

# Avec mes yeux je vois

## Medical Lessons of Community Ophthalmological Services

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*Every eye such as sees, sees in three dimensions.  
Not so the mind; the mind's dimensions vary as with use.*

I wrote the above short verse in the early phase of my specialist training in pathology, somewhat past the age when most young people write verses and poems. I wrote it in America, during my brief sojourn in that country in the mid-1960s. It was an unfortunate time to be in the USA as that young, vibrant country, as colourful as any, saw nothing at that time except as black and white. I suppose I was not the only one that was impressed with how much havoc the mind could play on the visual senses.

### INTRODUCTION

Dr Theodore Okechukwu, in whose honour this lecture series was instituted, was the pioneer ophthalmic surgeon in eastern Nigeria. He initiated ophthalmic services in Eastern Nigeria in the early 1950s with the first eye clinic in Enugu in or about 1953. Before Dr Okechukwu, there were only two ophthalmologists in Nigeria, namely, Drs Kofo Abayomi and Herbert Kodilinye, who made indelible marks in surgery and public administration. Ophthalmology is by no means an old science in Nigeria, however, among the medical specialists, the ophthalmologists have been the most organized and have had the greatest impact in the society. This is manifested in the blindness prevention initiatives and programmes and the numerous vision missions which have been carried out and which have had considerable impact, not only on awareness of the importance of sight to productivity and comfort, but also on public or mass medical programmes. Notably, these initiatives are professionally generated and led. This is a lesson that the rest of Nigerian medicine is yet to learn.

I have in the past drawn attention to the phenomenon whereby Nigerians who are presumed to

prefer other treatments to scientific medicine leave such treatment houses to obtain free scientific medical care. This suggests that what takes patients to those therapies may be the cost factor. The ophthalmologists were the first and till today are the most successful in dealing with the cost factor. While the cost factor is not to be ignored, however, it is to be borne in mind that in no circumstances could such offerings be without cost. Someone (or some other people) pays for these programmes. Such offerings also have an obvious problem of being associated with the principle of half a loaf being better than none. Unfortunately, this may mean some measure of sacrifice of standards, and doing things that a volunteer participant would not do in his own country. It is for this reason that some have not been entirely comfortable with some of the medical treatment missions. Again, the eye surgeons, aware of their obligations in dealing with the most sensitive of senses, leave no room for compromise in their treatment and what they offer to the people.

Are Nigerians convinced of the need for eye tests or the use of spectacles? I have not encountered an attempt to answer that question. The fact that five hundred people in one morning flock to a centre that announces free eye tests does not answer the question clearly, although it may indicate an awareness of the desire for good vision. To answer the question, a proper analysis of the clients and their needs is required. In this country of more than one hundred and twenty million people, only about 60% are literate, and perhaps more than one half of those that have had some education do not use their education for a means of livelihood. The demands on vision in activities that do not require reading or writing are generally not of great acuity.

**IGNORANCE OF EVERYDAY THINGS**

In spite of all the eye camps that have taken place, the populace is still not sure of some everyday things. For example, whether or not harm comes from putting on sunglasses, and similar mundane things. Doctors are not free of such uncertainties. For instance, one hears at clinical presentations, that a mother instilled her infant's urine into its eyes and the urine caused damage to the eyes or resulted in blindness. The myth of such a bland fluid as cow's urine causing eye damage and blindness in children has also established itself in Nigerian medical lore or superstition, especially in western Nigeria. Curiously, it gets taught to generation after generation of students without any suggestion of a proof or even a need for proof. It seems then that some work needs to be done in the public information and medical education sectors.

On the other hand, the people are not stupid. They have a good understanding of a number of things that affect the eye, sometimes enough to shame the doctor. For example, one sees an excited doctor contemplating heroic measures for the removal of an eye-worm, which at the time straddles the patient's cornea. The patient sits calmly, having gone to the doctor with complaints not related to the eye-worm. The patient knows with certainty that the *Loa loa* worm that is migrating across his or her eyes poses no threat to vision, and is only one of a number of worms in his or her body. Surgery is of greater threat than the worm, and the swelling of the eye that might occasionally accompany adult worm migration, more often occurs in the absence of obvious worm migration. The patient also knows that to be meaningful, treatment ought to include eradicating the insect vector from the community.

