

Occupational Ocular Morbidity and Productivity Interventions among Ready-Made Garment (RMG) Workers in Bangladesh

An Empirical Evaluation of AI-Driven Community Eye Care Interventions

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Article Info	ABSTRACT
Manuscript Status: Retrospective, single-camp empirical evaluation (N=202), benchmarked against WHO/IAPB/ILO reference data. Not a representative sectoral survey. Keywords: occupational eye health; ready-made garment sector; Bangladesh; uncorrected refractive error; AI-assisted vision screening; decent work; global health equity; colour vision deficiency	Background. Bangladesh's Ready-Made Garment (RMG) sector employs an estimated 4 million workers, the majority women, in visually demanding, detail-oriented assembly work — shade and colour matching, seam inspection, defect detection — yet occupational eye health remains largely absent from the sector's safety agenda. The WHO estimates at least 2.2 billion people worldwide live with a near or distance vision impairment, for at least 1 billion of whom it could have been prevented, at an estimated annual global productivity cost of US\$411 billion. Methods. This paper evaluates a joint free eye care camp organised by CHRSD Foundation, Lunera Eye Care, and Nevronus Systems on 22 May 2026 at Omi Sweaters Limited, Deora, Tongi, Gazipur, which screened 202 garment-factory workers and community members using AI-assisted handheld colour fundus photography and a mobile diagnostic application. Findings draw on CHRSD's audited clinical dataset and public after-action report, benchmarked against WHO, IAPB, and ILO reference data. Key Findings. The patient base was nearly gender-balanced (49.5% male, 50.5% female) and predominantly working-age (18–44 years, ≈62%). Refractive error was the leading presenting condition (25.2%, male-skewed), followed by dry eye syndrome (20.3%, female-skewed) and medication-related complaints (15.8%) — together over 61% of visits. Roughly half of patients were prescribed spectacles and 3.0–3.5% were referred for specialist care. Policy Impact. Occupational eye health — including an under-recognised burden of colour vision deficiency with direct implications for quality control and workplace safety — constitutes a measurable, currently unaddressed gap in Bangladesh's RMG occupational health framework, with direct relevance to SDG 3, SDG 8, and SDG 5. The paper concludes with an institutional policy framework for the Ministry of Labour and Employment, BGMEA/BKMEA, international buyers, and civil society actors.

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1. INTRODUCTION AND BACKGROUND

1.1 The Ready-Made Garment Sector and an Overlooked Occupational Hazard

Bangladesh's Ready-Made Garment (RMG) industry is the world's second-largest apparel exporter and the country's principal source of industrial employment, providing a livelihood for an estimated 4 million workers, the substantial majority of whom are women (Ghosh & Kirttania, 2025). The sector's occupational health and safety agenda has, since the Rana Plaza collapse of 2013, been dominated — for good reason — by structural, fire, and chemical-exposure risk. Vision health has received comparatively little attention, despite the fact that core RMG tasks — shade and colour matching, seam and stitch inspection, fabric-defect detection, machine operation under artificial lighting — are among the most visually demanding of any manufacturing occupation. A longitudinal retrospective study of RMG workers found that the majority normally worked 8–9 hours with 2–3 hours of overtime, and that headaches, general weakness, and eyestrain were common complaints linked to inadequate lighting and ventilation (Ghosh & Kirttania, 2025) — a pattern consistent with asthenopia, or visual fatigue from sustained near-work under suboptimal conditions.

1.2 The Global and National Burden of Vision Impairment

The World Health Organization estimates that at least 2.2 billion people worldwide live with a near or distance vision impairment, of whom at least 1 billion could have been prevented or remain unaddressed (WHO, 2023). Uncorrected refractive error and presbyopia (826 million people, near vision) are, alongside cataract, the leading causes (WHO, 2023). In Bangladesh specifically, the National Eye Centre's 2021 national cross-sectional survey of adults aged 40 and above recorded an age- and sex-adjusted blindness prevalence of 1.0%, higher among women and rural populations (cited in IAPB, 2022) — evidence that directly informed Bangladesh's 2020 endorsement of the WHO World Report on Vision and its co-sponsorship of the 2021 UN General Assembly resolution "Vision for Everyone by 2030" (IAPB, 2022). Despite this policy commitment, dedicated occupational eye health surveillance within the RMG sector remains sparse, leaving employers, regulators, and buyers without sector-specific evidence on which to act.

