



HOLD MY HAND
POLICY BRIEF SERIES

Seeing to learn:

Scaling eye health and vision screening

Prioritising early detection and intervention
through schools, ECD centres and communities

■ OCTOBER 2026



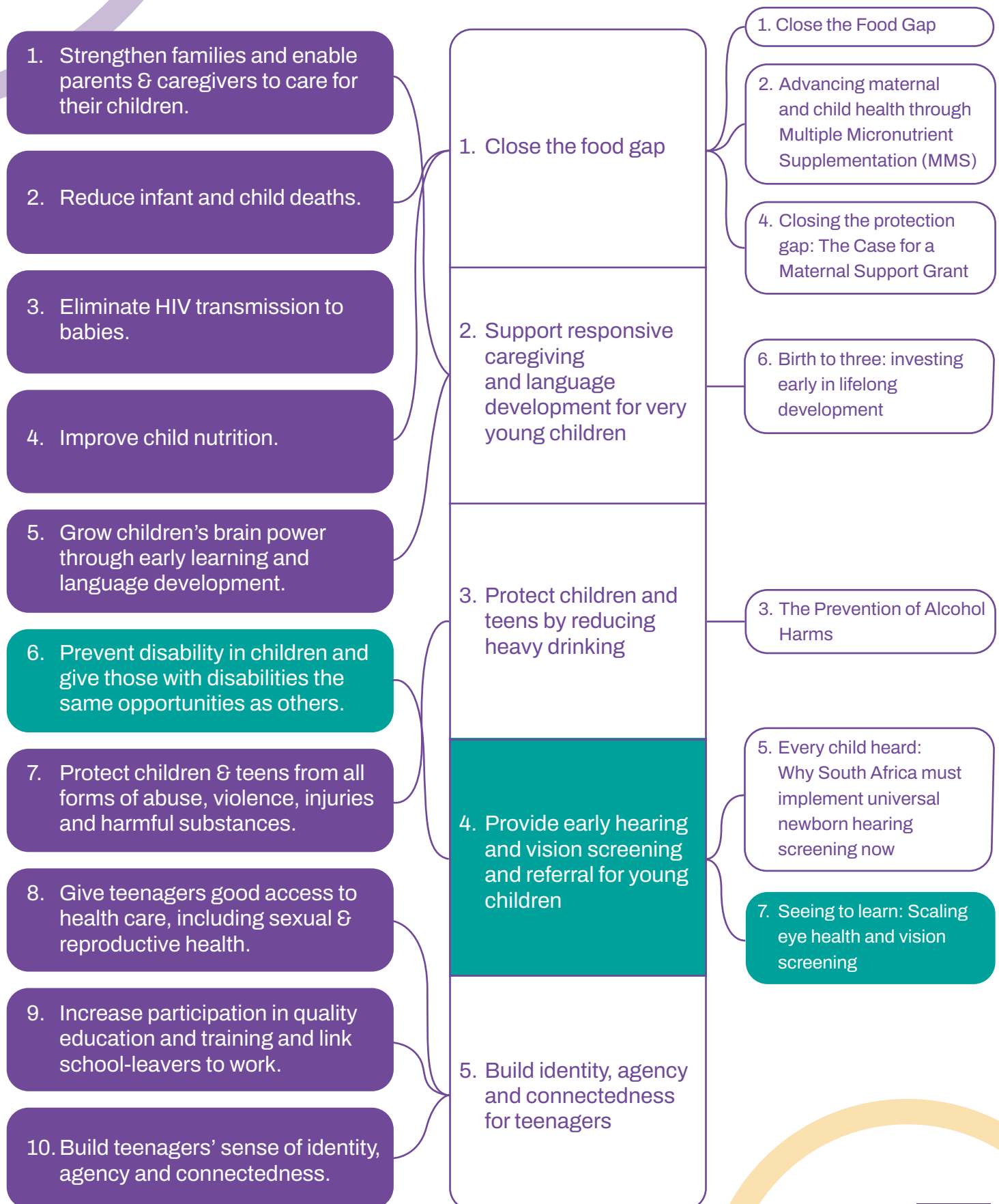
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NSAAC's ten priorities to accelerate progress for children and teenagers

The Accelerators

Five Initial Strategies

Policy Briefs



Hold My Hand Accelerator

Every day, 3 000 children are born in South Africa, which equates to 1 million every year whose childhood experiences will shape both their future and the nation's. Ensuring they thrive would unlock massive opportunities – a stronger economy and a safer, happier society. Global experience shows that progress accelerates when the president leads, society unites behind a national programme for children, and a dedicated, energetic organisation drives action. This is the logic behind the National Strategy to Accelerate Action for Children, led by the Presidency and the Department of Social Development. The Strategy identifies 10 key priorities and calls for broad partnerships across government, civil society, trade unions and the private sector.

A key mechanism is the Accelerator for Children and Teens, established through a partnership between the Presidency and DGMT. It fast-tracks critical strategies that require public-private collaboration, focusing on closing the food gap, supporting responsive caregiving and language development for very young children, protecting children and teens by reducing heavy drinking, providing early hearing and vision screenings and referrals for young children and building identity, agency and connectedness for teenagers.

A series of policy briefs is being developed to support this work.

POLICY BRIEF SERIES

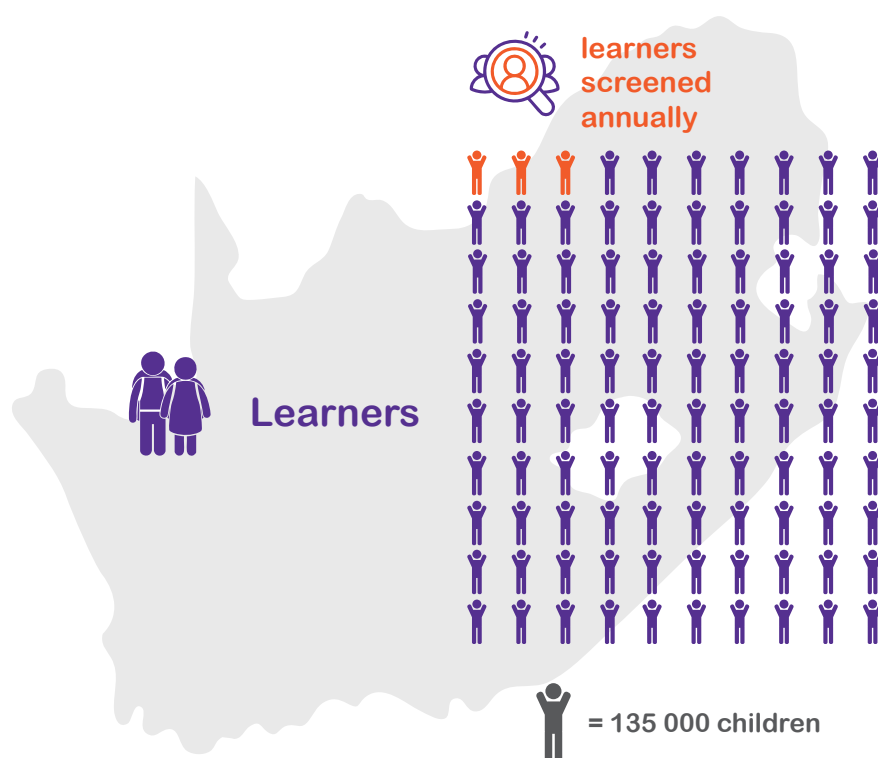
Glossary of key terms	
Eye health screening	A quick visual check of a child's eyes to identify obvious signs of eye disease or abnormalities, such as redness, discharge or ocular misalignment.
Designated screener	A trained non-optometrist who conducts eye health and vision screening and refers children who require further assessment, for example a nurse, community health worker or trained non-clinical worker.
Integrated School Health Programme (ISHP)	South Africa's national policy framework for delivering health services to learners through schools, including screening, health education and promotion and referrals.
Optometrist	An eye-care professional who assesses vision, eye health and eye function, diagnoses refractive errors and prescribes spectacles.
Red flags	Visible signs that a child may have an eye condition requiring further assessment, such as ocular misalignment, discharge or a white pupil reflex.
Referral pathway	The process that links screening to diagnosis, treatment and spectacle provision for children who need further care.
Refractive error	A common cause of blurred vision that occurs when light does not focus properly in the eye. It is usually corrected with spectacles.
Task-sharing	The delegation of specific tasks to trained non-specialists, allowing specialised professionals to focus on more complex services.
Vision screening	A simple test that checks how clearly a child can see. Children who do not pass are referred for further assessment.
Visual acuity (VA)	A measure of how clearly a person can see details at both near and far distances, usually tested using an eye chart.

Executive summary

Many children at South African schools are unable to see the board, read printed text or follow classroom activities because their vision problems have never been detected. Vision impairment is one of the most common and overlooked barriers to learning in this country. It often goes unnoticed because affected children assume the way they see is normal.¹

The scale of the problem is significant. An estimated 1.3 million learners have eye-health problems, with at least 130 000 in immediate need of spectacles. Yet fewer than 3% of learners are screened each year.² At that rate, it would take decades to screen all learners even once – despite a policy mandate, through the Integrated School Health Programme (ISHP), that requires every child to be screened at least once per educational phase (i.e. three times across their school career).³

Figure 1: The coverage gap in school-based vision screening in South Africa



Source: Hold My Hand⁴

The gap between policy and practice is not a failure of intent; it is a failure of system design and governance. Screening responsibilities are split between two government departments without clear joint accountability. Referral pathways are weak and thus many children who are identified never receive treatment. Optometric services – concentrated overwhelmingly in the private sector and in urban areas – are out of reach for most children in rural and lower-income communities. The result is a system that screens too few children, follows up too few referrals, and leaves most vision problems uncorrected for years.⁵

This brief argues that the solution is within reach, without new policy being needed. South Africa already has the frameworks, the delivery platforms and, in many places, the partnerships. What it requires is coordination, clear accountability and the will to connect what already exists into a system that functions consistently at scale.

