June 2025

ONESIGHT
EssilorLuxottica Foundation

ADVOCACY FACT SHEET

Zambia Overview

Population 20.7 million [1] - Lower middle income[1] - HDI 0.569[2] - GDP USD 27.58 billion / ZMW 557.41 billion[1]

1. **Urgent Need - High Vision Impairment and Low Specialist Density**: Over 6.2 million Zambians (31% of the population) need vision correction, of whom 87% (5.4 million) have uncorrected poor vision. Yet there are only 1.9 ophthalmologists per million serving the country.
2. **Inequitable Access - Rural, Youth, and Refugee Barriers:** Rural populations, schoolchildren, and refugees face major barriers to eye care due to poverty, limited screenings, low spectacle availability, high out-of-pocket costs, and a shortage of trained personnel.
3. **Path Forward:** Integrate school-based eye health into national programs, scale up workforce training, and implement the WHO SPECS 2030 Initiative to address gaps in refractive services, data systems, and long-term sustainability.

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

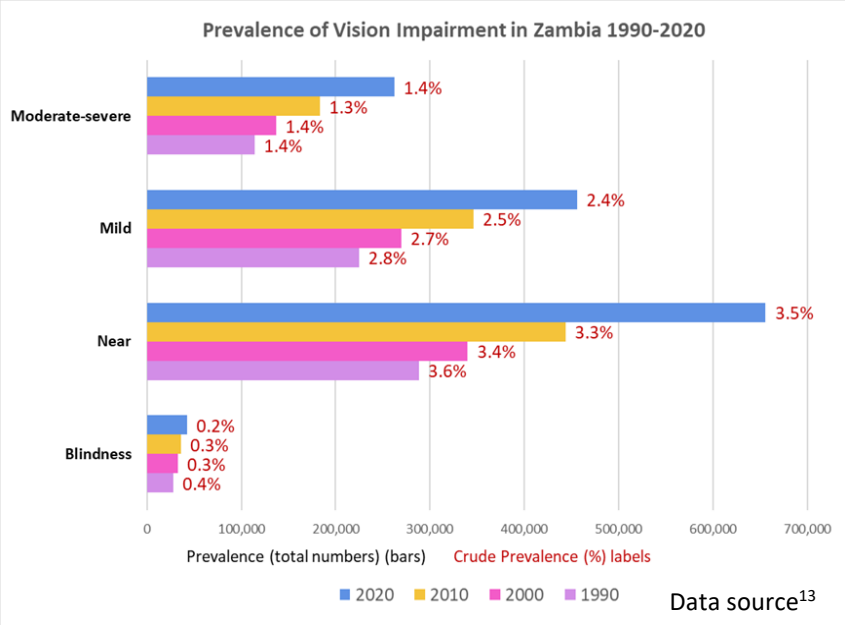
With this baseline (36%), the 74th World Health Assembly (WHA) endorsed a global target for a **40% increase in effective coverage of refractive errors (eREC)** by 2030.[8]

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.

SPECS 2030 | World Health Organization initiative

Vision Needs in Zambia (Research Studies)

- **In 2022, 31%** (nearly 6.21 million people) of Zambia required vision correction. **Over 87%** (over 5.40 million people) of them have ***uncorrected*** **poor vision**[12].



Data source[13]

- In 2020, total VI (near, mild, moderate-severe) was 1,374,537- an increase from 2010 - 2020 by 41%, and an increase from 1990 - 2020 by 119%[13].
- **2025**: High VI prevalence demonstrated among children; ~50,000 in need of refractive services. Spectacle compliance was low (17%) and only 59% of referred children visited the mobile clinic due to seasonal barriers. Awareness improved post-intervention, but parent and teacher knowledge were limited[14].
- **2023**: In Kafue district, a school-based eye health pilot found 20% of children had unmet needs. The program trains teachers, uses mobile clinics, and requires stronger community support for sustainable scaling[15].
- **2022**: In Zimba, 1.33% of 676 schoolchildren had visual acuity impairment; 55.56% had mild VI, and 22.22% were blind[16].
- **2022**: Approximately 50,000 Zambian children were in need of vision correction. School programs boosted awareness and spectacle access through screenings and sensitization. Local health workers are skilled, and integrating services into existing programs could cut costs[17].
- **2020**: In Kafue, 20.9% of students had eye diseases, mostly allergic conjunctivitis (17%) and RE (3.3%). Among those with RE, 66.9% had myopia,

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12.7% hypermetropia, and 20.4% myopic astigmatism. The study Indicates a substantial portion of vision problems were significant and uncorrected, and urban learners were more affected, underscoring the need for national/school screening and education[18].