**IMPORTANCE OF NON-DIRECT EYE CONDITIONS, IN PARTICULAR HIV/AIDS**

It is also necessary to bear in mind some important diseases of public health import that do not directly impact on vision. The most notorious of these is HIV/AIDS. If ophthalmologists shut their eyes to the problem of HIV and AIDS because it does not directly affect vision, then there might be very few people left who need eye care or surgery. This dreadful infection has caused great devastation in Africa, even though knowledge regarding its cause, mode of spread, prevention and treatment is increasing. All medical professionals must join in the fight against this disease, which has demonstrated its ability not only to neutralize but to reverse development and economic progress. The situation in many African countries, including Nigeria is so overwhelming that all medical groups must rise to meet the challenge. Hard data is characteristically difficult to obtain in Nigeria, but the table below shows the situation in a large hospital in Malawi in 2003.

**HIV/AIDS in a Large Hospital in Malawi in 2003**

	HIV pos		AIDS
	All Adults	30-40 yrs	
Medical	70%	91%	45%
Surgical	36%	56%	8%

Deaths 70% caused by TB, AIDS, severe bacterial sepsis.

Thus, HIV dominates adult medicine, is a major part of adult surgery, and is the main cause of death in hospitals. Also, the disease affects the economically active group of the population.

The ophthalmologist must participate in formulating and implementing AIDS policy for the hospital, clinic and surgery. This will also put him or her in a position to be aware of the best practices in the handling of instruments in the clinic, hospital ward and surgery. For example, an eye examination procedure in which a mucous membrane comes into contact with the instrument, might result in HIV transmission, unless the clinic practice includes routine appropriate cleaning that would prevent the transfer of HIV from one patient to another.

The pioneer ophthalmologist, Dr Theodore Okechukwu, whose memory we celebrate today served the people in more ways than one. His duties as a special grade medical officer included the female out-patient clinic, children's out-patient clinic, doctor in charge of the tuberculosis clinic and ward, and setting up an eye clinic for the Eastern Region, which is now made up of nine states; all this, after he had specialized in ophthalmology. No doubt, if HIV/AIDS had been present at that time, his job description would have included it as well.

I shall not leave the matter of HIV/AIDS without a word about the perception of AIDS as a treatable disease. This is good news indeed, even if there is yet no cure. This perception has rapidly gained currency for good reason. Patients that had been devastated by the disease are seen to return to full health and maintain that status. Unfortunately, in Africa today, less than ten percent of those that need life-saving medical treatment have access to such treatment. It is the duty of the medical profession to ensure that all who should receive treatment do so.

It is often stated correctly that medicine is too important a matter to be left to doctors alone. This should not be interpreted to mean that the profession is not the prime mover and leader of health programmes. Failure to provide medical leadership often results in serious errors. The latest example is the case with polio vaccination, in which professional default resulted in political activity that ended in a disaster in Kano State. This disaster naturally does not respect political boundaries. The medical profession, therefore, has a

greater the responsibility. In the case of HIV and AIDS, unless we conquer this disease, all shall be lost in every field of endeavour.

**PRIORITIES IN EYE CARE**

The eye camps naturally are inclined to pay attention to the great problem of blindness and treatment of the treatable eye problems. However, the preventive and public health aspects are just as urgent. Fortunately, ophthalmology has been conscious of this and has taken action to ensure professional participation and to provide the necessary leadership in public health and community measures that bear on the sustenance of sight. In Africa, opportunities abound for this in such widespread diseases as trachoma and the filarial infection, onchocerciasis. Onchocerciasis causes blindness in millions of people that live along river basins. Trachoma is the leading cause of blindness in many African countries, including the dry parts of Nigeria. We shall examine the possibilities in such actions.

**Primary eye diseases**

- Cataract
- Trachoma
- Refractive errors and low vision
- Glaucoma

**Secondary eye diseases**

This group of eye diseases occur as a secondary condition or complication.