The most important single action is to make vision and hearing screening a standard part of Grade R entry, the earliest point at which the formal education system reaches most children. Schools and early childhood development (ECD) centres provide the primary platform. This model relies on task-sharing.⁶ Designated screeners can conduct routine eye health and vision screening, allowing optometrists to focus on diagnosis, determining refractive correction and spectacle prescription. Supported by standardised training, supervision and quality assurance, this approach makes universal screening achievable without waiting for a specialist workforce that is insufficient in number and unevenly distributed across the country.⁷ Furthermore, a digital management information system that tracks every child from first screening to follow-up can turn screening into a functioning programme.⁸

Grade R should be the entry point – not the only opportunity – for screening. Although this brief focuses initially on vision, it supports a comprehensive approach to child health screening through the ISHP, bringing together all priority health checks, including vision and hearing screening, through a coordinated school-based platform. Learners should continue to receive screening at key stages throughout their school careers, as envisaged by the ISHP. The investment required is modest relative to the returns. A national costing model estimates approximately R235 per child across the full care pathway. Of this, about R62 covers screening, R49 goes towards diagnostic assessment and R123 for the intervention and follow-up required for children who need further care. The figures reinforce an important point: screening itself is relatively inexpensive. Its value lies in ensuring that children who are identified receive diagnostic assessment, spectacles or other treatment, and follow-up.⁹ Against a lifetime of impaired learning, reduced employment opportunities and increased dependence on state support, this represents an investment in the future of South Africa's children.¹⁰

This brief calls on the departments of health and basic education to establish clear joint governance and accountability arrangements for vision and hearing screening at national, provincial and district level; to formalise the role of non-government organisations (NGOs) and designated screeners within a coordinated national system supported by standardised training, supervision and quality assurance; and to engage the private eye care sector – optometrists, ophthalmologists, optical suppliers and technology providers – as structured partners rather than occasional contributors.¹¹ The children are already in the classrooms; the system needs to be ready for them.

1. The problem: vision impairment is widespread and under-detected

Across South Africa's classrooms, vision problems are common but often go undetected. Children who cannot see clearly may struggle to read, copy from the board or participate fully in class. Without early identification, these difficulties can be mistaken for poor academic performance or behavioural problems, delaying getting children the support they need. The child is seen as the problem, while the problem is actually one that a pair of spectacles could solve.¹²

Most children who struggle to see simply need spectacles. Refractive error is the leading cause of impaired vision in South African children.¹³ Other conditions – such as strabismus (squint), conjunctivitis or more serious eye health conditions that require medical or surgical attention – affect a smaller group. Both can be identified through a basic external eye examination at the point of screening.¹⁴

The core problem is timing. Routine vision and hearing screening does not occur systematically at or before school entry. The ISHP identifies school entry as an important opportunity for routine health screening. Yet Grade R – the earliest point at which the formal education system is accessed by most children – is not being used consistently as the entry point for routine hearing and vision screening. Many learners progress through the foundation phase – grades R to 3 – with undetected vision problems, identified only once the consequences have already taken hold: falling behind, disengaging, and losing confidence in their own ability.¹⁵

Short-sightedness – difficulty seeing things at a distance – is the most common form of refractive error and the leading cause of poor vision in school-age children worldwide.¹⁶ Globally, numbers are surging, with an additional 200 million children expected to develop short-sightedness between 2000 and 2050.¹⁷ When vision problems go unaddressed in the early years, children are less likely to get the most out of school – with consequences that can follow them into adulthood.

This is also the case in South Africa and the most common reason local children cannot see clearly is simply that they need spectacles but do not have them. This vulnerability was highlighted by a study in KwaZulu-Natal which revealed that 81% of children who needed spectacles had never received them. A smaller group of children had conditions such as strabismus or infections that required specialist assessment and treatment rather than vision correction alone.¹⁸

Grade R is now compulsory in South Africa following the commencement of the Basic Education Laws Amendment Act in 2024.¹⁹ For the first time, nearly every child in the country passes through a single, predictable entry point into the school system. That entry point is not yet being used consistently to check whether children can see well. The National Department of Health has identified Grade R as a priority for routine hearing and vision screening – a commitment that, if fully implemented, could transform early identification.

Grade R is not just a convenient entry point. It is the earliest moment in the formal system at which South Africa can reach virtually every child, before poor vision has had the chance to affect how they learn to read and write. Teachers are often the first to notice when a child is struggling to see. Routine screening gives them a clear pathway for referring concerns before learning is affected.

Key point: South Africa has a clear and time-sensitive opportunity. Grade R is the moment to act.



2. Why this matters: vision underpins learning

For most children, clear vision is central to how early learning unfolds – through reading, writing, copying from the board and following a teacher’s demonstration. When that ability is compromised and goes unaddressed, children do not simply fall behind academically. They disengage, lose confidence and, over time, internalise a narrative about their own ability that has nothing to do with their actual potential. South African research confirms that vision impairment affects not only academic performance but also self-confidence, social inclusion and overall wellbeing.²⁰

The early years are the critical window. The foundation phase is when children develop the literacy and numeracy skills that underpin everything that follows. Vision problems that go unaddressed at this stage do not simply delay progress – they can permanently alter a child’s educational trajectory. Once a child has fallen behind their peers, the gap is difficult to close.²¹ This is why the timing of identification matters as much as the identification itself.

What makes this particularly important – and particularly tractable – is that most of these problems are straightforward to detect and inexpensive to correct.^{22,23} A basic vision screen takes no more than five to ten minutes per child, requires no specialist intervention and can be conducted in a school or community setting with minimal equipment.^{24,25} For the majority of children identified, the intervention is a pair of spectacles.^{26,27} Evidence consistently shows that correcting refractive error can improve educational outcomes and quality of life.²⁸

What does eye health and vision screening involve?

Eye health and vision screening combines two straightforward assessments conducted at the same point of contact – typically at school or in a community setting. Both can be conducted by a trained lay screener.²⁹

The first is an external eye health check. The screener looks for visible signs that may indicate an eye health problem – such as redness, discharge, eye misalignment or a cloudy cornea. Children with these signs are referred for further assessment by an appropriate health professional.³⁰

The second assessment measures how clearly the child can see using a printed eye chart or a validated digital application. Children who do not meet the referral threshold are referred to an optometrist for a comprehensive eye examination.³¹

Most children complete screening without needing further care. Only those who do not meet the assessment criteria are referred for additional testing. This makes efficient use of limited specialist services while ensuring that children who need treatment receive it.³²

Figure 2: Visible eye abnormalities in school-age children that require referral

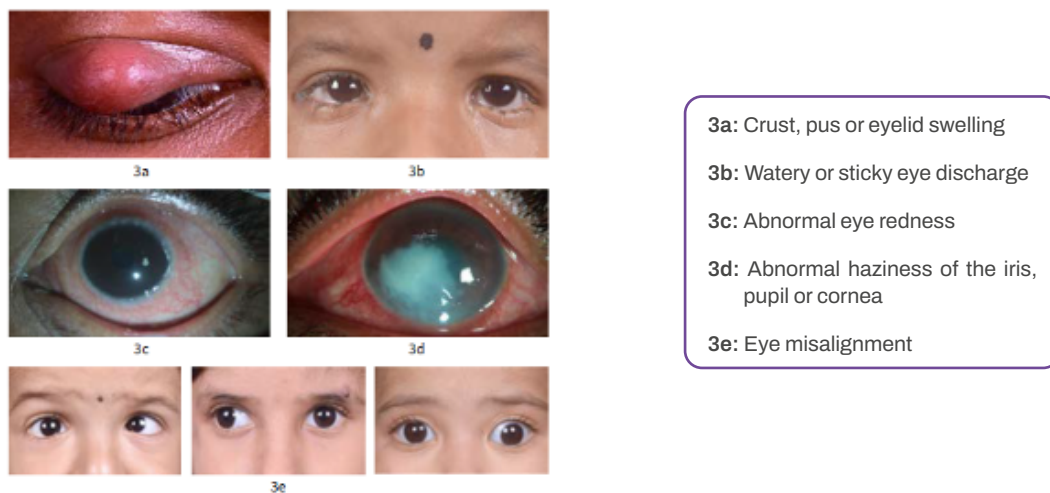
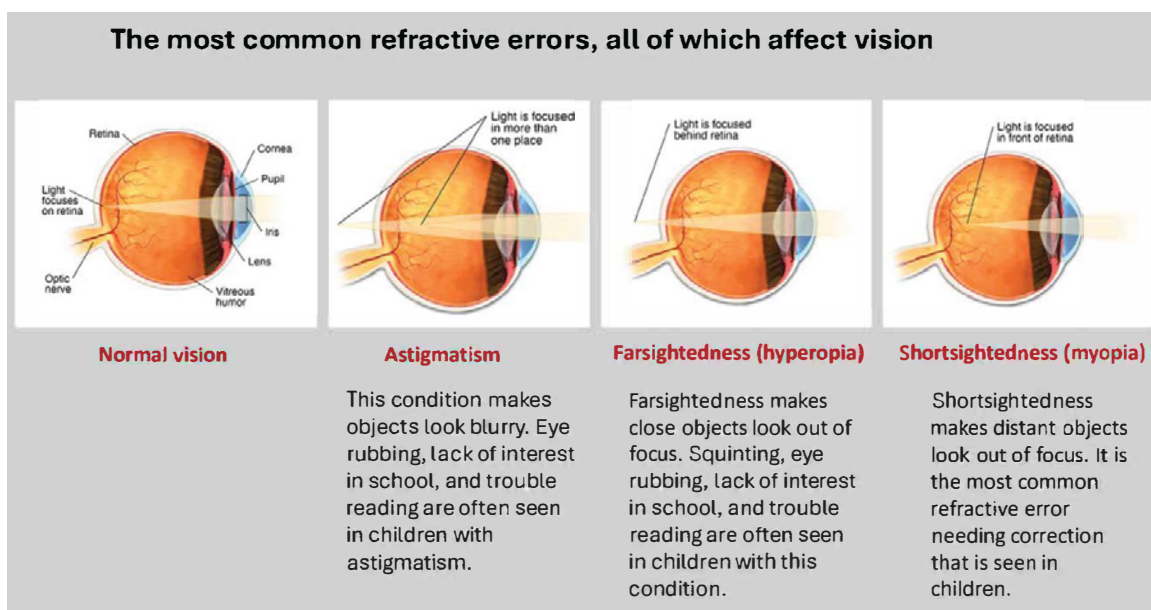
Source: World Health Organization ³³

