doi.org/10.58931/cect.2026.5166

ABOUT THE AUTHOR



Myrna Lichter, MD, FRCSC, MSM

Dr. Myrna Lichter received her undergraduate and MD degrees from the University of Manitoba and completed her ophthalmology training at the University of Toronto. She followed this with a Pathology fellowship at AFIP in Washington, DC, and returned to Toronto to do comprehensive ophthalmology. She joined Saint Michael's Hospital as outdoor attending physician, and in 2000 was asked to run the HIV eye clinic, after Saint Michael's Hospital merged with the Wellesley Hospital. At her clinic she met a blind homeless Indigenous patient and recognized the need to do more for the homeless community. Since 2010, she has been actively involved in Eyecare for Homeless. She has visited over 50 shelters, given out hundreds of pairs of glasses (thanks to a generous donor), and encouraged many students who have volunteered with her over the years. She has also been involved with refugee vision screening, examining over 1000 refugees in collaborative clinics. She is director of Public Health and Global Ophthalmology at the university Department of Ophthalmology and is Vice Chair at CAPHGO (Canadian Association for Public Health and Global Ophthalmology for the Canadian Ophthalmological Society. She has won awards for her work, including EPSO Innovator of the year Award in 2015, Saint Michael's Urban Angel award, and the John Vincent Hughes Humanitarian award, as well as the Governor General Meritorious service decoration in 2024.

Affiliations: The Department of Ophthalmology and Vision Sciences, University of Toronto, Toronto, ON
St. Michael's Hospital, Toronto, ON

My Experience in Advocacy for Eye Care

Myrna Lichter, MD, FRCSC, MSM

Introduction

Advocacy is defined as" **the act or process of supporting a cause or proposal**; the act or process of advocating". When thinking about advocacy in the context of this article, three thoughts came to mind: **1)** Who was I advocating for–my patients? My profession? Myself? **2)** How did I go about advocating? **3)** What has changed because of my advocacy? The last question is perhaps the most difficult to address.

Patient advocacy is a process in health care concerned with advocacy for patients, survivors, and caregivers. When considering our most vulnerable patients—the homeless, the elderly, refugees, minority groups such as our First Nations, those with poor access to care, those with disabilities (mental and physical), and children—advocating for their care is a daunting task. Providing eyecare for the most vulnerable and advocating for their care has been a major goal of my group over the past decade.

I first explored providing eyecare for individuals experiencing homelessness and those who are marginally housed in Toronto in 2010 and received a Ministry of Health Grant. It was not until 2013, with the help of two medical students, that this initiative was accomplished. Our first study, published in *JAMA* in 2014,[1] detailed vision screening in 100 homeless adults living in shelters. Consistent with subsequent studies, we showed a 25% incidence of visual impairment, mostly refractive. More importantly, the study highlighted that patients who were unhoused had poorer access to care compared with the general population. The study was rudimentary, limited by poor follow up and an inability to ameliorate the situation. We repeated this screening the following year with unhoused youth living in shelters,[2] again finding visual impairment in approximately 20% of participants. Notably, this second study showed the impact of visual impairment on vulnerable youth, and their lived experiences.

In 2017, I received a substantial grant from a generous donor (Gerry Schwartz and Onyx Foundation) which enabled us to purchase better equipment. This funding allowed me to hire an assistant to facilitate our outreach visits. The funding also allowed me to prescribe and cover the cost for, eyewear, as well as to provide procedures not covered by the healthcare system. Findings from this more comprehensive study were subsequently published.[3] In collaboration with Nasrin Tehrani, a pediatric ophthalmologist, we also examined eyecare access among families living in shelters. This work showed that while children generally had good care, parents often neglected their own care.[4] One case remains particularly vivid: a woman who presented to my clinic shortly after obtaining permanent housing. She had been diagnosed with advanced glaucoma, but because of circumstances did not attend follow up.

By the time she presented to my clinic, she had irreversible vision loss, one of many tragic outcomes encountered through this work. My group went on to examine women who were survivors of violence or human trafficking,[5] Indigenous homeless adults and children, and individuals living in encampments during the COVID-19 pandemic.[6] My most recent "passion project" focuses on late-life homelessness, and the results of this work will be published soon.