1.3 Relevance to Humanitarian and Social Development Goals

This paper's subject matter sits squarely at the intersection of three Sustainable Development Goals. SDG 3 (Good Health and Well-Being) is engaged directly: globally, two in three people in low-income countries who need eyeglasses do not have them (WHO, 2023). SDG 8 (Decent Work and Economic Growth) is engaged through the direct link between eye health, task accuracy, and workplace safety in a sector built on visual precision. SDG 5 (Gender Equality) is engaged because the RMG workforce is majority-female, and because, as this paper's findings show (Section 3), the burden of specific ocular conditions is not gender-neutral. The Tongi camp — and the clinical dataset it generated — is treated here as a case study in closing this evidence gap through a low-cost, AI-assisted, factory-based screening model.

1.4 Objectives and Scope of This Paper

This paper has three objectives: (i) to present and analyse the clinical and demographic data generated by the 22 May 2026 camp; (ii) to situate these localised findings within the global and national evidence base on vision impairment and occupational health; and (iii) to derive actionable, institution-specific policy recommendations. The paper is explicitly a retrospective analysis of a single-camp dataset (N=202) rather than a representative sectoral survey, and its policy recommendations are framed accordingly.

2. METHODOLOGY AND INTERVENTION DESIGN

2.1 Setting and Partnership Structure

The intervention was a single-day free eye care camp held on Friday, 22 May 2026, at Omi Sweaters Limited, a garment manufacturing facility in Deora, Tongi, Gazipur. It was jointly organised by CHRS Foundation (programme design, community mobilisation, and data governance), Lunera Eye Care (clinical diagnostic technology and optometric personnel), and Nevronus Systems (technical and AI systems support). Professional eye care services were delivered by a qualified optometrist from Enam Medical College, and the factory's management hosted the camp on-site, minimising the opportunity cost that otherwise deters RMG workers from seeking eye care.

2.2 AI-Powered Screening Modality

The clinical protocol centred on a handheld colour fundus photography device paired with an AI-powered mobile diagnostic application, designed to screen, within minutes per patient, for diabetic retinopathy, glaucoma, age-related macular degeneration (AMD), cataracts, and refractive errors. This point-of-care, AI-assisted modality substitutes a trained technician operating a portable imaging device and an automated triage algorithm for the specialist ophthalmologist equipment a factory-based outreach camp could not otherwise mobilise at this scale and cost. Patients flagged by the AI triage or presenting with symptomatic complaints were examined by the attending optometrist, who made the clinical determination on dilation, spectacle prescription, or referral.

2.3 Sampling and Data Collection

The camp screened 202 individuals, comprising garment-factory workers and self-selected community members — a convenience sample rather than a stratified sample of the RMG workforce (Section 6). For each patient, the clinical team recorded demographic data, presenting complaint, clinical findings, and treatment decision. This dataset was subsequently subjected to a formal, independent data-quality audit by CHRS's Clinical Data Quality Team (CHRS Foundation, 2026b), which identified 14 categories of data-entry error — four high-severity, four medium, six low — across the 202-record dataset. Records with apparent age-condition mismatches were flagged for manual clinical verification.

2.4 Analytical Approach

This paper synthesises CHRS's two primary source documents into a single, internally reconciled clinical and demographic profile (Section 3), benchmarks that profile against WHO, IAPB, and ILO reference data (Section 4), and derives a policy framework from the resulting gap analysis (Section 5). No new patient data collection, clinical re-examination, or statistical inference was performed for this paper; all percentages in Section 3 are descriptive statistics as reported in the primary source documents.