Figure 3: Refractive errors

Source: Stanford Medical ³⁴

Two referral pathways

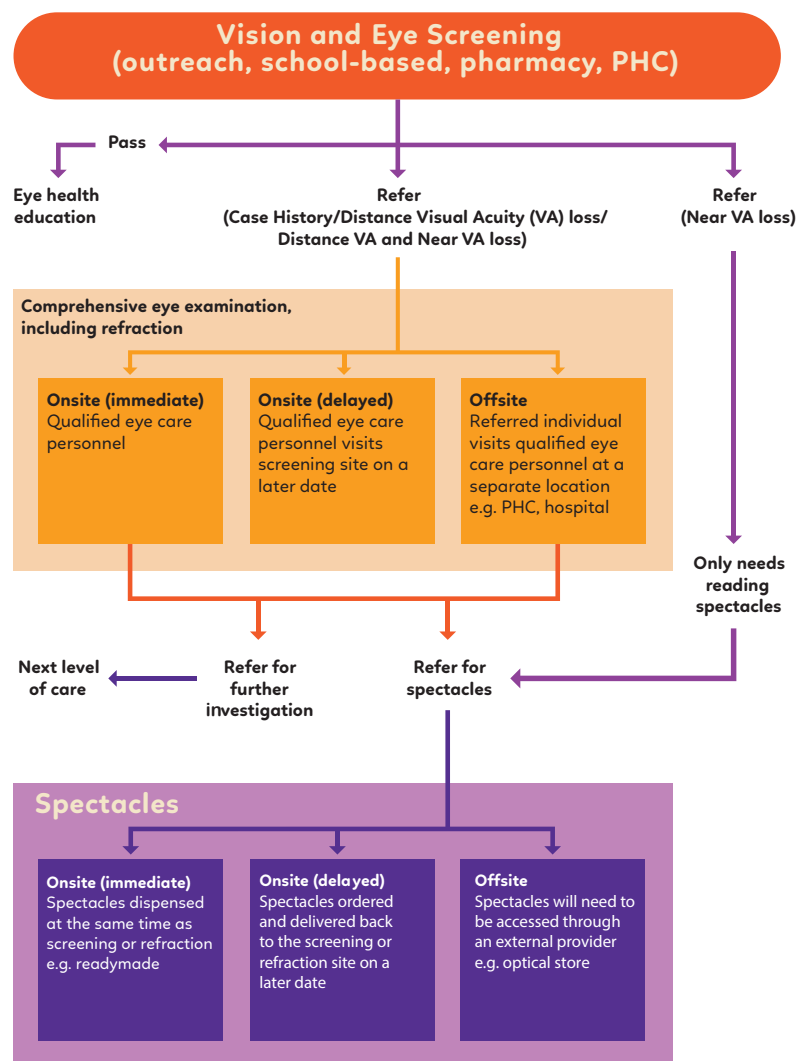
Not every child who is referred needs to see an optometrist.³⁵

- **Eye health concerns:** Children with visible signs such as redness, discharge, eye misalignment or a cloudy cornea should be referred for medical assessment.³⁶
- **Reduced vision:** Children who do not meet the vision screening threshold should be referred to an optometrist for a comprehensive eye examination and, where needed, spectacle prescription.³⁷

Separating eye health concerns from reduced vision ensures that children receive the most appropriate care while avoiding unnecessary referrals to specialist services.³⁸

Screening is only the first step. Its value depends on children completing the referral pathway and receiving the treatment they need, including spectacles where appropriate.

Figure 4: From screening to care: refraction assessment and spectacles service delivery



Children who do not pass a vision screen are referred for a comprehensive eye examination, which includes a refraction assessment. Where spectacles are needed, they can be dispensed onsite immediately, onsite with a short delay, or at an off-site optical facility. The process is designed to be flexible across different healthcare settings and resource contexts.

PHC = primary healthcare centre; VA = visual acuity

Source: World Health Organization³⁹

The screening process is straightforward. The challenge is not the screening itself, but ensuring that every child who needs further care is successfully referred, treated and followed up.

Key point: Early detection is simple, inexpensive and delivers high returns for learning and human capital.

3. The system gap: policy exists, implementation falls short

3.1. Existing policy

South Africa is not starting from scratch. The ISHP provides a national framework for routine hearing and vision screening, recognising the importance of early identification of barriers to learning. This brief focuses specifically on vision screening, while supporting the broader policy objective of dual sensory screening. The ISHP establishes schools as the primary delivery platform and mandates that every child be screened at least three times across their school career. The policy exists; the problem is that it is not being implemented consistently or at the scale required.⁴⁰

First, implementation of the ISHP remains uneven across provinces and districts, with coverage shaped by available school-health capacity and local service arrangements. Second, the policy focuses on schools, not ECD centres. Although Grade R is now compulsory, many Grade R classes continue to be delivered through ECD centres that fall outside the routine reach of the ISHP.^{41,42} Unless these centres are included, universal coverage at school entry will remain difficult to achieve.

Implementation falls short across three interrelated constraints: low coverage, weak referral pathways and fragmentation across providers. Each one undermines the others. Low coverage means fewer children are identified; weak referral pathways mean that many who are identified never receive treatment; fragmentation means that the different parts of the system – public services, NGOs and private providers – operate in parallel rather than as a coordinated whole. Underpinning all three is a structural gap: the ISHP is a joint policy, but roles and responsibilities between the departments of health and basic education are not consistently defined or operationalised at national, provincial or district level.⁴³

3.2. Implementation challenges

a. Low coverage

Screening coverage is uneven across provinces and districts, shaped more by local capacity than by a consistent national approach. Where screening does occur, it typically relies on school health nurses who carry competing priorities alongside their screening responsibilities, and whose ability to follow through on referrals is constrained by an already stretched workload. The result is a system that screens inconsistently, with coverage determined largely by where a child happens to live and which services happen to be available nearby.⁴⁴ Teachers frequently identify learners who appear to be struggling to see, but without a routine screening programme they have limited pathways for referral and follow-up.

b. Weak referral pathways

Screening alone does not improve outcomes. Children must complete the referral pathway and receive appropriate treatment. A large-scale programme in KwaZulu-Natal reached over 200 000 learners but struggled to ensure that those identified received

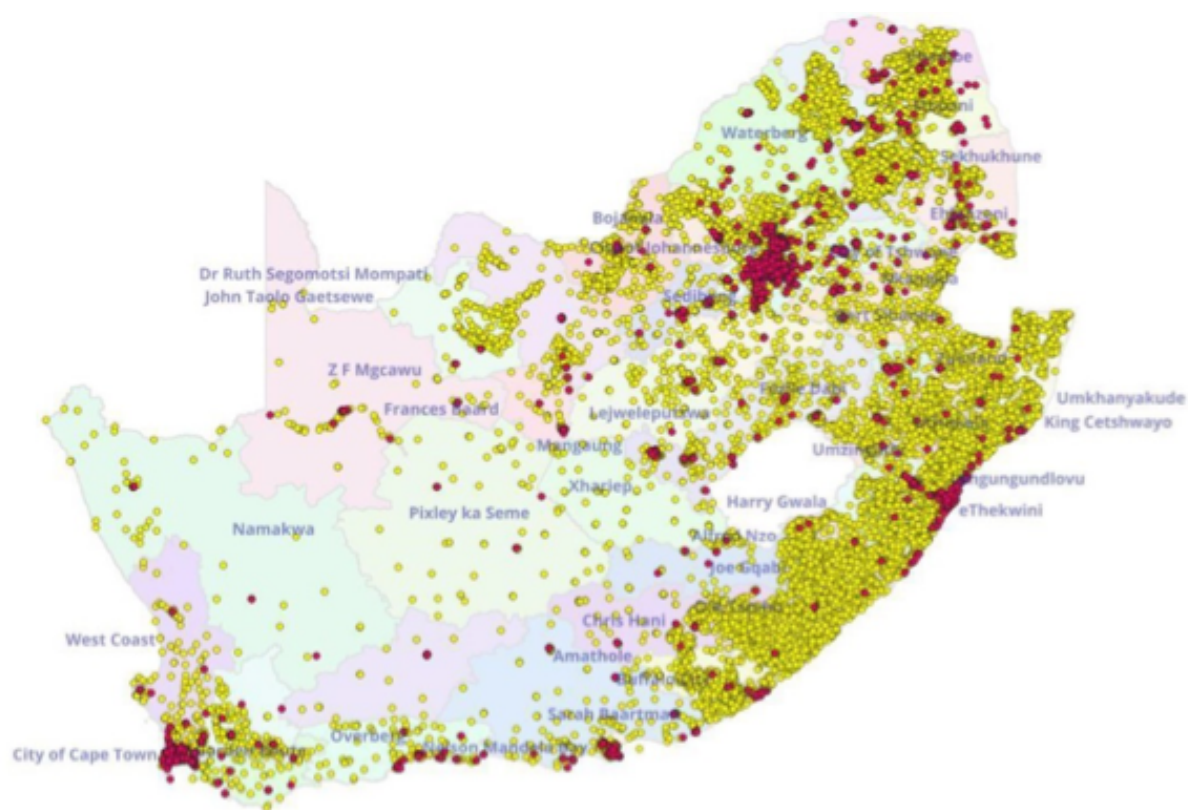
follow-up care – illustrating a pattern that is widespread across the system.⁴⁵ The World Health Organization (WHO) is unambiguous on this point: screening programmes are effective only when supported by functional referral systems and reliable access to treatment.⁴⁶ In South Africa, that connection is frequently broken.

