate the model of sports, education, and employment to bring about gender equality and social change.

Key community eye health messages

When improving access to eye care for women and girls:

- Collect and use gender-disaggregated data to monitor who is accessing services and identify gaps between women's and men's access.
- Consult women and girls directly through conversations or focus groups to understand the real barriers they face and design practical, culturally sensitive solutions.
- Recognise and address intersectional barriers by involving women from diverse backgrounds, including those living with disabilities, in poverty, or from minority groups.

When working with communities for solutions:

- Consult women and girls separately to understand the specific barriers they face in accessing eye care and gather honest feedback without external influence.
- Design culturally appropriate services by involving women in planning, ensuring options like flexible appointment timings, childcare support, and female health workers are available.
- Address intersectionality intentionally by recognising that factors such as age, disability, ethnicity, and poverty create additional barriers that must be considered in service design.

When working with communities for solutions:

- Train health workers in gender sensitivity to foster understanding of gender barriers and encourage supportive, inclusive practices.
- Offer women-friendly services by scheduling female-only clinics, providing female health staff, and allowing women to bring children to appointments.
- Engage men and community leaders to collaborate with male family members and community leaders, shifting cultural norms and encouraging women's access to services.
- Emphasise the need to adapt health services to be more inclusive and accessible, ensuring that women feel comfortable and supported when accessing healthcare.