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ADVOCACY FACT SHEET

Kenya Overview

Population 55.3 million[1] - Middle income[2] - HDI 0.601[3] - GDP USD 108.04 billion / KES 15.11 trillion[1]

1. **Millions Underserved, Children at Risk**: Over 16.7 million Kenyans need vision correction, yet 87% remain uncorrected. Uncorrected refractive error (URE) is the leading cause of visual impairment (VI), with affordability, stigma, and lack of access as major barriers. URE affects 86,000 children and adolescents with significant impact on learning.
2. **Systemic Gaps Limit Access**: Kenya's health system is evolving, with major reforms aimed at Universal Health Coverage. Yet only 19.1% have insurance, with stark disparities by income, gender, and geography. Eye care is particularly underserved—71% of the population lives in rural areas where professionals are scarce. Spectacles remain uncovered by public insurance.
3. **Urgent Action for Equity**: Efforts must focus on affordable spectacles, integration of eye care into primary health care, equitable workforce distribution, data-driven planning, and targeted policies to close the access gap.

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]

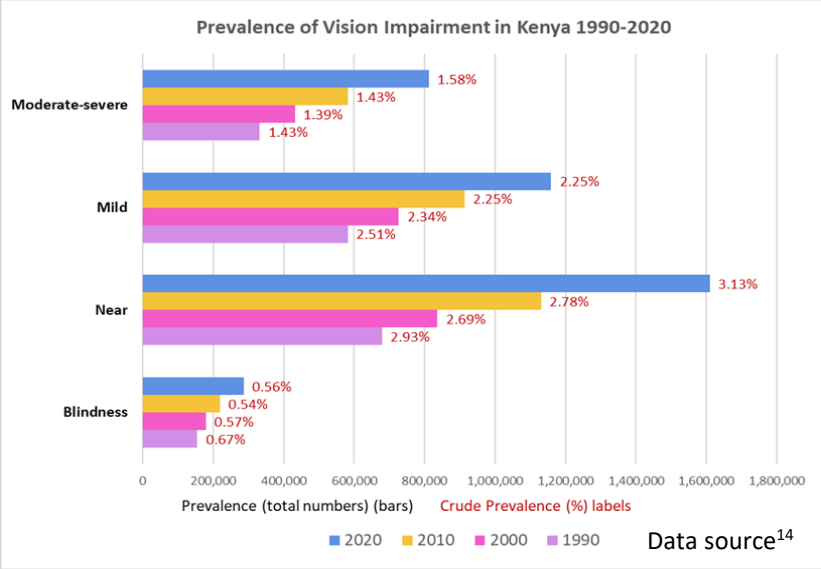
40% eREC

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 WHA[10]/UNGA[11] resolutions, particularly the eREC target, assists countries and stakeholders in addressing the unmet need for spectacles while ensuring the delivery of quality eye care.

Vision Needs in Kenya (Research Studies)

- **In 2022, 31%** (over 16.7 million) of Kenya required vision correction. Among them, **nearly 87.1%** (over 14.6 million) have **uncorrected poor vision**.[13]



- In 2020, total VI (near, mild, moderate-severe) was 3,580,051 - an increase from 2010 - 2020 by 30.7%, and an increase from 1990 - 2020 by 76.8%.[14]
- **2024**: Around 86,000 Kenyan children and adolescents experience vision problems due to URE. One year of sub-optimal learning from URE costs Kenya 14.8 billion KES every year.[15]
- **2024**: In rural Kakamega, VI among schoolchildren (8–14 years) was 1.26%, with 76.2% due to URE.[16]
- **2024**: In Kakamega Municipality, affordability (18.3%) was the main barrier to spectacle use, followed by availability, and accessibility of refractive services.[17]
- **2024**: Estimated lost productivity to GDP from URE is about US$ 671,455,575 - US$ 1,044,486,450 annually for those 16–60 years.[18]
- **2023**: Among schoolchildren in Kakamega County, research findings showed a significantly better quality of life in the URE group after spectacle correction.[19]
- **2022**: URE is the leading cause of VI in schoolchildren. Economic status affects spectacle access, especially among public-school parents.[20]
- **2020**: VI affects 2.4% of children aged 5–16. The main cause is URE (62%).[21]
- **2020**: 15.5% Kenyans need quality eye care.[22] <25% of them have access.[23,24]
- **2016**: Among Nairobi high school students, only 39% had a previous eye exam. Among 30.7% advised to wear spectacles previously, only 10.5% complied. Barriers to use include stigma/teasing, cost, misinformation, and limited school screenings.[25]
- **2013**: Among 4,414 ≥50 years in Nakuru, RE caused 51.7% of VI, with myopia (59.5% of RE) more common than hyperopia (27.4%).[26]

