

POLICY BRIEF

NO WOMAN LEFT BEHIND: CLOSING THE GENDER AND INCLUSION GAP IN EYE HEALTH

WHY IMPROVING WOMEN'S EYE HEALTH IS ESSENTIAL TO ACHIEVING THE SDGS

INTRODUCTION

Vision impairment is both a contributor to gender inequalities and an outcome of gender inequality. Preventing and treating avoidable vision impairment has a crucial role to play in reducing gender inequalities and achieving the Sustainable Development Goals (SDGs). This brief provides evidence of gender disparities in eye health and highlights gender-related barriers to eye care access and utilization for women. Bringing women's views and solutions to the forefront of discussions, the brief provides an opportunity to hear directly about the specific risks and challenges these women face, who is most at risk of being left behind and how national partners and the international community can most effectively tailor policies and programmes to meet their needs and fulfil their rights. Key recommendations include: amplifying the voices and ensuring the meaningful participation of women who are blind or have vision impairment at all levels of decision-making, increased resources to policies and programmes in all relevant sectors that impact women's eye health, upholding women's and girls' rights, tackling multiple and intersecting forms of discrimination, and eliminating gendered barriers preventing women's access to eye care.

Women's Health and Rights

Gender inequality and regressive gender norms have long-term effects on the health and life chances of women and girls – as well as their families and society at large. Meeting women's health needs and eliminating gender inequality are moral imperatives and fundamental human rights. As such, investment in women's health, including their eye health, should not require justification.¹

A woman's right to the highest attainable standard of health is a human right recognized in international human rights law and various international and regional human rights instruments, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which has been ratified by 189 states to date. State parties' compliance with Article 12 of CEDAW remains central to the health and well-being of women. The Convention requires states to eliminate discrimination against women in their access to health-care services, and CEDAW General Recommendation

No. 24: Article 12 of the Convention (Women and Health) re-affirms that access to health care is a basic right of women. Significantly, the General Recommendation requires that a "gender perspective" be mainstreamed into all policies and programmes affecting women's health and that "special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups." Though not explicitly stated in the General Recommendation, this includes women who are blind or affected by vision impairment.² In addition to CEDAW, the Convention on the Rights of Persons with Disabilities (CRPD) contains relevant protections for the rights of women and girls who are blind or have vision impairment. Specifically, the CRPD guarantees the right to equality and non-discrimination in Article 5 and the rights of women and girls with disabilities in Article 6. General Comment No. 3 on Article 6 (women and girls with disabilities) recognizes the multiple and intersecting forms of discrimination faced by women and girls with disabilities, including in health care.

Eye Health and SDG 5: Gender Equality

The Beijing Declaration and Platform for Action, CEDAW and the SDGs all reinforce that development is only sustainable if women and men benefit equally. However, the rate of progress in tackling gender equality remains slow. According to the 2023 Global Gender Gap Index, it will take 131 years to achieve full gender parity, a marked increase from the 99.5 years outlined in the 2020 report.³ Addressing eye health inequalities can help close the gender gap and ensure women are able to exercise their rights in all areas of society.

Worldwide, around 2.2 billion people are living with vision impairment, and almost half of those cases are preventable or treatable.⁴ Up to nine out of ten women and girls do not need to be blind, as the most common eye conditions – cataracts and refractive errors – can be easily prevented or treated through cost-effective interventions.⁵

Vision impairment disproportionately affects women and girls. Evidence suggests that in all regions of the world, and at all ages, women are more likely to be visually impaired than men. Women represent 55 per cent of the world's 43 million people who are blind,⁶ and 55 per cent of the 295 million people with moderate to severe vision impairment.⁷ Yet, they are the least likely to receive treatment and face barriers to accessing services.⁸ Women living with vision loss also represent some of the poorest and most marginalized populations, with 90 per cent of those with vision loss in low- and middle-income countries. The COVID-19 pandemic exacerbated these trends: every recent study on gender-disaggregated patient attendance or surgery rates suggests that the gap has widened between men and women since the pandemic began.⁹ This is likely to worsen existing disparities in eye health experienced by women and girls. This reinforces that eye health is not only a health and development issue but also a critical gender equality issue.

A 2023 report by The Fred Hollows Foundation demonstrates that investments in eye health offer among the highest investment returns of any disease intervention modelled by similar cases.¹⁰ Investment in the two leading causes of blindness and vision impairment will return on average \$9.40 for each U.S. dollar spent, with cataract surgery returning on average \$20.50. If women are aware of their right to health, including access to eye health services, they may have increased and more equitable access to better health outcomes and can contribute more to their communities economically, socially and culturally.¹¹

Efforts to improve eye health outcomes, therefore, contribute to the advancement of several SDGs, beyond those related to health (SDG 3). This includes increased gender equality (SDG 5) and reduced inequalities (SDG 10)¹² and indirect links to other

goals as well, including poverty (SDG 1), education (SDG 4) and economic productivity (SDG 8).¹³

UN Resolution on Vision

In July 2021, the United Nations (UN) General Assembly unanimously adopted Resolution A/RES/75/310 – Vision for Everyone: accelerating action to achieve the Sustainable Development Goals. The resolution is the first agreement on tackling preventable sight loss adopted by the UN, and it enshrines eye health as part of the SDGs. The resolution's adoption followed the publication of The Lancet Global Health Commission on Global Eye Health, which was officially launched by the UN Friends of Vision group in February 2021. The Commission found that improving eye health is essential to achieving many of the SDGs, including SDG 5, and that pervasive gender inequality in eye health must be addressed.¹⁴

BOX 1

UN Friends of Vision

The UN Friends of Vision is a group of UN Member States consisting of country representatives, including at Ambassador level, from more than 60 countries. As of August 2023, the Friends of Vision Group is chaired by Ambassador Dr. Aubrey Webson of Antigua and Barbuda, Ambassador Muhammad Abdul Muhith of Bangladesh, and Ambassador Fergal Mythen of Ireland. Friends of Vision champion women's right to health, actively highlighting the links between women's eye health, gender equality and the empowerment of all women and girls. The group continues to advocate for these issues within UN political processes, including forums such as the Commission on the Status of Women.

