

ADVOCACY FACT SHEET

South Africa Overview



Population 63.2 million¹ - Upper-middle Income¹ - HDI 0.717² - GDP USD 380.7 Billion USD¹

- Vision Needs:** In 2022, around 42% of South Africans needed vision correction, with over 13.2 million experiencing uncorrected vision impairment. School-based studies reveal high levels of undetected vision issues, especially myopia in older children and presbyopia among adults, highlighting widespread unmet needs.
- Access and Barriers:** Access is severely constrained by high out-of-pocket costs, a fragmented public eye care system, and uneven distribution of optometrists—particularly in rural and low-income areas. Stigma, cost, and lack of awareness also deter many from seeking care, despite widespread need.
- Action and Recommendations:** A revised national eye care plan is critical to modernize policy, expand access to spectacles, and prioritize screening in schools. Expanding the public optometry workforce, strengthening rural outreach, and implementing equitable financing models can bridge gaps and reduce disparities.

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



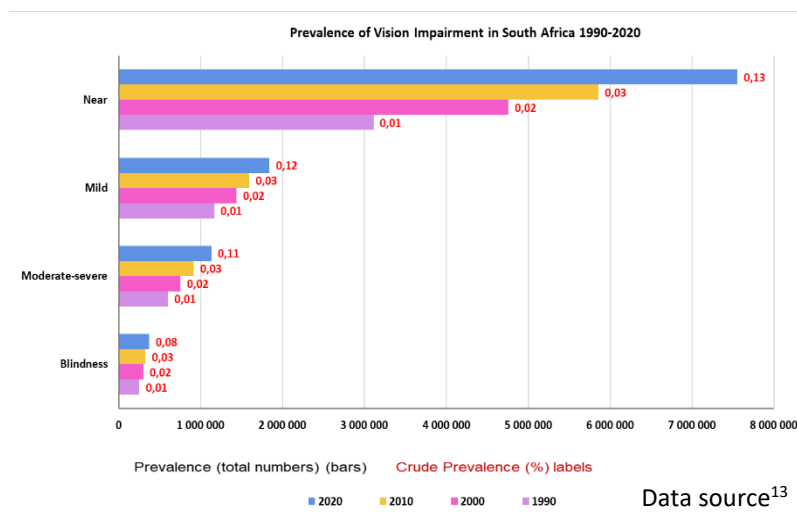
With this baseline (36%), the 74th World Health Assembly (WHA) endorsed a global target for a **40% increase in effective coverage of refractive errors (eREC)** by 2030.⁸

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**.



Vision Needs in South Africa (Research Studies)

- In 2022, **42% (over 25.2 million people)** of South Africa required vision correction. Among them, over **52% (over 13.2 million people)** have uncorrected poor vision.¹²



- In **2020**, over 10.5 million people were living with VI, including near, mild, and moderate-severe cases—a 25.8% increase since 2010 and a 115.8% rise since 1990, more than doubling the VI burden in 30 years.¹³
- 2024:** As part of the Sub-Saharan Africa region, South Africa shares the third highest global burden of URE-related blindness among adults aged 50+, with prevalence of blindness at 0.11% (higher in men) and moderate to severe VI at 3.16% (higher in women).¹⁴
- A **2022** university-based study reported that although 95% of students understood that spectacles could correct poor vision, only 46% of those advised to wear glasses used them; barriers included cost, aesthetics and stigma.¹⁵
- A **2020** school-based study in Limpopo found a 12.3% prevalence of VI among children aged 6-18 years, with 80% attributable to URE and higher prevalence among older children. Myopia was the most prevalent refractive condition.¹⁶
- A **2016** population-based study in KwaZulu-Natal reported a 57.3% prevalence of URE in adults aged 35-90 years, with 37.7% hyperopia and 11.4% myopia.¹⁷
- A 2013 community-based study in KwaZulu-Natal found presbyopia in 77% of adults aged 35+, with only 4.8% spectacle coverage, highlighting an extensive unmet need.¹⁸

