

GLOBAL DATA ON VISUAL IMPAIRMENTS 2010



World Health
Organization

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Population Prospects: the 2008 Revision, from the United Nations Population Division (4).

The estimates are reported for the 6 WHO regions ([htt](#)

cation of Economies (Low Income, Lower Middle Income, Upper Middle Income, High Income) (6) and prevalence of blindness in the age group 50 years and older, chosen because of the many studies available, a consequence of the prevailing use of rapid assessment survey protocols focused on this age group. Since prevalence of blindness and visual impairment were strongly correlated with each other, only prevalence of blindness was selected as the parameter. The correlation between PPP and prevalence of blindness was consistently strong in all regions, with coefficients >0.8, other socio-economic (5,7,8) or health indicators (9) were tested and showed only weak correlations (0.5 or less). In each WHO region the countries were clustered into ranges of PPP and World Bank Classification of Economies (6). A weighted prevalence of visual impairment and blindness was calculated for countries with data within a PPP cluster and imputed to the other countries in the same cluster. A discussion of methods for missing data can be found in reference 11.

Estimates of causes of visual impairment

For the age groups 0 to 14 and 15 to 49 years the causes of visual impairment are based on previous estimates (2,3) For the age group 50 years and older the causes were calculated using the causal attribution provided by the studies that were used to estimate the prevalence. Each cause was calculated as an average percentage of the total causes at regional level first and then at global level, by including all the regional values.

Error analysis

Since only simple imputation using deductive methods was used and no regression analysis was conducted, the known errors on the regional estimates come from the reported uncertainties of the studies, which for the age group 50 years and older are around 10%, for the other ages around 20%.

Additional uncertainties are due to data imputation: these can be assumed to be lower in regions with more numerous studies.

RESULTS

Data sources

53 surveys from the 39 countries, listed in Table 1, met the inclusion criteria for this study: details are found in Annex 1 and 2. The majority of the studies, 38, took place between 2005 and 2008, 15 between 2001 and 2004; the largest majority were rapid assessments of cataract surgical services or of avoidable blindness (12, 13), a minority were national studies for all ages, some were targeting specific age groups or settings.

Other studies not satisfying fully the inclusion criteria provided supporting evidence for the estimates developed by the model.

WHO Region	Countries with studies
African Region	Botswana, Cameroon, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Mali, Nigeria, Rwanda, Uganda, United Republic Of Tanzania
Region of the Americas	Argentina, Brasil, Chile, Cuba, Dominican Republic, Guatemala, Mexico, Paraguay, Peru, Venezuela
Eastern Mediterranean Region	Islamic Republic of Iran, Oman, Pakistan, Qatar
European Region	Russian Federation, Turkmenistan
South-East Asian Region	Bangladesh, Democratic Republic of Timor-Leste, India, Indonesia, Myanmar, Nepal
Western Pacific Region	Cambodia, China, Papua New Guinea, Philippines, Viet Nam

Model of visual impairment in the six WHO Regions

Visual impairment was estimated in each WHO Region with a model built using prevalence of blindness and countries' economic status from available data as described in Methods.

The African Region comprises 46 countries of which 40 are classified by the World Bank either as Low Income (LI) or Lower Middle Income (LMI) within a narrow range of PPP, representing 93.2 % of the population in the Region. Five countries are classified as Upper Middle Income (UMI) and one as High Income (HI) representing 6.8 % of the region population. 19 surveys from 12 countries, all classified as LI or LMI, were available for inclusion in the model for the region. Given the similar economic status of these countries they were considered as a single cluster of PPP. The weighted prevalence of visual impairment and blindness from the 19 surveys was imputed to the whole Region.

In the Region of the Americas the 36 countries were divided into three clusters of PPP corresponding to the World Bank classifications: LMI (10 countries), UMI (20 countries), HI (6 countries). Data were available from three countries in the LMI cluster, and seven in the UMI cluster. The combined population in the 10 countries with available data in the LMI and UMI clusters represented 80% of the total population in these 30 countries. The weighted average of the prevalence of visual impairment and blindness was derived separately in the two clusters and imputed to the other countries in the

same cluster. Recent data satisfying the inclusion criteria for this study for the HI cluster were not available: prevalence was derived from previous WHO estimates (2,3).