The unhoused population is rapidly increasing. Historically, homelessness was most commonly associated with mental illness and addiction; however; economic pressures have now come to bear. As noted in a recent study: "*Homelessness in Toronto has more than doubled since 2021, with over 15,400 people experiencing homelessness as of late 2025, driven by a severe housing crisis, high cost of living, and, in many cases, evictions. Shelters are consistently at capacity, and the city is exploring solutions like micro-shelter communities to address the rising need.*" Similar trends are evident in other Canadian cities, including Vancouver (5200 people) as well as smaller cities such as Red Deer, Calgary, and Edmonton, which report higher per capita numbers of homeless individuals. Although people experiencing homelessness have other pressing health and social issues, poor vision increases the risk of violence, makes navigating their environment more difficult, and serves as a major barrier to employment or education.

I often ask myself whether this work (over 1000 unhoused patients seen) makes a meaningful difference? I believe it did. The work with the Women Victims of Violence group had a very positive effect; many of these women were returning or participating in the workforce after escaping domestic violence, and good vision was certainly an asset. Among older adults experiencing late-life homelessness, access to proper eyecare, including expedited cataract surgery, glaucoma diagnosis and management, as well as free corrective eyewear, did improve the quality of their lives. For the rest of my patients, I can say unequivocally that the work mattered. One of the ministers at the church participating in the "Out of the Cold" program, recently shared that during our church visits, a patient who received glasses subsequently got a haircut, and re-joined the work force. I cannot overemphasize that benefit is not only to our patients, but to our learners and all who participate in these visits. I am sure my friend and colleague Benoit Tousignant (who does similar work in Montreal) will agree, that the attitudinal change in treating these patients spreads into clinic and emergency settings.

The next group that I would like to discuss is newcomer (refugee) vision screening. Following the outbreak of the civil war in Syria, large numbers of people were displaced and resettled to Canada as refugees. When a student approached me with the idea of a refugee vision screening clinic, I readily agreed. We held five screening clinics between July 2016 and November 2017. This was a very collaborative effort, partnering with Mes Amis Canada (a volunteer group), as

well as a team of volunteer ophthalmologists, optometrists, medical students, residents and technicians. In total we screened 248 adults and 274 children.[7,8] Among the adults 27% were found to have uncorrected vision problems, nearly 19 times the Canadian average. Other diagnoses included cataract, glaucoma, and other retinal diseases. One family encountered at our first clinic was particularly poignant. A young man presented with his elderly parents and his two dysmorphic siblings in their forties.

After carefully examining his siblings, it was determined that they had retinitis pigmentosa. Upon examining the young man who brought them in, it was determined that he also had early retinitis pigmentosa. He had a wife and four children at home. Fortunately, we were able to refer him for excellent retinal care, as well as appropriate social supports.

Did advocating for this refugee population have a measurable impact? Unequivocally yes. We subsequently applied a similar model with Afghan refugees,[9] conducting five clinics at Saint Michael's Hospital. Again 350 newcomers were examined, and their results paralleled the Syrian study. Similar studies have been planned in London, Ontario and by other organizations such as Forsee Canada, which recently published their results in *BMJ*.[10] This screening is not without its difficulties, including language barriers, transportation to screening sights, organizing and recruiting examiners, as well as food and entertainment for participants.

A survey conducted in 2025 identified 73,000 refugees living in Canada, originating from a wide range of countries, including Nigeria, Uganda, Congo, and Ethiopia.[11] In response to the ongoing needs of these and other underrepresented populations, I currently lead a clinic at Kensington Eye Institute that serves multiple shelters as well as the Canadian Centre for Victims of Torture.

Through a generous grant to Kensington Eye Institute, I conduct clinics at least once a month seeing up to 25 patients per session, from various shelters and organizations serving the underrepresented populations of Toronto. These clinics provide free eye examinations (regardless of insurance coverage), along with free glasses and procedures as needed, and a referral to specialists as needed.

It has now been over ten years since this program has started, during which time over 1,000 individuals experiencing homelessness and 1,000 refugees have received free eyecare. I lead the Public Health program at the department of Ophthalmology at the University of Toronto. I have been very fortunate to work alongside a wonderful chair (and friend), Marie-Josee Aubin at the Canadian Association for Global Health and Public Ophthalmology (CAPHGO) within the Canadian Ophthalmological Society (COS) The aim is to bring those of us in the field working together to promote the needs of those who are largely under-represented. In the upcoming year, my group is planning to start a project with refugee and unhoused youth, providing free eyecare, as well as comparing their experiences and needs. We are also exploring a small project engaging the First Nations community, under their guidance and leadership.

