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Refractive Error in Nigerian Adults: Prevalence, Type, and Spectacle Coverage

Christian Ezelum,1 Hessom Razavi,2 Selvaraj Sivasubramaniam,3 Clare E. Gilbert,3 Gudlavalleti V. S. Murthy,4 Gabriel Entekume,4 Tafida Abubakar,5 and Nigeria National Blindness and Visual Impairment Study Group6

PURPOSE. To provide data on prevalence and types of refractive error and the spectacle-wearing rate among adults in Nigeria and the degree to which the need for distance correction could be met by off-the-shelf spectacles.

METHODS. Multistage, stratified, cluster random sampling with probability proportional to size was used to identify a nationally representative sample of 15,027 persons aged ≥40 years. Distance vision was measured using a reduced logMAR tumbling-E chart. All participants underwent autorefration, and those with presenting acuity of <6/12 in one or both eyes had their corrected acuity measured and underwent detailed clinical examination to determine the cause.

RESULTS. Included in the survey were 13,599 (89.9%) of the 15,122 persons aged ≥40 years who were enumerated. Uncorrected refractive error was responsible for 77.9% of mild visual impairment (<6/12–6/18), 57.1% of moderate visual impairment (<6/18–6/60), 11.3% of severe visual impairment (<6/60–3/60), and 1.4% of blindness (<3/60). The crude prevalence of myopia (≤0.5 D) and high myopia (≥5.0 D) were 16.2% and 2.1%, respectively. Spectacles could improve the vision of 1279 (9.4%) and 882 (6.5%) participants at the 6/12 and 6/18 level, respectively, but only 3.4% and 4.4% of these individuals wore spectacles to the examination site. Approximately 2,140,000 adults in Nigeria would benefit from spectacles that improved their vision from <6/12 to ≥6/12. More than a third of the need could be met by low-cost, off-the-shelf spectacles.

CONCLUSIONS. Uncorrected refractive errors are an important cause of visual impairment in Nigeria, and services must be dramatically improved to meet the need. (Invest Ophthalmol Vis Sci. 2011;52:5449–5456 DOI:10.1167/iovs.10-6770)

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Corresponding author: Gudlavalleti V. S. Murthy, International Centre for Eye Health, London School of Hygiene and Tropical Medicine, Keppel Street, LondonWC1E7HT, UK; gvs.murthy@lshtm.ac.uk.
D. Astigmatism (minus cylinder format) was defined as a cylindrical error worse than 0.75 D (Table 1).

**Improvers.** Participants whose unaided VA was <6/12 in the better eye but subsequently improved by one or more visual categories, either with their spectacles or with best correction, were labeled ‘improvers.’

**Need for Spectacles.** The need for spectacles among the improvers could either have been ‘met’ or ‘unmet.’ So as to be comparable with other surveys, ‘met need’ describes the number of participants who wore distance spectacles and had VA <6/12 in the better eye without correction, but who achieved 6/12 or better in the better eye with their present distance spectacles. ‘Unmet need’ was defined as the number of participants who did not wear spectacles and who had VA <6/12 in the better eye without correction, but who could achieve ≥6/12 in the better eye with correction. Met need and unmet needs were also calculated with a cutoff of <6/18 in the better eye.

Some participants presented for VA measurement wearing spectacles, but with an incorrect prescription, defined as a presenting VA of <6/12 (or <6/18), which improved by one or more VA categories with best correction. If best correction improved their VA to ≥6/12 (or ≥6/18) they were defined as having unmet need at the relevant cutoff.

**Spectacle Coverage.** The percentage of spectacle coverage was defined as: met need/total need × 100%, where total need is met need + unmet need.

