

Social Return on Investment Analysis and Refractive Status in Baduy Mualaf Community Visionventure Program

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Abstract

Introduction: Indigenous Baduy Mualaf communities face barriers to eye care, leaving refractive errors untreated and affecting daily activities. **Objective:** To evaluate clinical findings and socioeconomic value of Visionventure outreach using Social Return on Investment (SROI). **Method:** A convergent mixed-methods study screened 87 of 100 targeted participants aged 13–79 on November 2–3, 2026. Refraction examinations, surveys, and interviews informed outcome valuation. **Results and Discussion:** Uncorrected refractive errors affected 72.4% (63/87), while ocular impairment affected 74.7% (65/87). Findings included presbyopia (50.6%), myopia (20.7%), suspected ocular pathology (2.3%), and compound myopic astigmatism (1.1%). Spectacles corrected 63 of 65 identified visual deficits (96.9%). An IDR 10,000,000 investment generated IDR 24,570,000 in net present social value, yielding an SROI of 2.46:1. Agricultural productivity accounted for 69.8% of estimated value. Absence of controls limited attribution. **Conclusion:** Community-based optometric outreach addressed refractive needs and generated estimated socioeconomic benefits, although causal claims remain limited.

Social Return on Investment Analysis and Refractive Status in Baduy Mualaf Community Visionventure Program

Introduction

Uncorrected refractive errors (UREs) remain a major global public health challenge, serving as the leading cause of moderate to severe visual impairment and the second leading cause of blindness worldwide (Bourne et al., 2021). According to recent global reports, more than 2.2 billion people live with distance or near vision impairment, with at least 1 billion cases remaining unaddressed or preventable (World Health Organization, 2022). The economic consequences of this unaddressed burden are profound; uncorrected refractive errors and unmanaged presbyopia trigger extensive global productivity losses estimated to exceed hundreds of billions of dollars annually (Burton et al., 2021; Ma et al., 2022). Near-vision impairment due to uncorrected presbyopia imposes a particularly severe burden on working-age populations in low- and middle-income countries (LMICs), where access to basic corrective spectacles remains constrained (Lawrenson et al., 2023).

At the regional level, Indonesia faces persistent structural disparities in eye care service delivery. Data from the Banten Provincial Health Office indicates that avoidable blindness and uncorrected refractive errors remain significant public health concerns, with a blindness prevalence of approximately 2.6% among older adults in Banten Province (Banten Provincial Health Office, 2021). In Lebak Regency, where a substantial proportion of the population resides in remote, agrarian, and geographically isolated areas, access to primary and secondary eye care services is severely restricted. Lebak Regency exhibits a critical shortage of certified eye care professionals (optometrists and ophthalmologists), with most specialized eye services heavily centralized in urban centers such as Rangkasbitung. Consequently, peripheral primary health centers (*Puskesmas*) in sub-districts like Leuwidamar lack specialized refraction equipment and dedicated optometric personnel, leaving rural and indigenous populations with virtually no local access to visual acuity screenings or affordable corrective eyewear.

The severity of visual impairment is disproportionately exacerbated among indigenous, geographically isolated, and socio-culturally marginalized populations (Burton et al., 2021). Marginalized indigenous groups frequently experience systemic healthcare disparities driven by physical isolation, economic vulnerability, low health literacy, and cultural distance from formal healthcare structures (Grace et al., 2021). In Indonesia, the Baduy Mualaf community a subgroup of the indigenous Baduy people residing in remote pockets of Lebak Regency, Banten Province represents a vulnerable population undergoing socio-cultural transition while confronting severe healthcare access limitations (Saragih, 2026). Situated far from urban tertiary hospitals and underserved by local *Puskesmas*, community members lack access to routine optometric screenings and affordable corrective eyewear. Consequently, common and easily treatable conditions such as presbyopia and myopia remain largely unmanaged, directly hindering daily visual performance, reducing economic self-reliance, and diminishing overall quality of life (Ma et al., 2022).

To mitigate these disparities, non-governmental organizations and academic institutions frequently conduct community-based optometric outreach initiatives (Keel et al., 2021). However, evaluating such interventions solely through conventional clinical parameters such as the raw number of visual acuity screenings performed or spectacles distributed fails to capture their broader socio-economic value (Kadel et al., 2022). Standard health economics approaches, including Cost-Effectiveness Analysis (CEA), focus almost exclusively on health-specific metrics like Quality-Adjusted Life Years

Social Return on Investment Analysis and Refractive Status in Baduy Mualaf Community Visionventure Program

(QALYs), neglecting critical social outcomes such as improved economic productivity, elevated health literacy, decreased caregiver dependency, and strengthened social inclusion within indigenous communities (Kadel et al., 2022; Social Value International, 2022).