This is reaffirmed in UN Resolution A/RES/75/310, which expresses concern that the prevalence of vision impairment is higher among women and stresses the need to achieve gender equality in eye health and in access to eye care to ensure progress on SDG 5. The resolution further calls upon member states and other stakeholders to eliminate barriers and discrimination against women and girls in accessing support and health-care services.

Global Gender Inequalities in Eye Health

Evidence indicates that social, economic, and cultural factors play a bigger role than biology in women's disproportionate representation among people with avoidable vision impairment.¹⁵

While certain biological factors,¹⁶ particularly longer life spans, may influence women's increased risk of being visually impaired, structural barriers and social norms that underpin gender inequality play a significant role in increasing women's risk of exposure to eye health issues.¹⁷ Women, regardless of age, are more likely than men to develop certain preventable or treatable vision impairment conditions, like cataracts and trachoma due to these factors.

BOX 2

The Social Ecological Model: a framework for analysing and addressing gender inequalities in eye health

UN Women applies a 'gender lens' to the Social Ecological Model of health-related behaviours to understand how gender and gender inequality affect women's health and their ability to access vital services.

This model recognizes multiple levels of influence on women's eye health, including individual factors that influence behaviour (e.g. women's health literacy), interpersonal factors (e.g. traditional gender roles in the household), institutional (e.g. gender discrimination in patient care), community (e.g. societal stigma and shame around vision impairment) and policy and enabling environment factors (e.g. the extent to which laws and policy initiatives reflect equitable principles, with a focus on gender and disability). In partnership with The Fred Hollows Foundation, UN Women uses this framework for analysing and addressing gender inequalities in eye health.

INDIVIDUAL FACTORS

Women's lack of knowledge and agency

Women's rates of literacy are often lower than men's, especially among older people. Consequently, women are often 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. Research conducted in south India suggests that literacy levels among individuals with vision impairment are predictors of receiving cataract surgery.¹⁸ Lack of education and the self-perception of being a "burden" may also lead women to neglect their own health and well-being, with some believing that they have been cursed with vision impairment or that they simply have bad luck. When women experience a lack of agency or control in their daily life and health seeking behaviour, they often de-prioritize their own eye health.

INTERPERSONAL FACTORS

Discriminatory gender roles

Traditional gender roles increase eye health risks for women and girls at all stages of life. In India, the elevated risk of developing cataracts associated with solid fuel use is mainly limited to women, with the difference in risk attributed to women's traditional role in cooking.¹⁹ Health providers acknowledge that women's multiple roles and responsibilities within the family, and the interaction of gender-specific barriers, has an important influence on their ability to seek eye health services. This is especially the case for older women, due to their caretaking role.²⁰ Studies suggest that women, as a result of their caretaking role in the family, are also more susceptible to trachoma infection than men due to having disproportionately higher contact with children (who harbour the highest rate of infection).²¹ In some countries, women are approximately three times more likely than men to be blinded by trachoma.²² Gender norms mean women's needs for eye care may not be considered as urgent or important as that of male family members, or they may not have financial decision-making authority within the family to pay for eye care services. Research has shown women's lack of access over household resources and attitudes of male heads of household can be important in either supporting or discouraging women from seeking eye health care, including financially.²³

INSTITUTIONAL FACTORS

Gender bias and discrimination in health-care settings

Limited training for health professionals on how to care for those who are blind or have vision impairment means that women may face stigma and discrimination from health-care providers, substandard care and/or challenges around medical disclosure and confidentiality.²⁴ These are compounded by system-level factors, such as health facilities that do not consider women's needs and responsibilities (including long waiting times that adversely affect women given their household responsibilities, or lack of accessible washrooms, privacy screens, safe areas to breastfeed and baby changing areas). Together, these factors can undermine women's trust in the health system, which in turn results in poorer access to and engagement with eye health services.

Women's limited participation and leadership in eye health

Gender bias in health care is reinforced by the lack of women in leadership positions. Though women make up 55 per cent of the world's vision impaired, leadership in the field of eye health is highly skewed towards men. Women represent 25 to 30 per cent of ophthalmologists and 25 to 45 per cent of trainees

globally yet remain underrepresented in key positions.²⁵ Women's leadership in eye health is more than an issue of equity – it is the missing link that will help health professionals and policymakers more effectively address eye diseases and achieve better eye health outcomes for women.

● COMMUNITY FACTORS

Societal norms and harmful stereotyping

Social norms that limit women's decision-making autonomy, cultural restrictions on travelling and seeking treatment,²⁶ and societal stigma and shame associated with vision impairment can result in marginalization and social exclusion.²⁷ A lack of understanding around vision impairment and the rights of women and girls can foster discrimination that leads to girls being hidden by their families and women abandoned by their husbands or separated from their children.²⁸ Social stigma can be so deeply ingrained in the subconscious of women who are blind or have vision impairment that shame prevents them from seeking help.²⁹

● POLICY AND ENABLING ENVIRONMENT FACTORS

Lack of disaggregated data

Lack of disaggregated baseline and service delivery data, including by sex, age, disability and income/economic status, hinders the ability of policymakers and health authorities to

plan appropriate strategies to reduce gender inequality and track progress towards equitable eye health. The gender gap needs to be closed in other areas of development as well, such as primary and secondary education, given the links between literacy and eye health.³⁰ Studies suggest that girls are much less likely to finish primary school than boys, if both present disabilities (which may include vision impairments).³¹

National eye care policies unresponsive to women's needs

Gender-discriminatory laws and policies as well as a lack of legal protections deny women equal access to rights and opportunities, including in health, education, the administration of justice and other sectors. For example, laws requiring a husband's or father's permission to seek services can severely limit women's access to health care. Quality, equitable eye care is not always integrated into national health policies, plans and accountability frameworks or into the policies and plans of other relevant sectors (education, employment, social protection, etc.). Additionally, women and their voices are too often missing from the places where eye health policy, funding and research decisions are made and implemented. Consequently, invaluable insights from women's leadership talents and lived experiences are excluded.³² The result is that national eye health policies, plans and programmes are rarely responsive to the needs and rights of women who are blind or have vision impairment.