### Sampling Design and Sample Size

The sample size necessary to meet the parameters of the study was calculated as 15,375 persons aged 40 years or above. Multistage, stratified, cluster random sampling, with probability proportional to size was used to identify a nationally representative sample. Stratification was by place of usual residence (urban/rural). A cluster size of 50 eligible adults was used in randomly selecting a total of 310 clusters across the country, of which 226 (72.9%) were rural and 84 (27.1%) were urban. Five clusters had to be abandoned due to civil unrest or refusal to participate.

### Visual Acuity Measurement

Visual acuity was measured by an ophthalmic nurse at the central examination site, using a reduced log MAR tumbling-E chart to take three separate measurements. This chart has been validated for use in surveys.29 First, unaided VA of each eye was measured at 4 m (even if they habitually used distance spectacles), followed by a second assessment of both eyes together (unaided VA). Those who had distance glasses were then reassessed wearing their available glasses (presented vision). Participants with VA ≤6/12 in one or both eyes underwent extensive examination, including dilated funduscopy.

### Refractokeratology

All participants had noncycloplegic refraction by an optometrist using an autorefractokeratometer (ARKM-100; Takagi Seiko, Japan) that was regularly calibrated. If automated readings could not be obtained, refraction was done manually. Participants with VA <6/12 in one or both eyes had their corrected VA measured by subjective refraction based on autorefractive readings. This method was used to estimate the contribution of RE to a participant’s VI. VI due to significant RE and uncorrected aphakia was defined as acuity of <6/18 in the better eye before refraction improving to ≥6/18 in one or both eyes after refraction.

### Data Table

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Low Myopia (&lt;−5 D SE)</th>
<th>High Myopia (≥−5 D SE)</th>
<th>Emmetropia (±0.50 D)</th>
<th>Hypermetropia (&gt;±2 D SE)</th>
<th>Hypermetropia (≥±5 D SE)</th>
<th>Astigmatism (≤±0.50 DC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>155 (160)</td>
<td>3 (4)</td>
<td>15 (15)</td>
<td>5 (5)</td>
<td>3 (3)</td>
<td>15 (15)</td>
</tr>
<tr>
<td>40–49</td>
<td>126 (129)</td>
<td>20 (20)</td>
<td>20 (20)</td>
<td>10 (10)</td>
<td>10 (10)</td>
<td>20 (20)</td>
</tr>
<tr>
<td>50–59</td>
<td>28 (30)</td>
<td>4 (4)</td>
<td>16 (16)</td>
<td>12 (12)</td>
<td>8 (8)</td>
<td>16 (16)</td>
</tr>
<tr>
<td>60–69</td>
<td>35 (37)</td>
<td>12 (12)</td>
<td>23 (23)</td>
<td>17 (17)</td>
<td>8 (8)</td>
<td>23 (23)</td>
</tr>
<tr>
<td>70–79</td>
<td>26 (28)</td>
<td>10 (10)</td>
<td>16 (16)</td>
<td>10 (10)</td>
<td>5 (5)</td>
<td>16 (16)</td>
</tr>
<tr>
<td>80+</td>
<td>15 (15)</td>
<td>5 (5)</td>
<td>10 (10)</td>
<td>5 (5)</td>
<td>2 (2)</td>
<td>10 (10)</td>
</tr>
<tr>
<td>Men</td>
<td>140 (145)</td>
<td>3 (3)</td>
<td>15 (15)</td>
<td>5 (5)</td>
<td>3 (3)</td>
<td>15 (15)</td>
</tr>
<tr>
<td>40–49</td>
<td>115 (120)</td>
<td>15 (15)</td>
<td>15 (15)</td>
<td>15 (15)</td>
<td>10 (10)</td>
<td>15 (15)</td>
</tr>
<tr>
<td>50–59</td>
<td>27 (27)</td>
<td>4 (4)</td>
<td>16 (16)</td>
<td>16 (16)</td>
<td>8 (8)</td>
<td>16 (16)</td>
</tr>
<tr>
<td>60–69</td>
<td>32 (32)</td>
<td>12 (12)</td>
<td>20 (20)</td>
<td>10 (10)</td>
<td>6 (6)</td>
<td>20 (20)</td>
</tr>
<tr>
<td>70–79</td>
<td>24 (24)</td>
<td>10 (10)</td>
<td>14 (14)</td>
<td>7 (7)</td>
<td>3 (3)</td>
<td>14 (14)</td>
</tr>
<tr>
<td>80+</td>
<td>15 (15)</td>
<td>5 (5)</td>
<td>10 (10)</td>
<td>5 (5)</td>
<td>2 (2)</td>
<td>10 (10)</td>
</tr>
<tr>
<td>Total</td>
<td>335 (335)</td>
<td>45 (45)</td>
<td>160 (160)</td>
<td>90 (90)</td>
<td>45 (45)</td>
<td>160 (160)</td>
</tr>
</tbody>
</table>

