improve patients' adherence, as was reported by Kizor-Akaraiwe[10] for glaucoma patients during the COVID-19 lockdown.

Conclusion: Financial constraints, ignorance and loss to follow-up hamper management of patients. Education on early presentation and adherence to management plans is vital.

Conflict of interest: The authors declare no conflict of interest

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Community utilization of ophthalmic services: Assessment of Agbowa rural community, Lagos State, Nigeria

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Background: Eye health is a public health concern. Community-based ophthalmic services aim to bring eye care to the people's doorsteps, particularly rural dwellers who are often deprived of essential health care.[1,2] The World Health Organization (WHO) and the International Agency for the Prevention of Blindness (IAPB) promote Integrated Primary Eye Care (IPEC) within existing primary health systems to facilitate eye services delivery.[3,4] Studies have, however, revealed that even where available, community utilization sometimes remains poor.[5,6] Most studies have focused on interviewing people in rural communities to assess their use of eye care services and the barriers they face.[7,8] However, very limited

studies within the study environment have assessed ophthalmic services utilization at the base primary eye care centers. This study aims to assess ophthalmic service utilization at a rural community, determine the prevalence of ocular diseases and identify gaps in service delivery with the goal of suggesting measures for improved and sustainable service.

Methods: A retrospective cross-sectional study was conducted. The study duration was February 2021 (from the inception of the IPEC) to December 2023. All eye clinic attendees in this agro-based (farming and fishing) community were included. Data on demographics, ocular diseases, medical, optical and surgical interventions were obtained from the eye clinic, refraction clinics, and operating theatre records. Data analysis was done using IBM SPSS version 29. Ethical approval was obtained from Ikosi–Ejirin Local Council Development Area and Institutional Health Research and Ethics Committee.

Results: There were 1,102 patient visits, with 735 (66.7%) as new cases. Age ranged from 4 months to 88 years (mean 47.29 ± 22.78 years). Females constituted 54.3%. Utilization of ophthalmic services was most prevalent among females (54.3%); patients in the presbyopic age range, 40-49 years (17.6%); older adults aged 60-69 years (15.7%); and middle-aged 50-59 years (15.1%) (Table 1).

Table 1: Age distribution and frequency of clinic attendance (new and follow-up visits)

Age (in years)	New cases	Follow-up	Total	Test statistics
0 - 9	59 (78.7)	16(21.3)	75 (6.8)	X^2 = 41.520
10 - 19	95 (76.0)	30 (24.0)	125 (11.3)	p = **<0.001**
20 - 29	49 (77.8)	14 (22.2)	63 (5.7)	
30 - 39	60 (64.5)	33 (35.5)	93 (8.4)	
40 - 49	145 (74.7)	49 (25.3)	194 (17.6)	
50 - 59	113 (68.1)	53 (31.9)	166 (15.1)	
60 - 69	98 (56.6)	75 (43.4)	173 (15.7)	
70 - 79	79 (53.7)	68 (46.3)	147 (13.3)	
80 and above	37 (56.1)	29 (43.9)	66 (6.0)	
Total	**735 (66.7%)**	**367 (33.3)**	**1102 (100.0)**	

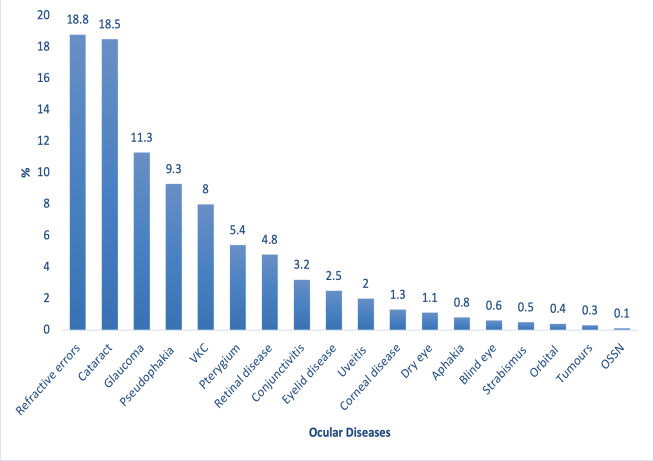

Figure 1: *Prevalence of ocular diseases at the integrated primary eye care centre*
**VKC vernal keratoconjunctivitis*

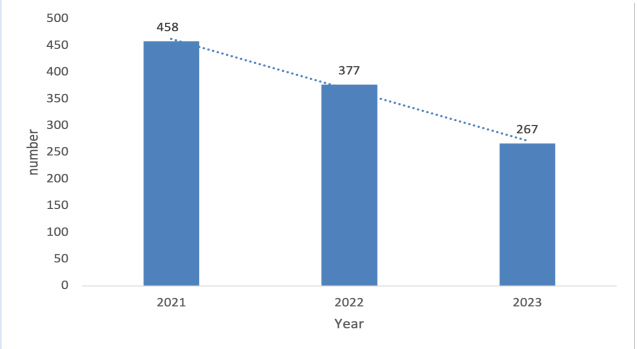

Figure 2: *Yearly clinic attendance at the integrated primary eye care centre*

Follow-up visits were more frequent among patients aged 40 years and above (Table 1).
Prevalent ocular diseases (Figure 1) were uncorrected refractive errors (18.8%), cataracts (18.5%), glaucoma (11.3%), vernal conjunctivitis (8.0%), and pterygium (5.4%). A total of 401 (36.4%) individuals benefited from refractive error services, predominantly middle-aged patients in the 4th (28.4%) and 5th decades (18.0%), as well as adolescents aged 11-20 years (17.0%), while 99 (8.9%) had surgery.
Figure 2 shows a fall in yearly attendance from 458 to 267 cases - a 17.4% decline in service utilization. Declines in surgical uptake (51.6%) and refraction services (27.4%) were also recorded.

Discussion: In this study, an initial satisfactory ophthalmic service utilization was reported. Females, middle-aged, elderly and adolescents utilized the services more, similar to previous studies[8,9], probably because they are more domiciled in the community. All age groups reported appreciable initial service uptake, followed later by poor uptake similar to an earlier study.[10] The community needs for presbyopic correction, age-related cataract, refractive errors, glaucoma, pterygium, and allergic conjunctivitis are comparable to earlier studies.[11-13] Major identifiable gaps were a decline in ophthalmic, surgical and refractive services uptake. Barriers to clinic utilization may be accessibility, affordability, lack of eye health education, personnel and infrastructure deficiencies. [7,14-16]

Conclusion: Ophthalmic services, though well utilized at inception, suffered a significant decline over the following years. Efforts to improve service utilization and sustainability, such as reinforced community awareness outreach and school eye health programs, are recommended.

Keywords: community utilization, integrated primary eye care, ophthalmic services, rural eye care

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