integrity Research Journals

Journal of Public Health and Diseases
Volume 8(1), pages 14-23, April 2026
Article Number: C6CA302E2
ISSN: 2705-2214
https://doi.org/10.31248/JPHD2025.166
https://integrityresjournals.org/journal/JPHD

Full Length Research

Self-reported history of ocular conditions and knowledge of glaucoma among faith-based leaders in Anambra State, Nigeria: A population-based cross-sectional survey

Arinze A Onwuegbuna[1], Ugochukwu A Eze[2]*, Akunne I Apakama[1], Ogugua N Okonkwo[3], Chidiebele M Ezeude[4], Chigozie I Echieh[5], Emeka A Chianakwalam[6] and George U Eleje[7]

[1]Department of Ophthalmology, Nnamdi Azikiwe University, Awka, Nigeria.
[2]Department of Ophthalmology, Federal Medical Centre, Asaba, Nigeria.
[3]Eye Foundation Hospital, Ikeja, Nigeria.
[4]Department of Internal Medicine, Nnamdi Azikiwe University, Awka, Nigeria.
[5]Department of Ophthalmology, University of Calabar Teaching Hospital, Calabar, Nigeria.
[6]Department of Ophthalmology, Federal Medical Centre, Umuahia, Nigeria.
[7]Department of Obstetrics and Gynaecology, Nnamdi Azikiwe University Awka, Nigeria.

*Corresponding author. Email: ugorexeze@gmail.com

Received Date: 15 July 2025 | Accepted Date: 25 February 2026 | Published Date: 30 April 2026

ABSTRACT: Faith-based leaders are highly respected and influential members of society, shaping the values and habits of their followers. This study explored self-reported ocular conditions and glaucoma knowledge among faith-based leaders in Anambra State. A cross-sectional survey was conducted among 167 faith-based leaders selected through multistage sampling. An interviewer-administered, pretested, and validated questionnaire was used to collect information on sociodemographic variables, ocular condition history, and glaucoma knowledge. A structured scoring system was used to assess glaucoma knowledge. A 70% (7/10) cutoff was set for adequate knowledge, while scores below the cutoff were considered inadequate. Data was analysed using IBM SPSS software version 23. The results show that the study population was predominantly male (73.7%), with a mean age of 47.02 ± 13.84 years, and the majority (79.6%) attained at least a tertiary level of education. The predominant ocular symptoms were blurred vision, difficulty reading, itching, and ocular pain. Glaucoma awareness was poor as only 27.5% of respondents showed a good (adequate) knowledge of the condition, and a higher level of education was significantly associated with an adequate knowledge of glaucoma (p=0.022). Inability to read was the most common symptom reported, followed by allergies and blurred vision. In conclusion, knowledge of glaucoma among faith-based leaders was generally low in this survey. Given their high level of influence within communities, the importance of integrating faith-based leaders into glaucoma awareness and primary eye care education initiatives cannot be overemphasised, as this may improve community-based eye health education and significantly reduce the burden of glaucoma-related blindness.

Keywords: Anambra State, faith-based leaders, glaucoma, ocular conditions.

INTRODUCTION

Faith-based organisations are considered the most organised civil institutions, and their leaders are highly influential and respected members of our society, as they enjoy the allegiance of billions of people across different communities worldwide (Johns Hopkins University, 2024). The influence these leaders enjoy confers on them special privileges and abilities to shape the values and habits of the people they lead in society. Religious leaders have significant influence over their congregations' health decisions, which are shaped by their faith, beliefs, and

opinions. This influence can impact health behaviours, practices, and decisions, reflecting the complex interplay between faith and health (Swihart *et al*., 2023). Faith leaders are important agents of change, social mobilisers, and stakeholders in health information dissemination at the community level. A hospital-based study in Onitsha, Nigeria, reported that religion influences treatment choice in approximately 10% of the study population (Nwosu, 2010). It's crucial for influential individuals, such as religious leaders, to possess the knowledge and skills to communicate effectively with and guide their followers, especially on critical issues like health. This enables them to provide informed support and guidance.