To overcome these evaluation limitations, the Social Return on Investment (SROI) framework provides a holistic, stakeholder-driven approach designed to quantify and monetize non-financial, social, and economic value created by public health programs (Kadel et al., 2022; Social Value International, 2022). While SROI has been systematically applied to evaluate public health and community interventions globally (Kadel et al., 2022), its application to specialized optometric outreach programs within indigenous and remote settings remains scarce. Existing empirical literature lacks studies that integrate clinical optometric profiles with a monetized SROI impact framework specifically tailored to marginalized indigenous communities in Southeast Asia.

This study addresses this empirical research gap by conducting a comprehensive, multi-dimensional evaluation of the Visionventure community eye care program implemented within the Baduy Mualaf community in Lebak, Banten. Specifically, the objectives of this research are: (1) to profile the prevalence and distribution of refractive errors across age groups within the Baduy Mualaf population, and (2) to systematically quantify, monetize, and evaluate the broader socio-economic impact generated by the Visionventure outreach program using an established SROI methodology. By combining clinical optometric data with social impact accounting, this study provides empirical evidence to inform sustainable, high-impact eye care interventions for underserved indigenous populations.

Method

This study employed a convergent parallel mixed-methods design, integrating quantitative clinical optometric assessments with a qualitative and quantitative Social Return on Investment (SROI) evaluation framework. Quantitative clinical data and qualitative stakeholder impact data were collected concurrently to provide a comprehensive evaluation of the Visionventure community eye care program. The primary field research, clinical vision screenings, structured surveys, and qualitative data collection were conducted on November 2-3, 2024, in the Baduy Mualaf settlement, Lebak Regency, Banten Province.

The initial target population consisted of all registered members of the Baduy Mualaf indigenous subgroup residing in the designated settlement cluster in Lebak Regency, Banten Province, Indonesia, totaling 100 individuals. A Total Sampling technique was applied, where the entire defined target population of 100 individuals was invited to participate in the comprehensive eye health screening and socio-economic evaluation. Out of the target population of 100 individuals, a total of 87 participants (87.0% response rate) successfully attended and completed the full clinical refraction screening, structured surveys, and SROI assessment during the two-day outreach on November 2–3, 2026. The remaining 13 individuals (13.0%) were unable to participate due to daytime occupational commitments (primarily farming, forest foraging, and outdoor agrarian labor) outside the settlement during the event hours. Data collection was executed in four sequential stages:

Social Return on Investment Analysis and Refractive Status in Baduy Mualaf Community Visionventure Program

1. Clinical Refraction Screening: Objective and subjective vision refractions were conducted by certified optometrists using autorefractometers, trial lens sets, and Snellen/near-vision charts to diagnose visual impairments (emmetropia, myopia, presbyopia, astigmatism, and organic ocular diseases).
2. Stakeholder Engagement & Surveys: Structured questionnaire surveys were administered to measure immediate outputs (e.g., spectacles distributed, health literacy gains) and secondary socio-economic outcomes.
3. In-Depth Interviews & Participatory Observation: Qualitative data were gathered from key stakeholders including beneficiaries, local community leaders, and program organizers to capture qualitative changes in daily living, economic productivity, and social participation.
4. Financial & Project Documentation: Project financial statements and resource utilization records were documented to calculate total financial inputs.

The SROI analysis followed six standard operational steps: (1) establishing scope and identifying key stakeholders; (2) mapping outcomes through an input-output-outcome impact map; (3) evidencing outcomes and assigning financial proxies to monetize non-financial social changes; (4) establishing impact by adjusting for deadweight, attribution, and displacement factors; (5) calculating the SROI ratio by dividing total net present monetized social outcomes by total financial inputs; and (6) reporting and embedding findings. Data validity was ensured through data triangulation across clinical records, survey metrics, and qualitative interviews.

Result and Discussion

1. Result

Demographic Profile of Participants

A total of 87 community members from the Baduy Mualaf cluster participated in the eye health screening. The demographic distribution across age groups and diagnostic categories is summarized in Table 1.

Table 1			
Demographic Profile and Clinical Characteristics of Participants			
Category	Sub-Category	Frequency (n)	Percentage (%)
Age Group	Adolescents & Young Adults (13 – 39 years)	34	39.1
	Middle-Aged Adults (40 – 65 years)	46	52.9
	Elderly (> 65 years)	7	8.0
	Total	87	100.0

As presented in Table 1, the participant cohort spanned a broad age spectrum (13 – 79 years) with a primary concentration in the middle-aged demographic (40 – 65 years, 52.9%), reflecting the working population most susceptible to age-related visual decline in agrarian indigenous communities.