c. Fragmentation across providers

Public services, NGOs and private providers each have a role in delivering vision screening – but they operate largely in parallel, with limited coordination, no shared data systems and no unified referral pathways.^{47,48} This fragmentation is compounded by a profound geographic inequality in the distribution of optometric services. Recent data confirms that 96% of optometrists in South Africa are based in the private sector, with the majority concentrated in Gauteng and the Western Cape.⁴⁹ Rural provinces – including the Eastern Cape, Limpopo and the Northern Cape – face severe shortages.⁵⁰ The consequence is a stark mismatch between where services exist and where children are. Vision problems in these areas remain uncorrected not because they cannot be treated, but because the services required to treat them are simply not within reach.

The challenge is not just the number of optometrists, but also where they practise. Most services are concentrated in urban private practice, leaving many rural and lower-income communities with little or no access.⁵¹

Map 1: Private optometric practices vs school distribution by district



Optometric services are concentrated in urban centres, leaving many rural schools far from available services.

Source: Hold My Hand⁵²

The map illustrates the geographic mismatch at the heart of the system gap. Schools – shown as yellow dots – are distributed across the country, including in rural and underserved areas. Private optometrists – shown as red dots – are concentrated in urban centres. In many districts, no optometric services exist within reach of the schools that need them.⁵³

NGOs have become important implementation partners, working with government, schools and private-sector optometrists to expand access to vision screening in many parts of the country. They have developed and tested a range of delivery models – from school-based screening and mobile outreach to community partnerships – which demonstrate that screening at scale is feasible. But no NGO has achieved national coverage, and none should be expected to – that is the role of a functioning national system, not of civil society working at its margins.⁵⁴

Table 1 illustrates the range of delivery models currently operating across South Africa and the lessons each offers for a coordinated national system. Taken together, these models show that delivery at scale is feasible but not yet coordinated.

Table 1: Current delivery models

Model category	Sub-model	Programme	Delivery approach	Scale	Measured outcomes	Key lessons for policy and scale
School-based screening	Technology-enabled screening (dedicated screening service) Teacher engagement strengthens early identification and follow-up.	One School at a Time (OSaaT) – African Eye Institute, in partnership with CooperVision, OneSight EssilorLuxottica, Berkeley Vision and the Ruya Project. ⁵⁵ Launched 2021.	Smartphone/tablet-based screening using the Peek Vision app; school-based pre-screening; onsite optometry; referral tracking; free spectacles. Designated screeners conduct initial screening; optometrists provide onsite diagnostic support.	Multi-province (KwaZulu-Natal, Gauteng, Eastern Cape, Western Cape)	In 2024, 32 schools participated. 26 096 learners pre-screened. 6 385 children with potential visual problems were identified and referred to the African Eye Institute optometry team. 2 613 children received onsite eye examinations. 1 388 children received free spectacles 1 201 children referred to their nearest hospital or clinic for further care. Strong referral and treatment conversion rates.	- Technology improves efficiency and standardisation. - Onsite diagnosis fast-tracks early intervention and reduces loss to follow up. - Multi-partner model – combining NGOs, government, the private sector and global foundations – enables rapid scaling but requires active co-ordination across all parties.

Model category	Sub-model	Programme	Delivery approach	Scale	Measured outcomes	Key lessons for policy and scale
	Technology-enabled screening (integrated service)	Keready-Umbono (Keready Mobile Outreach Clinics was a pilot project and has since been discontinued; Umbono/SPF* continues to deliver hearing and vision screening in the Eastern Cape. The model is retained here because it provides useful lessons for integrated outreach and youth-employment-linked delivery.) *SPF = Small Projects Foundation (also see Case study 2 (Section 5.4).	Digital screening tools (Tumbling E app) and auto-refraction, integrated into broader health outreach programmes, ISHP-linked services and youth employment initiatives.	Eastern Cape	High-throughput outreach model	- Integration into existing government-linked outreach and youth employment initiatives improved reach and cost-efficiency. - The model demonstrates that embedding screening within existing public platforms supports both scale and sustainability.
	Paper-based screening (dedicated screening)	EyeCare4Kids ⁵⁸	School-based screening with access to lenses, a laboratory and frames; working with local optometrists. Established in 2024 as part of the US-based EyeCare4Kids organisation.	Multi-province	Not consistently reported	Accessible and low-cost entry point.
	Paper-based screening (integrated approach)	ISHP ⁵⁹	Nurse-led screening using visual acuity charts, referral to public sector clinics. Implementation and coverage are uneven across provinces and districts. Grade R children in ECD centres outside the formal school system are not consistently reached.	National	Uneven implementation across provinces. Estimated spectacle waiting time of 3-12 months in the public sector, which significantly limits programme effectiveness even where screening does occur. ⁶⁰	- Lower cost but inconsistent delivery. - Weak referral follow-up reflects limited optometry capacity in the public sector rather than a failure of the screening itself. - The 3-12 month waiting time for spectacles is a critical bottleneck that undermines the value of early detection. - NGO partnerships with government to provide designated screeners offer one viable path to addressing capacity gaps.
		Bona uBuntu Programme ⁶¹	Assistive technology (tablets), low-vision rehabilitation, therapy and teacher support	Eastern Cape	Improved classroom participation for learners with visual impairment.	- Vision care must extend beyond screening to functional inclusion and learning support. - Children with visual impairment who are identified but not supported in the classroom remain disadvantaged.
Community-based delivery	Mobile clinic model (dedicated screening)	Grace Vision ⁶²	Fully equipped mobile clinics providing screening, refraction assessment, dispensing and referral within communities – at schools, clinics and local settings, including surgery pathways.	Eastern Cape	152 000 children screened; 2 397 spectacles dispensed over 10 years	- Mobile clinics deliver comprehensive care close to where children live and learn. - Sustained investment and logistics capacity are prerequisites for this model; without both, continuity of care is difficult to maintain. - Parent engagement improves referral completion and spectacle use.

Model category	Sub-model	Programme	Delivery approach	Scale	Measured outcomes	Key lessons for policy and scale
	Mobile clinic (integrated service)	Mobile Health Clinics Foundation ⁶³	Mobile clinics deliver integrated school health screening at schools (vision, dental and general health).	Multi-province (Northern Cape, Gauteng and North West)	According to its website, the foundation has delivered eye tests and glasses to approximately 16 077 children. Provides hearing and vision screening.	• Effective for reaching underserved schools in low-income communities. • Scalable through partnerships; the integrated model spreads delivery costs across multiple health outcomes.
	Community based technology-enabled screening (dedicated screening)	HearX Foundation ⁶⁴	Digital screening tools; screening provided at community centres and ECD centres; dual sensory screening for both hearing and vision for children and adults	Multi-province (Gauteng and Western Cape) Approximately 117 136 hearing and vision screening tests performed to date	4 406 children received hearing and vision screening in 2024. Referral rates of 7.9% (hearing); 7.6% (vision).	• Technology enables dual sensory screening at primary healthcare clinics and community level while maintaining clinically reasonable referral rates. • Demonstrates that quality screening does not require specialist input at the point of first contact.
	School based and mobile clinics: NGO delivery model	Sight to Nations Eyecare Foundation ⁶⁵ (SA programmes)	Offers school-based screening followed by onsite or follow-up optometry visits and spectacle provision since 2015. National programme-based delivery with mobile clinics. Through outreach programmes, mobile clinics and partnerships with schools and healthcare providers, the model offers accessible, affordable, and comprehensive eye care services.	National, programme-based	Not consistently reported	• School-linked NGO delivery improves access and continuity of care. • Consistent outcome reporting across programmes would strengthen the evidence base for scale. • Long-term partnerships enable sustainable delivery at district level.

Taken together, these models demonstrate that vision screening at scale is achievable in South Africa – and that it is already happening in many parts of the country. What the analysis also shows is that reach and impact depend less on the chosen delivery model than on the strength of the system that supports it: designated trained screeners; clear referral pathways; reliable access to spectacles; active follow-up; and ongoing programme monitoring. The task is not to design something new, but to connect and coordinate what already works.



Supporting learners with visual impairment requires both clinical care and classroom support

Credit: Bona uBuntu

Two recent developments create practical opportunities to accelerate progress.