The 21 countries in the Eastern Mediterranean Region were sorted into two clusters of PPP. The first included 13 countries classified as LI and LMI, the second 8 countries classified as UMI and HI. Data from three countries in the LI/LMI cluster and from one in the UMI/ HI cluster were available for estimates.

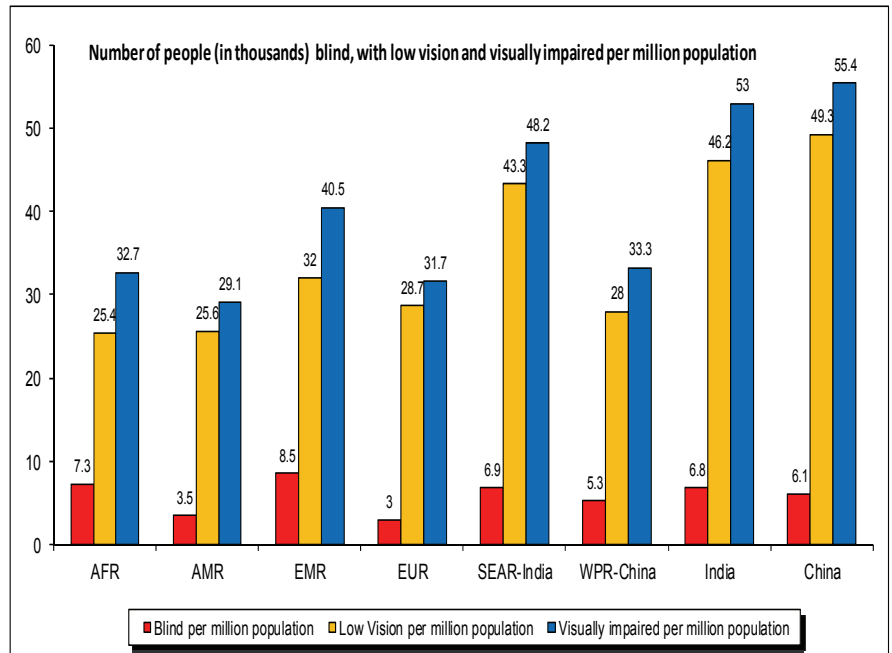
In the European Region three economic clusters were defined, one including 25 HI countries, a second, 11 UMI countries and the third, 14 LMI and 3 LI countries. Data were available from one country each in the UMI and in the LMI /LI clusters. The data from a single country were imputed to the UMI cluster and analogously data from a single country to the LMI/ LI cluster. Recent data for this study were not available for the HI cluster and previous WHO estimates were used (2,3).

The estimates for the South-East Asian Region were derived for India and for the other countries in the Region separately. The prevalence for India was derived from 3 recent surveys (see Annex 1 and 2). The other 10 countries in the Region are classified either as LMI or LI and given the similarity of PPP were all included in one single cluster. Data were available from 5 of the 10 countries comprising almost 80% of the population in the region (India excluded). The weighted prevalence estimated from the data in the five countries was imputed to the whole cluster.

The estimates for China were derived separately from the other countries in the Western Pacific Region and were based on recent surveys conducted in the rural areas combined with data from urban settings (see Annex 1 and 2). The other countries in the Region were sorted into 3 clusters: the first included 7 countries classified as HI and one as UMI ; the second included all 15 Pacific Islands with 14 countries classified as LMI and one UMI ; the third comprised 4 countries, 2 classified as LI and 2 as LMI. For the first cluster prevalence was derived from the previous estimates (2,3). Data from one country were used for the second cluster and data from 3 countries for the third cluster (see Annex 1 and 2).

Global Prevalence of Visual Impairment

The estimated number of people visually impaired in the world is 285 million, 39 million blind and 246 million having low vision; 65 % of people visually impaired and 82% of all blind are 50 years and older (Table 2). The distribution of people visually impaired in the six WHO Regions is shown in Table 3 with the percentage of the global impairment shown in parentheses. Figure 1 shows the number of people visually impaired, with low vision and blind per million population in the six WHO Regions and in India and China separately.



Cause of visual impairment

Globally the principal causes of visual impairment are uncorrected refractive errors and cataracts, 43% and 33 % respectively. Other causes are glaucoma, 2%, age related macular degeneration (AMD), diabetic retinopathy, trachoma and corneal opacities, all about 1%. A large proportion of causes, 18%, are undetermined, (Figure 2A).