Health System in Zambia

- Zambia's NHIS (2018), mandatory for citizens and residents, aims to reduce catastrophic spending and provide comprehensive care.[19] While primary healthcare is free for locals and refugees, refugees are excluded from NHIS benefits[20] and face access barriers like discrimination, documentation issues, and under-resourced facilities[21].
- The 2022–2026 National Health Strategic Plan prioritizes decentralized care and workforce expansion[22]. Health worker density improved to 15 per 10,000 by 2023 (from 8 in 2011)[23], but shortages remain[24]. National initiatives like the Hilti Foundation's nurse training program aim to address rural workforce gaps by 2026[25].
- Healthcare is delivered through a three-tier system[26], with services delivered through hospitals and regional health centers and posts[15], but many bypass primary care due to perceived quality gaps, convenience, and stigma[26]. Zambia faces funding constraints, high debt[27], and rural-urban inequities[20,26] (Gini index 51.5)[28], all which challenge progress toward universal health coverage[27].

Vision Care in Zambia

- Zambia has one of the lowest GDPs, with 75% of the population living in poverty. In 2022, only 38 ophthalmologists served 17 million people, contributing to high blindness rates[29]. In 2011, there were just 191 full-time eye health workers, including 150 community eye workers from NGOs. Spectacle access in rural areas was mainly through donations and outreach[30]. Eye health personnel per million: 1.9 ophthalmologists (2019), 3.4 optometrists (2019), and 10 allied staff (2014). Despite a national eye care strategy, integration into broader health programs remains limited[13].
- In Zambia, URE causes US$42M in annual economic losses and 8,250 years of lost schooling. Correcting vision at age five could boost income by 86%[13]. Refractive correction is highly cost-effective at US$375/QALY but hampered by system constraints[31]. Fewer than 25% of school-age children receive routine screening. Spectacles cost $35 (public) and $55 (private), limiting access[13].
- USAID's REACH initiative with CHAI, Sightsavers, and Zambia Federation of Disability Organizations seeks to improve access. Zambia has had mobile outreach since 2002, but further community engagement and integration with primary care are needed[32]. A 2014 VISION 2020 evaluation cited major gaps in HR, equipment, and urban–rural access[33]. Eye care integration by MOH and Operation Eyesight[34] improved demand, screening[35], training, primary health integration, community engagement and infrastructure[34]. The University Teaching Hospital in Lusaka strengthens specialist training[29]. Access[36] and availability[37] gaps persist due to limited funding, equipment, and staffing[36,37], as well as low spectacle dispensing despite recent service delivery improvements; findings are only of surveyed facilities receiving external support[37]. NGOs like Vision Action, Specsavers[38], Orbis[39] and OneSight[40] support school and primary eyecare[38].
- Professional Bodies and Associations: Zambia Association of Optometry; Zambia Ophthalmological Society (ZOS)

Key Recommendations from Evidence

- Investing in the health workforce[24] through incentives, especially in rural areas[41], and financing additional staff can improve care quality[24]. Vision screening programs can help governments identify, treat, and reduce visual issues in schoolchildren[42]. National school screenings, targeted prevalence studies (especially for younger children), and early detection and treatment services are critical[43]. Integrating school-based eye health into existing programs, ensuring steady government funding, adapting scale-up pace to local contexts, and strengthening political commitment are essential[17]. Persistent challenges like low spectacle compliance and referral uptake must be addressed, including parental concerns. Sustainable screening and community engagement can secure long-term gains in low resource settings[14]. Eye health must be fully integrated into the health system and across sectors. Updated data on URE prevalence, refractive error coverage, and spectacle access is vital for targeted planning. Full national coverage is still needed to ensure equitable access to care[13].
- The World Health Assembly set a global target of a 40% increase in effective refractive error coverage (eREC) [44]. 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[45].

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