

“If I Wear Glasses, I Will Go Blind”: Misconceptions, Stigma, and Nonadherence to Spectacle Wear in Somalia’s Outpatient Eye Clinics

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Abstract: This commentary examines how misconceptions and stigma undermine adherence to spectacle wear in Somalia’s outpatient eye clinics, despite clinically meaningful visual improvement during refraction. In routine practice, patients may refuse spectacles or wear them inconsistently because they believe spectacles weaken the eyes, create dependence, or lead to blindness, and because of social concerns such as being labeled as blind or disabled. These perceptions interact with service delivery constraints, including limited counselling time, variable optical quality, affordability barriers, and weak follow up, resulting in avoidable persistence of functional vision impairment and reduced educational and occupational performance. We synthesize commonly encountered themes in Somali outpatient care with relevant published evidence and propose pragmatic actions to improve acceptance and sustained wear. These include brief myth focused counselling integrated into routine workflow, clear separation of refractive error from blinding disease in patient communication, attention to comfort and dispensing quality, family engagement, early follow up for first time wearers, and low cost community normalization strategies delivered through trusted messengers.

Keywords: spectacles, refractive error, stigma, misconceptions, adherence, Somalia

Introduction

Refractive error is a leading contributor to distance vision impairment worldwide and is among the most cost effective conditions to manage in eye care through accurate refraction and appropriate spectacle correction.¹ Global strategies increasingly emphasize effective outcomes rather than prescriptions alone, reflected in the adoption of effective refractive error coverage as a monitoring construct and in the WHO SPECS 2030 initiative, which calls for a 40 percentage point increase in effective coverage of refractive error by 2030.^{2,3} In this context, a technically correct prescription has limited value if spectacles are not accepted, not worn, or are dispensed with poor fit and quality.

Somalia is a fragile health system setting where access to affordable, good quality refraction and dispensing services is uneven, and shortages of trained personnel and other barriers can constrain the delivery of refractive services and the provision of spectacles.⁴ Nationally compiled Somalia specific data on spectacle adherence remain limited in the accessible published literature; however, data from Somaliland show a high burden of visual impairment in school aged children with low spectacle use among those who need correction, underscoring the importance of strengthening the pathway from prescription to use.⁵ Against this background, clinicians frequently observe that misconceptions and stigma are decisive drivers of nonadherence to spectacle wear.

The purpose of this commentary is to describe commonly encountered beliefs and social barriers to spectacle wear in Somali outpatient practice, to situate these observations within the broader evidence base, and to propose feasible clinic and community actions that may improve acceptance and sustained wear without implying new empirical findings.



Commentary Method Approach

This evidence informed commentary draws on the authors' clinical experience in outpatient eye care in Mogadishu and on illustrative narrative selection of relevant peer reviewed literature and WHO technical resources on refractive error services, spectacle use, misconceptions, stigma, and adherence. The intent is to synthesize practical themes and implementation considerations rather than to report a systematic review or primary data collection.

Clinical Observations in Somalia's Outpatient Eye Clinics

In our clinical experience, a recurring pattern is the patient who presents with blurred vision, demonstrates substantial improvement during refraction, yet expresses reluctance to wear spectacles after the prescription is provided. Some patients state that spectacles weaken the eyes, create dependence, or will eventually cause blindness. Beliefs and misconceptions about spectacle related harm have been documented in other populations, suggesting that misinformation can persist even when refraction is available.^{6,7}

Stigma driven avoidance is also frequently encountered. Patients describe fear of being judged or labeled as blind or disabled if they wear spectacles publicly, and they may anticipate negative effects on social standing, employability, or marriage prospects. Studies report that spectacle wearers may be perceived as visually handicapped, that teasing is anticipated, and that fear and stigma can reduce uptake and continued use, including among females in some settings.⁷⁻¹⁰

A further pattern is selective or concealed use. Some patients obtain spectacles but wear them only privately or only for specific tasks, even when consistent wear would provide greater functional benefit. This behaviour is commonly linked to social anxiety, cosmetic concerns, discomfort, or distrust in the long term safety of spectacle wear.

Why Misconceptions Persist

Misconceptions often follow a narrative that natural vision is weakened by spectacles. Several mechanisms sustain this belief. Refractive error progression over time, particularly during childhood and adolescence, may be misattributed to spectacle wear rather than expected biological change. Early adaptation symptoms such as headache, asthenopia, or spatial distortion can occur with first time wear or with astigmatic correction, anisometropia, or higher prescriptions; without anticipatory guidance, patients may interpret these symptoms as evidence of harm. In addition, low quality dispensing can produce discomfort and poor visual satisfaction, reinforcing community stories that spectacles cause problems. These dynamics align with evidence that knowledge and beliefs influence undercorrection and nonuse, and that misconceptions are common where eye health literacy is limited.⁶

For clinicians, this implies that misconceptions are best addressed through brief, specific explanations that separate refractive correction from blinding disease processes and through service quality that consistently produces comfortable, clear vision.