Globally, it is currently estimated that there are about 81 million people with glaucoma, and this number has been projected to reach 185 million by 2060 (Wang *et al.*, 2026). In Africa, the prevalence of open-angle glaucoma ranges from 3.9% to 4.9% across central and western Africa (Wang *et al*., 2026). According to the Nigeria National Blindness and Visual Impairment Survey, the prevalence of glaucoma in Nigeria was estimated at approximately 5.0% (Kyari *et al*., 2015). Studies have shown that early intervention can effectively slow the progression of the disease and consequent related vision loss. However, there is an alarmingly high rate of underdiagnosis globally, exceeding 90% in some low- and middle-income countries and about 50% in high-income nations (Peng *et al*., 2026). Previous studies in parts of West Africa have shown a low level of awareness of glaucoma (Budenz, 2013; Durowade, 2014; Opoku and Murdoch, 2013; Balo *et al*., 2004; Ntim-Amponsah *et al.*, 2004). Results from various studies have reported low glaucoma knowledge in Nigeria (Nwosu, 2010; Mbadugha and Onakoya, 2016). Another study in a Ghanaian faith-based community showed a low level of awareness (29%), whereas the reported study also reported higher awareness among educated professionals (Murdoch, 2014). Being the most common cause of irreversible blindness and having the highest prevalence, earlier onset, and rapid progression in people of African descent compared to other races (Quigley and Broman, 2006; Tham *et al*., 2014; Kyari *et al*., 2013; Budenz *et al*., 2001), it is important to have a good awareness and knowledge of the condition to have better attitudes towards glaucoma care and prevention of glaucoma-related blindness. From reports of the National Blindness And Visual Impairment Survey, South-East Nigeria has the highest burden of glaucoma (Kyari *et al*., 2015), and yet glaucoma screening in this region is still quite poor, even among relatives of glaucoma patients. It is therefore pertinent for stakeholders to devise multifaceted public health approaches that involve health promotion and health protection strategies for improved awareness and requisite behavioural change that will encourage regular eye checks and screening exercises (especially among glaucoma high-risk groups) that will aid early detection, treatment of glaucoma, and consequent prevention of glaucoma-related blindness. So far, it appears there is no study on the self-reported history of ocular conditions and knowledge of glaucoma among faith-based leaders within or outside the country, however, a recent study by Onwuegbuna *et al*. (2014), where the authors made a case for engaging faith-based leaders in the fight against glaucoma related blindness showed that the faith-based leaders had a fairly perception of their roles in the prevention of glaucoma blindness. A qualitative study in Calabar, Nigeria, which explored the attitudes of Christian religious leaders towards orthodox eye health, reiterated the need for greater engagement between eye health workers and faith-based leaders (Ibanga *et al*., 2021). This shows that some health promotion interventions/advocacy can be targeted at this influential group of potential stakeholders in the much-desired fight against glaucoma-related blindness. Therefore, the purpose of this study is to explore the self-reported history of various ocular conditions and glaucoma knowledge among faith-based leaders in parts of Anambra State, Nigeria.

METHODOLOGY

Design, study population and sample size

Stage 1: Selection of Local Government Areas (LGAs)

There are three senatorial districts in Anambra State, which were identified: Anambra Central, Anambra North, and Anambra South. Stratification of the districts was first done to ensure a fair geographical representation. Using random sampling, one or more local government areas (LGAs) were selected from each senatorial district. A list of all LGAs in each district was used to select the LGA by ballot. In total, four LGAs were selected. The selection was also guided. The selection of LGAs was based on factors such as population size, accessibility, and representation of the state's diverse communities (urban and semi-urban).

Stage 2: Selection of church communities

In each selected LGA, we randomly selected a town, and a list of registered churches was compiled with guidance from community and religious leaders. Using convenience sampling based on accessibility, leadership willingness to participate, and congregation size, we selected about 10–15 churches.

Stage 3: Selection of participants

For each selected church community, the presiding pastor (priest or superior) was contacted and briefed on the project's objectives. After receiving their approval, 3-5 members of the congregation were asked to complete a self-administered questionnaire. Participants were selected using a convenience sampling technique, based

on their willingness to participate, informed consent, and availability at the time of the visit. There was no randomisation at this stage. The contact details of willing participants were also recorded to aid availability at the time of the visit.

Scoring system/rationale for categorising knowledge

The questionnaire comprised 10 multiple-choice questions covering the definition of glaucoma, risk factors for glaucoma, symptoms of glaucoma, potential treatment modalities, and strategies to prevent glaucoma blindness. A cutoff of 70% (7/10), a commonly used threshold in educational and research settings to indicate adequate knowledge of glaucoma, was used in this study.