Voices of Women and Women's Organizations on Eye Health

To bring women's views and solutions to the forefront of discussions and decisions on the gender gap in eye health, UN Women initiated a series of regional consultations in 2023. Sessions were held in Asia and the Pacific, Eastern and Southern Africa, Europe, Central Asia and the Arab States, Latin America and the Caribbean, and West and Central Africa with 173 participants.³³

Participants included women with vision impairments, women and girls' rights organizations, disability rights non-governmental organizations (NGOs), national organizations for the blind, eye health NGOs and research institutes, eye health professionals and primary and hospital care providers. Each brought their own perspective from working with diverse groups of women and girls, including young and older women, women with vision impairment, women in rural areas and urban centres, women with disabilities, women from minority ethnic groups, indigenous women, Afro-descendant women, women living with HIV and female sex workers. Together, their resourceful and innovative suggestions enable eye health care support and services that are truly needs based and critical for women and girls who are currently at greatest risk of being left behind.

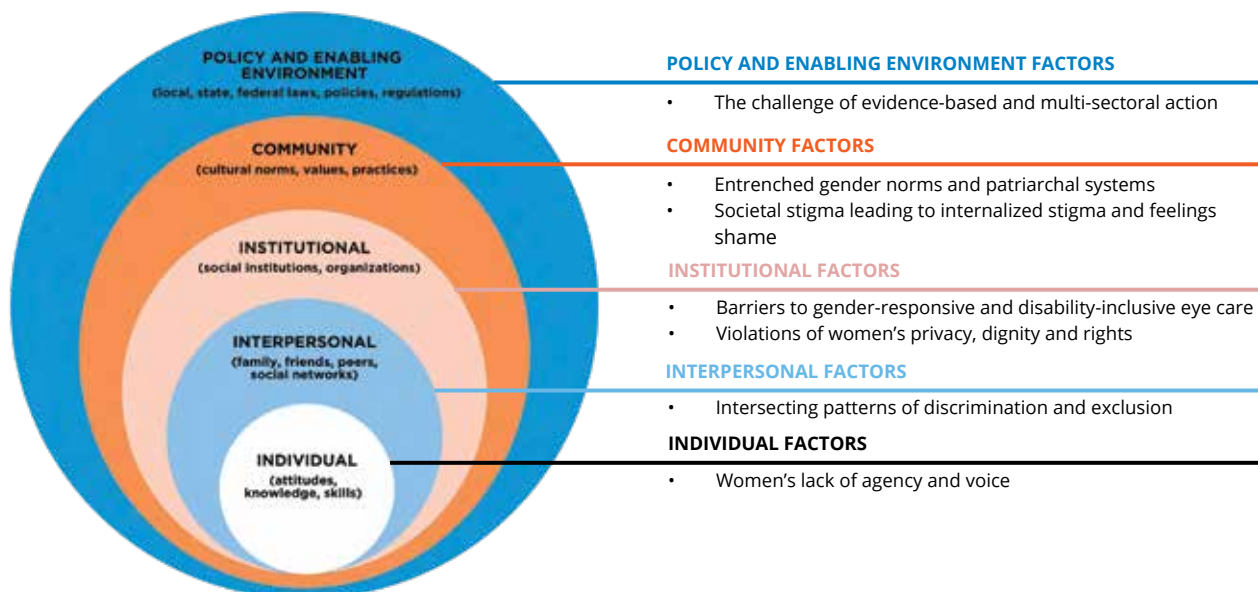
The consultations provided an opportunity to hear directly about the specific risks and challenges that women face related to vision impairment. Discussions also focused on the opportunities and solutions being provided by women's organizations, eye health NGOs, health-care providers and governments so that the strategic focus of support can be adjusted in a gender-responsive manner to reflect women's diverse experiences.

Women, women's groups, organizations of persons with disabilities, health-care practitioners and NGOs described many women's experiences of eye health that are well documented – and some lesser-known outcomes of poor eye health.

For example, these discussions covered the links between sexual and reproductive health and rights (SRHR) and eye health across women’s lives, the impact of gender-based violence on eye health and vice versa, eye diseases caused or exacerbated by environmental factors (including climate change) and the connection to gender roles and the extent to which internalized stigma poses a challenge to improving eye health outcomes for women and girls. They noted the strong solidarity of women and men working together, including eye health professionals, eye health NGOs and primary care and community health workers, to address all these challenges and build the long-term well-being of their societies. They called for the provision of public resources to support their work in closing the gender gap in eye health, starting with increased investments in sex, age and disability disaggregated data for evidence-based policymaking.

What Challenges Do Women Face and Who is Being Left Behind?

The principal underlying concern reported by women in all regions was the impact of patriarchal norms, systems, and structures on (i) women’s agency and autonomy to access eye health services, (ii) societal stigma and discrimination, and (iii) the design and implementation of eye health policies, programmes, and related services. Key themes and insights identified during the UN Women-led consultations are presented below.



INDIVIDUAL FACTORS:

Women’s lack of agency and voice

Women and women’s organizations from **Bangladesh, Malawi, Moldova, and Nigeria** raised the issue that female family members must often seek permission from the male head of the household to attend community health awareness meetings or health clinics. This was observed as contributing to low health literacy and eye health inequalities among women. Even when permission is granted, women’s lack of agency and voice can limit positive eye health behaviours, such as temporarily delegating caregiving responsibilities to others, seeking financial support to cover transport and treatment costs and de-prioritizing their own health.

The important role of women’s empowerment programmes in increasing women’s agency was highlighted by women’s organizations in every region.