The causes of blindness are cataract, 51%, glaucoma, 8%, AMD, 5%, childhood blindness and corneal opacities, 4%, uncorrected refractive errors and trachoma, 3%, and diabetic retinopathy 1%, the undetermined causes are 21% (Figure 2 B).

DISCUSSION

This study presents some limitations, the most significant are the following: the surveys in the last 10 years have been mostly Rapid Assessments for ages 50 years and older, and national studies for all ages with or without WHO Eye Survey Protocol have been few. As a consequence data could be limited in representation of countries and of ages. The imputation of prevalence for missing data can give errors that are difficult to estimate: clearly they could be high in regions with sparse data. In the Eastern-Mediterranean Region recent data were unavailable for most of the countries, hence the estimates were in large extent based on surveys from 1993-1998 (2,3) Data from HI countries were also missing or were dated as far back as 15 years. However it must be noted that in HI countries from available information there was no evidence of major changes in prevalence.

The combined effect of these uncertainties is possibly an over or under estimation of visual impairment and blindness of approximately 20%.

The attribution of the causes of visual impairment and blindness is also prone to uncertainty. This is often the instance in surveys carried out in the field with limited diagnostic capacity, but it is particularly true in the case of

rapid assessments whose aim is primarily to survey cataract surgical services for ages 40 or 50 years and older. The large percentages of undetermined causes are also likely to be a reflection of these protocols.

The strengths of the estimates derive firstly from the fact that new data were available to replace previous extrapolations. Furthermore, to estimate the prevalence of visual impairment in countries missing data, a model was used based on the same economic parameters for all countries. This is a new approach in producing estimates of visual impairment. The imputation process via a model is more transparent than using expert assumptions and it provides consistency between countries and regions. It also allows for adjustments and corrections as soon as new information becomes available and it could also be adapted for estimating trends.

Because data available and methods used have changed, it is not possible to draw conclusions from differences in present estimates and previously published estimates. In areas where surveys were repeated with similar protocols for ages 50 years and older a reduction of visual impairment is shown despite the rapid growth of this age group. This decline fits with increased socio-economic development, but it is also the direct consequence of investments made by Governments and of interventions by international partners.

Posterior segment (retinal) diseases are a major cause of visual impairment worldwide, and likely to become more and more important, with the rapid growth of the aging population. The proportion of the total visual impairment and blindness from age related macular degeneration, glaucoma and diabetic retinopathy is currently greater than from infectious causes such as trachoma and corneal opacities.

This requires the urgent development of eye care systems that address chronic eye diseases with rehabilitation, education and support services.

CONCLUSION

Monitoring the magnitude of visual impairment is essential for policies aiming at the prevention and elimination of the avoidable causes. The global estimates have significant uncertainties that could be reduced with population based studies from regions with limited or old data and with studies conducted at national level for all ages recording all causes of blindness. Particularly urgent is to determine the extent of posterior segment diseases as causes of visual impairment, since these require the development of eye care systems, including human resources and infrastructures.

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Funding statement

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Table 2. Global estimate of the number of people visually impaired by age, 2010; for all ages in parenthesis the corresponding prevalence (%).

Ages (in years)	Population (millions)	Blind (millions)	Low Vision (millions)	Visually Impaired (millions)
0-14	1,848.50	1.421	17.518	18.939
15-49	3548.2	5.784	74.463	80.248
50 and older	1,340.80	32.16	154.043	186.203
all ages	6,737.50	39.365 (0.58)	246.024 (3.65)	285.389 (4.24)

Table 3. Number of people visually impaired and corresponding percentage of the global impairment by WHO Region and country, 2010