Good knowledge: Respondents who scored 7 or more (≥7) accurate responses out of 10 (≥70%) were categorised as having "good" (adequate) glaucoma knowledge.

Poor Knowledge: Respondents who scored 6 or fewer (≤6) accurate responses out of 10 (<70%) were categorised as having inadequate glaucoma knowledge.

Survey tool/data collection

An interviewer-administered, semi-structured, pre-tested questionnaire, adapted from previously published studies that focused on glaucoma knowledge and attitudes in communities, was used to collect information from participants. The questionnaire was drafted in English and then reviewed by content validity experts (two consultant ophthalmologists and one public health specialist) who were co-authors, but not part of the initial drafting of the tool. A 4-point Likert scale (1 = not relevant, 2 = slightly relevant, 3 = relevant, 4 = highly relevant) was used to evaluate the tool and ensure that the questions were relevant, clear, and effective in achieving the study's objectives. A content validity index (CVI) was calculated at the item level (I-CVI) and scale level (S-CVI). Items with an I-CVI < 0.78 were revised or removed, and the final S-CVI was 0.89, indicating good content validity. A pilot study was conducted among ten religious leaders in a non-selected LGA to assess feasibility, average completion time, and internal consistency. The average completion time was approximately 12 minutes, and no major difficulties in understanding the items were reported. The internal consistency of the glaucoma knowledge items was assessed using Cronbach's alpha, which yielded a value of 0.81, indicating good reliability. Then, face validity was assessed among 10 religious leaders at a nearby eye clinic to ensure clarity, comprehension, and language suitability for the target population. This led to some slight modifications to enhance the clarity and contextual relevance. Subsequently, a pilot study was conducted among ten religious leaders in a non-selected LGA within the state to determine the average completion time, internal consistency, and feasibility. The average time to completion was 12 minutes, and no major challenges with comprehension of the items were reported. Using Cronbach's alpha to assess the consistency of glaucoma knowledge items, a value of 0.81 was obtained, which indicated a good reliability. The feedback was further used to review the draft and obtain a final, updated version of the questionnaire, which was used for the study. The questionnaire had four sections with thirty-three semi-structured questions. The first section collected sociodemographic variables such as age, sex, highest level of education, ethnicity, years of practice, denomination, number of members, number of services per week, and location of the church/ministry.

The second section obtained information on ocular history (previous and current eye conditions, knowledge of such problems, treatment received and by whom, family history of any eye condition, and blindness). The third section collected information on knowledge of glaucoma (having heard of glaucoma before, its effects on the eye, the age group most affected, the cause of the disease, knowledge, and the types of treatment available for glaucoma). This section on attitude towards the campaign against glaucoma blindness has been previously published.16 The final section of the questionnaire explored the attitude of the religious leaders towards the prevention of glaucoma (previous glaucoma screening, reason for screening and not screening where applicable, willingness to be involved in glaucoma prevention campaigns, preferred platform for such campaign, best way to prevent glaucoma blindness, any relative with glaucoma blindness). Because the questionnaire was interviewer-administered, the data collection team helped ensure complete filling, which eliminated almost all the possibility of missing information in the completed questionnaire.

Data management and analysis

The complete data obtained from the respondents (n = 167) were entered into an Excel sheet and transferred to a statistical software (IBM SPSS version 23) for data cleaning and analysis. Descriptive analysis was conducted, and the results were summarised and expressed as means and percentages. Inferential analysis was performed using the Chi-square test, with a statistical significance level set at $p<0.05$.

Ethical consideration

The study adhered to the tenets of the Helsinki Declaration for the use of human subjects in research. Ethical clearance

Table 1. Sociodemographic characteristics.

Variable	Frequency (n=167)	Percentage
Gender		
Female	44	26.3
Male	123	73.7
Age Group		
20-29yrs	17	10.2
30-39yrs	39	23.4
40-49yrs	39	23.4
50-59yrs	37	22.2
>60yrs	35	21.0
Level of Education		
Primary	3	1.8
Secondary	31	18.6
Tertiary	73	43.7
Postgraduate	60	35.9
Occupation		
Clergy	102	61.1
Religious Personnel	21	12.6
Trader	18	10.8
Others	26	15.6
Ethnicity		
Igbo	155	92.8
Yoruba	6	3.6
Others	6	3.6

was obtained from the research and ethics committee of Chukwuemeka Odumegwu Ojukwu University Teaching Hospital, Amaku, Awka, Anambra State. The data obtained from the participants was anonymised to ensure confidentiality. Also, all participants (soon to be referred to as respondents) were free to withdraw at any time during the study period. Participants provided written informed consent before responding to the study questions. This also helped minimise bias, and, in addition, when an individual declined, other members were recruited to replace them. Furthermore, the questionnaires were administered in a quiet, conducive, non-judgmental environment.

