

ADVOCACY FACT SHEET

Malawi Overview



Population 21.6 million¹ - Lower income¹ - HDI 0.517 (low)² - GDP USD 11.01 billion / 19.14 trillion MWK¹

- High Unmet Vision Needs:** Over 6.3 million Malawians (31% of the population) require vision correction, with more than 87% remaining uncorrected. Vision impairment (VI) has increased since 1990, affecting children, older adults, and refugees. The leading causes are uncorrected refractive error and cataract, with low spectacle use, myths, cost, and stigma continue to limit access to care.
- Limited Access and Barriers:** Eye care is limited in rural areas, among women, migrants, and refugees. Workforce shortages (1 ophthalmologist/million, 5 optometrists/million), high spectacle costs, limited outreach, and weak referral pathways restrict service use. School-based programs face funding, personnel, and stigma barriers.
- Pathways to Strengthening Services:** Integrate eye care into primary health and education systems, expand tele-optometry, train teachers and community health workers, subsidize spectacles, provide mobile and refugee services, and institutionalize citizen-led innovations to improve access, equity, and progress toward Universal Health Coverage.

The Global State of Vision

The World Health Organization (WHO) recognizes uncorrected refractive error (URE) as the **primary cause of vision impairment (VI)**, the **second cause of blindness**, and the **largest unaddressed disability worldwide**.³

Two sets of research estimate **global prevalence of poor vision** caused by URE (URE includes myopia, hyperopia, astigmatism and presbyopia. It results in reduced visual acuity, leading to blurred vision and, when severe, visual impairment).⁴ **-1.1 billion** people live with **avoidable VI** (WHO; visual acuity cut-off 6/12)³, and **2.7 billion** or **1 in 3 people** have URE (Essilor; visual acuity cut-off 6/9)⁵.

 **Vision impairment costs the global economy US\$411 billion** in yearly **productivity losses**.⁶

Without action, **half the global population**, roughly **4.8 billion**, is set to have a VI, primarily myopia, by **2050**.⁶

Over 90% of VI cases are **preventable**, and/or **treatable** with existing, cost-effective interventions.⁶ Globally, only 36% of people with distance VI due to refractive error (RE) have access to the appropriate care they need.⁷

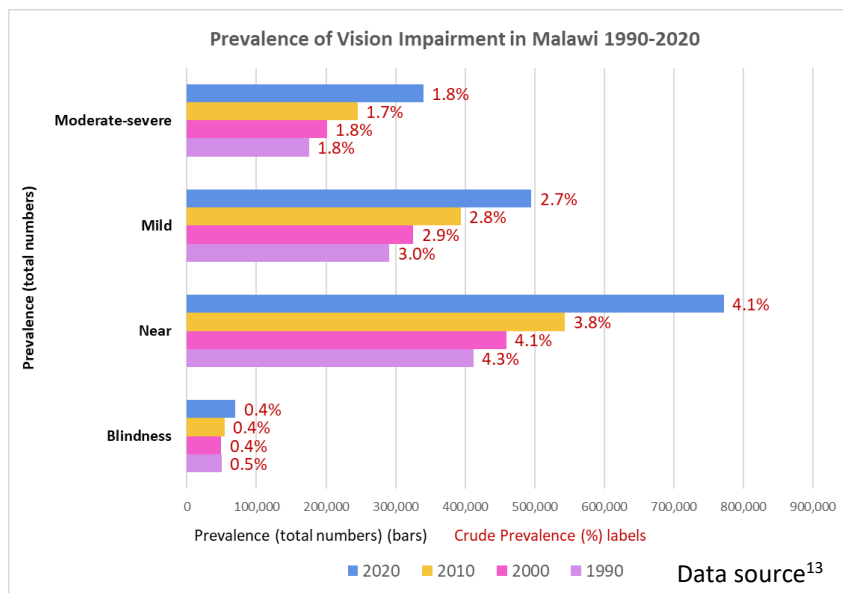
 With this baseline (36%), the 74th World Health Assembly (WHA) endorsed a global target for a **40% increase in effective coverage of refractive errors (eREC)** by 2030.⁸

The **WHO SPECS 2030 Initiative**⁹, building on WHA¹⁰/UNGA¹¹ resolutions, particularly the eREC target, assists countries and stakeholders in addressing the unmet need for spectacles while ensuring the delivery of **quality eye care**.