- Investments in ECD system strengthening – including improved registration and administrative data systems – provide a platform for identifying and reaching children before formal schooling begins, extending the screening entry point beyond schools to include ECD centres.
- The development of South Africa's Electronic Medical Record system for primary health care facilities – currently at beta-testing stage across 85 facilities ahead of large-scale rollout – lays the groundwork for children to be tracked seamlessly across public, private and NGO providers for the first time.⁶⁶

Together, these developments signal the direction in which a coordinated national system should move: one in which a child's journey from first screening to treatment is recorded, monitored and followed up, regardless of where they live or which healthcare sector serves them.

Key point: The challenge is not policy, but implementation at scale.

4. What works: lessons from global practice

School-based eye health programmes are among the most effective and cost-efficient ways to reach children at scale, particularly in low- and middle-income countries. But what the evidence makes clear is that outcomes are shaped less by the screening activity itself and more by the strength of the system surrounding it. Screening without a functioning referral pathway, reliable access to spectacles and active follow-up is not an intervention; it is a missed opportunity.^{67,68}

Effective programmes share four core features.

- **Schools are the primary access point.** Schools provide the most practical platform for delivering health services to large numbers of children, particularly where access to facility-based care is limited. When screening is integrated into routine school health services rather than delivered as a standalone activity, programmes consistently achieve higher coverage and better continuity.⁶⁹
- **Referral systems must work.** The evidence is consistent: programmes fail when referral systems are weak. Financial barriers, geographic distance and the absence of coordinated follow-up mechanisms all contribute to children dropping out between screening and treatment. Detection without a clear and supported route to care does not improve outcomes.⁷⁰
- **Treatment must be accessible, not just available.** Refractive error is the leading cause of vision impairment in children globally, and the treatment – spectacles – is straightforward and inexpensive. Yet access to spectacles remains limited in many settings. Where spectacles are provided, the evidence is clear: educational outcomes, wellbeing and quality of life improve.⁷¹
- **Follow-up is not optional.** Without active follow-up – through schools, caregivers or community systems – many children do not complete referrals. A programme that screens well but follows up poorly delivers only a fraction of its potential impact.⁷² Systems that build follow-up in from the outset, rather than treating it as an afterthought, consistently achieve better outcomes.

These principles are best understood through practice. Zambia offers a relevant example of how they can be made to work at national scale.⁷³

Global evidence consistently show that effective programmes are system-wide, not activity-based.⁷⁷

The research identifies five cross-cutting requirements as the conditions that separate programmes with lasting impact from those that screen children but lose them along the pathway:

- standardised protocols;
- appropriate workforce models;
- sustained community engagement;
- long-term financing; and
- ongoing caregiver communication.

Case study 1:**Scaling a national school-based eye health programme in Zambia⁷⁴**

Zambia's School-Based Eye Health Programme is embedded in the national School Health and Nutrition Programme, demonstrating that vision screening does not need to be built from scratch but can be integrated into existing systems, delivered through existing platforms and scaled through existing relationships. The programme connects screening, referral and treatment in a coordinated system, supported by trained personnel and underpinned by national policy.⁷⁵



School-based screening in action in Zambia

Credit: Sightsavers

Zambia differs from South Africa in scale and in system structure, but the lesson it offers is directly transferable: scaling is feasible, provided four enabling conditions are in place, namely alignment with national policy and existing delivery platforms; a trained and supported workforce; reliable supply chains for spectacles and equipment; and sustained financial and political commitment. Where these conditions are absent, the programme's own experience shows the consequences: weak supply chains, funding instability and the system constraints that follow.

The evidence is clear: collaboration between government, the private sector and civil society is critical to ensure reach and sustainability.⁷⁸

There is also a growing body of evidence supporting integrated sensory screening – combining vision and hearing checks at the same point of contact. Integrating these services makes practical sense. Combined sensory screening can make more efficient use of the same school-based infrastructure and limited screening resources and reduce disruption to the school day, while allowing vision and hearing problems to be identified at the same point of contact.⁷⁹

Combined programmes can improve early detection rates, but implementation and follow-up remain challenges. The system being built for vision screening should be designed from the outset to accommodate hearing screening as a natural next step, providing dual-sensory screening before formal school entry.

The evidence, taken together, points in one direction: vision screening works when it is part of a coherent, end-to-end system – one that links the moment of screening to referral, treatment and follow-up, and is embedded in the health and education structures that children already move through.^{80,81}

The global benchmark is clear, even if the starting point is not. In 2021, WHO Member States endorsed a target of a 40% increase in effective refractive error coverage by 2030 – meaning that countries with baseline coverage below 60% should be working towards that threshold, while those already above it should be striving for universal coverage. The baseline data emphasises the scale of the challenge: effective refractive error coverage in the African region stands at just 12.4% – the lowest of any WHO region, and far below the global median of 35.7%.⁸² South Africa's coverage figures, while not separately reported in the global data, sit within this regional context. The 2030 target is not an abstraction: it is a specific, internationally endorsed benchmark against which South Africa's progress can – and should – be measured.

The lessons from international evidence are directly applicable to South Africa. Even when the policy frameworks exist and delivery platforms exist, integration – and the governance structures that make integration last – is required to make the system work.⁸³

Key point: Screening works when it is part of a system, not a standalone activity.

5. A scalable model for South Africa: reaching all children

Closing the gap in vision screening coverage requires a shift from fragmented delivery to a coordinated national model. No single delivery channel, no single sector and no single workforce can reach all children. Schools cannot reach children who are not enrolled. The public sector cannot reach children in areas where services do not exist. Nurses and optometrists alone cannot generate the screening volume required at the scale needed. A scalable model requires all of these elements working together – school-based platforms, community outreach, task-shifted screeners and public-private partnerships – coordinated within a single system rather than operating in parallel.^{84,85}

Six policy actions are briefly summarised in Table 2 for easy reference, but subsequently developed more comprehensively.

Table 2: Summary of key policy actions

Synopsis of key policy actions: what needs to happen model	
Make vision screening standard at Grade R entry	Establish screening at school entry as a routine part of early learning support across all public schools and ECD centres.
Adopt a mixed delivery model	Use schools and ECD centres as the core platform, complemented by outreach and community-based services to reach children in rural and underserved areas.
Strengthen the screening-to-care pathway	Define and operationalise referral systems with clear links to optometry, primary health care and specialist services; ensure timely access to spectacles and active follow-up.
Define roles across health and basic education	Establish clear joint governance and accountability arrangements at national, provincial and district level; clarify who screens, who refers, who follows up, who is responsible when children fall through the gaps, and how data moves between departments to support tracking and measure outcomes.
Leverage public, NGO and private-sector capacity	Formalise and fund partnerships with NGOs and the full range of private eye care providers and spectacle suppliers to expand access, particularly in underserved areas.
Deploy designated trained screeners	Train, formally recognise and sustainably fund lay screeners as designated eye health and vision screeners, allowing optometrists to focus on comprehensive eye examination, refraction and prescription.

5.1 Schools and ECD centres as the foundation

Schools and ECD centres are where most children can be found – consistently, repeatedly and at the age when early identification matters most. The ISHP already establishes a framework for delivering health services through schools and should remain the central delivery channel for vision screening. Global evidence is unambiguous: school-based platforms are the most effective way to deliver screening at scale, and the most practical foundation on which a national system can be built.⁸⁶

Strengthening this platform requires three things: prioritising the foundation phase as the entry point for screening, when early identification has the greatest impact on learning outcomes; expanding coverage systematically across schools through improved planning and resourcing; and standardising screening protocols to ensure that a child in, for example Limpopo, receives the same quality of screening as a child in Gauteng.⁸⁷

Not all Grade R learners are in schools. A significant number attend ECD centres that fall outside the ISHP framework. As ECD registration and data systems improve, a practical opportunity exists to draw ECD learners into the screening processes at nearby schools. Including ECD centres with Grade R cohorts should be a priority from the outset.⁸⁸ Large early learning centres with Grade R or the school could serve as a Saturday venue for children from other early learning programmes. Local improvisation will be needed.

Consistent with the ISHP, this approach should support routine hearing and vision screening while recognising that different delivery platforms will be needed to reach all children.

5.2 Extending reach through outreach and community delivery

Schools are the foundation, but they are not sufficient on their own. Not all children attend school consistently, and in many rural and underserved areas, schools themselves are far from the optometric services that follow-up requires. Community-based and outreach models are essential to bridge this gap – and South African evidence shows they can do so effectively.⁸⁹

NGO-led programmes, mobile teams and community health workers have demonstrated the ability to screen large numbers of children outside formal school settings. In many parts of the country – particularly in rural areas like the Eastern Cape – NGOs are already delivering the majority of vision screening services, not as a complement to a functioning public system but as a substitute for one that has not yet arrived.⁹⁰

These approaches are essential for:⁹¹

- children who are not consistently attending school;
- children in remote or underserved areas; or
- communities with limited access to facility-based eye care.

Community-based programmes have also demonstrated that non-specialist screeners

can deliver high-quality screening when properly trained and supervised – a finding that is central to the task-shifting argument developed in Section 5.4.⁹²

However, the persistent challenge is follow-through. Where outreach is not connected to accessible referral services, children drop out of the pathway. Screening without a functioning link to care is not an intervention.