		Blindness	Low vision	Visual Impairment
WHO Region	Total population (millions)	No. in millions (percentage)	No. in millions (percentage)	No. in millions (percentage)
Afr	804.9 (11.9)	5.888 (15)	20.407 (8.3)	26.295 (9.2)
Amr	915.4 (13.6)	3.211(8)	23.401 (9.5)	26.612 (9.3)
Emr	580.2 (8.6)	4.918 (12.5)	18.581 (7.6)	23.499 (8.2)
Eur	889.2 (13.2)	2.713 (7)	25.502 (10.4)	28.215 (9.9)
Sear (India excluded)	579.1 (8.6)	3.974 (10.1)	23.938 (9.7)	27.913 (9.8)
Wpr (China excluded)	442.3 (6.6)	2.338 (6)	12.386 (5)	14.724 (5.2)
India	1181.4 (17.5)	8.075 (20.5)	54.544 (22.2)	62.619 (21.9)
China	1344.9 (20)	8.248 (20.9)	67.264 (27.3)	75.512 (26.5)
World	6737.5 (100)	39.365 (100)	246.024 (100)	285.389 (100)

Fig. 2A

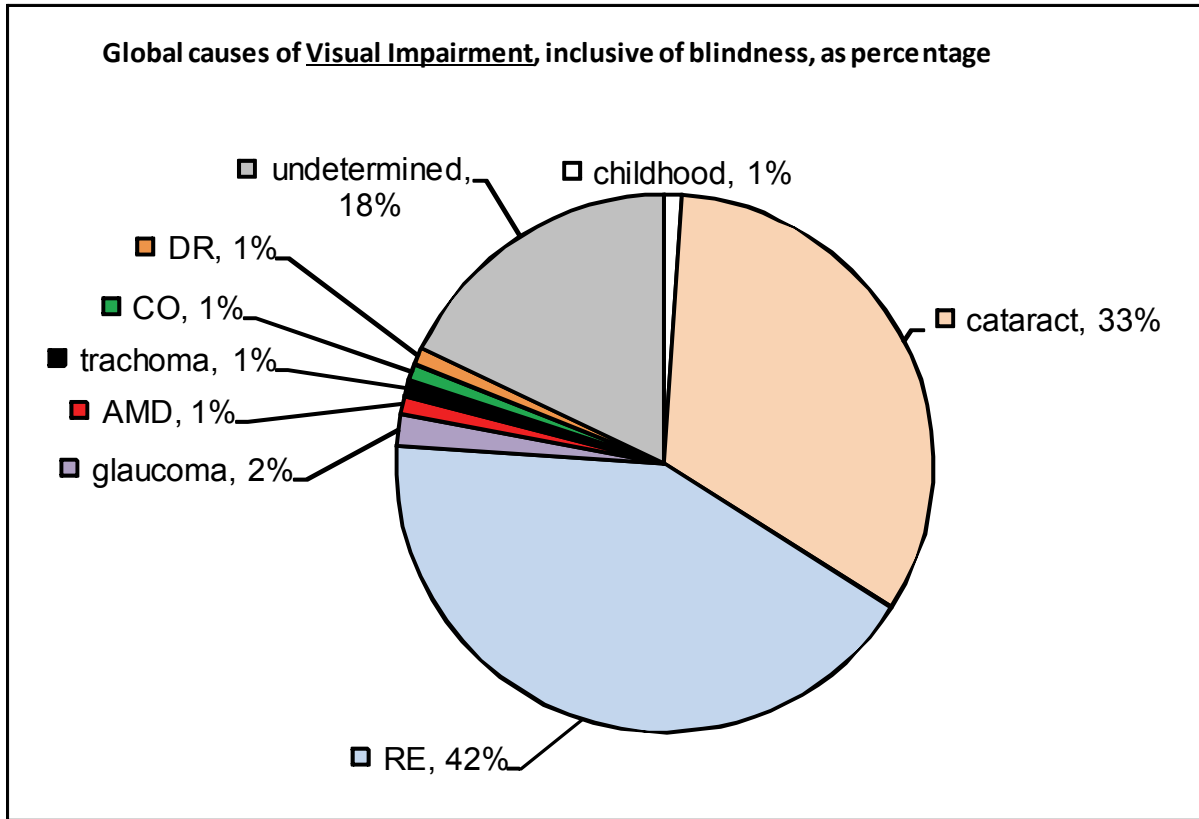
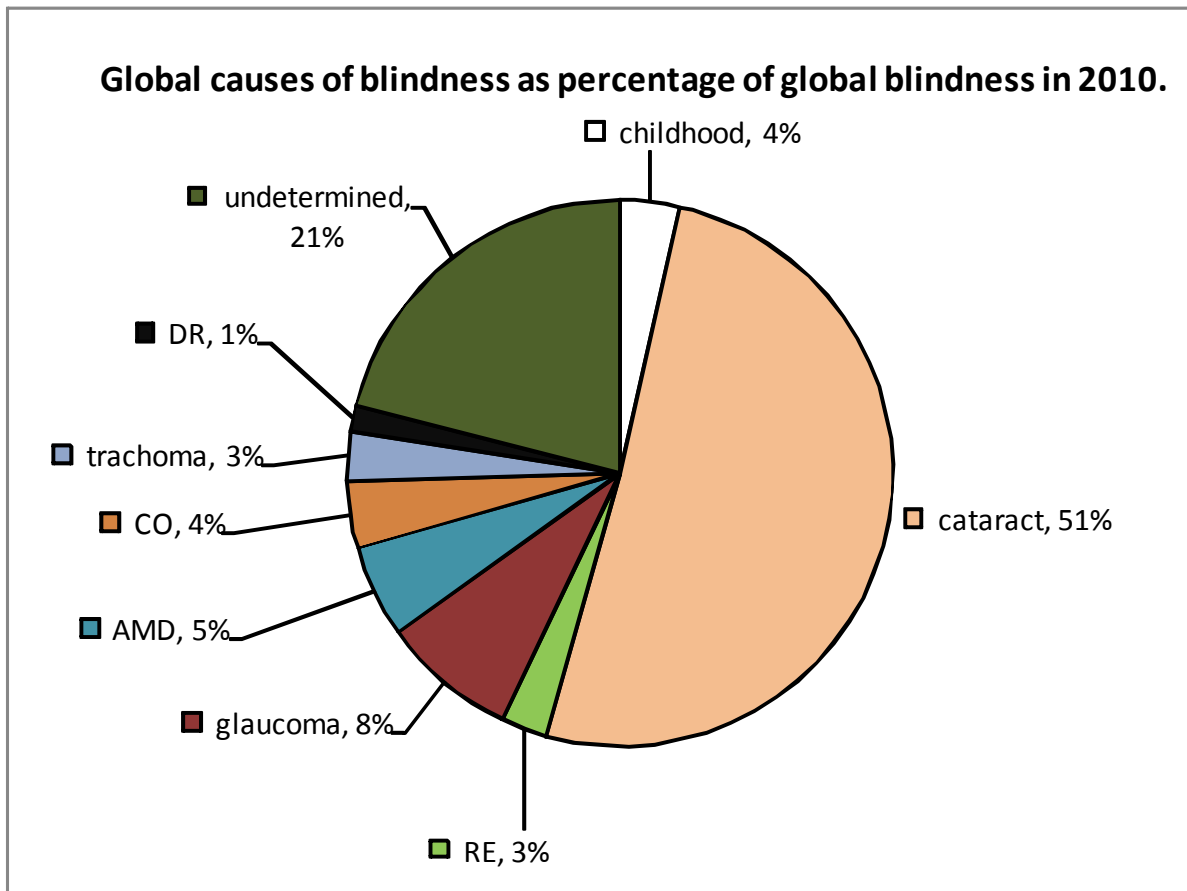