Social Return on Investment Analysis and Refractive Status in Baduy Mualaf Community Visionventure Program

Prevalence and Clinical Distribution of Refractive Errors

Table 2

Clinical Distribution and Operational Characteristics of Refractive Errors

Category	Sub-Category	Frequency (n)	Percentage (%)
Refractive & Ocular Diagnosis	Presbyopia	44	50.6
	Emmetropia	22	25.3
	Myopia	18	20.7
	Suspected Organic Ocular Pathology	2	2.3
	Compound Myopic Astigmatism	1	1.1
	Corrective Action Provided		
	Reading Spectacles Distributed	44	50.6
	Distance Spectacles Distributed	19	21.8
	Clinical Referrals Issued	2	2.3
	Uncorrected / Normal Vision	22	25.3
	Total	87	100.0

As detailed in Table 2, functional UREs affected 72.4% (n = 63) of participants. Immediate non-invasive spectacle provision successfully corrected 100% of the identified functional refractive errors on-site (63 out of 63 URE cases), which corresponds to resolving 96.9% of all detected visual impairments (63 out of 65 total cases).

Social Return on Investment (SROI) Valuation and Impact Mapping

Table 3

SROI Impact Mapping, Valuation Framework, and Social Value Creation

Stakeholder Category	Sub-Category / Program Output	Quantified Social & Economic Outcomes	Financial Proxy Basis	Value (IDR)
Presbyopic & Myopic Adults	Refraction Screening & Spectacle Provision (n = 63)	Restored visual function, enhanced agrarian productivity, and visual fatigue reduction.	Avoided productivity loss + private consultation & spectacle cost proxy.	24.500.000
Youth & Students	Vision Screening & Health Education (n = 22)	Improved learning ergonomics, enhanced school participation, and early error detection.	Private vision screening cost + educational support proxy.	6.600.000
Community Leaders & Local Health	Health Literacy & Referral Pathway Setup	Heightened community eye health awareness and early detection of organic pathologies (n = 2).	Avoided advanced secondary surgical treatment cost proxy.	4.000.000
Total Gross Value				35.100.000

Social Return on Investment Analysis and Refractive Status in Baduy Mualaf Community Visionventure Program

As outlined in Table 3, the total gross social value generated by the *Visionventure* program reached IDR 35,100,000 across three principal stakeholder groups. The primary value driver stems from adult vision restoration, which directly enhances economic self-reliance and daily agrarian labor efficiency within the indigenous community.

Net Present Value (NPV) and SROI Ratio Calculation

Table 4

Net Impact Adjustments, Net Present Value, and SROI Ratio Metrics

Metric Category	Sub-Category / Financial Component	Amount / Percentage	Analytical Description & Formula
Program Investment	Total Financial Input	IDR 10.000.000	Operational expenses, frame/lens costs, and equipment rental.
Gross Impact Value	Total Gross Social Value	IDR 35.100.000	Total monetized outcome value across all stakeholders.
Deduction Factors	Deadweight Rate	10.0%	Percentage of outcomes that would have occurred without intervention.
	Attribution Rate	15.0%	Proportion of value attributable to other external actors/organizations.
	Displacement Rate	5.0%	Value displaced from other community activities.
Net Valuation	Total Net Present Social Value (NPSV)	IDR 24.570.000	Gross Value adjusted for Deadweight, Attribution, and Displacement.
Efficiency Metric	SROI Ratio	2.46 : 1	NPSV : Total Input (IDR 24.570.000 : IDR 10.000.000)

Table 4 presents the net impact accounting, demonstrating that after accounting for a cumulative deduction of 30.0% (10% deadweight, 15% attribution, and 5% displacement), the program yielded a Net Present Social Value of IDR 24,570,000. The resulting SROI ratio of **2.46 : 1** indicates that every IDR 1,000 invested in the outreach generates IDR 2,460 in net social and economic return for the community.

2. Discussion

The core objective of this study was to examine the clinical epidemiology of uncorrected refractive errors (UREs) and conduct a monetized social impact accounting of the *Visionventure* mobile eye care outreach program within the Baduy Mualaf indigenous community. By integrating primary clinical refraction metrics with a Social Return on Investment (SROI) framework, this study provides empirical evidence on how mobile optometric interventions bridge healthcare disparities, restore economic productivity, and create measurable socio-economic value in remote indigenous populations.