5.3 From screening to care: building effective pathways and partnerships

Screening is only the beginning. Its value depends entirely on what follows – and in too many cases what follows is nothing. Referral pathways must be standardised, with defined and operational links between schools, primary health care services and contracted providers. Simple tracking systems, embedded from the outset, are what ensure that a child who is identified at a school screening actually receives the care they need.⁹³

Formalising district-level contracting with private-sector optometrists – to provide refraction assessment and spectacle dispensing within the public pathway – is a practical step towards expanding access where public provision is insufficient. National Health Insurance (NHI) provides a possible future mechanism for purchasing these services as part of a more integrated system of care.⁹⁴ In the meantime, structured contracting can create a more accountable role for the private sector than reliance on ad hoc or voluntary arrangements.⁹⁵

Effective models do not treat screening as a standalone activity. They combine visual acuity screening, basic eye health checks and clear referral pathways to the appropriate level of care. Each element is necessary; none is sufficient on its own.⁹⁶

The partnerships outlined in Table 3 are already operating across South Africa – each one connecting public platforms, NGO delivery capacity and private eye care services in a different configuration. Together they make a single, important point: cross-sector collaboration in vision screening is not theoretical. It is already delivering results. The challenge now is to formalise what works, fund it sustainably, and build it into the architecture of a national system.

Table 3 below summarises examples of existing and successful cross-sectoral partnerships that deliver vision screening.

Table 3: Models of various public-private and NGO-private collaborations

Organisation	Collaboration	Description	Services
Ukubona Foundation ⁹⁷	NGO + Gauteng Department of Health	School-based vision screening programme linking NGO coordination, private-sector optometrists and public hospital services.	- School-based screening, diagnosis and spectacle dispensing on school premises. - Hospital partnership to reduce waiting times and ensure children receive timely intervention without the delays that routinely compromise outcomes.
Grace Vision ^{98,99}	NGO + Eastern Cape Department of Health	Mobile vision screening service linking schools, clinics and optometry services through a continuous referral pathway. By operating across both, Grace Vision creates a continuous care pathway rather than a series of disconnected encounters. <i>Also see Table 1 for Grace Vision's inclusion in the community-based delivery models.</i>	- Mobile screening at schools and clinics. - Direct optometry services linked to the local clinic, providing children with a clear and accessible route to ongoing care and measurably reducing loss to follow-up.
Preferred Provider Negotiators (PPN) ¹⁰⁰	CSI Initiative/ NGO (Masibonisane) + private providers	A private organisation supporting over 300 private optometry practices nationally with billing services. Through its CSI initiative with Masibonisane, PPN leverages its established private sector relationships (private optometrists) and industry knowledge to reduce the cost of school-based screening outreach, drawing on a network of providers willing to operate at or below standard rates.	- Support for school-based screening outreach teams at negotiated rates. - A voucher-based dispensing model that caps expenditure on lenses and frames, with many offered at discounted rates. - The digital voucher system simultaneously controls costs, tracks referrals and generates the reporting data programmes need to demonstrate impact and attract continued investment.
One Sight/ EssilorLuxottica ¹⁰¹	NGO/ Foundation + National Department of Health and NGO partners	Global foundation supporting affordable spectacle provision through donated and subsidised optical products and laboratory services. OneSight works with programmatic partners and the National Department of Health to remove the affordability barriers that prevent children from receiving spectacles even after they have been screened and diagnosed. OneSight also functions as a supply chain partner to OSaaT – see Table 1.	- Discounted and donated spectacles and frames to programmatic partners and the NDoH. Frames available at less than R20, fundamentally reframing the economics of spectacle provision for under-resourced programmes. - Subsidised optical laboratories supporting the cutting and fitting of lenses at scale – particularly valuable for smaller programmes that lack the volume to negotiate favourable pricing independently.
Umbono Vision Foundation / Keready Mobile Clinic Mega-outreach Model ¹⁰²	Partnership between government health services, schools, NGOs (Umbono), private-sector partners (Essilor, Royal Dutch Visio) Eyecare4Kids, educators and people employed through the Social Employment Fund.	<i>(Note: Keready Mobile Outreach Clinics was a pilot project and has since been discontinued; Umbono/SPF continues to deliver hearing and vision screening in the Eastern Cape. The model is retained here because it provides useful lessons for integrated outreach and youth-employment-linked delivery.)</i> A high-throughput, integrated outreach model operating through school-based pre-screening followed by large-scale centralised events. Educators identify learners who may be experiencing vision difficulties before a high-volume outreach event. Screening is then conducted by trained Eye Care Ambassadors funded through the Social Employment Fund, with schools also identifying teacher assistants or parents to support the programme where appropriate.	- Screening is conducted by trained Eye Care Ambassadors funded through the Social Employment Fund. - Schools may also identify educators, teacher assistants or parents to support screening and referral activities where appropriate. - Mobile app-based vision screening using Tumbling E technology. Auto refraction assessment for younger children and learners with communication difficulties. - Full optometric examinations. - Eye infection treatment and general health checks. Referral for ophthalmology review and surgery. Spectacle provision and school-based follow-up visits.

In 2026, the Department of Basic Education enrolled 725 692 Grade R learners.¹⁰³ The National Department of Health has identified Grade R screening as a specific school-health priority, with its 2026/27 Annual Performance Plan setting a target of 442 500 Grade R learners to be screened during the year. Its Strategic Plan 2025–2030 sets a longer-term target of 800 000 Grade R learners having been screened by 2030.^{104,105} However, there are not enough optometrists or school health personnel to deliver screening at this scale through specialist services alone. If universal screening depends on specialist capacity, it will not be achieved. The immediate solution to the bottleneck is not to simply expand the specialist workforce. The immediate solution lies not in finding more optometrists, but rather by deploying existing optometrists more wisely.

5.4. Designated screeners: expanding screening capacity at scale

The shortage in specialist (school) health services is particularly severe in rural provinces, where most schools are located far from optometric services.¹⁰⁶

A scalable national programme will therefore require a broader screening workforce. One practical solution is using of designated trained screeners to conduct routine eye health and vision screening in schools and communities, allowing optometrists to focus on diagnosis, refraction assessment and spectacle provision. To maintain quality, this approach requires standardised training, regular supervision and ongoing quality assurance.¹⁰⁷

Teachers also have an important role by recognising children who appear to be struggling to see and encouraging referral through the routine screening programme.

Under this approach, designated trained screeners would not replace optometrists. Instead their role would be to:¹⁰⁸

- conduct basic visual acuity screening;
- detect visible eye-health abnormalities or “red flags”;
- support referrals and follow-up; and
- assist with health promotion and parent engagement.

Children who do not pass screening would then be referred to optometrists, mobile outreach teams or ophthalmology services for further assessment and treatment.

The University of Johannesburg offers an accredited School Vision Screening course at NQF Level 5, which can be completed in three to five days.¹⁰⁹ Although this comes at a cost, the course considers the South African context. WHO also provides free Primary Eye Care screening courses,¹¹⁰ with supporting step-by-step guides targeted at lay or non-professional community members. Community members – including unemployed matriculants identified through local structures such as churches and community clubs – have been successfully trained as screeners through programmes like BonaBolo. BonaBolo connects designated screeners with local optometrists working in the private sector to provide screening and training support, with a focus on diagnostic services and spectacle provision.¹¹¹

This model opens a significant opportunity. Funding designated screener roles through existing mechanisms – such as the Social Employment Fund – could simultaneously expand screening capacity and create meaningful employment in underserved communities.¹¹² In addition, well-structured collaborations with private-sector optometrists enable designated screeners to not only increase screening coverage but also maintaining local referral pathways.

No single sector holds the full answer to addressing childhood vision impairment. Government carries the mandate but lacks the reach; the private sector has the skills but not always the incentive; civil society has the trust but rarely the resources. Small Projects Foundation (SPF) has spent three decades figuring out how to bring these pieces together – and their vision screening programme in the Eastern Cape shows what becomes possible when they do.¹¹³

Case study 2:

Small Projects Foundation: building a vision for the whole child



Credit: Small Projects Foundation

What makes a vision screening programme work is not technology alone, but trust. SPF has been working in the Eastern Cape for over 30 years, and that history matters. Long before a screening team arrives at a school gate, SPF already has relationships with the community, the teachers and the families.

Since 2022, SPF has screened 47 881 learners and dispensed 4 044 pairs of spectacles – demonstrating both reach and follow-through.

A model built around efficiency and access

SPF operates a hybrid delivery model, combining school-based screening with a mobile unit. The mobile unit has proved transformative: where a school-based team might cover one school every three days, the mobile unit can reach up to three schools in a single day.



Credit: Small Projects Foundation

The programme also integrates dual sensory screening, testing both hearing and vision at the same point of contact. This reduces duplication and creates a more efficient service for children and schools.

Task-shifting, made real

SPF has taken the principle of task-shifting and built it into the architecture of the programme. Rather than relying on a single professional to carry the full pathway, SPF has disaggregated the screening process into distinct functions, each assigned to the most appropriate member of a multi-cadre team. The screening component is done by a designated screener called an Eye Ambassador, who is supported by a team including an optometrist. To date, over 350 eye ambassadors have been trained.

Technology has been central to making this work. Designated screeners use open-source applications to conduct both hearing and vision screening quickly and accurately. The same screeners also staff a toll-free helpline, supporting children and families after they have been seen and actively reducing loss to follow-up. Where possible, screener posts have been funded through existing mechanisms such as the Social Employment Fund, keeping costs within reach.

A web of partnerships that holds the model together

What distinguishes SPF's approach is the density and diversity of its partnerships.

- **Various partner NGOs** provide SPF with free or discounted optical supplies – lenses, frames and the open-source technology that powers the screening applications.

- **Private optometrists** show up in three distinct ways: two full-time optometrists provide onsite diagnostic support onsite at schools, including writing optical scripts on the spot and eliminating the need for a separate referral visit, community-based follow up to dispense the spectacles ensuring every pair of spectacles reaches a child and facilitating referrals to optometrists or ophthalmologists to fast-track complex cases to local private providers (pro bono).
- **Schools** create a school-based support team that includes an SPF reading champion to bridge intervention and impact – addressing stigma, confidence in wearing spectacles and promoting language and learning – the ultimate impact. Teachers are also educated on the importance of vision screening and identifying red flags.