Fig. 2B



Annex 1

WHO African Region	date of survey	study population	sample size	age group	reference
Botswana	2006	<i>national urban/rural and rural</i>	2127	50 years and older	BWA 1
Cameroon	2006	<i>subnational urban</i>	2215	40 years and older	CMR 1
Cameroon	2004	<i>subnational rural urban</i>	1787	40 years and older	CMR 2
Eritrea	2008	<i>national urban and rural</i>	3163	50 years and older	ERI 1
Ethiopia	2005	<i>national urban and rural</i>	25650	all ages	ETH 1
Gambia	2007	<i>national</i>	2992	50 years and older	GMB 1
Ghana	2001	<i>subnational</i>	2289	40 years and older	GHA 1
Ghana	2005	<i>subnational rural</i>	9117	40 years and older	GHA 2
Kenya	2005	<i>subnational rural</i>	3475	50 years and older	KEN 1
Kenya	2007	<i>subnational rural</i>	3376	50 years and older	KEN 2
Kenya	2007	<i>subnational urban</i>	2419	50 years and older	KEN 3
Mali	2008	<i>subnational</i>	2438	50 years and older	MLI 1
Nigeria	2008	<i>national urban and rural</i>	13593	10 to 15 years 40 years and older	NGA 1
Nigeria	2006	<i>subnational urban and rural</i>	2424	50 years and older	NGA 2
Rwanda	2006	<i>subnational rural</i>	2006	50 years and older	RWA 1
Uganda	2007	<i>subnational</i>	3294	50 years and older	UGA 1
UR Tanzania	2007	<i>subnational rural</i>	3202	50 years and older	TZA 1
UR Tanzania	2007	<i>subnational rural</i>	3463	50 years and older	TZA 2
UR Tanzania	2007	<i>subnational urban and rural</i>	3160	50 years and older	TZA 3