- River blindness — Onchocerciasis
- Night blindness — Vit. A deficiency xero-keratopathy
- Measles
- Leprosy
- DM
- Ophthalmia neonatorum

These diseases also occur in a background of poor environment and poor diet.

**Poor Eye Health Background**

- Eye disease
- Poor environment
- Poor diet

**PROFESSIONAL LEADERSHIP**

Ophthalmologists have given professional leadership in their field through such organizations as the OpS which produces informed plans of action that are an example to the other specialities or disciplines of medicine. At the international level, they have produced the Global Initiative for the Elimination of Avoidable Blindness, the strategy that is known as Vision 2020. This programme is sufficiently strong as not to be swallowed by the World Health Organization (WHO). In fact, WHO has had to seek and obtain a slot in this powerful

movement. The WHO Alliance for the Global Elimination of Trachoma (GET) falls under the umbrella of Vision 2020.

There are definite advantages in having professional leadership in important medical issues. Allowing health issues to be decided by organizations that are primarily interested in mass social environment (e.g., the UN) is to risk a loss of focus. With every respect for all its achievements, WHO is one such and the best known of such organizations. As has happened at the table of the UNO, the term global is not as used in VISION 2020. Global and globalization in the UNO context are as defined by the World Trade Organisation, with its dominating profit orientation and heady liberalization policy that has not shown great sensitivity to situations of poverty. The other agencies of the UNO now must take their cue from that. Even WHO has sometimes had to turn a blind eye to its own basic tenets.

One experience that I shall now briefly relate brought home to me the weakness of dependence on WHO. In the mid 1980s, I spent some months in the UK studying the design and implementation of medical curricula and especially academic programmes on general medical practice. At the end of a seminar on a communicable disease of international significance, I remarked that no one had mentioned the role of WHO. The students were rather surprised that I should mention such an organization as it had no role whatsoever to play in the healthcare of their country. They certainly had heard of it, but they saw it as an organization which served countries that did not take responsibility for the health or well being of their citizens.

**THE MOST IMPORTANT EYE DISEASES FOR COMMUNITY ACTION**

Vision 2020 has identified and defined the five most important eye diseases to focus on. These are cataract, trachoma, childhood blindness, refractive errors and low vision, and onchocerciasis.

<p><b>VISION 2020 — Main Diseases Focused On</b></p> <ul style="list-style-type: none"> <li>• Cataract</li> <li>• Trachoma</li> <li>• Childhood blindness</li> <li>• Refractive errors and low vision</li> <li>• Onchocerciasis</li> </ul>
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Cataract and trachoma are primary diseases of the eye. Childhood blindness is of special interest on account of its implications for the development and life-time functioning of the child. Every country or region must ascertain the causes of childhood blindness so as to determine the necessary action against them. The data

suggest high refractive errors and corneal scarring from vitamin A deficiency, frequently associated with measles as the most common. Onchocerciasis is an environment-related, insect-borne, mass parasitic infection. It is a systematic infection that causes considerable pathology in the skin and soft tissues, and affects vision or causes blindness in patients in whom eye infection becomes established.

**Nature of Disease: Vision 2020 Main Diseases**

	Primary Eye	Secondary Eye	Nature
Cataract	+		Age, DM
Trachoma	+		Conj. infection
Childhood blindness			
High refr. errors	+		
Vitamin A deficiency		+	
Others-cong. cataract, deg retl			
Refractive errors and low vision	+		
Onchocerciasis		+	System filarial inf.

**COMMUNITY ACTIVITY IN CARE OF PRIMARY EYE DISEASE**

In considering the actions that organized ophthalmology has taken in combating these diseases and conditions, we shall draw attention to their medical implications and aspects of public perception. Before considering the eye diseases, we shall take a look at the poor background environment and diet that we referred to earlier. The environment includes general conditions of hygiene, with an adequate supply of safe water, free from water-borne parasites; and a supportive and available health service, deriving from a supportive health policy environment. A population with a good nutritional status is able to fight disease and is less liable to secondary eye disease, especially those related to poor nutrition. A good example is measles-related corneal scarring in infants and children.