Credit: Small Projects Foundation

The programme also works closely with public health services to support referrals for children requiring specialist care.

What this means for South Africa

SPF demonstrates that large-scale screening is achievable when trusted community relationships, designated screeners, mobile outreach and specialist services are brought together in a single system. The lesson is not that government should replicate the SPF model exactly, but that national scale will require the same combination of partnerships, task-sharing and coordinated referral pathways.

Information retrieved from <https://www.spf.org.za/> (May 2026)¹¹⁴ and supplemented personal communication with Dr Paul Cromhout, CEO of the Foundation and Mita Pema-Keshaw, optometrist and project manager at Umbono, 2026. (Dr Cromhout, one of SPF's founding members in January 1988, recently passed away. He was also involved in the field of HIV/AIDS prevention, treatment and care for almost three decades.)

5.5 Towards integrated vision and hearing screening

Vision screening does not exist in isolation. Hearing and vision problems share the same starting point – both affect how children learn, both routinely go undetected, and both cause harm that compounds the longer it goes unaddressed. They also share the same natural delivery infrastructure: the same schools, the same screeners, the same referral pathways.¹¹⁵

There is a practical logic to this convergence. Combined sensory screening programmes consistently demonstrate efficiency gains – earlier detection, better use of limited resources, and less disruption to the school day.¹¹⁶ SPF has shown what this looks like in practice: working in the Eastern Cape, their community-based screeners conduct both vision and hearing checks in a single school visit, using open-source technology that requires no specialist input. The result is one visit, two screens, and more children reached.¹¹⁷

The immediate focus of this brief is vision screening. It responds to the NDoH's commitment to strengthen Grade R health screening through the ISHP. The Department's 2026/27 Annual Performance Plan includes Grade R screening as a specific output indicator and defines this as comprehensive screening covering vision, hearing, oral health, nutrition and general health.¹¹⁸

The workforce, referral systems, digital platforms and community partnerships proposed in this brief should therefore be designed to support this broader child-health screening mandate. Vision provides an immediate entry point, but the system should be built from the outset so that hearing and other priority health checks can be delivered through the same coordinated platform. Dual sensory screening should remain an important longer-term objective.

5.6 Building a coordinated system

None of this moves without someone being responsible for moving it. A formal governance structure between the departments of health and basic education – with clear lines of accountability at national, provincial and district level – is not a bureaucratic formality to be sorted out once the real work begins.¹¹⁹ It is where the real work begins. The questions that seem administrative are in fact clinical: who screens, who refers, who follows up, and who answers for the child who was seen once and never again. Until those questions have written and agreed answers, the system will continue to function as it does now: competently in places, invisibly in others, and accountably in neither.

The coordinated model this brief calls for has five components.^{120,121} None of them needs to be invented from scratch – each exists, in some form, somewhere in the system already. The work does not call for creation but for connection.

- 1. School-based screening as the primary platform**, explicitly extended to include ECD centres where Grade R cohorts are found outside the formal school system.^{122,123}
- 2. Outreach and community services** capable of reaching children in rural and underserved areas who will never come to a fixed facility.^{124,125}

3. **A trained, formally recognised cadre of designated screeners**, supported by standardised training, supervision, quality assurance and sustainable funding mechanisms.^{126,127}
4. **Technology-enabled information systems** that track every child from screening through referral, treatment and follow-up, while providing the data needed for ongoing programme monitoring and improvement.^{128,129}
5. **Clear, standardised referral pathways** that reliably connect screeners to optometrists, nurses and specialist eye care services – pathways that are known, used and monitored.^{130,131}

The system should also support parents and caregivers through clear communication, consent processes and follow-up, recognising their essential role in ensuring children receive assessment and treatment, or spectacles where needed.

These five components reflect the realities of the South African system – where capacity exists but is unevenly distributed and insufficiently coordinated – and align with existing local policy and international guidance on integrated, people-centred care.^{132,133}

Key point: A scalable model for South Africa is not a theoretical proposition. The delivery platforms, the workforce models and the partnerships are already in place. What is needed now is the governance structure that brings them together and holds them accountable for reaching every child.

6. Implementation: a phased pathway to scale

The distance between where South Africa is now and a system that reaches every child is not covered in a single step. Instead, three stages are proposed, each one building on the last and, each deliberately paced to strengthen what works before expanding what does not yet exist at scale.¹³⁴

That sequencing matters. But what makes a phased approach more than a timetable is governance. Without it, phases are merely intentions.

Governance, in this context, starts with a simple question: who is responsible? Joint leadership between the departments of health and basic education is not a structural formality, but instead the mechanism through which accountability becomes real. Coordination needs to be owned at the national level, and delivery needs to be ensured across provinces and districts. These functions need to be in place before implementation begins.^{135,136}

Drawing on implementation analysis of current delivery models and system constraints in South Africa, the pathway unfolds across three phases, with data management, communications and the strengthening of eye health within primary health care running as a continuous thread throughout.¹³⁷

Figure 5: Scaling vision screening: a phased pathway



Ongoing across all phases

Data management and information systems – continual tracking of screening, referral and follow-up data, with regular reporting against coverage targets.

Communications and demand generation – community awareness, caregiver engagement and school-level promotion sustained throughout all phases

Strengthening eye health within primary healthcare – embedding vision screening and referral support into primary healthcare services and building their capacity to receive, manage and follow up referrals

6.1 Short term (0–2 years): test and strengthen the foundation

The immediate priority is to strengthen existing platforms while piloting integrated delivery models in selected districts. This phase should focus on demonstrating what works across different geographic and service contexts.¹³⁸

Key actions in this phase are:

- Pilot integrated delivery models in selected districts – combine school-based screening with ECD centre outreach and community delivery, with clear referral pathways.
- Formalise public-private partnerships to work together at scale – put in place agreements with NGOs and private optometrists that define roles, responsibilities and payment arrangements across the care pathway.
- Train and deploy designated screeners – recruit, train and formally contract local lay screeners as designated eye health and vision screeners, drawing where possible on youth employment mechanisms such as the Social Employment Fund.¹³⁹
- Establish a coordinated implementation structure that includes a national or provincial task team with joint representation from Health and Basic Education to oversee delivery and alignment.¹⁴⁰
- Strengthening implementation of existing screening platforms within the Integrated School Health Programme through improved planning, coordination, and consistency.¹⁴¹
- Support primary healthcare clinics as the first referral point – nurses in clinics are the entry point for children with eye health concerns that require medical or surgical attention. Building their capacity to receive and manage these referrals is an essential part of the pathway that is currently underinvested.¹⁴²
- Introduce a basic data system – practical tracking of who is screened, who is referred and who completes treatment.¹⁴³

This phase should prioritise learning and adaptation. The evidence from existing programmes (as illustrated in Table 1) is clear: high volume screening is feasible when school-based delivery is combined with community mobilisation and structured outreach. What consistently fails is follow-up.^{144,145} Building follow-up systems from the outset is the most important design decision in this phase.

6.2 Medium term (2-5 years): expand coverage and strengthen the system

Once delivery models have been tested and refined, the focus should shift to expansion and system strengthening. This phase involves scaling mixed delivery models while addressing the key constraints identified in earlier stages.

Key actions in this phase are:

- Expand mixed delivery models across districts, with schools as the primary platform,

complemented by ECD and community-based services.¹⁴⁶

- Formalise and expand partnerships with private-sector optometrists, NGOs, and mobile service providers to improve reach and coordination.
- Strengthen referral systems at every level by linking schools, primary health care services, and service providers.¹⁴⁷
- Secure reliable supply chains. Access to spectacles remains one of the persistent points of failure. Affordable, reliable supply must be treated as a system requirement.¹⁴⁸
- Introduce mobile clinics and outreach services in underserved areas with no fixed optometric services. Mobile units that can reach multiple schools in a day are a practical and proven solution.¹⁴⁹

Investment in workforce development, contracting and data systems is critical in this phase to support sustained delivery at scale.

6.3 Long term (5+ years): achieve national coverage and integration

The long-term goal is to achieve national coverage through a fully integrated system that links screening to care across health and education sectors.

Key actions in this phase are:

- Embed eye health and vision screening within routine health and education services, ensuring consistent delivery across all provinces.¹⁵⁰
- Integrate screening into broader child health and development platforms, including early childhood services and school health programmes.¹⁵¹
- Institutionalise data systems and performance monitoring to support continuous improvement.¹⁵²
- Maintain routine quality assurance and programme evaluation.¹⁵³
- Strengthen eye care within primary healthcare services by investing in public sector capacity.¹⁵⁴
- Align delivery with broader system reforms, including opportunities for integration under National Health Insurance.¹⁵⁵

Over time, this approach can also create conditions for broader development – local spectacle supply chains, expansion to older learners, and the foundation for the integrated vision and hearing screening model described in Section 5.5.¹⁵⁶

Key point: The destination is a system where no child's ability to learn is limited by a vision problem that was never found.