RESULTS

The study had a total of 167 respondents, in this study with a marked male preponderance as 73.7% were male, while 26.7% were female, and a male-to-female (M: F) ratio of 2.8:1. The mean age of the population was 47.02 ± 13.84, and the age range was 21 to 88 years. Respondents were predominantly Igbos (92.8%), and a majority had tertiary and postgraduate qualifications (Table 1).

Table 2 shows respondents' self-reported history of eye pathologies; the majority report an ongoing eye condition or having experienced one in the past. The majority complained of blurred vision, while others reported difficulty reading, itching, ocular pain, and tearing. Ninety-three respondents could state their diagnosis, with presbyopia having the highest frequency (38.7%), while cataract and glaucoma accounted for 14.0% and 6.5% of the reported diagnoses. About 12.0% did not know their diagnosis. A majority used spectacles for their condition, some others used eye drops, and surgery. However, 8.7% did not receive any treatment for their condition. The majority received professional treatment in the hospital, while very few just patronised medicine vendors. Only 12 respondents reported a family history of blindness, with glaucoma accounting for half of those cases.

Table 3 below shows that about 80.0% of the respondents have heard of glaucoma; however, only 9.1% of this population are aware that it is an important cause of blindness, while 67.0% have no idea that it affects the eyes. Also, 70.7% did not know the age group most affected by glaucoma. Only 18.0% are aware of the

Table 2. Assessment of history eye pathologies amongst respondents.

Variable	Frequency	Percentage
Have you had eye problem before?		
No	50	29.9
Yes	117	70.1
Do you have eye problem now?		
No	74	44.3
Yes	93	55.7
If yes what was the problem? (n=93)		
Blurred vision	51	54.8
Difficulty reading	13	14.0
Itching	18	19.4
Pain	7	7.7
Tearing	4	4.3
What was the problem? (n=93)		
Allergy	19	20.4
Cataract	13	14.0
Glaucoma	6	6.5
Myopia	3	3.2
Presbyopia	36	38.7
Tearing	1	1.1
Trauma	1	1.1
Other	3	3.2
I don't know	11	11.8
What did you do about the eye problem? (n=93)		
Surgery	8	8.6
Used eye drop	28	30.1
Used eye glasses	49	52.7
Nothing	8	8.7
Where did you receive treatment?		
Drug vendors	6	6.5
Eye clinic/Hospital	81	87.1
No treatment	6	6.5
Do you have family history of poor vision/blindness?		
No	155	92.8
Yes	12	7.2
If yes, what type? (n=12)		
Cataract	4	33.3
Glaucoma	6	50.0
Others	2	16.6

hereditary nature of glaucoma, while 27.8% have an idea of anything responsible for the occurrence of glaucoma. Furthermore, 45.9% are aware that there is a treatment for glaucoma, and the majority of this population listed surgery and eye drops as treatment options for glaucoma.

Figure 1 is a bar chart that illustrates the distribution of self-reported ocular conditions among respondents. Presbyopia was the predominant condition, accounting for about two-fifths of participants, and ocular allergic conditions also accounted for about one-fifth of responses,

Table 3. Knowledge about glaucoma amongst respondents.

Variable	Frequency	Percentage
Have you heard of glaucoma?		
No	34	20.4
Yes	133	79.6
How does it affect the eyes? (n=133)		
Poor vision	21	15.8
Increase pressure	8	6.0
It causes blindness	12	9.1
Itching	3	2.3
No idea	89	67.0
What age group is mostly affected? (n=133)		
Young people	3	2.3
Elderly	36	27.1
I don't know	94	70.7
What is responsible for glaucoma disease? (n=133)		
Hereditary	24	18.0
Infection	8	6.0
Old age	11	8.3
Poor nutrition	2	1.5
Others	51	38.3
No idea	37	27.8
Is there a treatment for glaucoma? (n=133)		
No	72	54.1
Yes	61	45.9
If yes, what type? (n=61)		
Eye drop	23	37.7
Eye glasses	6	9.8
Surgery	29	47.5
Others	3	4.9