*Data are for right eyes, excluding eyes with cataract surgery.*
Eye Examination
Participants had an initial anterior segment examination using a torch, including grading lens opacities (LO) against the red reflex, using the Mehra-Minassian (MM) system. Information on the location and type of cataract surgery was elicited, as well as on the use of aphakic correction. Participants proceeded to a more detailed examination by a clinical ophthalmologist if they met certain criteria, including presenting VA <6/12 in one or both eyes. For these participants, the ophthalmologists determined the cause(s) of visual loss by using the principles outlined in the WHO Prevention of Blindness Performa (Version III). All participants with VI were referred to the nearest eye facility.

A detailed examination was performed with a slit lamp microscope (SL 115 Classic Slit Lamp; Carl Zeiss Meditec AG, Jena, Germany), 81-D aspheric condensing lens (Volk Optical, Mentor, OH), Goldmann applanation tonometer, a two-mirror lens (Volk) with no flange for gonioscopy, and a digital camera (Visucam Lite Desktop Fundus Camera; Carl Zeiss Meditec AG).

Approvals
The study adhered to the tenets of the Declaration of Helsinki and was approved by Ethics Committee of London School of Hygiene and Tropical Medicine and Nigeria’s Federal Ministry of Health. Informed consent was obtained from the head of the household and all adult respondents.

Statistical Analysis
There was a high correlation between right and left eyes (Pearson’s correlation 0.72; \( P = 0.001 \)), and therefore, data are reported only for right eyes. All those with no recorded autorefraction results and those who were pseudo/aphakic in their right eyes were excluded. To ascertain effects of LO on RE, a further analysis excluded participants with significant LO, defined as grade 2B or more (MM grading). The odds ratio (presented with the 95% confidence interval) was used in univariate analysis of spectacle use with key variables, such as sex, literacy, education, occupation, and location of residence.

The following analyses were undertaken to determine proportion of individuals with significant RE who could potentially benefit from off-the-shelf spectacles. Individuals with presenting VA <6/12 in the better eye but improving to 6/12 or better were identified first. Individuals who had undergone procedures for cataract in both eyes (cataract surgery with/or without IOL, or couching) were then excluded. Prevalence increased significantly with age (Fig. 1). The overall mean and median SE were +0.36 D (95% CI, 0.32–0.41) and +0.63 D (IQR −0.13, 1.25), respectively. After excluding participants with significant LO, these were +0.67 D (0.63, 0.70) and +0.63 D (IQR: 0.15, 1.38), respectively (Fig. 1).

Myopia. The crude prevalences of myopia (< −0.5 D) and high myopia (< −5.0 D) were 16.2% (\( n = 2003; \) 95% CI, 15.2–17.1) and 2.1% (\( n = 259; \) 95% CI, 1.8–2.4), respectively (Table 1). After excluding participants with significant lens opacities, the crude prevalence of myopia was 9.4% (95% CI, 8.7%–10.2%) and of high myopia 0.7% (95% CI, 0.5–0.9%). The men had a significantly higher prevalence of myopia (16.9% versus 15.5%; \( OR = 1.29; \) 95% CI, 1.14–1.47). The prevalence of myopia increased steadily with increasing age (\( P < 0.001 \); Fig. 2).