3. EMPIRICAL FINDINGS AND CLINICAL DATA REVIEW

Source reconciliation note: CHRS's two primary sources agree closely but not exactly on treatment-outcome figures: the audited Clinical Data Review reports 51.5% of patients prescribed spectacles, 45.0% requiring no correction, and 3.5% (7 patients) referred onward, while the after-action report states 53.9% prescribed spectacles and 3.0% referred. This is a minor but unreconciled discrepancy between CHRS's two own published sources, most plausibly arising from a

denominator or rounding difference; CHRSD should confirm the authoritative figure before this paper's next revision. The audited Clinical Data Review figures are treated as primary throughout this paper.

3.1 Table A — Demographic and Epidemiological Profile of Camp Beneficiaries (Tongi, Gazipur)

Indicator	Value
Total patients screened	202
Sex — Male	100 (49.5%)
Sex — Female	102 (50.5%)
Age — mean / median / range	33.9 / 33.0 / 11–60 years
Age cohort 18–29	32.7%
Age cohort 30–44	29.2%
Working-age (18–44) subtotal	≈62%
Residence — Deora, Tongi	137 (67.8%)
Residence — Gazipur district (total)	179 (88.6%)
Residence — Dhaka district	23 (11.4%)
Occupation — Garment/factory employment	26.2%
Occupation — Student	22.3%
Occupation — Business	9.9%
Occupation — Teacher	9.9%

The catchment is hyper-local — over two-thirds of patients resided within Deora, Tongi itself, and nearly 89% within Gazipur district. The gender balance (49.5% / 50.5%) is notable against the backdrop of a nationally majority-female RMG workforce, suggesting the camp also drew meaningfully from non-factory community members alongside garment employees specifically.

3.2 Table B — Distribution of Presenting Ocular Conditions

Condition	Patients (n)	% of total	Sex distribution
Refractive error	51	25.2%	33 male / 18 female
Dry eye syndrome	41	20.3%	18 male / 23 female
Medication-related visit	32	15.8%	not disaggregated in source
Eye infection	24	11.9%	8 male / 16 female
Presbyopia	23	11.4%	10 male / 13 female
Top-3 conditions (combined)	124	61.3%	—

Treatment outcomes: dilation performed in 44.6% of consultations; 51.5% of patients prescribed spectacles; 45.0% required no correction; 3.5% (7 patients) referred onward for specialist care (Clinical Data Review, Vol. 2, June 2026).

3.3 Analysis: A Clear Gender Patterning of Occupational Eye Disease

The sex-disaggregated condition data reveal a pattern directly relevant to occupational health design, not merely a clinical curiosity. Refractive error skews markedly male (33 vs. 18), while dry eye syndrome and eye infection both skew female (23 vs. 18, and 16 vs. 8, respectively), and presbyopia skews mildly female (13 vs. 10). CHRS's after-action report explicitly frames the female-skewed dry eye finding as “consistent with prolonged exposure to garment factory environments” — a plausible occupational-exposure hypothesis given that Bangladesh's RMG sewing-machine-operator workforce is predominantly female. This paper treats that explanation as a reasonable working hypothesis rather than an established causal finding, since the dataset does not report exposure duration, job role, or factory-section assignment for individual patients.