Stigma and the Social Meaning of Spectacles

Stigma reduces spectacle uptake through anticipated judgement and avoidance. In contexts where spectacle wear is not normalized, glasses may be interpreted as a visible marker of disability, weakness, or aging. Evidence shows that community attitudes, fear of teasing, and perceptions of spectacle wearers as visually handicapped can influence acceptance and continued use.⁷⁻¹⁰

Gender related stigma deserves explicit attention. In some settings, girls and women face additional appearance related scrutiny and may experience stronger social penalties when wearing spectacles, which can reduce adherence even when correction is clinically beneficial.¹¹ In Somali communities where family and social networks strongly influence health decisions, patient acceptance may depend on whether close contacts endorse spectacle wear, making family engagement and culturally sensitive communication central to stigma reduction.

Health System Contributors That Amplify Nonadherence

Beliefs and stigma do not operate in isolation. In Somali outpatient settings, limited consultation time reduces opportunities for counselling and myth correction. Fragmented optical pathways can expose patients to variable quality and cost, and weak follow up allows adaptation issues, frame discomfort, or power errors to persist until the patient abandons spectacles. At the system level, shortages of trained personnel and service delivery barriers can constrain refraction and dispensing capacity, and counselling skills are often underemphasized relative to technical refraction steps.⁴ WHO has emphasized competency based approaches and team models for refractive services, including competency based refractive error teams, as practical resources to strengthen quality and consistency of care.¹²

These factors also matter for monitoring progress. Effective refractive error coverage focuses on whether people who need correction have correction that delivers adequate vision improvement.² When spectacles are not worn or are poorly made, nominal coverage may increase while effective coverage remains low.

Practical Actions for Somalia's Outpatient Refractive Care

Improving spectacle adherence in Somalia requires interventions that fit real clinic workflows and address both social drivers and quality related drivers. Counselling should be a standardized clinical step. A brief myth focused message can clarify that spectacles do not damage the eyes, that they correct the focusing error to restore clarity, and that vision changes over time are usually due to the underlying condition or aging rather than spectacle wear. Demonstration based counselling can be persuasive because it links correction to immediately valued functions, such as reading, recognizing faces, or performing work safely. Dispensing quality should be treated as an adherence intervention, because accurate lens power, appropriate centration, and comfortable frame fitting reduce early discontinuation. Family inclusive counselling can reduce conflicting advice at home, and early follow up for first time wearers can identify adaptation and fit problems before spectacles are abandoned.

A suggested 60–90 second counselling script and first time spectacle wearer checklist are provided in (Box 1).

Low cost community strategies can complement clinic based counselling. Posters in clinics and schools, brief radio messages, and peer normalization through teachers, religious leaders, and respected health workers can help shift social meaning and reduce stigma. Systematic reviews indicate that adherence can remain suboptimal even when spectacles are provided, reinforcing the need for combined educational and service quality interventions.^{13,14}

Implications for Research and Service Evaluation in Somalia

Somalia can strengthen local evidence on spectacle nonadherence and link service improvement with publishable implementation learning. Cross sectional outpatient surveys can quantify misconceptions and stigma and identify predictors of nonuse. Qualitative studies can map dominant narratives, sources of health information, and perceived social consequences. Prospective audits can measure the proportion of patients wearing spectacles at follow up and document reasons for discontinuation. Implementation evaluations can test brief counselling scripts, family engagement, dispensing quality improvements, and low cost community messaging using outcomes aligned with effective correction and real world wear.^{2,3,12}

Box 1 Suggested 60–90 second Counselling Script and First Time Wearer Checklist

Clinician: Your eyes are not being damaged by glasses. The problem is focus, and these lenses correct the focus so the image becomes clear.
 Clinician: Glasses do not cause blindness. If your vision changes in the future, it is usually due to the underlying condition or aging, not because you wore glasses. Clinician: It can take a few days for your eyes and brain to adapt, especially if this is your first pair. Mild headache or strain can occur early and usually settles. Clinician: If discomfort persists or vision is not clear after one to two weeks, please return so we can check the fit and the prescription. Clinician: Wearing the glasses consistently as advised will help you read, work, and move safely with less strain.
 For first time wearers, the clinician can confirm that the spectacles are comfortable on the nose and ears, that the vision is clear for the intended tasks, that adaptation expectations were explained, and that the patient understands when to return, including persistent headache, dizziness, double vision, distortion, poor clarity, or social concerns that are limiting use.