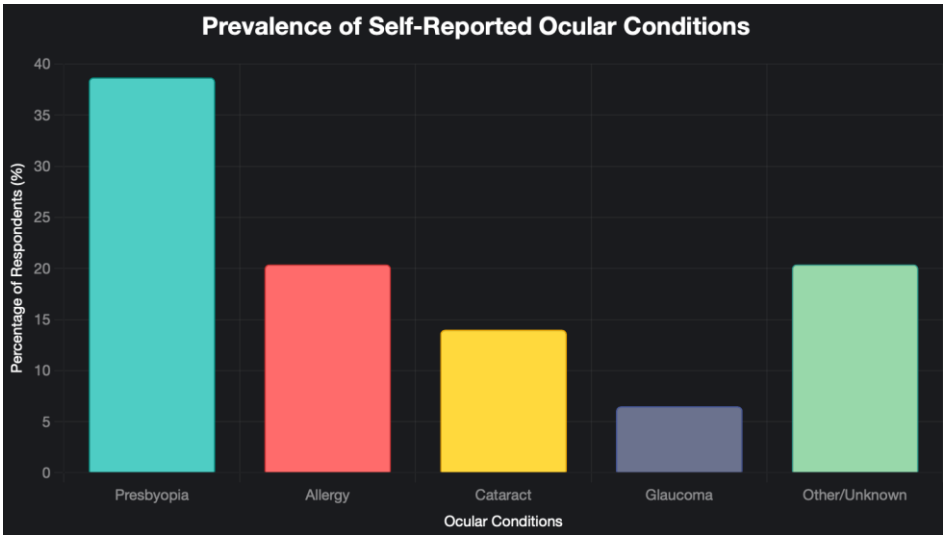

Figure 1. Prevalence of self-reported ocular condition.

whereas cataract and glaucoma were less frequently reported.

Figure 2 shows a pie chart that illustrates the distribution of responses based on their perceived level of glaucoma knowledge, which was categorised as poor or good, with 72.5% exhibiting poor knowledge. This suggests an overall low level of glaucoma awareness among the study participants.

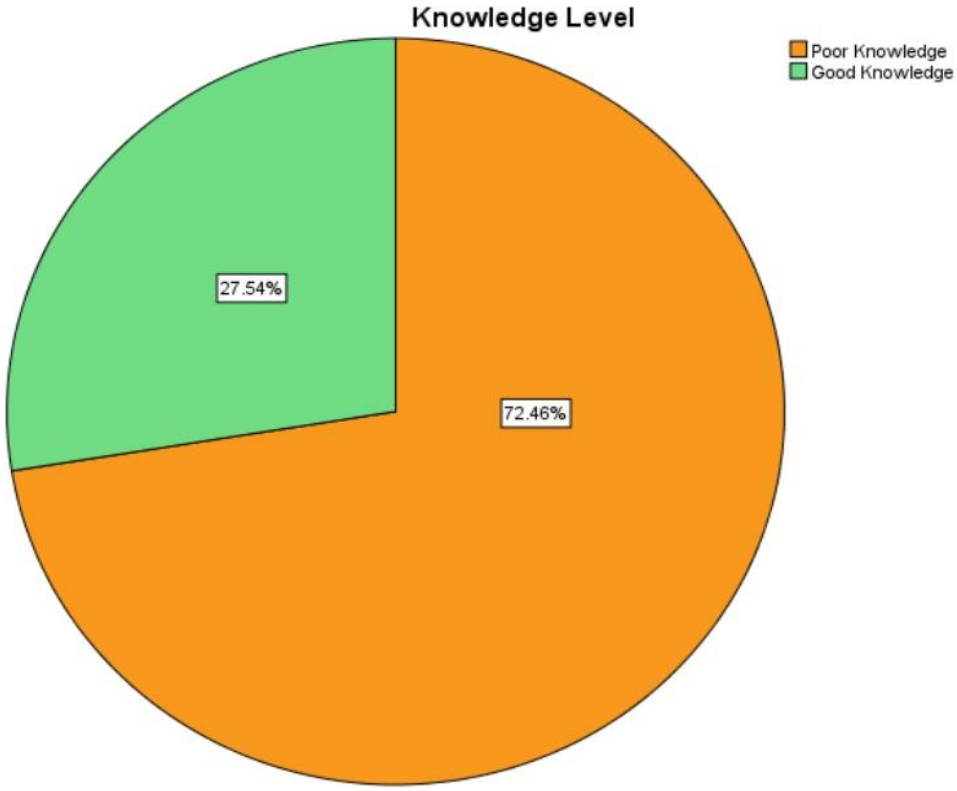

Figure 2. Knowledge Level of respondents about Glaucoma.