SPECS 2030 World Health Organization initiative

Vision Needs in Malawi (Research Studies)

- In **2022**, **31%** (over 6.3 people) of Malawi required vision correction. Among them, **over 87%** (over 5.5 million people) have **uncorrected poor vision**.¹²



- In 2020, total VI (near, mild, moderate-severe) was 1,606,642 - an increase from 2010 - 2020 by 35.9%, and an increase from 1990 - 2020 by 83.1%.¹³
- 2025:** A child vision clinic in Mzuzu served 2,054 children (2022–2024); 18% received glasses, with 77.8% uptake. Key challenges: lack of inclusive education admission policies, myths, and limited teacher–provider referrals.¹⁴
- 2024:** (i) Elderly patients at a private Mzuzu facility showed refractive error as the most common condition (40.4%), followed by cataract (25%).¹⁵ (ii) Nationally (2019–2020) 60.6% individuals with eye problems sought care. Higher use among educated, males, urban, middle-aged. Regional use: South 74.8%, Central 50.4%, North 42.7%. Care sources: 85.6% government, 7.9% private. Among non-users, 46.5% lacked funds, 53.5% felt problem was minor.¹⁶ (iii) Southwest Malawi VI prevalence was 2.6%, severe VI 2.5% (~11,300), mainly cataract; spectacle use was low (1.2% distance, 5.3% near). Early VI was mainly due to refractive error (46.9%).¹⁷
- 2023:** (i) Central Malawi primary schools rarely tested vision; distrust, lack of eye health education, high spectacle cost, and stigma hindered uptake.¹⁸ (ii) Half of visually impaired ≥40 years need presbyopia correction.¹⁹

(1) World Bank Group. (2024). Malawi | Data. Worldbank.org; The World Bank Group. <https://data.worldbank.org/country/malawi> (2) World Population Review. (2024). Human Development Index (HDI) by Country 2024. World Population Review. <https://worldpopulationreview.com/country-rankings/hdi-by-country> (3) World Health Organization. (2019, October 8). World report on vision. <https://www.who.int/geneva/world-report-on-vision> (4) WHO TEAM Noncommunicable Diseases. (2013, October 6). Blindness and vision impairment: Refractive errors. <https://www.who.int/news-room/questions-and-answers/item/blindness-and-vision-impairment-refractive-errors> (5) Burton, MJ, Ramke, J, Marques, AP, Bourne, RRA, Congdon, N, Jones, I, et al. The Lancet Global Health Commission on Global Eye Health: Vision beyond 2020. [https://doi.org/10.1016/S2214-109X\(20\)30488-5](https://doi.org/10.1016/S2214-109X(20)30488-5) (6) Essilor. (2019, November 5). Eliminating Poor Vision in a Generation. What Will It Take To Eliminate Uncorrected Refractive Errors by 2050? The OneSight EssilorLuxottica Foundation. <https://onesight.essilorluxottica.com/research/eliminate-poor-vision-by-2050/> (7) World Health Organization. (2022). Report of the 2030 targets on effective coverage of eye care. World Health Organization. <https://iris.who.int/handle/10665/363158> (8) World Health Organization. (2021). Integrated people-centred eye care, including preventable vision impairment and blindness Global targets for 2030 Draft decision. In World Health Organization. https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_9Add3-en.pdf (9) World Health Organization. (n.d.). SPECS 2030. <http://www.who.int/initiatives/specs-2030> (10) Resolution WHA73.4. Integrated people-centred eye care, including preventable vision impairment and blindness. In: Seventy-third World Health Assembly, Geneva, 3 August 2020. Geneva: World Health Organization; 2020. https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R4-en.pdf (11) United Nations General Assembly Resolution A/75/L.108 – Vision for Everyone; accelerating action to achieve the Sustainable Development Goals, 6 July 2021. New York: United Nations; 2021. <https://www.undocs.org/en/A/75/L.108> (12) OneSight EssilorLuxottica Foundation data (13) IAPB. (2025, April 23). Country Data - Malawi - IAPB Vision Atlas. IAPB Vision Atlas; The International Agency for the Prevention of Blindness. <https://visionatlas.iapb.org/country-data/malawi/> (14) Kalua, K, Solomoni, E, Mkwandawire, H, Chitimbwe, T, Mopamboli, P, Manda, C, et al. (2025). Advancing Global Eye Health: Progress and Insights from the Child Blindness and Low Vision Program in Northern Malawi, Southern Africa. Research Square [Preprint]. <https://doi.org/10.21203/rs.3.rs-5944251/v1> (15) Banda, O, Ogbonna, G, & Mzumara, T. (2024). Ophthalmological conditions among elderly patients attending a private eye care facility in Malawi: A retrospective study. Health Science Reports, 7(5). <https://doi.org/10.1002/hsr2.2112> (16) Mzumara, T, Kantaris, M, & Afonne, J. (2024). Eye Care Service Use and Associated Health-Seeking Behaviors Among Malawian Adults: Secondary Analysis of the Malawi Fifth Integrated Household Survey 2019-2020. JMIR Med, 5(1), e44381. <https://doi.org/10.2196/44381> (17) Mdala, S, Kalua, K, Pye, S, Adera, T, Jolley, E, Zungu, T, et al. (2024). Rapid assessment of avoidable blindness in south west zone, Malawi 2023. <https://research.sightsavers.org/wp-content/uploads/2024/07/Sightsavers-research-south-west-zone-malawi-2023.pdf> (18) Yashadhana, A, Lee, L, Serova, N, Nthete, E, & Burnett, A. M. (2023). Access to school-based eye health programs in Central Region, Malawi: a qualitative case study. Health Promotion International, 38(2). <https://doi.org/10.1093/heapro/daad002>