In **Tajikistan**, efforts are being made to increase the agency of women who are blind and affected by vision impairment so that they can exercise their rights in all areas of society.

“In Tajikistan, we’ve recently been taking active steps to bring in and mobilize women who are blind and severely visually impaired. They have become part of our school of gender champions. We’re training and we’re educating them, and they’re becoming gender champions in their own right.”

Guljahon Bobosodikova, Chairperson of the Tajik (NGO) coalition, “From Equality de Jure to Equality de Facto,” Tajikistan.

“Sometimes women need to beg their spouses to make time [to visit a health facility], or to make alternative arrangements for someone to take care of the home and children.”

Mabel Ade, Executive Director, Adinya Arise Foundation, Nigeria

“Eye health is a gender issue because of the norms that surround women. These emphasize women’s position as caregivers and in that [role] they make sure everyone else is okay except themselves, and this hinders them seeking eye health services. Issues around finances and decision-making power also makes women not seek out eye health care.”

Christie Banda, Executive Director, Foundation for Civic Education and Social Empowerment, Malawi

INTERPERSONAL FACTORS:

Intersecting patterns of discrimination and exclusion

In all regions, women experience multiple and intersecting forms of discrimination that make it harder for them to access eye health services. Gender can intersect with age, disability and other identity factors such as poverty, ethnicity, indigenous origin or identity, albinism, HIV status, refugee status and others to increase women’s risk of vision impairment and their ability to access proper and early treatment.

Participants from **Latin America and the Caribbean, Asia and the Pacific, Western Africa and Central Asia** reflected that intersecting forms of discrimination are rooted in gender inequality and harmful stereotypes. Women’s organizations in **Nigeria and Mozambique** highlighted how women living with Albinism can experience lifelong eye problems, such as vision impairment, compounded by social isolation and discrimination based on gender. In **Mexico**, Dr. Gloria Ornelas, a female ophthalmologist, described the intersection between gender, poverty and indigenous identity. Many of the patients attending her eye health facility are indigenous women of low socio-economic status, and she explained that this is not always understood at the national level, or in policymaking.

The consultations identified older women in particular as facing multiple and intersecting barriers to realizing their right to health. The intersection of gender, age and poverty can lead to older women from lower socio-economic

backgrounds facing numerous barriers to accessing health. They are often more likely to have lower levels of education, be less mobile and experience a vision impairment compared to their younger counterparts or married men. Women’s organizations based in **Nigeria and Thailand** describe how older women are frequently “written off” by society once they have vision impairment or loss, leaving many housebound, socially isolated and unable to access eye health information and eye care services. However, the consultations also captured stories of positive change as exemplified by the story from **Bolivia** below.

“There is the story of Juana, who lives in a rural area near the Titicaca Lake. She is 60 years old, and she never had children, her siblings were in the city and she became isolated [because of her vision loss]. They were telling her that she had to leave her community because there was no one to take care of her because she was blind. She could not do any work until last year, when the [eye health] campaign came to the community, and she gained access to cataract surgery. Thanks to this surgery, she was able to see again. Today, she is taking care of her animals and she can take care of herself. I think this is a great story.”

Elsa Gabriela Zea, Ojos de Bolivia/Ojos del Mundo (Eyes of Bolivia/Eyes of the World), Bolivia

Women with disabilities experience additional eye health challenges, and they are frequently neglected in awareness campaigns and taken less seriously by health-care providers. They also face double discrimination because of disability-related stigma and gender-based social exclusion and abuse. In all regions, participants highlighted how stigma around all forms of disability negatively impacts women who are blind or living with vision impairment.

“Socially, disability is seen as incapacity and that is very conditioning because one ends up being a focus of admiration or pity, both of which are profoundly discriminatory. Having a vision-related disability restricts the possibilities of job development. Even with all my experience and training, I must fight to work. And I always think that I am privileged because...I was fortunate to grow up in a family that didn’t set limits for me.”

Veronica Carolina Gonzalez, Red por los Derechos de las Personas con Discapacidad (Network for the Rights of People with Disabilities), Argentina

The lived experiences shared during the consultations are a reminder that women’s overlapping identities and experiences must be considered to understand the challenges they face in accessing eye health care and exercising their rights. This intersectional approach is important for devising and delivering solutions that can positively impact women’s eye health.

“Intersectionality and the diversity within communities and backgrounds, ethnicities, social standing and status plays a huge role.”

Sabina F. Rashid, Medical Anthropologist, BRAC University, Dhaka, Bangladesh

INSTITUTIONAL FACTORS:

Barriers to gender-responsive and disability-inclusive eye care

The consultations highlighted both demand-side and supply-side constraints that present barriers to gender-responsive and disability-inclusive eye care. On the supply side, lack of access to health-care providers, including eye care workers, at primary and secondary levels is a critical issue. Women from **Uganda and Rwanda** report a limited number of specialists as well as eye clinics (including mobile clinics) that can reach women from underserved populations, including those living in humanitarian and conflict-affected areas. Eye health NGOs in **West Africa and Latin America** describe how the lack of optometrists and ophthalmologists is exacerbated by the uneven distribution of eye care professionals across countries, and women’s organizations in **Belize** note the absence of any surgical ophthalmologists at all. Even when these providers exist, women and girls in hard-to-reach areas such as isolated rural communities and urban slums encounter poorly accessible or often completely unavailable transportation systems to visit an eye care specialist. In **Viet Nam and Bangladesh**, positive examples were shared of health sector efforts to overcome these challenges and increase eye care services at the community level.

“In Viet Nam, the Ministry of Health has issued the quality protocol for cataract surgery and district eye care model guidelines. It has set up eye care at the grassroots, and this is something that is making it easier for women to access eye care services.”