WHO Region of the Americas	date of survey	study population	sample size	age group	reference
Argentina	2004	<i>subnational peri-urban</i>	4302	50 years and older	ARG 1
Brazil	2004	<i>subnational urban</i>	2224	50 years and older	BRA 1
Chile	2006	<i>subnational urban and rural</i>	2915	50 years and older	CHL 1
Cuba	2005	<i>subnational peri-urban</i>	2716	50 years and older	CUB 1
Dominican Republic	2008	<i>national urban and rural</i>	3873	50 years and older	DOM 1
Guatemala	2004	<i>subnational urban and rural</i>	4806	50 years and older	GTM 1
Mexico	2006	<i>subnational rural</i>	3764	50 years and older	MEX 1
Paraguay	2002	<i>national urban and rural</i>	2136	50 years and older	PRY 1
Peru	2002	<i>subnational rural</i>	4782	50 years and older	PER 1
Venezuela	2005	<i>national urban and rural</i>	3317	50 years and older	VEN 1
WHO Eastern Mediterranean Region	date of survey	study population	sample size	age group	reference
Iran (Islamic Republic of)	2005	<i>subnational urban and rural</i>	5456	10 years and older	IRN 1
Oman	2005	<i>national urban and rural</i>	2339	40 year and older	OMN 1
Pakistan	2004	<i>national urban and rural</i>	16507	30 years and older	PAK 1
Qatar	2008	<i>urban peri-urban</i>	2433	50 years and older	QAT 1
WHO European Region	date of survey	study population	sample size	age group	reference
Russian Federation	2008	<i>subnational peri-urban</i>	3837	50 years and older	RUS 1
Turkmenistan	2001	<i>subnational urban/rural</i>	6011	50 years and older	TKM 1

WHO South-East Asian Region	date of survey	study population	sample size	age group	reference
Bangladesh	2005	<i>subnational rural</i>	4868	50 years and older	BGD 1
Democratic Republic of Timor Lester	2005	<i>subnational urban and rural</i>	1414	40 years and older	TLS 1
India	2007	<i>national urban and rural</i>	40447	50 years and older	IND 1
India	2003	<i>subnational urban and rural</i>	7084	50 years and older	IND 2
India	2006	<i>subnational urban and rural</i>	13016	5 to 15 years 50 years and older	IND 3
Indonesia	2004	<i>subnational rural</i>	2629	50 years and older	IDN 1
Myanmar	2005	<i>subnational rural</i>	2076	40 years and older	MMR 1
Myanmar	2003	<i>subnational rural</i>	2885	50 years and older	MMR 2
Myanmar	2003	<i>subnational rural</i>	2990	50 years and older	MMR 3
Nepal	2002	<i>subnational rural</i>	5002	45 years and older	NPL 1
Nepal	2005	<i>subnational rural</i>	5138	50 years and older	NPL 2
WHO Western Pacific Region	date of survey	study population	sample size	age group	reference
Cambodia	2007	<i>national urban and rural</i>	5902	50 years and older	KHM 1
China	2007	<i>subnational rural</i>	45747	50 years and older	CHN 1
China	2003	<i>subnational urban and peri-urban</i>	3040	60 years and older	CHN 2
Papua New Guinea	2005	<i>subnational urban and rural</i>	1174	50 years and older	PNG 1
Philippines	2006	<i>subnational urban and rural</i>	5951	50 years and older	PHL 1

WHO Western Pacific Region	date of survey	study population	sample size	age group	reference
Viet Nam	2007	<i>national urban and rural</i>	28073	50 years and older	VNM 1
Viet Nam	2007	<i>national urban and rural</i>	28800	0 to 15 years	VNM 1

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