- **2019:** Among schoolchildren, VI was 2.2%, RE 3.4%. Only 53.5% of children wore glasses as prescribed mainly due to parental disapproval and the belief that regular wear is not needed.²⁰
- **2016:** (i) Decreased Visual Acuity in school-aged children (4-18 years) was 4% (rural Erukweni 5.8%, urban Mzuzu 1.8%). Amblyopia and uncorrected RE were the major causes of visual decrease.²¹ (ii) In Dzaleka refugee camp, among 635 screened; VI was 5.4%, blindness was 1.3% of which >90% were avoidable; >50% of individuals had RE/presbyopia; only 5% had prior exams.²²

Health System in Malawi

- Malawi's decentralized health system has²³ 28 District Health Offices²⁴ managing local policy, resources, and implementation. The country aims for Universal Health Coverage (UHC), but rural access is limited, and most pay out-of-pocket with no universal insurance. The government partners with the Christian Health Association of Malawi (35% of facilities) via Service Level Agreements to expand rural access and remove user fees; initial gains in equity and service use declined due to weak planning and resource gaps.²³ Nationwide, fewer than 300 doctors and ~7,000 nurses serve all three tiers of care.²⁴
- Government health services are free¹⁹ per the constitution, guided by the Health Sector Strategic Plan II and National Community Health Strategy, offering a basic package, but constrained by health workforce shortages (1.48/1,000) and limited rural access non-state actors provide ~29% of services²⁵; the UHC service coverage index is 48/100.²⁶
- Migrants, refugees, and rural populations face access challenges.²² Over 57,000 refugees in Dzaleka camp (from DRC, Rwanda, Somalia, Burundi, Ethiopia) face overcrowding and limited health care access.²⁷

Vision Care in Malawi

- Eye health personnel per million (2019): 1 ophthalmologist²⁸, 5 optometrists²⁹, 7 allied personnel.³⁰ VI and avoidable blindness cause US\$32M annual productivity loss (ages 50–64).³¹ 12,115 school years lost from URE, and 72% income gain expected if corrected at age 5.³² Estimated 51–75% of school-age children receive periodic eye screening.³³ School-based eye programs in Central Malawi face funding, personnel, infrastructure, high spectacle cost, poor access, and stigma barriers.¹⁸
- Free eye exams and treatment for conjunctivitis, trachoma, injury, and cataract are offered via Malawi's UHC Essential Health Package.³⁴ Limited refractive services come from public-private-NGO partnerships.¹⁸ Eye care is guided by policy and outdated National Eye Health Plan (2017-2022); services are integrated but gaps persist, with limited outcome data and outdated eREC data. ECSAT was used in 2023.³³ Assistive technology is covered by legislation but lacks public funding.³⁵ Disability-inclusive primary school grants exist but are limited.³⁶
- Rural areas (70% population) lack transport, EHP funding, and outreach for follow-up eye care. With 50.7% below poverty line, US\$20¹⁸–25³³ spectacles are largely unaffordable. Willingness to pay is 500–3500 MWK (US\$0.70–4.80).¹⁸ Public healthcare does not provide glasses because of a lack of local manufacturing and supply of eye health products and technologies.¹⁹ Referral pathways are unclear, and NGO glasses are often poorly fitted.¹⁸ Dzaleka Health Centre provides care to refugees and locals but lacks eye services; patients referred 30 km to Dowa District Hospital or Lions Sight First Eye Hospital; eye health status and need data is limited.²²
- **Professional Bodies and Associations:** Ophthalmological Society of Malawi (OSM); [Medical Council of Malawi](#); [Medical Association of Malawi](#); [Malawi Optometry Association](#) (MOA).

Key Recommendations from Evidence

- Operational plans aligned with the national eye care strategy exist but remain unimplemented. Integrating eye care into primary health services and using updated eREC data can guide planning. The 2023 ESCAT identified gaps in leadership, access, workforce, data, and financing. Strengthening the workforce through targeted, country-specific training is essential.³³
- Teachers and community health workers can deliver screenings if trained. Raising awareness of vision's impact on learning, addressing stigma, improving inter-ministerial coordination, and ensuring affordable spectacles can enhance children's eye care.¹⁸ Integrate eye health into education and health systems via early assessments, policy support, and sustainable services.¹⁴
- Social support, women empowerment, awareness for literate, illiterate, and disadvantaged groups, plus mobile clinics for older adults and rural areas, can expand eye care access.¹⁶ Comprehensive services, including refractive and cataract care, and education should reach refugee camps.²² Expand tele-optometry, include glasses in elderly social-security programs,¹⁵ and, scaling innovations like CCPF can strengthen equitable eye care and advance universal health coverage.²⁵
- The World Health Assembly set a [global target](#) of a 40% increase in effective refractive error coverage (eREC).³⁷ The [WHO SPECS 2030](#) Initiative is a global framework aimed at supporting Member States to achieve this target through 5 strategic pillars; (s)ervices, (p)ersonnel, (e)ducation, (c)ost, and (s)urveillance and research.³⁸

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