Minh Anh Tran, Head of the School of Optometry, Hanoi Medical University, Viet Nam

“In Bangladesh, we have a National Eye Care (NEC) Programme, which is recognized as a multi-sectoral issue. There are plans to establish community vision centres in all health complexes by 2030. The government has already established 135 community vision centres, with more to follow. Another 300 or 400 maybe, by 2030. This is a very good initiative. Including eye health care in the primary health facilities will really help women access these services in their own communities.”

Mohammad Rofiqul Islam, Senior Programme Manager, Sightsavers, Bangladesh

Women’s rights organizations in **Haiti, Cameroon and Lebanon** also highlight supply-side challenges in humanitarian and emergency situations (including climate-induced events), where women find access to eye health care almost impossible. Affordability of treatment and women’s lack of access to health financing support mechanisms was a further barrier noted by women in **Lebanon, Tunisia, Rwanda and Zimbabwe**. The cost of spectacles or adaptive and assistive technologies, such as screen readers and braille devices, were described as prohibitive for many women and girls, particularly those living in poverty.

“I think that access to assisted technology is an important tool for us to access education, employment and work to reduce the gaps in our access to opportunities. These technologies can help us achieve financial independence, help us to do banking transactions, get jobs and have autonomy over our lives.”

Veronica Carolina Gonzalez, Red por los Derechos de las Personas con Discapacidad (Network for the Rights of People with Disabilities), Argentina

These types of access challenges are compounded when health systems and providers overlook the demand-side barriers associated with the needs and rights of women who are blind or have vision impairment. Women across **Eastern and Southern Africa and Asia and the Pacific** highlight that health workers need to be trained and sensitized to the gender dimensions of eye health and disability. By better understanding women’s experiences, health professionals can reduce the stigma and discrimination faced by women and girls who are blind or have vision impairment and ensure services meet their needs and protect their rights. Women’s organizations in **Europe and Central Asia** emphasize that this

includes women living with HIV (particularly those diagnosed in later stages of HIV when they may experience vision impairment or loss), as there is not enough awareness among health workers about the interplay between gender, HIV status and eye health issues.

“When we are in a hospital setting, it’s very rare that we are communicated with on an equal basis or treated by doctors as individuals who are equal to non-visually impaired people. And many times, our caretakers – for example, people who take us to the hospital – they speak for us. We don’t really get our voices heard.”

Shen Chengqing, Executive Director of Minority Voice, a grassroots disability rights organization, China

“There is no training for health professionals on how to care for women with vision loss or impairment. We could implement training policies for multidisciplinary health teams to be able to support these women, as well as policies to ensure girls and boys with vision impairments have access to schooling and don’t face exclusion.”

Constanza Letelier, Tremendas (NGO), Chile

INSTITUTIONAL FACTORS:

Violations of women’s privacy, dignity and rights

For women who are blind or affected by vision impairment, lack of confidentiality and privacy can be a major barrier in accessing eye health services. In every region, it was observed that they are often accompanied by a spouse or family member to appointments and other services, and the potential lack of confidentiality is a concern. Health-care providers may lack training to communicate with them directly in a manner that respects their right to privacy. Women from **Tunisia and Mexico** pointed out that even if a health-care provider does not talk directly with a family member or caregiver, they may give them documents to sign or printed information that is not accessible for the blind or visually impaired patient (including treatment-related information). Concerns about confidentiality and privacy extend beyond health-care settings as well. Women with vision impairment also face difficulties accessing justice when their rights have been violated, whether in health-care settings or other environments.

“The problem is that when it comes to visually impaired people, we like to take decisions for them instead of including them in decision-making places. We don’t give them enough voice. When you are accompanied [to a health centre] by someone, [health workers] automatically start addressing the person who is next to you. When it comes to health services, sometimes you do not get the information yourself. For example, with pregnancy tests you must have someone else read it for you.”

Besma Essoussi, Association IBSAR, Tunisia

“Women with blindness or vision impairment often go to the doctor with someone they don’t want to go with. A lot of their rights are violated. This happens during eye health visits, and it happens even more during sexual and reproductive health visits.”

Veronica Carolina Gonzalez, Red por los Derechos de las Personas con Discapacidad, (Network for the Rights of People with Disabilities), Argentina

Although research on the prevalence of violence against women with vision impairment is limited, there is evidence that women who are blind, partly sighted or have low vision are highly vulnerable to violence, crime and assaults in private and public spaces and face challenges accessing services and support as survivors of violence.³⁴ The risk of experiencing sexual assault appears to be higher in individuals with vision impairment than in the general population.³⁵ Women across **Eastern and Southern Africa** described how women and girls who are blind or have vision impairment are especially vulnerable to sexual violence and have difficulties in accessing health care and justice. Women’s rights organizations in **Tunisia** note they are often less trusted as witnesses and not seen as reliable.

“In the community, these women [who are blind or have vision impairment] feel marginalized and they also face the potential risk of violence, including sexual violence, [and] of being raped. Suddenly, a man can come and touch her, but she doesn’t see the person who is touching her.”

Dr. Dikey Dikitele, Girls Community (NGO), Democratic Republic of the Congo

COMMUNITY FACTORS:

Entrenched gender norms and patriarchal systems

Across all regions, women and women’s organizations emphasized how gender norms and patriarchal structures severely impact women’s ability to access eye health care and services.

“Women in Haiti are in a macho society. All the attention, all [medical] forms and guidance are generally based on the needs of men or boys. A woman who finds herself in a situation of blindness is much more neglected than a man. Because it is believed that, unfortunately, women can live without sight. Yet, steps are taken in search of a solution and visiting specialists when it comes to men and boys.”

Myriam Narcisse, Executive Director, Haiti Adolescent Girls Network, Haiti

In **Latin America and the Caribbean**, participants spoke about the gendered division of labour and resources, especially around care work in the home and access to adequate nutrition, and how this negatively affects the eye health of women and their ability to seek treatment. In **Asia and the Pacific and Europe**, women spoke of young mothers suffering from anaemia and the associated increased risk to their eye health. The role of women as childcare providers was identified by participants from **West and Central Africa** as a reason why more women are affected by trachoma and trichiasis. Women from **Nigeria** noted that caregiving responsibilities make it harder for women to obtain a diagnosis or receive treatment, even when eye care is free, because they are reluctant to leave their homes. In every region, traditional gender roles were cited as a factor limiting women’s movement and visits to health centres.