Hypermetropia. The crude prevalence of hypermetropia (> +0.5 D) was 50.7% (\( n = 6283; \) 95% CI, 49.5–51.9), showing an inverse J-shaped distribution with age (Fig. 2). Excluding those with significant LO did not significantly affect prevalence of hypermetropia (52.1%; 95% CI, 50.8–53.5). Prevalence of high hypermetropia was 0.5% (0.4%–0.6%). The women had a significantly higher prevalence of hypermetropia (55.6% versus 44.7%; \( OR = 1.55; \) 95% CI, 1.43–1.68).

Astigmatism. The crude prevalence of astigmatism was 63.0% (95% CI, 61.8–64.1), which decreased to 58.7% (95% CI, 57.5–59.9) after those with visually disabling lens opacity were excluded. Prevalence increased significantly with age (\( P = 0.001 \)). After adjusting for age, the prevalence of myopia was 14.1% and of hypermetropia was 51.1%, which changed to 9.7% and 55%, respectively, when LO were excluded (Table 2).

Sex, Literacy, Residence, and Occupation
Univariate analysis showed that the men had a greater risk of myopia (OR 1.29, 95% CI, 1.14–1.47), but a lower risk of hypermetropia (OR 0.61, 95% CI, 0.55–0.66) than did women.

Distribution and Prevalence of Refractive Error
The distribution of SE refractive error for right eyes was leptokurtotic (Fig. 1). The overall mean and median SE were +0.36 D (95% CI, 0.32–0.41) and +0.63 D (IQR −0.13, 1.25), respectively. After excluding participants with significant LO, these were +0.67 D (0.63, 0.70) and +0.63 D (IQR: 0.15, 1.38), respectively (Fig. 1).

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RESULTS
Demographics
A total of 15,122 eligible adults aged 40 years and older were enumerated, 13,599 of whom were examined (89.9% response rate, which was similar across all geopolitical zones). The age and sex of those enumerated and those examined were similar, but younger men (40–49 years) were underrepresented (Pearson \( R = −3.94; \) \( P < 0.001 \)).
Illiteracy was associated with myopia (OR 1.37, 95% CI, 1.19–1.58), hypermetropia (OR 1.35, 95% CI, 1.23–1.48), and astigmatism (OR 1.57, 95% CI, 1.44–1.72). Residence in a rural area was associated with an increased risk of myopia (OR 1.35, 95% CI, 1.11–1.63) and astigmatism (OR 1.21, 95% CI, 1.08–1.35). Manual occupation was also associated with myopia (OR 1.57, 95% CI, 1.35–1.84) and astigmatism (OR 1.50, 95% CI, 1.38–1.63; Table 3; Fig. 3).

Spectacle Wear

Only 1.2% (169) of phakic participants (1.2%) wore distance spectacles to the examination site. Another 38 claimed to own distance spectacles, but did not habitually wear them and were classified as nonwearers. Of the 2003 adults identified as having myopia, only 28 (1.4%) were wearing spectacles, and none of those had high myopia (n = 258). Of the 6823 participants identified with hypermetropia, 79 (1.3%) were wearing spectacles. The prevalence of spectacle wear increased with age (0.69% in 40–49-year-olds, 0.97% in 50–59-year-olds, 1.22% in 60–69-year-olds, and 1.47% in ≥70–79-year-olds). The 299 participants who had undergone cataract surgery were also more likely to be wearing spectacles (14.4% versus 0.9% in phakic participants).

Improvers and Incorrect Prescriptions

A total of 2248 (16.5%; 95% CI, 15.7–17.4) participants were improvers. We estimate that 3,890,000 (95% CI, 3,700,000–4,100,000) adults over 40 years of age would require optical correction to improve VA status by at least one vision category. Just over half (n = 80, 51.0%) of the spectacle wearers had an incorrect prescription at the 6/12 cutoff; this number was lower at the 6/18 cutoff (n = 65, 41.4%).