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Health System in Kenya

- Kenya's health system is governed by the Ministry of Health (MOH) and delivered at the county level, funded by the government (40%), households (31%), and other (29%). Only 19.1% of Kenyans have insurance, and cost remains a barrier, with 12.7% not seeking treatment.[22] The Social Health Insurance Fund (SHIF) [27] replaced NHIF in 2023[28], expanding coverage to informal sector workers.[29]
- 70% of health services are public, with significant support from donors. UHC aims to expand service access, strengthen primary care, and digitize operations.[30] Despite progress in increasing the health workforce, Kenya faces a 32% shortfall in meeting SDG health worker density.[31]
- 74% of Kenyans live in rural areas with limited access to health services.[32] Only 13% of households receive free care, and 32 out of 47 counties have insurance coverage below 20%.[33] Kenya hosts over 800,000 refugees[34], many with VI (44% in urban areas)[35]. Barriers to healthcare access include cost, lack of documentation, and language issues.[36] 2021 Refugee Act implementation can grant expanded rights, including health registration with SHIF.[37] Disabled face healthcare barriers, with half unable to access services.[38]

Vision Care in Kenya

- Total no. / No. per million: Ophthalmologists - 120 / 1[14]; Optometrists: 704 / 12.5 (2024); Allied ophthalmic personnel: 410 / 8 (2019)[14]
- The National Eye Health Strategy (2020-2025) aims to integrate eye care into the health system but faces challenges, including inadequate human resources and underfunding of refractive services. Public insurance covers treatments and surgeries but excludes spectacles and low-vision aids, despite[22] spectacles being considered a medical device.[39]
- The cost of eye exams and spectacles is a significant barrier[17], with spectacle affordability (between KSh2000-KSh5000+) being below the cheapest available (Kshs.5000+).[17]
- Kenya has 1,091 eye care professionals[40] for a population of 55.3 million[1], with urban-rural disparities.[40] 58% of ophthalmologists are in Nairobi, 55% in the public sector, and refractive services are poorly regulated[22] and fragmented, with urban and private sector concentration.[41]
- Investing in eye care could require US$ 246.8M for corrective devices, US$ 108.3M for refractionist training, and US$ 39.8M for vision centers, with annual productivity gains at US$ 41.1M, and total returns nearly US$ 1.4B.[18] Mobile clinics[42], technology[43,44,45,46] and collaborations[43,44,45,46,47] like the Vision Impact Project[48] are improving access, particularly in rural areas.[46] Convenings like the KNOW (Kenya National Ophthalmic Workers) conference, bring together eye-care workers from all 47 counties[49] to advance quality refractive care coverage.
- **Professional Bodies and Associations:** The College of Ophthalmology of Eastern, Central and Southern Africa (COECSA); Optometrists Association of Kenya (OAK); Kenya Association of Opticians (KAO); The Ophthalmological Society of Kenya (OSK)

Key Recommendations from Evidence

- Improving access through integrated social enterprises, Teleoptometry, and cross-subsidization; strengthening public-private-NGO partnerships for affordability; expanding training for primary vision technicians; and establishing vision centers in public health facilities for underserved populations.[50]
- Implementing School Eye Health interventions to enhance early detection[16,25,51], support academic success, and raise awareness.[16] Task-shifting, by training school nurses and teachers for basic eye screenings to help address personnel shortages.[25, 52, 53, 54, 55] Educating pediatricians to improve their knowledge of pediatric eye diseases.[56]
- Providing affordable low-vision devices, quality spectacles, and presbyopic correction to increase refractive care coverage.[22]
- Collecting sociodemographic data for equitable access.[24]
- Increasing funding for national eye care services in refugee-hosting areas.[35]
- Tackling affordability, ensuring the government integrate refractive services into public hospitals to offer lower rates in the public scheme.[17]
- Enhancing equity in Kenya's health reforms, including informal workers via cooperative-based premiums, ensuring fund transparency, building SHIF support, and prioritizing health equity.[s7]
- The World Health Assembly set a global target of a 40% increase in effective refractive error coverage (eREC).[58] 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.[59]

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