Table 4 shows the association between the core socio-demographic characteristics of the respondents and their knowledge of glaucoma. There was a significant association between educational status and knowledge of glaucoma (p = 0.022). This suggests that the higher the level of education, the greater the likelihood of better knowledge of glaucoma. Table 5 shows the results of the multivariable logistic regression analysis conducted to identify independent factors associated with good glaucoma knowledge among respondents. From the table, educational level was the only variable significantly associated with knowledge after adjusting for gender and occupation. The odds of having a good knowledge reduced significantly for respondents with a lower level of secondary education compared with their counterparts who attained a higher level of higher education (aOR = 0.38; 95% CI: 0.14–0.99; p = 0.049). Gender (aOR = 0.95; 95% CI: 0.41–2.19; p = 0.903) and occupation (aOR = 0.60; 95% CI: 0.28–1.30; p = 0.196) were not independently associated with glaucoma knowledge.

DISCUSSION

History of ocular conditions among the respondents

The majority of the respondents either had an ocular problem before the survey (70.1%) or were experiencing an ocular challenge at the time of this survey (55.7%). This can be explained by the age distribution of the respondents, which is slightly skewed towards the older age groups of the study population, as indicated by the mean and standard deviation of the respondents. Most significant ocular complaints are known to occur with increasing age in the general population. Visual impairment encompasses a range of symptoms, including blurred vision and reading difficulties, which together account for approximately 70% of ocular symptoms. These issues can affect distance vision, near vision, or both. These symptoms are common with increasing age. Studies in Nigeria have reported that blurred vision begins at age 35 and peaks slightly after age 40 (Idowu *et al*., 2016; Seidu *et al*., 2016; Eze *et al*., 2021).18-20 Furthermore, ocular conditions such as presbyopia, cataract, and glaucoma, which can cause near and distance visual impairment, were reported by the respondents. Presbyopia is the most common diagnosis reported by respondents, accounting for 38.7% of the symptoms/conditions reported. This possibly suggests that the burden of age-related visual problems was high in the study population. This self-report is somewhat similar to the result of a study by Nwosu (1998) in which presbyopia accounted for 33.3% of ocular conditions in the study population. Spectacle was the most common treatment option reported in this study. This further supports the respondents' self-reports of presbyopia.

Table 4. Distribution of sociodemographic parameters and Knowledge level about glaucoma.

Variable	Knowledge Level		χ2	P-value
	Poor Knowledge [N (%)]	Good Knowledge [N (%)]		
Age Group				
20-29yrs	10 (58.8)	7 (41.2)		
30-39yrs	25 (64.1)	14 (35.9)		
40-49yrs	32 (82.1)	7 (17.9)	5.136	0.274
50-59yrs	27 (73.0)	10 (27.0)		
>60yrs	27 (77.1)	8 (22.9)		
Gender				
Female	34 (77.3)	10 (22.7)	0.695	0.05
Male	87 (70.7)	36 (29.3)		
Ethnicity				
Igbo	133 (72.9)	42 (27.1)		
Yoruba	3 (50.0)	3 (50.0)	1.865^F	0.575
Others	5 (83.3)	1 (16.7)		
Occupation				
Clergy	68 (66.7)	34 (33.3)		
Religious Personnel	19 (90.5)	2 (9.5)	6.202	0.05
Trader	15 (83.3)	3 (16.7)		
Others	19 (73.1)	7 (26.9)		
Level of Education				
Primary	3 (100.0)	0 (0.0)		
Secondary	28 (90.3)	3 (9.7)	9.599	0.022*
Tertiary	53 (72.6)	20 (27.4)		
Postgraduate	37 (61.7)	23 (38.3)		

* - significant.

Table 5. Multivariable logistic regression analysis of factors associated with good glaucoma knowledge.