Spectacle Coverage

A need for spectacles was identified in 1279 (9.4%) and 882 (6.5%) individuals at the 6/12 and 6/18 cutoffs, respectively, only 43 and 39 of whom were wearing appropriate spectacles. The overall spectacle coverage was 3.4% (95% CI, 2.9–4.4%) at the 6/12 and 6/18 cutoffs, respectively.

There were 1190 individuals with significant RE at the 6/12 level who were phakic in one or both eyes (Table 4). The proportion of the need that could be met by off-the-shelf spectacles, using different criteria for anisometropia and astigmatism, ranged from 33.9% to 44.4% (Table 4).

Unmet Need

Over 90% (OR 96.6%, 95% CI, 95.5–97.7) of participants who needed spectacles did not own them, owned a pair but did not use them routinely, or used an incorrect prescription. Our results show that 9.1% (95% CI: 8.5–9.6) of all Nigerian adults over 40 years (2,140,000 individuals), have an unmet need for spectacles, which would improve their distance vision from 6/12 to 6/12.

DISCUSSION

This survey provides the first population-based data on the magnitude of RE in Nigeria. The two main findings are the

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**TABLE 2.** Age-Adjusted Prevalence of Different Refractive Errors among Nigerian Adults

<table>
<thead>
<tr>
<th>Refractive Error</th>
<th>N</th>
<th>Crude (%)</th>
<th>Adjusted (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myopia</td>
<td>12402</td>
<td>16.2</td>
<td>14.1</td>
</tr>
<tr>
<td>Emmetropia</td>
<td>12402</td>
<td>33.2</td>
<td>34.8</td>
</tr>
<tr>
<td>Hypermetropia</td>
<td>12402</td>
<td>50.7</td>
<td>51.1</td>
</tr>
<tr>
<td>Myopia LO</td>
<td>10687</td>
<td>9.4</td>
<td>9.7</td>
</tr>
<tr>
<td>Emmetropia LO</td>
<td>10687</td>
<td>35.5</td>
<td>35.3</td>
</tr>
<tr>
<td>Hypermetropia LO</td>
<td>10687</td>
<td>55.1</td>
<td>55.0</td>
</tr>
<tr>
<td>Astigmatism</td>
<td>12402</td>
<td>63.0</td>
<td>60.3</td>
</tr>
<tr>
<td>Astigmatism LO</td>
<td>10687</td>
<td>58.7</td>
<td>59.2</td>
</tr>
</tbody>
</table>

(−)LO, excluding lens opacities (cataract).
Figure 3. Prevalence of refractive error by place of residence, literacy, and sex.
(60.4% and 59.1% in rural and urban participants in Tamilnadu, respectively).59

Participants who were illiterate were more likely to be myopic or hypermetropic and to have astigmatism. Participants with manual occupations and those living in rural areas were also more likely to be myopic and have astigmatism. Some of these findings contrast with other population-based studies, which have shown associations between myopia, higher education levels, professional occupations and residence in urban areas.26-32,40,50,53 After participants with significant LO were excluded, the mean spherical equivalent was similar to that of Australians aged 80 years.25,26,32-34,40,43,46,48,51 (In support of the use–abuse theory of myopia). There are, however, exceptions to these trends: The Baltimore Eye Study showed that the association between years of education and myopia was stronger for white persons than for black persons,35 the Bangladeshi study showed a significantly lower risk of myopia with residence in urban areas25,26,32,33,40,43,46,48,51 (in support of the use–abuse theory of myopia). Some of these findings contrast with other population-based studies, which have shown associations between myopia, higher education levels, professional occupations and residence in urban areas.25,26,32,33,40,43,46,48,51

Spectacle coverage rates were significantly lower than reported among similar age groups in Bangladesh (3.0%),43 Pakistan (6.2%),25 and India (17.4%),31 although it should be appreciated that the definition of “unmet need” for spectacles does not necessarily equate with demand for correction. None of the participants with high myopia were wearing spectacles. Incorrect prescriptions were common among the few wearing spectacles, with just over half improving by ≥1 VA category with best correction. This suggests a need to improve both quality and affordability of optical and refractive services in Nigeria. Over one third of the need for distance correction among individuals who were phakic in one or both eyes could be met by off-the-shelf spectacles.