“By the time we women, who are visually [vision] impaired leave school, we just repeat and reprise our role as caretakers. Once locked into this caretaker role, we are stuck inside the family. We can’t really study or pursue other personal development opportunities that expand our futures.”

Shen Chengqing, Executive Director of Minority Voice, a grassroots disability rights organization, China

Girls’ rights organizations and eye health NGOs in **Ghana, Tajikistan, Uzbekistan and the Kyrgyz Republic** describe the reluctance of parents to allow girls and young women to wear glasses for fear it would reduce their chances of getting

married. Gender norms as drivers of stigmatization was also an issue highlighted by women’s organizations in **Europe and Central Asia**. Participants from **Moldova and Tajikistan** observed that female sex workers, including those with vision impairment, struggle to access eye health services because societal stigma and discrimination limits their ability to access basic health care.

COMMUNITY FACTORS:

Societal stigma leading to internalized stigma and feelings of shame

Patriarchal norms stigmatize women and girls with vision impairment or loss, “devaluing” them in society. Women’s organizations and eye health NGOs in **West and Central Africa** describe how women and girls with vision impairment are marginalized and excluded within their communities.

“The moment things became invisible for me, I became invisible to society.”

Besma Essoussi, Association IBSAR, Tunisia

Women from **Moldova, Tunisia, Tajikistan, China** and several countries in **Latin America and the Caribbean** report that girls who are blind or have serious vision impairments are often kept home from school because of stigma.

“I look back at my personal life and my best friends with [vision] impairments, when we tried to attend school social activities, we were not welcome. And when we invited fully sighted classmates to our gatherings, there were so many concerns and worries.”

Shen Chengqing, Executive Director of Minority Voice, a grassroots disability rights organization, China

In **Bolivia, Colombia and the Kyrgyz Republic**, women’s organizations highlight how girls’ school performance is negatively affected because they are discouraged from wearing glasses. The psychological impact can lead to internalized stigma and feelings of shame that prevent women from seeking treatment throughout their lives, even for common refractive errors that are easy to correct or reverse.

“In the case of refractive defects, we must consider patriarchal systems. In the case of boys and girls, for example, providing glasses to boys is prioritized over providing glasses to girls, and we see this in schools in rural areas.”

Patricia Tarraga, Programme Director, Ojos de Bolivia/Ojos del Mundo (Eyes of Bolivia/Eyes of the World), Bolivia

In parts of **Eastern and Southern Africa and the Pacific Islands**, women and women’s organizations describe cultural myths that associate vision impairment with sin or witchcraft. In these contexts, social exclusion can be especially marked for women and girls, as families often hide them at home due to societal pressure and to protect them from harassment and violence.

“We are in a society where difference is scary. As soon as you are different, you are marginalized. The marginalization is there. The stigma is there. These are important elements that affect the opportunities of women with ocular disability.”

Marie Mboundzi, gender equality and social inclusion advocate, Cote d’Ivoire

Even in areas where public awareness campaigns seek to address harmful beliefs and encourage women and girls to access treatment, information struggles to reach families in rural and nomadic areas or from ethnic minority communities.

“Within communities, we need our leaders to advocate and raise more awareness about eye health issues. Because much of our rural population, as well as women and men in urban areas, aren’t aware of how important it is to seek services before your eyesight gets worse.”

Mohammad Rofiqul Islam, Senior Programme Manager, Sightsavers International, Bangladesh

POLICY AND ENABLING ENVIRONMENT FACTORS:

The challenge of evidence-based and multi-sectoral action

A lack of research and data on eye health issues from a gender perspective was highlighted as a critical barrier to improving eye health among women in all regions.

“Because there is an absence of statistics, there is a denial of women’s rights and there is a voice that is not heard in a world that is supposed to leave no one behind.”

Besma Essoussi, Association IBSAR, Tunisia

According to women’s organizations in **Asia and the Pacific**, the lack of women in research and eye health professions contributes to this scarcity of research.

“Although the number of the male optometrists is very low, men usually find it easier to get the job because the recruiters are usually looking for a male optometrist or male ophthalmologist. Many leadership positions in the eye care profession belong to men. I think that we need to have more educational opportunities and more opportunities for younger girls and young women in general, so they can take up leadership roles.”

Minh Anh Tran, Head of the School of Optometry, Hanoi Medical University, Viet Nam

In **Latin America**, eye health NGOs and girls’ rights organizations point to inadequate data and research on vision impairment and its link to educational outcomes among girls and young women. In **Central Asia**, women’s and disability rights organizations report that public health research is dominated by surveys in clinical settings with scant attention paid to the lived experiences and opinions of women who are blind and affected by vision impairment. Their perspectives are also missing in policy development and implementation.

“I wish there were resources or support that would enable our participation in policymaking or decision-making spaces. Supporting specialized trainings to enable women with vision impairment to be able to take up leadership roles and enter policymaking spaces – that would be very beneficial.”

Shen Chengqing, Executive Director of Minority Voice, a grassroots disability rights organization, China

Action to eliminate gender discrimination and unequal opportunities in the education and employment sectors for women and girls who are blind or have vision impairment was cited as an urgent priority in every region. To address this, the need for greater multi-sectoral coordination and engagement was highlighted in areas such as education, energy and the workplace.

Women’s organizations in **Uganda** report that stable electricity supply can promote cleaner household energy, mitigating the risk of major eye diseases associated with cooking with coal or wood, which has an outsized impact on women because of traditional gender roles. The importance of private sector engagement was highlighted by women’s organizations and eye health NGOs in **Bangladesh**, where high rates of vision impairment among women garment workers is associated with earning a lower monthly salary, even adjusting for other factors such as years on the job and daily working hours.