7. The investment case

Vision screening is a high-value intervention, but screening alone is not enough. A national costing model developed for South Africa estimates that a programme covering the full pathway from screening to diagnostic assessment, intervention and follow-up would require an investment of approximately R220 million at scale. This equates to an average of about R235 per child across the full pathway.¹⁵⁷

7.1 The cost of screening versus the cost of care

In 2026, Summit Actuaries and Advisors developed a national costing model for vision screening in South Africa. The model traces the full care pathway – from initial screening to diagnostic assessment, intervention and follow-up – for Grade R learners and those in the foundation phase who have not previously been screened. The target population is just under 1.2 million children.¹⁵⁸

Under the modelled workforce assumptions, existing capacity supplemented by approximately 200 designated screeners could screen about 932 000 children in the first year of implementation. The costing should therefore be understood as an estimate of the investment required as the programme scales towards high national coverage, rather than an assumption of 95% coverage being achieved immediately.¹⁵⁹

The model distinguishes between finding children with possible vision problems and ensuring that they receive the care they need. Screening is only the first step. The larger investment lies in diagnostic assessment, spectacle provision and follow-up. This reinforces the central argument of this brief: screening only delivers value when it is linked to effective referral and treatment.¹⁶⁰

The breakdown of the modelled full-pathway cost per child is as follows:¹⁶¹

Full pathway per child	Estimated cost
Screening	R62
Diagnostic assessment	R49
Intervention	R123
Total	R235

Note: May not add up due to rounding

The breakdown clearly shows that screening is not the principal cost driver. The larger investment lies in ensuring that children identified through screening complete the pathway to diagnosis, treatment and follow-up.

Experience from established dual sensory screening programmes provides useful context. Published South African research has shown that combined hearing and vision screening can be delivered at relatively low cost. For example, in one school-based programme using trained lay health workers and mobile technologies, dual sensory screening cost US\$6.67 per child.¹⁶²

HearX Foundation's current programme expenditure is approximately R180–R210 per child screened when expenditure on diagnostic assessment and intervention is

included.¹⁶³ This is not directly comparable with the national vision costing model because the populations, service packages and delivery arrangements differ, particularly with reference to the donation of hearing aids and spectacles which significantly reduces the cost of intervention. It nevertheless reinforces the same point: screening itself is relatively inexpensive; ensuring that children complete the pathway to care requires the larger investment share.

For additional international context, a school-based vision screening programme in India has been delivered for as little as US\$0.60 per child per year.¹⁶⁴ The national South African costing is substantially higher because it measures a more complete pathway – not simply the initial screening, but also diagnostic assessment, intervention and follow-up where required. Screening that does not lead to a pair of spectacles when a child needs them has not solved the problem.

Evidence shows that trained non-specialist screeners can conduct vision screening effectively when supported by standardised training, supervision and quality assurance.¹⁶⁵ The costing model also shows that reducing loss to follow-up – the proportion of children who are screened but never complete the referral pathway – is important for programme efficiency: higher loss to follow-up substantially increases the cost of achieving successful diagnosis and treatment.¹⁶⁶ If loss to follow-up doubles from the model's baseline assumption, the cost per child successfully diagnosed more than doubles. The efficiency of the programme therefore depends not just on how many children are screened, but on how many are seen all the way through to care.¹⁶⁷

Screening is inexpensive. Care is the investment

The costing model shows that identifying children with vision problems represents only part of programme expenditure. Most investment supports the care that follows: diagnostic assessment, spectacles, referral and follow-up. The value of screening therefore depends on completing the pathway to treatment.

In short, vision screening is affordable at scale – provided the delivery model is designed to make intelligent use of existing systems, task-shifted screeners and cross-sectoral partnerships.

7.2 Returns in the classroom

The returns on this investment are visible quickly, and they show up where it matters most – in children's ability to learn. Although this brief focuses on vision, the broader case for early sensory screening is that identifying and addressing hearing and vision problems can remove important barriers to learning.¹⁶⁸

The evidence on providing spectacles and learning is compelling. Randomised trials have shown that providing spectacles to children with uncorrected refractive error can

improve academic performance. These gains are educationally meaningful and can compare favourably with (or even exceed) more costly school-based interventions.¹⁶⁹

There is also a less visible cost to undetected vision problems. Children who cannot see clearly may struggle to read, complete schoolwork, concentrate in class or participate fully in learning. Without early identification, these difficulties can be mistaken for poor performance or disengagement, delaying the support that children need and affecting their educational progress.¹⁷⁰

7.3 Economic returns across a lifetime

The economic case for vision screening does not end at the school gate. Vision impairment can limit educational attainment, employment opportunities and economic participation later in life.¹⁷¹ These are not abstractions. They are the predictable, documented consequences of a condition that, in most cases, can be corrected with a pair of spectacles costing a few hundred rand.

WHO estimates that vision impairment imposes an annual global productivity cost of approximately US\$411 billion.¹⁷² In South Africa, the lifetime burden falls across the education system, the labour market and the health system simultaneously – compounding over decades in ways that make the upfront cost of early intervention look modest by comparison. The condition at the centre of this burden – refractive error – is among the most treatable in medicine. The gap between what is possible and what is currently happening is a systems problem.

Investing in early detection and correction generates benefits beyond eye health, including better educational outcomes and improved opportunities for participation later in life.¹⁷³ Vision screening is not a line item in the health budget. It is an investment in the productive capacity of the next generation

“

Investing in early detection and correction generates benefits beyond eye health.

”

Burton et al. 2021

7.4 Value for money

The numbers, taken together, make a clear case. At scale, an investment of approximately R218.8 million would support screening for about 932 000 children, diagnostic assessment for more than 224 000, and intervention for about 10 700 children who need further care, including spectacles.¹⁷⁴ Set against a status quo in which only a small proportion of learners are reached through routine screening, this provides a strong case for public investment in a coordinated pathway to care.

The financial case also depends on how the programme is designed. The costing model shows that the main pressures lie not in the initial screening, but in the services required afterwards – particularly diagnostic assessment, spectacle provision, human resources and outreach. Costs are also sensitive to the mix of staff used, their productivity and the proportion of children lost to follow-up. This makes efficient referral, task-sharing and strong follow-up systems central to both affordability and impact.

International evidence also shows that school-based vision screening and correction can be delivered affordably and at scale. WHO identifies refractive error correction as one of the most cost-effective and feasible eye health interventions available and has set a global target to substantially increase effective refractive error coverage by 2030.¹⁷⁵ South Africa is therefore not being asked to build an unusual intervention, but to put in place the systems needed to deliver an established one at national scale.

7.5 Invest in systems, not just services

A screening programme is only as strong as the system surrounding it. The costing model reinforces the importance of a digital management information system – one that tracks each child from initial screening through referral to treatment and follow-up – is essential to effective implementation. Without it, loss to follow-up is harder to manage, programme performance is more difficult to assess, and the value of the investment in screening is reduced.¹⁷⁶

Sustainable impact requires sustained investment across the full pathway: functional referral systems, reliable access to affordable spectacles, a trained and supported workforce, and the data infrastructure to hold the system accountable.^{177,178} These are what turns a screening event into a screening programme.

South African evidence points to the importance of linking screening to clear referral and follow-up pathways. Research on the implementation of vision screening through the ISHP has identified weaknesses in referral, follow-up and communication between role-players, reinforcing the need to treat screening as part of a coordinated pathway to care.¹⁷⁹

The costing model demonstrates that the financial case is not simply for screening but rather to support a coordinated system capable of moving children efficiently from identification to treatment. Investment in referral systems, data management and follow-up is therefore as important as investment in screening itself.

The investment required is modest; the cost of failing another generation of children is not.

Key point: Vision screening offers strong value when it is linked to an effective pathway to care.

Conclusion

South Africa has the evidence, the policy frameworks and the delivery platforms to implement an effective vision screening programme in place. The next step is to connect them through coordinated implementation and shared accountability.

The current system screens fewer than 3% of learners annually.¹⁸⁰ Undetected vision problems can contribute to difficulties with reading, classroom participation and academic progress, and these difficulties can be mistaken for poor academic performance, delaying the support children need and the effects accumulating over the entire school career.

That fragmentation is fixable and the tools already exist: a policy mandate through the ISHP, delivery infrastructure through schools and ECD centres, and a growing body of South African experience showing what coordinated, task-shifted and technology-enabled screening can look like in practice. SPF's work in the Eastern Cape and HearX Foundation's experience with dual sensory screening are instructive.^{181,182} They show what becomes possible when partnerships are in place and when screening is linked to referral and follow-up.

The investment required is modest relative to the potential returns. The national costing model estimates an average cost of about R235 per child across the full pathway – from screening and diagnostic assessment to intervention and follow-up where needed. The central lesson is that screening itself is not the major investment; instead, the larger cost lies in ensuring that children identified with vision problems actually receive care.¹⁸³ The cost of not acting – in lost learning, reduced productivity and lifetime dependence on government support – compounds year on year in ways that dwarf the upfront investment.

Implementing a system at scale that has already been shown to work requires specific decisions from specific actors:

- The departments of health and basic education, working through the ISHP, should establish Grade R as the routine entry point for eye health and vision screening, while maintaining screening at later stages of the school career, and put in place clear joint governance and accountability arrangements.¹⁸⁴

- The private eye care sector – optometrists, ophthalmologists, optical dispensers, retail optical chains and the laboratories that manufacture spectacles – need to move from ad hoc participation to structured partnership. Technology providers that have already demonstrated scalable, affordable screening solutions also have an important role in building the digital infrastructure needed to support a national programme.
- The NGO sector, which has carried much of this work on fragile and inconsistent funding, needs to be brought into a national system with sustainable resourcing – rather than continuing to operate through short-term projects outside a coordinated national system.

The ask is proportionate. The evidence is clear. The children are already in the classrooms.

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Eye Health and Vision Screening Community of Practice: An open, collaborative network bringing together stakeholders from across the care pathway to strengthen early detection and intervention for eye health and vision impairment. Shared learning, coordinated action, and continuous improvement are fostered. All who play a role in the eye health and vision landscape are welcomed and invited to participate, connect, exchange insights, and co-create solutions that advance accessible, equitable eye health and vision screening services for all children and families across South Africa.



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