Limitations

This manuscript is a commentary grounded in clinical observations and illustrative narrative use of published literature rather than a formal quantitative or qualitative study in Somalia. As nationally compiled Somalia specific evidence on spectacle adherence remains limited in accessible literature, the proposed actions should be evaluated prospectively through implementation studies that measure real world wear, comfort, and patient reported barriers in Somali communities.

Conclusion

In Somalia's outpatient eye clinics, spectacle nonadherence is commonly shaped by misconceptions that spectacles cause harm and by stigma that equates spectacle wear with blindness or disability. These barriers interact with limited counselling time, variable dispensing quality, affordability constraints, and weak follow up, leading to avoidable persistence of functional vision impairment. A practical response is available within routine clinical practice through brief myth focused counselling, demonstration of functional benefit, attention to comfort and dispensing quality, family engagement, structured early follow up, and low cost community normalization. Because this is an evidence informed commentary rather than a formal study, the effectiveness of these approaches should be tested locally using implementation designs that measure sustained wear and functional outcomes.

Abbreviations

eREC, effective refractive error coverage; OPD, outpatient department; SPECS, services, personnel, education, cost, and surveillance; WHO, World Health Organization.

Ethics Statement

This manuscript is a commentary based on clinical observations and published literature. No primary data were collected and no identifiable patient information is reported; therefore, institutional ethics approval and informed consent were not required.

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Author Contributions

All authors made a significant contribution to the work reported, whether in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising, or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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Disclosure

The authors report no conflicts of interest in this work.

References

1. Flaxman SR, Bourne RRA, Resnikoff S, et al. Global causes of blindness and distance vision impairment 1990–2020: a systematic review and meta-analysis. *Lancet Glob Health*. 2017;5(12):e1221–e1234. doi:10.1016/S2214-109X(17)30393-5
2. Bourne RRA, Cicinelli MV, Sedighi T, et al. Effective refractive error coverage in adults aged 50 years and older: estimates from population-based surveys in 61 countries. *Lancet Glob Health*. 2022;10(12):e1754–e1763. doi:10.1016/S2214-109X(22)00433-8
3. World Health Organization. SPECS 2030. Available from: <https://www.who.int/initiatives/specs-2030>. Accessed March 21, 2026.

4. World Health Assembly. Integrated people-centred eye care, including preventable vision impairment and blindness. WHA73.4; 2020. Available from: https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R4-en.pdf. Accessed March 23, 2026.
5. Abdi Ahmed Z, Alrasheed SH, Alghamdi W. Prevalence of refractive error and visual impairment among school-age children of Hargeisa, Somaliland, Somalia. *East Mediterr Health J.* 2020;26(11):1362–1370. doi:10.26719/emhj.20.077
6. Rosman M, Wong TY, Wong W, Wong ML, Saw SM. Knowledge and beliefs associated with refractive errors and undercorrection: the Singapore Malay Eye Study. *Br J Ophthalmol.* 2009;93(1):4–10. doi:10.1136/bjo.2007.132506
7. Ebeigbe JA, Kio F, Okafor LI. Attitude and beliefs of Nigerian undergraduates to spectacle wear. *Ghana Med J.* 2013;47(2):70–73.
8. Alrasheed SH, Naidoo KS, Clarke-Farr PC. Attitudes and perceptions of Sudanese high-school students and their parents towards spectacle wear. *Afr Vision Eye Health.* 2018;77(1):a392. doi:10.4102/aveh.v77i1.392
9. Vankudre GS, Noushad B. Barriers and perception towards spectacle wear among a student population of University of Buraimi, Oman. *Sultan Qaboos Univ Med J.* 2021;21(3):416–422. doi:10.18295/squmj.4.2021.004
10. Narayanan A, Kumar S, Ramani KK. Spectacle compliance among adolescents: a qualitative study from Southern India. *Optom Vis Sci.* 2017;94(5):582–587. doi:10.1097/OPX.0000000000001070
11. Shah M, Kumar S, Sahu AB. Addressing gender disparities in eye health services: practical actions. *Commun Eye Health J* 2025;38(126):17. doi:10.56920/cehj.857
12. World Health Organization. Competency-based refractive error teams. Geneva: World Health Organization; 2025. Available from: <https://www.who.int/publications/i/item/9789240109209>. Accessed April 1, 2026.
13. Dhirar N, Dudeja S, Duggal M, et al. Compliance to spectacle use in children with refractive errors: a systematic review and meta-analysis. *BMC Ophthalmol.* 2020;20(1):71. doi:10.1186/s12886-020-01345-9
14. Wu L, Feng J, Zhang M. Implementing interventions to promote spectacle wearing among children with refractive errors: a systematic review and meta-analysis. *Front Public Health.* 2023;11:1053206. doi:10.3389/fpubh.2023.1053206

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