Variable	Adjusted OR	95% CI	p-value
Male gender	0.95	0.41 – 2.19	0.903
Lower education (Secondary)	0.38	0.14 – 0.99	**0.049**
Non-clergy occupation	0.60	0.28 – 1.30	0.196

Knowledge of glaucoma among respondents

There was a very low level of glaucoma awareness among the respondents of this study, with only 27.5% having an acceptable knowledge of glaucoma. The comparatively low proportion of glaucoma may reflect limited awareness or underdiagnosis, which has implications for eye health education and screening programmes. This finding is similar to that of previous studies in Nigeria and Ghana, which reported low levels of glaucoma awareness (Nwosu, 2010; Bodunde *et al*., 2006; Ntim-Amponsah *et al*., 2004; Onwuegbuna *et al*., 2024). Only 31.0% of respondents reported that glaucoma either causes poor vision, blindness, or increased intraocular pressure, while 67.0% knew nothing about how glaucoma affects the eye. This is still part of the spectrum of low awareness of glaucoma. In another study on awareness of glaucoma among glaucoma patients in Onitsha, although the level of awareness was generally low, as in the index study, 78.9% of the study population were aware that glaucoma could cause irreversible blindness (Nwosu, 2010). The possible reason for this discrepancy is that, unlike the index study,

which included respondents who were not glaucoma patients, the earlier study included patients who must have received a health talk on glaucoma at some point in their follow-up. The comparatively low proportion of glaucoma may reflect limited awareness or underdiagnosis, which has implications for eye health education and screening programmes. Subsequent knowledge-related responses in this study consistently showed poor knowledge of glaucoma. While 70.7% of respondents did not know the age group at higher risk of developing glaucoma, only 27.1% reported that elderly people had a higher risk. This is higher than a report from Turkey, where 12.5% of patients and 3.5% of their first-degree relatives reported ageing as a risk factor for glaucoma (Celebi, 2018). The same trend applies to the awareness of the hereditary link of glaucoma, where only 18.0% were aware that glaucoma could be hereditary, while 27.8% had no idea at all. The figure is less than the results from a study in Turkey, where 31.3% of patients and 26.3% of their first-degree relatives were aware that heredity/family history is a risk factor for developing glaucoma (Celebi, 2018). The reason for this is not very clear; however, it may be plausible to expect glaucoma patients who are on treatment and follow-up in the hospital to have a better understanding of the disease than members of the population not known to have glaucoma. Over half of the study respondents know that glaucoma is a treatable disease. However, among the proportion who believed glaucoma was treatable, there was a fair distribution of the correct treatment modality. This is similar to the report by patients in Onitsha (Nwosu, 2010). The results in Table 4 suggest that higher levels of education were associated with greater awareness of glaucoma. This is similar to the report in Onitsha, where patients with at least primary education were more likely to have a better basic understanding of the disease. The study did not show any association between these and post-primary education (Nwosu, 2010). The demographic differences between the populations may account for the variation noted. The results of this study have highlighted several salient points regarding the subject matter.

Possible limitation

There are some potential limitations in this hospital-based cross-sectional study. The quantitative approach used limited the depth of the insight on the subject obtained from the respondents. A mixed-methods approach would have been more appropriate for this. Furthermore, potential sources of bias, such as self-reporting (over-reporting, under-reporting, and recall bias) and the selection process, could have affected our results. While over-reporting and under-reporting can either cause a false impression of good knowledge or underestimation of the real problem (in this case, knowledge of glaucoma), both giving inaccurate results and associations, selection bias could have caused over- or under-representation of certain groups of the population, exclusion of certain perspectives and limited generalisation of our results. Despite these limitations, it is obvious that there is poor knowledge of glaucoma among religious leaders in the study. This is a call for stakeholders to consider glaucoma advocacy among these highly influential members of our society.

Conclusion

The study highlights the need for basic eye health education among faith-based leaders, who reported various eye symptoms and conditions, including poor awareness of glaucoma. Including them in eye health education initiatives can help disseminate crucial information to hard-to-reach populations, ultimately advancing the primary eye care objectives outlined by the World Health Organisation and Nigeria's National Eye Health Program. The Federal Ministry of Health and Social Welfare's National Eye Health Program is currently undertaking a project to train primary health workers in primary eye care, providing them with the necessary skills and equipment to deliver essential eye care services. This project, which aims to integrate primary eye care into primary health care in the country, should also formulate an actionable policy framework that empowers and includes faith-based leaders in its education intervention projects. Religious leaders should be prioritised for basic eye health education training, facilitated by Primary Health Care Development Agencies at the state level. With increased awareness, they can become effective eye care ambassadors, positively influencing their communities.

COMPETING INTERESTS

The authors declare that there are no competing interests.

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