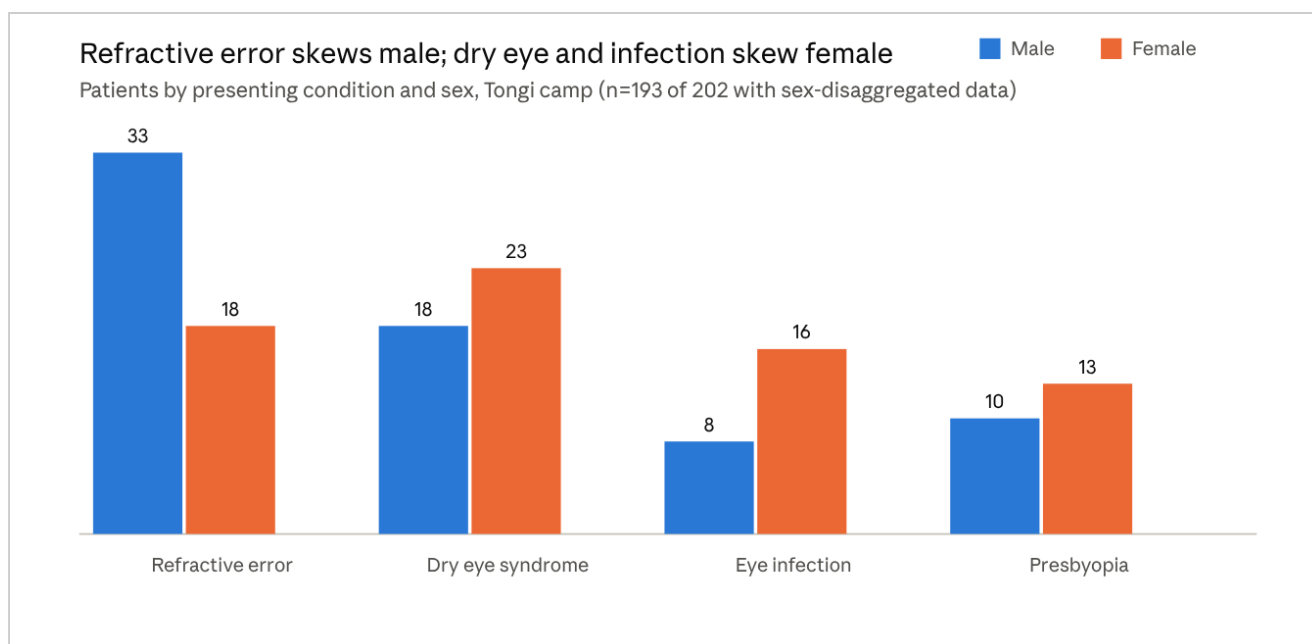


Figure 1. Patients by presenting condition and sex, Tongi camp (n=193 of 202 with sex-disaggregated condition data). Source: CHRS Foundation (2026b), Clinical Data Review Vol. 2. Medication-related visits (32 patients) are omitted as the source does not disaggregate that category by sex.

3.4 The Colour Vision Deficiency Finding

CHRS Secretary General Md Motalib Hossain highlighted, in remarks at the camp's concluding session, that “many garment workers unknowingly live with color blindness and color recognition deficiencies,” and that in an industry where shade-matching and defect identification are daily tasks, this directly affects both productivity and workplace safety. *Editorial flag: this is a qualitative observation from camp leadership, not a quantified finding in either CHRS source document — the 202-patient dataset as reported does not appear to include a tabulated colour-vision (e.g., Ishihara) screening result. CHRS is encouraged to report the quantitative colour-vision screening rate and prevalence from this camp, if collected, in a future data release.*

4. SOCIO-ECONOMIC AND OCCUPATIONAL HEALTH IMPACT ANALYSIS

4.1 Benchmarking Against the Global Economic Burden of Vision Impairment

Two independent health-economics analyses, separated by a decade, establish the order of magnitude of what uncorrected vision impairment costs the global economy: Smith, Frick, Holden, Fricke, and Naidoo (2009) estimated the annual global productivity loss from uncorrected distance refractive error alone at approximately

US\$202 billion (I\$269 billion), covering 158 million affected people; WHO's current estimate (2023) places the global annual productivity loss from vision impairment at US\$411 billion, against an estimated one-off cost of only US\$25 billion to close the unmet need gap. Fricke et al. (2012) further calculated that a one-off US\$28 billion global investment in eye care personnel and infrastructure would generate US\$202 billion in annual recurring productivity savings — a benefit-to-annual-cost ratio illustrating why correcting refractive error is routinely ranked among the most cost-effective interventions in all of public health.

Vision-health indicators across three scales

Scale	Indicator	Value	Source
Global	People living with a near or distance vision impairment	2.2 billion	WHO (2023)
Global	Estimated annual productivity loss from vision impairment	US\$411 billion	WHO (2023)
Global	Cost gap to close the unmet need for eye care	US\$25 billion (one-off)	WHO (2023)
Bangladesh (national, adults 40+)	Age- and sex-adjusted blindness prevalence	1.0%	National Eye Centre survey, cited in IAPB (2022)
Tongi camp (this study, ages 11–60)	Refractive error among presenting conditions	25.2% (51 of 202)	CHRS Foundation (2026b)
Tongi camp (this study)	Dry eye syndrome among presenting conditions	20.3% (41 of 202)	CHRS Foundation (2026b)

These figures are not directly comparable prevalence estimates — the Tongi rows describe presenting complaints within a symptomatic, self-selected clinic sample, not general-population prevalence — but they establish that the specific conditions driving the global and national burden are the same conditions observed on the factory floor in Gazipur.