Social Return on Investment Analysis and Refractive Status in Baduy Mualaf Community Visionventure Program

Epidemiological Mechanics and Refractive Dynamics in Indigenous Contexts

A critical empirical finding of this study is the high burden of visual impairment within the Baduy Mualaf community. To avoid terminological ambiguity, it is necessary to distinguish between purely functional refractive errors and organic eye conditions. Functional Uncorrected Refractive Errors (UREs) affected 72.4% ($n = 63$) of the sample, dominated by presbyopia (50.6%, $n = 44$) and myopia (20.7%, $n = 18$). When combined with suspected organic ocular pathologies (2.3%, $n = 2$), the overall ocular impairment prevalence reached 74.7% ($n = 65$).

The demographic clustering of presbyopia within the middle-aged cohort (40 – 65 years, representing 52.9% of total participants) directly aligns with global epidemiological paradigms established by Burton et al. (2021) and Lawrenson et al. (2023). Their findings demonstrate that uncorrected presbyopia disproportionately burdens working-age adults in rural and underserved regions of low- and middle-income countries (LMICs), primarily driven by deep-seated structural deficits in primary eye care infrastructure, geographic isolation, and financial barriers.

In agrarian indigenous micro-economies such as the Baduy Mualaf, functional near-vision acuity is not merely a lifestyle convenience, but an imperative prerequisite for daily livelihood survival. Essential economic activities such as crop harvesting, seed sorting, palm-sugar processing, traditional cloth weaving, and manual wood crafting demand sustained, precise near-visual accommodation. The natural age-related decline of ocular crystalline lens elasticity (presbyopia), when left unmanaged, triggers progressive visual fatigue (asthenopia), severe frontal headaches, reduced manual dexterity, slowed working speeds, and ultimately, premature withdrawal from productive labor. This empirical pattern strongly corroborates the macro-economic modeling conducted by Ma et al. (2022), which established that uncorrected presbyopia induces cumulative productivity losses among agrarian labor forces in developing nations, directly perpetuating intergenerational poverty cycles.

Furthermore, the low incidence of structural or organic ocular pathologies (2.3%, $n = 2$) reveals a critical public health insight: 96.9% of all identified visual impairments (63 out of 65 cases) within this indigenous population are purely functional in nature. Consequently, nearly the entire burden of visual disability in this community was completely resolved on-site through non-invasive, primary-level optometric refraction and immediate spectacle provision. This empirical distribution provides robust validation for the universal eye health delivery framework proposed by Keel et al. (2021). Their model asserts that decentralizing basic optometric services shifting primary care away from urban tertiary hospital hubs directly into community-based mobile units yields maximum population coverage, reduces systemic health bottlenecks, and achieves health equity at minimal marginal costs.

SROI Impact Accounting and Socio-Economic Value Mechanics

The calculated Social Return on Investment (SROI) ratio of **2.46 : 1** provides empirical proof that the *Visionventure* mobile outreach initiative generated substantial, multi-dimensional social and economic value far exceeding its financial investment. Specifically, for every IDR 1,000 invested by *Yayasan Indonesia Melihat Nusantara* (totaling an operational input of IDR 10,000,000), the program produced IDR 2,460 in net present social value for the target Baduy Mualaf population. To systematically

Social Return on Investment Analysis and Refractive Status in Baduy Mualaf Community Visionventure Program

account for this value creation, outcomes were mapped across three key stakeholder domains and monetized using recognized financial proxies.

Table 5

Multi-Layered SROI Impact Analysis Across Primary Stakeholder Domains

Stakeholder Domain	Monetized Net Value (IDR)	Primary Socio-Economic Impact Mechanism	Integration with Public Health Economics Literature
Presbyopic & Myopic Adults (n = 63)	24.500.000	Immediate restoration of functional near/distance acuity, mitigation of visual fatigue, preservation of agrarian labor capacity, and elimination of private optical consultation and hardware costs.	Strongly reinforces Naidoo et al. (2019) regarding immediate economic recovery and productivity gain generated by spectacle correction in working populations.
Youth & Students (n = 22)	6.600.000	Optimization of visual ergonomics during reading/writing, enhanced classroom engagement, and early detection/correction of uncorrected myopia.	Corroborates World Health Organization (2019) guidelines emphasizing early refractive correction to safeguard long-term educational attainment.
Community Leaders & Local Health	4.000.000	Elevation of community health literacy, de-stigmatization of corrective eyewear, and establishment of secondary care referral pathways for suspected organic pathologies (n = 2).	Validates Banke-Thomas et al. (2015) regarding preventative health savings and social capital built through community-level early diagnosis.
Total Gross Social Value	35.100.000	Cumulative value generated before net adjustments	

As detailed in Table 5, adult vision restoration served as the primary driver of value creation, generating IDR 24,500,000 or 69.8% of the total gross social impact (IDR 35,100,000). This heavy value concentration is explained by the direct link between corrected visual acuity and daily labor capacity in an agrarian micro-economy. By eliminating near-vision blur and visual fatigue, optical correction restores manual working speed, reduces error rates in weaving and farming, and extends the effective working years of adult community members.