The ophthalmologist cannot expect successful eye care programmes in the absence of the essential elements of a good background for eye health. Neither can he/she wait considering the present circumstances of serious mass eye diseases and vision-threatening conditions. It is therefore logical for the ophthalmologist to be a part of the team to make the background conditions conducive to eye health and care.

**Operational Methods**

We also need to look at the methods that organized ophthalmology applies in implementing its community

programmes. The principles are the standard procedures for health promotion as enunciated in the 'Ottawa Charter on Health Promotion', 1986. The Ottawa Charter followed the Alma Ata declaration on primary health care in 1978. Its strategy is based on five key elements, namely, healthy public policy, personal skills development, community participation, healthy supportive environments and re-organization of health services, in this case, to include eye care at the primary health care level.

**The Ottawa Charter on Health Promotion**

- Healthy public policy
- Personal skills development
- Community participation
- Healthy supportive environments
- Re-organization of health services (in this case, to include eye care)

The application of these principles by organized ophthalmology is shown in the table below. This is what the ophthalmologist sees. We shall now consider these operative methods and their practice as seen by the rest of the medical profession and some aspects as seen by the public. In doing so, we shall consider the various eye conditions.

**Application of Health Promotion to Ophthalmology**

Healthy Public Policy	<ul style="list-style-type: none"> <li>• Develop formal eye care policies and set targets</li> <li>• Cost recovery schemes – design, implement, research, evaluate e.g. cataract surgery</li> </ul>
Personal skills	<ul style="list-style-type: none"> <li>• Training – community eye health promoters, health professionals</li> </ul>
Development	<ul style="list-style-type: none"> <li>• Literacy programmes – general and 'basic health' literacy skills</li> </ul>
Community participation	<ul style="list-style-type: none"> <li>• Involve community in planning, implementation, evaluation</li> <li>• Comm. members in eye care service, e.g., ivermectin</li> </ul>
Supportive Environment	<ul style="list-style-type: none"> <li>• Nutrition programmes e.g. Vit. A supplement fortification</li> <li>• Sanitation and safe drinking water (trachoma)</li> </ul>
Re-organization of health services	<ul style="list-style-type: none"> <li>• Integrate eye care services in local PHC programmes</li> <li>• Research into eye conditions and appropriate service delivery mechanisms</li> </ul>

Adapted from Dinee B, *Community Eye Health* J 2004.

**Community Action in Primary Eye Disease**

Cataract	Cataract surgery
Trachoma	'Clean hands and faces'
Night blindness, Xerophthalmia, Keratomalacia, Measles associated	Diet NPI, environment
Onchocerciasis	Ivermectin campaign
Refractive errors	Refraction tests and correction.

**Cataract and Cataract Surgery**

It is in cataract and cataract surgery that the community-minded eye surgeon holds sway and captivates public fancy and usually pulls a large crowd. Among other problems associated with this is an easily observable confusion of vision restoration through miracles. In addition to cost consideration and a possible persuasion of the efficacy of technology or science based treatment in eye disease already referred to, there may possibly be other motivating factors.

For more than two decades now, the nation has witnessed many claims of miraculous faith cure, including the restoration of sight to the blind. While these claims have not been taken seriously by the medical community or the society at large, they have gone on for so long that they might have become embedded in part of the subculture or cultural expectations of the people. The most dramatic claims of cure are orthopaedic or neuromuscular. This is followed by the cure of blindness. It may be one of the reasons, or indeed the main reason why people flock to eye treatment camps. In this way, some confusion persists between medical or surgical treatment and miraculous cures. To confound the picture, many of the organizations that conduct the free eye treatment camps are operated by religious zealots, and conduct a fair bit of religious activity as part of the camp. So, the confusion continues. All things considered, what is required is that every society or country be able to cater for the health and wellbeing of its people, or be assisted to do so in a systematic and sustainable manner. Community eye care is not exempted from this.

