Editorial: Quality eye health care and effective cataract surgical coverage in sub-Saharan Africa

Visual impairment and blindness remain a significant public health problem in sub-Saharan Africa (SSA). The leading causes of visual impairments are cataract and refractive error in the region. Effective and quality eye care service delivery faces many complex challenges that need systematic approachs. Effective Cataract Surgical Coverage (eCSC) helps to measure progress of improvement in access and quality eye care[1-4]

The burden of visual impairment in sub-Saharan Africa

Different population based studies or RAAB surveys in SSA report higher prevalence of blindness and visual Impairment, 0.1% to 9% mainly due to cataract[2,5]. A systematic review from 204 countries found that cataract is the principal cause of blindness and visual impairment[2]. Depending on the country the proportion of blindness attributable to cataract ranges from 21% - 67% in sub-Saharan Africa.Thus cataract remains the main avoidable cause of blindness among older population in SSA that require improved quality eye care service delivery in the region[5].

Current state eye health system in SSA

There are promising improvements in some components of eye health systems in many countries of SSA. The contribution of NGO partners is significant in many parts of Africa. There are measurable progress on governance, service delivery and health care financing[4].

However, there are significant gaps and issues to be addressed. Meta-analysis of health system assessment in SSA reveals that insufficient health workforce or maldistribution (urban concentration), limited infrastructure, uneven distribution of services, inadequate integration of eye care to broader health service or weak referral system, shortage of consumables and supplies, and poor health information system are some to mention[1,4]. Moreover, reliance on outreach campaigns (often NGO supported) remains high indicating major access gaps[1,4].

Effective Cataract Surgical Coverage in SSA (eCSC), mixed reality of access and quality

Phacoemulsification and Small Incision Cataract Surgery (SICS) are the main stay of management to reduce cataract blindness. The surgical coverage and visual outcomes varies among the settings and studies in SSA.. In general it is far below the WHO expected standards[6,7]. The 74th WHA endorsed a global target for eCSC of a 30-% point increase by 2030.

Reported eCSC spans a wide range from 12% to 96%. A metanalysis of pooled eCSC in SSA is about 15 far below some European and Asian countries report. Country eCSC estimates ranged from 6.6% (95% CI 3.9–9.4) in Malawi, 2023, to 33.9% (95% CI 25.6–42.3) in Rwanda, 2015, and the relative quality gap from 25.0% (CSC: 45.2%, eCSC: 33.9%) in Rwanda, 2015, to 52.2% (CSC: 27.1%, eCSC: 12.9%) in Uganda, 2010.eCSC is higher in men than women (148 studies pooled risk difference 3·2% [95% CI 2·3–4·1] and pooled risk ratio of 1·20 [95% CI 1·15–1·25][7].

Factors contributing to poor outcomes include ocular comorbidities (case selections), pre and post operative care, surgical capacity, systemic challenges of resource poor surgical settings, and refractive services[4, 8-10.]

In conclusion, in pursuit of 2030 targets, many countries in ECSA, should emphasise quality improvement together with increasing access to surgery. Equity must be embedded in efforts to improve access to surgery, with a focus on undeserved groups, rural people, women, PW Disability. For sub-Saharan African countries to make meaningful change, eye health must be prioritized within national health agendas, backed by sustainable financing, rigorous quality assurance and a commitment to reaching under-served populations[9-14].

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