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Health System in South Africa

- **Dual healthcare system:** South Africa operates a dual healthcare system—a severely under-resourced public sector serving over 80% of the population, and a well-funded private sector for the insured minority. Public primary care, including for refugees and asylum seekers, is free, but public facilities face overcrowding, staff shortages, and weak infrastructure such as poorly maintained buildings and equipment.¹⁹
- **Decentralized System:** The system is decentralized across national, provincial, and district levels, with poor coordination, underfunded district management, and uneven resource distribution resulting in fragmented service delivery.^{19,20}
- **Health workforce shortages,** particularly in rural and public settings, are intensified by emigration, ineffective retention strategies, and limited training capacity, which places additional strain on services.²¹
- **Healthcare priorities and access disparities:** South Africa faces a "quadruple burden of disease," - HIV/AIDS and Tuberculosis, maternal and child mortality, rising non-communicable diseases, and trauma-related injuries. These overlapping challenges overload the system. Despite equity-focused policies, rural and low-income groups face barriers such as long travel distances, extended wait times, and poor service availability.²²

Vision Care in South Africa

- **Services and workforce distribution:** Vision care is provided through a three-tiered public healthcare system and an active private sector.²³ As of April 2025, there are 4,542 registered optometrists, 168 dispensing opticians, and 8 orthoptists, with 604 ophthalmologists as of September 2024.²⁴ However, most professionals work in private practice, causing maldistribution and restricted access in rural and low-income areas.²⁵
- **Access and affordability barriers:** Public sector services are strained by long waiting periods²⁶, procurement inefficiencies and budget constraints²⁷. While tests are free in the public sector, the cost of spectacles is borne by patients in most cases.²⁸ In the private sector, services and corrective devices like spectacles are largely self-funded or covered by private medical aid, with varied coverage. For uninsured patients, full out-of-pocket payment restricts access, especially for lower-income groups.²⁹
- **Utilization and systemic gaps:** Almost 75% of South Africans do not access eye care services, due to cost, limited availability, stigma, and lack of awareness.²⁷ School-based screening, is part of national policy, but remains sporadically implemented.³⁰ The 2003, National Eye Care Guideline³¹ is outdated and misaligned with current needs and global frameworks³². Cost remains a major barrier despite the Uniform Patient Fee Schedule (UPFS) governing public hospital payments, limiting equitable access to eye care.^{33, 34}
- **Professional Bodies and Associations:** [South African Optometric Association](#), [Health Professions Council of South Africa](#), [Ophthalmological Society of South Africa](#), [Ocularists Association of Southern Africa](#), [South African Society of Paediatric Ophthalmology and Strabismus](#), [Blind SA](#), [South African National Council for the Blind](#), [South African Guide-Dogs Association](#), [Retina South Africa](#), [African Eye Institute](#).

Action and Policy

- **Develop a revised national eye care plan** by replacing 2003 guideline with a new with a new policy aligned to current epidemiological needs and global frameworks (e.g., WHO IPEC and SPECS 2030).³²
- **Expand and retain the public sector eye health workforce** by expanding training capacity, increasing public sector posts, improving rural placements, and implementing retention strategies to address attrition and maldistribution.²⁵
- **Institutionalize and scale school-based vision screening** through full implementation of the Integrated School Health Policy, with routine monitoring and equitable coverage. Leverage public-private partnerships to extend reach, particularly given the high number of optometrists.³⁰
- **Improve affordability and public awareness** by enhancing subsidies under mechanisms like the UPFS, supporting NGO-led delivery models, and introducing fee exemptions for vulnerable groups. Launch campaigns to raise awareness and improve health-seeking behaviors among underserved populations.^{31, 34}
- **Engage private health financing schemes** by collaborating with insurers and regulators to introduce minimum vision care benefits in medical schemes and promoting equitable access through private channels.³⁵
- The World Health Assembly set a [global target](#) of a 40% increase in effective refractive error coverage (eREC).³⁶ 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.³⁷

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