4.2 Table C — Socio-Economic Impact Matrix: What Is Measured, Benchmarked, or Still Missing

Impact dimension	Tongi camp evidence	Global/national benchmark	CHRS data status
Visual task precision (shade-matching, defect detection)	Leadership-reported colour-vision concern	Refractive error & colour-vision deficiency are established drivers of task-error rates	Not yet quantified — recommend Ishihara screening
Workplace productivity / output per shift	Factory management reported qualitative expectation of improvement	US\$411bn/yr global loss (WHO, 2023); US\$202bn/yr distance URE (Fricke et al., 2012)	Not measured at camp level
Absenteeism / sick leave	Not reported	Standard ILO decent-work indicator (Anker et al., 2012)	Not measured — recommend future intake capture
Income retention / wage continuity	Qualitative (leadership quote)	2 in 3 low-income-country patients needing eyeglasses lack access (WHO, 2023)	Not quantified
Referral & specialist-care access	3.5% referred onward (7 of 202)	1 in 2 globally needing cataract surgery lack access (WHO, 2023)	

			Measured at programme level; completion untracked
Gender-differentiated occupational exposure	Dry eye & infection skew female	RMG sewing workforce majority-female nationally	Partially measured; job-role data not collected

4.3 Reading the Matrix Against ILO Decent Work Indicators and the SDGs

The ILO's Decent Work Indicators framework treats occupational safety and health as one of its core substantive elements, alongside employment opportunities, adequate earnings, and social dialogue (Anker, Chernyshev, Egger, Mehran, & Ritter, 2012; ILOSTAT, n.d.). The table above shows that the Tongi camp generated real, programme-level clinical evidence against the health-screening and referral-access components of that framework (SDG 3), but that the productivity, absenteeism, and income dimensions that would let CHRS make a full decent-work and economic case (SDG 8) remain evidenced only qualitatively. Closing that specific evidentiary gap — linking individual vision-screening outcomes to individual or line-level productivity and defect-rate data, with appropriate worker consent and data-protection safeguards — is identified as this paper's single highest-value recommendation for future CHRS camps (Section 5).

On SDG 5 (Gender Equality), the gender-differentiated condition burden found in Section 3.3 suggests that a gender-neutral eye care intervention may nonetheless have gender-differentiated impact, since women are disproportionately represented in the specific RMG roles associated with prolonged near-focus exposure. A screening programme that does not disaggregate by job role risks under-targeting the occupational exposure pathway that most directly affects women workers.

5. POLICY RECOMMENDATIONS AND STRATEGIC FRAMEWORK

Table D — Policy Recommendations Matrix

#	Recommendation	Lead stakeholder(s)	Timeline
5.1	Formally recognise occupational eye health in the RMG sector's OSH regulatory framework	Ministry of Labour and Employment	18–24 months
5.2	Scale AI-assisted screening camps; add colour-vision and line-level productivity data capture	BGMEA/BKMEA, factory owners	Pilot in 12 months; scale in 24 months
5.3	Add eye-health screening access to supplier social-compliance and ethical-sourcing audits	International buyers and brand partners	Next audit cycle
5.4	Reconcile source-data discrepancies; capture job-role/exposure data; track referral completion	CHRS Foundation and peer NGOs	Next published data release
5.5	Establish consent-based data governance before linking health and productivity data	CHRS, factory partners, data protection authorities	Before any productivity-data pilot

5.1 For the Ministry of Labour and Employment

Formally recognise occupational eye health — including refractive error, dry eye syndrome, and colour vision deficiency — as a distinct category within Bangladesh's occupational safety and health (OSH) regulatory framework for the RMG sector, alongside the existing fire, structural, and chemical-hazard categories. This should include a minimum standard for factory-floor lighting and ventilation and a requirement that factories above a defined worker threshold provide, or facilitate access to, periodic vision screening.