Limitations of this study include possible overestimation of myopia in younger participants, as autorefraction was not performed after cycloglogia. The analysis used refractive data from the right eye, which is in keeping with several other studies,26,32,55 but differs from some studies that included the worse eye in their analyses.75,45,49 Younger males were underrepresented, as they were more likely to be at work at the time of examination, which may have led to a slight overestimation of refractive error. The MM lens-grading system was used to provide some data on lens opacities in all participants, regardless of their visual acuity. Individuals undergoing full ophthalmic examination had their lenses graded using LOCS III.55,56 Finally, presbyopia, and anisometropia were not addressed.

This is the first population-based, national RE survey in Africa, to the authors’ knowledge. The distribution of RE in

Table 4. Proportion of Need for Spectacle Correction at the 6/12 Level That Could Be Met by Off-the-Shelf Spectacles, Using Different Criteria for Anisometropia and Astigmatism

<table>
<thead>
<tr>
<th>Age Group</th>
<th>n</th>
<th>≤1D SE and ≤1D cyl</th>
<th>≤1.5D SE and ≤1.5D cyl</th>
<th>≤2D SE and ≤2D cyl</th>
</tr>
</thead>
<tbody>
<tr>
<td>40–49 years</td>
<td>138</td>
<td>43</td>
<td>31.2</td>
<td>138</td>
</tr>
<tr>
<td>50–59 years</td>
<td>278</td>
<td>105</td>
<td>37.8</td>
<td>278</td>
</tr>
<tr>
<td>60–69 years</td>
<td>393</td>
<td>170</td>
<td>43.3</td>
<td>393</td>
</tr>
<tr>
<td>70–79 years</td>
<td>285</td>
<td>111</td>
<td>39.0</td>
<td>285</td>
</tr>
<tr>
<td>≥80 years</td>
<td>96</td>
<td>57</td>
<td>58.5</td>
<td>96</td>
</tr>
<tr>
<td>Total</td>
<td>1190</td>
<td>466</td>
<td>39.2</td>
<td>1190</td>
</tr>
</tbody>
</table>

Criterria were anisometropia (SE) and astigmatism in one or both eyes.