“Studies among female garment workers in Bangladesh show a significant prevalence of near vision impairment, and the women who have near vision impairment earned \$13.3 less per month than those without. Workplace interventions are very important.”

Nazma Ara Begum Poppy, National Project Support Officer, UN Women, Bangladesh

Moving Forward Together: The Change Women Wish to See

Women and women’s organizations across every region called on stakeholders to close the gender gap in eye health by improving women’s access to resources, rights, and representation. In addition to those presented overleaf, their key recommendations were:



VOICE: Amplify the voices of women who are blind or have vision impairment in the design, implementation and monitoring of policies, plans, programmes, and research relevant to their health and well-being.



REPRESENTATION: Ensure the full and meaningful participation of women in policies, programmes, and research relevant to eye care, and greater female representation in eye health leadership.



RESOURCES: Increase resources to gender-responsive, disability inclusive multisectoral policies and programmes that impact women’s eye health, beyond the non-health sector to include other areas such as employment, social protection, justice, and energy.



RIGHTS: Uphold women’s rights and improve the lives of women and girls who are blind and vision impaired by tackling multiple and intersecting forms of discrimination that prevent them from accessing the services and support they need.

Recommendations to Governments and Policymakers

- 1. Improve national capacity for sex and age disaggregated statistical data collection and social science research and analysis** to better understand how eye health service usage and behaviours differ between women and men and the types of lived experiences, with a focus on gender-related barriers that women and girls face. This research can be compared with sex and age disaggregated prevalence data to understand gender disparities in access to eye health services over time.
- 2. Develop eye health policies and programmes that recognize and seek to eliminate gender inequalities** and other overlapping structural inequalities that determine and shape women's access to eye care services and support and their ability to exercise their rights.
- 3. Adopt a multi-sectoral approach to improve eye health for women and girls**, in which equitable eye care is supported by other interventions such as gender-responsive social protection and environmental policies, women's economic empowerment programmes and policies to improve educational and employment opportunities for women, men, girls and boys who are blind or have vision impairment.
- 4. Increase investment in integrated, people-centred eye care and multi-sectoral approaches to eye health** in recognition of the positive return on investment, taking care to ensure investments improve the services and support offered to women and girls and address both supply- and demand-side barriers.
- 5. Ensure that universal health care or national health-care programmes include eye care** and that programmes and services are rights-based, gender-responsive and disability-inclusive. Government-led monitoring and accountability mechanisms should ensure implementation of these principles. To reduce out-of-pocket expenses related to eye care, include eye care in existing insurance schemes.
- 6. Promote collaboration between the health and education sectors** to integrate eye health as part of inclusive, gender-responsive educational policies and practices. For example, schools should carry out eye screenings and sensitization trainings for teachers on the gender dimensions of eye health, such as the impact of vision impairment on educational attendance and attainment. In Viet Nam, for instance, the Ministry of Education and Training has issued guidelines on school eye health for teachers to provide knowledge for students and school staff on eye health issues that affect girls and boys. Uruguay also has well-established eye health programmes in its schools, supplying prescription glasses for girls and boys in need and making eye health check-ups mandatory for all children.
- 7. Ensure that existing laws and policies affecting or related to women's eye health are fully compliant with international conventions**, including CEDAW, CRPD and the Convention on the Rights of the Child (CRC), amending legislation when necessary. During the consultations, participants from Chile shared the positive progress being made to strengthen laws and policies to support men, women, girls and boys with disabilities in all their diversity. This includes advocacy efforts of feminist organizations and others to include gender-specific constitutional provisions to guarantee the rights of women with disabilities in all areas, including but not limited to health.
- 8. Enact comprehensive anti-discrimination laws** in the non-health sector and beyond to protect the rights of women and girls who are blind or have vision impairment and ensure that these laws include the realms of employment, social protection, access to public space, access to justice, among others.
- 9. Ensure the inclusion of women with lived experiences of vision impairment and disabilities in decision-making and policy/programme design.** Gender equity and inclusion can help address the systemic barriers that exclude women who are blind or have vision impairment from the decisions that affect them.
- 10. Create policies and incentives to increase the number of women in eye health leadership positions** and have them sitting at the table when decisions are made. Strategies can include the provision of leadership training grants, medical school scholarships for women, mentorship opportunities and improved maternity leave and childcare provisions for employed women.
- 11. Support technologies and innovations (including those developed by the private sector) that benefit women and girls.** This includes medical advancements to improve patient outcomes and assisted technologies to aid those who are blind or have vision impairment, taking care to overcome gendered barriers to access that may prevent women and girls from benefitting from innovations, such as the gender digital divide.

Recommendations to Health Providers

1. **Follow an integrated, people-centred approach to eye health that considers gender, age and disability-related issues.** As part of this approach, gender-responsive, age-sensitive and disability-inclusive eye health programmes should be incorporated into primary and community-based care. This requires rethinking the design of health-care services to better respond to women's intersecting identities, with a particular focus on older women in all their diversity. Integrated care models that consider the specific needs of older women can improve health outcomes, enhance patient experience and reduce health-care costs.
2. **Provide community health workers with information about women and girls' eye health and the gender-related barriers that prevent them from seeking services,** including harmful social norms, beliefs and stereotypes. Encourage community health workers to disseminate accurate gender- and disability-sensitive health information to all community members, identify women and girls at risk and follow up on referrals that recognize demand-side barriers.
3. **Sensitize health workers on the gender dimensions of health (including eye health) and health systems** so they can deliver better care without perpetuating gender and disability stereotypes, uphold the rights of women and girls in all their diversity and serve as role models for other health professionals.
4. **Work with eye health NGOs, women's networks, and organizations of persons with disabilities to ensure eye health information and services reach the women and girls furthest behind,** especially those who experience intersecting forms of discrimination. This includes partnerships between women's health organizations and eye health service providers to identify innovative and efficient ways to reach women and children who require screening and treatment and deliver these services in places where they access routine health care.
5. **Improve the distribution of eye health professionals and services in rural areas,** recognizing the potential benefit to women and girls and considering gender and social norms that constrain women's mobility.
6. **Bridge the digital divide and invest in technology** to ensure women and girls who are blind and have vision impairment can achieve their potential. Assistive technologies, such as screen readers, braille displays and voice assistants, help people with eye health issues navigate their environment, achieve independence and advance their educational and economic goals.