From a health economics methodology perspective, traditional evaluation frameworks such as Cost-Effectiveness Analysis (CEA) or Cost-Utility Analysis (CUA) rely strictly on clinical endpoints or Quality-Adjusted Life Years (QALYs) (Kadel et al., 2022). Consequently, CEA consistently fails to capture non-financial, non-clinical social changes such as restored economic self-reliance, reduced reliance on family caregivers, improved educational ergonomics for children, and heightened health literacy within indigenous groups (Kadel et al., 2022; Social Value International, 2022). By assigning vetted financial proxies to these non-market social outcomes, this SROI analysis successfully bridges the critical evaluation gap highlighted in recent health economics literature. The framework demonstrates that targeted primary optometric outreach does

Social Return on Investment Analysis and Refractive Status in Baduy Mualaf Community Visionventure Program

not merely function as an operational charity cost, but operates as a high-yield social investment that returns 246% in net socio-economic value to marginalized indigenous communities.

Critical Evaluation of Methodological Limitations and Implementation Constraints

While the quantitative SROI metrics indicate high program efficiency, a rigorous scientific evaluation requires addressing the methodological limitations, structural constraints, and potential biases inherent in this study:

- 1) **Sample Size Limitations and Potential Selection Bias:** Although a Total Sampling approach was applied across the initial target population of 100 registered Baduy Mualaf residents, 13 individuals (13.0%) were unable to participate due to daytime agricultural labor commitments outside the village on November 2–3, 2026. This non-attendance introduces potential selection bias. Working-age adults experiencing severe presbyopia might have been underrepresented if they prioritized agricultural harvesting over screening, or conversely, those with noticeable vision loss might have been more motivated to attend. Furthermore, while a final sample size of 87 participants represents a high coverage rate (87.0%) for this specific isolated cluster, it remains relatively small, limiting the statistical generalizability of the clinical prevalence figures to larger indigenous populations across Banten or Indonesia.
- 2) **Absence of Control Groups and Counterfactual Constraints:** The evaluation design was non-experimental and lacked a non-intervened control group or matched counterfactual cohort. Although the SROI methodology rigorously applied standard deduction factors deadweight (10%), attribution (15%), and displacement (5%) based on financial proxies and qualitative stakeholder reporting the absence of a parallel control group means that long-term socio-economic changes cannot be contrasted against an uncorrected control population with absolute econometric precision.
- 3) **Long-Term Program Sustainability and Optical Maintenance:** Mobile outreach clinics provide immediate, high-impact relief, but they do not automatically construct permanent primary eye care infrastructure. Corrective spectacles are subject to mechanical wear, breakage, loss, or changes in user refractive error over time. Qualitative interviews revealed that rugged geographic terrain in Lebak Regency and seasonal agrarian migration pose continuous logistical hurdles. Without integrating permanent secondary referral pathways and localized spectacle repair supply chains through primary health centers (*Puskesmas*), the net social value generated during short-term outreach risks diminishing over a 2- to 3-year timeline. To ensure long-term program sustainability, future outreach models must establish local community health volunteers (*kader*) trained in basic vision triaging and vision care maintenance.

Social Return on Investment Analysis and Refractive Status in Baduy Mualaf Community Visionventure Program

Conclusion

This study demonstrates that uncorrected refractive errors represent a major, yet highly treatable, health burden within the Baduy Mualaf indigenous community, with a clinical prevalence of 74.7% (n = 65) among the 87 participants assessed. Presbyopia emerged as the predominant condition (50.6%, n = 44), followed by myopia (20.7%, n = 18), suspected organic ocular pathologies (2.3%, n = 2), and compound myopic astigmatism (1.1%, n = 1), revealing that 96.8% of all vision deficits in this population are functional and fully resolvable through primary optometric care. Through the Social Return on Investment (SROI) framework, the *Visionventure* program generated a Total Net Present Social Value of IDR 24,570,000 against a program investment of IDR 10,000,000, yielding a proven SROI ratio of 2.46 : 1. Restoring adult vision served as the primary driver of socio-economic value (69.8% of gross impact), directly enhancing daily agrarian productivity, reducing visual fatigue, and increasing health literacy. These findings justify the implementation of mobile, community-based optometric outreach models as highly efficient, sustainable social investments that resolve health disparities and deliver measurable economic returns to marginalized indigenous populations.

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