Stakeholders: Ministries of Health, national digital-health/e-health agencies, medical device regulators. Timeline: incorporate into OSH policy review within 18–24 months.

5.2 For BGMEA / BKMEA and Factory Owners

Sponsor and scale factory-based AI-assisted eye screening camps of the kind piloted in Tongi, with two specific enhancements: (i) add a dedicated, tabulated colour-vision (Ishihara or equivalent) screening module; and (ii) pair screening with simple, consented productivity and defect-rate data capture at the line level. Omi Sweaters Limited’s own participation is a useable template for a sector-wide “eye health partner factory” programme that BGMEA/BKMEA could formalise and recognise.

Stakeholders: BGMEA, BKMEA, individual factory management. Timeline: pilot an enhanced-protocol camp within 12 months; scale within 24 months.

5.3 For International Buyers and Brand Partners

International buyers sourcing from Bangladesh’s RMG sector should incorporate occupational eye health screening access into their supplier social-compliance and ethical-sourcing audits, alongside existing fire-safety and labour-standards criteria, and should consider co-funding scaled screening programmes as part of supplier-development and worker-welfare commitments.

Stakeholders: International buyers, brand compliance teams. Timeline: next audit cycle.

5.4 For Civil Society and Implementing NGOs

CHRS Foundation and peer organisations should (i) reconcile the spectacle-prescription and referral-rate discrepancy between CHRS’s own two source documents (Section 3) in the next published data release; (ii) design the next camp’s intake form to capture job role, factory section, and approximate exposure duration; and (iii) track referral completion, since referral issuance alone does not establish that the access gap WHO documents nationally and globally was actually closed for this cohort.

Stakeholders: CHRS Foundation, Lunera Eye Care, Nevronus Systems, peer NGOs. Timeline: next published data release.

5.5 Data Governance and Ethical Safeguards

Any future productivity or defect-rate data linkage must be built on explicit, informed worker consent, with data held separately from any individual performance-management or disciplinary system, and with aggregate, de-identified reporting only. CHRS’s existing practice of commissioning an independent clinical-data-quality audit should be extended as a standing institutional practice for any future dataset combining clinical and productivity variables.

Stakeholders: CHRS, factory partners, data protection authorities. Timeline: before any productivity-data pilot.

6. CONCLUSION

The CHRS–Lunera Eye Care–Nevronus Systems free eye care camp in Tongi demonstrates that AI-assisted, factory-sited vision screening can generate a credible, audited clinical dataset on a working population that Bangladesh’s occupational health system otherwise does not systematically observe. Among 202 patients, refractive error, dry eye syndrome, and medication-related complaints together accounted for over 61% of presenting conditions, with a clear and occupationally plausible gender patterning, and a leadership-reported, not-yet-quantified concern around colour vision deficiency with direct implications for a sector built on shade-matching and defect detection. Set against global benchmarks — 2.2 billion people living with vision impairment; up to US\$411 billion in annual lost productivity; two in three low-income-country patients needing

eyeglasses still lacking them — the Tongi findings are a local, concrete instance of a well-documented global pattern.

Key takeaways:

- Occupational eye health in Bangladesh’s RMG sector is measurable, underserved, and currently outside the sector’s core OSH framework.
- The clinical burden is not gender-neutral: dry eye and infection concentrate among women, plausibly reflecting factory-floor exposure patterns tied to roles women disproportionately occupy.
- The single largest evidence gap is economic, not clinical: no Bangladesh-specific, factory-level data yet links individual vision correction to individual or line-level productivity, defect rates, or income retention.
- A leadership-identified colour-vision-deficiency concern merits a dedicated, quantified screening protocol in future camps rather than remaining an anecdotal observation.
- Two minor data-reconciliation gaps between CHRSD’s own source documents should be closed in CHRSD’s next published release.