Recommendations to NGOs and Civil Society

1. **Work with policymakers, communities and health providers to disseminate eye health information** in simple, user-friendly language and formats that are accessible to all communities. Use gender-sensitive language and images that do not reinforce gender stereotypes or stigmatize those who are blind or have vision impairment.
2. **Continue to foster multi-sectoral coordination and engagement at all levels.** Women's groups, organizations of persons with disabilities and eye health NGOs provide examples of civil society leadership that can collaborate with schools, health workers and leaders at the community level and form dialogues with national and non-health sectors at the technical and policy levels.
3. **Use collective action to ensure the rights of women and girls are protected, their needs are met and policymakers are held accountable** for removing barriers to eye care, including gender-related barriers. Alliance-building between women's groups, organizations of persons with disabilities and eye health NGOs can help to ensure policymakers and service providers are more responsive to the needs and rights of women and girls in all their diversity.
4. **Engage with grassroots organizations to reach families and women and girls furthest behind with eye health information and services.** Recognize that these individuals experience overlapping forms of discrimination based on intersecting identities.
5. **Advocate for the needs and rights of women and girls furthest behind, prioritizing those whose voices are least heard,** such as those living with Albinism, HIV or disabilities; those internally displaced; those from ethnic minority groups or indigenous communities; and female sex workers.
6. **Strengthen collaboration between organizations of persons with disabilities, women's groups and civil society organizations working on ending violence against women** to ensure that essential services for survivors of violence are available and accessible for women who are blind or affected by vision impairment. Recognize the gap in the evidence base on prevalence, causes and impacts of violence experienced by women who are blind, partly sighted or with low vision and work collaboratively to gather data to inform services and policies.

Recommendations to Community Leaders

- 1. Create space for women and girls and greater gender equality in community life and governance processes.** Addressing gendered barriers to women's representation and voice in community decision-making can strengthen women's agency, help shift gender relations and encourage equitable access to services, including eye care services.
- 2. Use leadership platforms to raise public awareness about women who are blind or affected by vision impairment** in a way that harmonizes with local cultural values but does not perpetuate gender and disability stereotypes. Support from community leaders, including traditional and religious leaders, can challenge harmful norms and beliefs, reduce stigma and discrimination and combat social exclusion felt by women and girls who are blind or have vision impairment.
- 3. Work with NGOs and civil society to support men's engagement activities** to make them aware of the importance of women and girls' eye health as part of their right to health. Create spaces for male community leaders and male family members to discuss these topics and promote gender equality and healthy lifestyles in the family environment.
- 4. Advocate with local health providers and policymakers** to ensure that eye health services and support reach women and girls who experience social exclusion and stigma shaped and reinforced by gender norms, such as older women, women with disabilities and women from ethnic minority groups or indigenous communities, among others.

Recommendations to the Private Sector

- 1. Extend partnership strategies to improve eye health** and tackle sustainability, affordability, accessibility and gendered barriers experienced by women and girls across the continuum of care, from health promotion to prevention and detection, treatment and rehabilitation. Work with the public sector and NGOs to create sustainable business models to ensure women and girls are not left behind and their rights are protected.
- 2. Prioritize employee eye health and recognize how gender norms prevent women from accessing eye care** (including sight tests and glasses), negatively affecting their well-being and workplace productivity. This is particularly important in sectors where evidence shows an increased risk of eye-related problems among women, such as the garment industry.
- 3. Accelerate research and innovation in eye health care, but do not neglect gender.** From eye health research and clinical trials to collaboration with the public sector and development of new technologies, the inclusion of female perspectives is critical to improving eye health outcomes and gender equality.
- 4. Promote the employment of women who are blind or affected by vision impairment in the private sector through affirmative action programmes and other measures.** Ensure that workplace policies and practices address disability from an intersectional perspective, recognizing the specific capacities, needs and rights of women who are blind and affected by vision impairment.
- 5. Microfinance institutions: Identify tailored approaches for women and families affected by vision impairment and be willing to refinance or issue emergency loans.** Consider using group guarantees in the absence of credit history.

Recommendations to UN Entities and Development Partners

1. **Advocate for adherence to internationally agreed human rights standards** on equality and non-discrimination in the formulation and implementation of national laws, policies, strategies and programmes that directly or indirectly affect women and girls who are blind or have vision impairment. Support civil society-led initiatives to monitor government implementation.
2. **Integrate eye health into the strategies, policies and programmes of relevant UN entities**, including measures to advance the health and rights of women and girls who are blind or affected by vision impairment.
3. **Promote and facilitate dialogue between women's organizations (including organizations of women with disabilities), disability rights organizations, eye health NGOs and state authorities** on improved eye health care for women and girls.
4. **Ensure ongoing and, when necessary, additional funding for women's organizations (including organizations of women with disabilities), disability rights organizations and eye health NGOs** so that they can continue to uphold the rights of women and girls, ensure their access to eye care services and support and promote their participation in decision-making, including policy development.
5. **Promote and support gender-responsive research and analysis on eye health**, making visible the lived experiences of women and girls who are blind or have vision impairment. Advocate and support enhanced national capacity for sex, age and disability disaggregated statistical data collection and analysis on eye health.
6. **Fund career-development grants or scholarships to cultivate female leadership in eye care professions** and health-care institutions within resource-poor countries.
7. **Encourage public and private sector investment in technologies and innovations that benefit women's eye health**, calling attention to the gender digital divide and other barriers faced by women and girls when accessing new technologies.

Endnotes

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