Table 5. Summary of Results from Selected Population-Based Refractive Error Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Sample Size</th>
<th>Age Group</th>
<th>Myopia</th>
<th>High Myopia</th>
<th>Hypermetropia</th>
<th>Astigmatism</th>
</tr>
</thead>
<tbody>
<tr>
<td>NBVIS</td>
<td>Pakistan25</td>
<td>14,490</td>
<td>≥30</td>
<td>&lt; −0.50D; 36.5</td>
<td>&lt; −5.00D; 4.6</td>
<td>&gt;0.50D; 27.1</td>
<td>&gt;0.75D; 27.1</td>
</tr>
<tr>
<td>NBLVS</td>
<td>Bangladesh26</td>
<td>11,624</td>
<td>≥30</td>
<td>&lt; −0.50D; 22.1</td>
<td>&lt; −5.00D; 1.8</td>
<td>&gt;0.50D; 20.6</td>
<td>&gt;0.50D; 34.6</td>
</tr>
<tr>
<td>APEDS</td>
<td>India31</td>
<td>10,293</td>
<td>≥40</td>
<td>&lt; −0.50D; 34.6</td>
<td>&lt; −5.00D; 4.5</td>
<td>&gt;0.50D; 18.4</td>
<td>&gt;0.50D; 37.6</td>
</tr>
<tr>
<td>MES</td>
<td>Myanmar52</td>
<td>1,865</td>
<td>≥40</td>
<td>&lt; −1.00D; 42.7</td>
<td>&lt; −6.00D; 6.5</td>
<td>&gt;1.00D; 15.0</td>
<td>&gt;1.00D; 30.6</td>
</tr>
<tr>
<td>SMES</td>
<td>Singapore35</td>
<td>2,974</td>
<td>40–80</td>
<td>&lt; −0.50D; 38.7</td>
<td>&lt; −5.00D; 4.9</td>
<td>&gt;0.50D; 27.4</td>
<td>&lt; −0.50D; 33.5</td>
</tr>
<tr>
<td>RES</td>
<td>Netherlands34</td>
<td>6,543</td>
<td>≥55</td>
<td>&lt; 1.00D; 17.6</td>
<td>&lt; −5.00D; 4.0</td>
<td>≤3.00D; 17.6</td>
<td>Not studied</td>
</tr>
<tr>
<td>BES</td>
<td>United States35</td>
<td>5,036</td>
<td>≥40</td>
<td>&lt; −0.50D; 19.4 (B)</td>
<td>&lt; −6.00D; 0.0–1.4 (B)</td>
<td>&gt;0.50D</td>
<td>&gt;0.5D</td>
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<tr>
<td>BDES</td>
<td>United States36</td>
<td>4,533</td>
<td>43–84</td>
<td>&lt; −0.50D; 26.2</td>
<td>&lt; −5.00D; 3.8</td>
<td>≥0.50D; 49</td>
<td>Not studied</td>
</tr>
<tr>
<td>MVIP</td>
<td>Australia57</td>
<td>4,744</td>
<td>≥40</td>
<td>&lt; −0.50D; 17.0</td>
<td>&lt; −5.00D; 2.1</td>
<td>&gt;0.50D; 37.0</td>
<td>Not studied</td>
</tr>
<tr>
<td>BMES</td>
<td>Australia58</td>
<td>3,654</td>
<td>49–97</td>
<td>&lt; −0.50D; 15.0</td>
<td>&lt; −4.00D; 3.0</td>
<td>≤0.50D; 57.0</td>
<td>&gt;1.00D; 57.0</td>
</tr>
<tr>
<td>BdES</td>
<td>Barbados59</td>
<td>4,709</td>
<td>≥40</td>
<td>&lt; −0.50D; 21.9</td>
<td>Not studied</td>
<td>≥0.50D; 46.9</td>
<td>Not studied</td>
</tr>
</tbody>
</table>

Data are expressed as the spherical equivalent in diopters and the prevalence (%). NBVIS, National Blindness and Visual Impairment Survey; NBLVS, National Blindness and Low Vision Survey; APEDS, Andhra Pradesh Eye Disease Study; MES, Meiktila Eye Study; SMES, Singapore Malay Eye Survey; RES, Rotterdam Study; BES, Baltimore Eye Study; BDES, Beaver Dam Eye Study; MVIP, Melbourne Visual Impairment Project; BMES, Blue Mountains Eye Study; BdES, Barbados Eye Study; (B), black; (W), white participants.
Nigeria appears closer to that of white and black populations in Europe and America, and differs from Asian populations. Findings indicate a low prevalence of myopia in Nigeria, exceedingly low spectacle coverage, a large unmet need for spectacles, and a need to improve the quality, access and affordability of optical and refractive services—a VISION2020 priority.

Acknowledgments

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References


**APPENDIX**

Additional Members of the Nigeria National Blindness and Visual Impairment Study Group

Abdull Mahdi, Adenike Abiose, Olufunmilayo Bankole, Fatima Kyari, Hannah Faal, Abudallah Imam, Pak Sang Lee, and Mansur Rabiu.