Call to institutional action: The evidence and the technology both already exist, as CHRSD Secretary General Md Motalib Hossain stated at the camp’s concluding session; what remains, in his words, “is the will to act.” This paper’s recommendations (Section 5) translate that call into a specific, sequenced agenda for Bangladesh’s Ministry of Labour and Employment, BGMEA/BKMEA, international buyers, and civil society partners.

Limitations: This paper synthesises a single-camp, convenience-sample dataset (N=202) rather than a representative sectoral survey; no new statistical testing was performed; two numerical discrepancies between CHRSD’s own primary sources are flagged but not independently resolved; and the socio-economic impact matrix (Table C) necessarily mixes measured clinical data with global benchmark figures and un-quantified qualitative observations.

REFERENCES (APA 7TH EDITION)

Anker, R., Chernyshev, I., Egger, P., Mehran, F., & Ritter, J. (2012). *Measuring decent work with statistical indicators* (ILO Policy Integration Working Paper No. 2). International Labour Organization.

CHRSD Foundation. (2026a). *CHRSD Foundation, Lunera Eye Care & Nevronus Systems host free eye care camp for garment workers in Tongi* [Blog post]. <https://chrstd.org/blog/chrstd-foundation-lunera-eye-care-nevronus-systems-host-free-eye-care-camp-for-garment-workers-in-tongi>

CHRSD Foundation. (2026b). *Patient records data quality report: Clinical data review, Vol. 2* [Blog post]. <https://chrstd.org/blog/clinical-data-review-june-2026-vol-2>

Fricke, T. R., Holden, B. A., Wilson, D. A., Schlenker, G., Naidoo, K. S., & Resnikoff, S. (2012). Global cost of correcting vision impairment from uncorrected refractive error. *Bulletin of the World Health Organization*, 90(10), 728–738. <https://doi.org/10.2471/BLT.12.104034>

Fricke, T. R., Tahhan, N., Resnikoff, S., Papas, E., Burnett, A., Suit, M. H., Naduvilath, T., & Naidoo, K. (2018). Global prevalence of presbyopia and vision impairment from uncorrected presbyopia: Systematic review, meta-analysis, and modelling. *Ophthalmology*, 125(10), 1492–1499. <https://doi.org/10.1016/j.ophtha.2018.04.013>

Ghosh, L., & Kirtania, T. (2025). *Occupational health risks among garment industry workers in Bangladesh: A public health concern* [Conference paper]. 7th International Conference on Integrated Sciences, Eastern University, Dhaka, Bangladesh.

International Agency for the Prevention of Blindness. (2022). *Bangladesh: Fresh evidence on blindness and visual impairment*. <https://www.iapb.org/?p=20685>

Smith, T. S. T., Frick, K. D., Holden, B. A., Fricke, T. R., & Naidoo, K. S. (2009). Potential lost productivity resulting from the global burden of uncorrected refractive error. *Bulletin of the World Health Organization*, 87(6), 431–437. <https://doi.org/10.2471/BLT.08.055673>

World Health Organization. (2023). *Blindness and visual impairment* [Fact sheet]. <https://www.who.int/news-room/fact-sheets/detail/blindness-and-visual-impairment>

World Health Organization. (2019). *World report on vision*. <https://www.who.int/publications/i/item/9789241516570>

Editorial Notes: Data-Completeness Checklist

- Spectacle-prescription / referral-rate discrepancy between CHRSD’s Clinical Data Review (51.5% / 3.5%) and the public after-action report (53.9% / 3.0%) is unreconciled (Section 3); the audited figure is used as primary throughout, but CHRSD should confirm the authoritative value.
- Colour vision deficiency is a leadership-stated, not a tabulated, finding in both source documents (Section 3.4); no Ishihara or equivalent screening count is reported.
- Table C (Section 4.2) mixes camp-level measured data with global benchmark figures and un-quantified qualitative statements by design; CHRSD-specific productivity, absenteeism, and wage-impact data for this cohort do not exist and are not estimated here.
- Job role / factory-section / exposure-duration data were not captured in the 202-patient dataset, limiting the gender-patterning analysis (Section 3.3) to a plausible hypothesis rather than a demonstrated exposure–outcome relationship.
- Referral completion (whether the 7 referred patients accessed specialist care) is not tracked in either source document.

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