Much of my advocacy has focused on underrepresented urban populations; however, it would be remiss not to acknowledge one of our most vulnerable populations, the First Nations communities. Self-advocacy has resulted in some meaningful changes for the community, including the institution of OCAP rules governing First Nations research: The OCAP® principles are a framework governing ethical research and data governance with First Nations communities in Canada. OCAP, which stands for Ownership, Control, Access, and Possession, provides an ethical framework for research and data governance, affirming that Indigenous peoples have authority over data collected about them and their communities.

The framework was developed by the First Nations Information Governance Centre (FNIGC) to address the historical misuse and exploitation of Indigenous data in research. OCAP establishes that Indigenous communities have the right to own, control, access, and physically possess data about themselves, ensuring ethical and respectful research relationships.[12] It is known that Indigenous people have a higher burden of eye disease and face barriers to accessing care due to geography, jurisdictional complexity, and racism. A notable example of community-engaged advocacy is the Indigenous Children's Eye Examination (ICEE) program spearheaded by Dr. Kourosh Sabri.[13] ICEE travels to remote communities, delivering eyecare to children in a compassionate and culturally respectful manner. Program details are provided below, and volunteer participation is welcomed. Similarly, Dr. Christian El Hadad travels eight times a year to Nunavut, with students. He and his student developed

eye charts in Inuktitut, Cree and Ojibway to better service those communities.[14,15] My group also embarked on a project looking at homeless Indigenous adults and children in Toronto. Data were collected and shared with the community with the intention that these findings can be purposed to benefit them. It was an enlightening experience to engage with many survivors of generational trauma and witness their resilience. The advocacy for better eyecare for First Nations did result in the Non-Insured Health Benefit (NIHB) program, a program covering eye examinations, glasses or contact lenses, replacement glasses, and vision aids.

Many underrepresented groups in Canada continue to require focused attention. Many rural communities are underserviced. Initiatives such as the Eye Van,[16] servicing northern Ontario communities since 1972, the Timmins project,[17] collaborating with University of Toronto; FYi doctors' mobile optometry clinics, and Indigenous Mobile Eye Clinics provide important services. However, wait lists and geographic barriers remain substantial, particularly for routine procedures such as cataract surgery, intravitreal injections for age related eye disease, and diabetes. Advances in teleophthalmology with AI capabilities may improve care in these areas. Many groups across the country have expanded their teleophthalmology practices. In Toronto, my group is developing a project comparing portable equipment with smartphone capability to conventional equipment, and we have just received RIB approval. I look forward to forming a nationwide collaborative group soon.

There is also a substantial need for advocacy in eyecare internationally, and many groups are involved. ORBIS,[18] for example, provides eyecare services and education internationally. The Department of Ophthalmology and Vision Services (DOVS) at University of Toronto supports an outreach program with resident involvement in Costa Rica, and my group supports a program in Nigeria, supplying eye surgery and glasses for children.[19] There are many more opportunities to support global eye health.

The federal government introduced a private member's bill—Bill C-284, the Canadian federal law called the National Strategy for Eye Care Act, introduced by Judy Sgro, the Member of Parliament for Humber River—Black Creek. The bill was introduced in June 2022 as a private member's bill and received Royal Assent on November 7, 2024, thereby becoming law in Canada. Its goal is to establish a national strategy for eye care in Canada. I had the privilege of attending a research meeting related to this bill, along with approximately 50 other participants.

My group represents only a small part of the advocates for better eyecare in the country. Through COS, as well as other organizations, I hope that we can have collective meetings to learn and benefit from each other.

Conclusion

I would like to conclude with a less frequently discussed topic—advocating for yourself. It is neither possible nor sustainable to care about everything. Within your limits, you can choose a focus—whether volunteering with the Eye Van, participating in the Timmins project, engaging in international missions, or supporting refugee vision screening clinics. Each contribution, no matter its scope, advances advocacy for underrepresented populations. We all are finite, each "paddling our kayaks down the river." It is important to enjoy the journey, even if there are rough waters. I encourage everyone to advocate for yourself, and find what gives you joy.[20]

Correspondence

Myrna Lichter, MD, FRCSC, MSM
Email: myrlichter@icloud.com

Financial Disclosures

M.L.: None declared.

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