However, there is a dilemma. There is an annual increase and accumulation of age-related cataract, the common form of cataract. I am yet to see an estimate of these for Nigeria. Certainly, it is a great number. I have also not seen an estimate of the cost for a cataract operation in an efficient system. I suspect that it will be a recoverable cost. Waiting to establish an efficient system means a large accumulation of cases. So, the keen helper feels very welcome, and that he or she is helping in a much-needed situation. However, even the keenest helper is likely to admit that the best situation is a stable one in which the services are sustained.

The consideration of cost recovery is a serious one. An unexpected factor can put the entire machinery of

free eye camps to an end or greatly affect its functioning and impact. Meanwhile, there has been a negative impact of free ophthalmic or medical missions. One has seen one local government turn down a cost recovery cataract programme because there had been a free cataract surgery mission to a neighbouring LGA.

**Trachoma - 'Clean hands and faces'**

Ethiopia, where trachoma is the leading cause of blindness, shall serve as the example, for the purpose of this presentation. The international charity, ORBIS, working in partnership with the Ethiopian government and rural health care centres creates a sustainable approach to eliminating avoidable blindness. With a population of 60 million, Ethiopia has only 62 eye doctors. A large proportion of these work in private practice in the capital city of Addis Ababa in which less than ten percent of the population live. ORBIS trains doctors and nurses locally in vital sight-saving techniques. In its system, which is generally judged as efficient, even severe trachoma can be cured by a simple operation for less than two pounds sterling. This cost is found to be recoverable, and so the programmes are economically self-sustaining. In this way they will continue. Partnership with the government affords an opportunity to influence policies on the provision of clean water. Easy access to clean water by the people gets rid of this scourge.

**Night blindness, Xerophthalmia, Keratomalacia**

This complex of diseases is caused by avitaminosis A. Surprisingly, with all the palm oil that is available and presumably being eaten in the country, Nigeria appears on WHO maps for this group of diseases. Palm oil is rich in vitamin A in a form that is used by the human body. Red palm oil contains 200 i.u. of vitamin A per ml. The richest source, fish liver oil contains 1000 i.u. per ml. Other local sources are leafy green vegetables, mangoes and papayas. Palm oil is produced only in the rain forest close to the coast, particularly of the eastern and midwestern parts of Nigeria. What is required to clarify the situation regarding the adequacy or deficiency of vitamin A in the diet in the various parts of the country is a simple definitive study. Is sufficient palm oil produced in the country to meet the needs of the population? The answer is probably yes, and the problem may be that of distribution related to transportation. Studies should uncover any other factors so that they can be dealt with. A recommendation for the wide distribution of vitamin A capsules in the absence of a diagnosed disease probably belongs in the realm of *desperate medicine* which we shall mention shortly.

The relationship between corneal ulceration as a result of measles and vitamin A deficiency seems to have been established about two decades ago. Measles

was, up to a decade ago, the most common cause of primary corneal inflammation, especially in children. This was frequently complicated by ulceration and loss of vision. This complication of measles was related to poor nutrition in the child, especially avitaminosis A. Vitamin A is regarded as a major determinant of severity and survival in measles and some other childhood infections.

Measles is a good example of the three faces of common diseases in poor countries. In a well nourished family with good living conditions, it is no more than a febrile illness with a rash that makes a child ill or indisposed for a couple of days. In the poor rural family of poorly nourished children, living many in a room, in poor hygienic conditions, and with little or no access to medical care, it is a fatal or potentially fatal illness. Complications such as pneumonia and diarrhoea, otitis media, and general sepsis result in death. In the middle level is the child of a city worker, above borderline nutrition status, that gets quite ill with measles, but has access to care. In this child the complications are mitigated. The child may be hospitalized for a few days, but survives. This demonstrates the important role of the health and environment background.

What is the role of the ophthalmologist in this? It is to energetically support immunization programmes. He must be seen and heard to do so. Also, consider a child that has been brought to the ophthalmologist for eye complications post-measles. The ophthalmologist successfully treats the eye, but the child fails to gain weight and maintain normal growth. Under such circumstances, it is the duty of the ophthalmologist or any doctor to diagnose tuberculosis, kwashiorkor or both, and refer for appropriate investigation and treatment. Failure to do so could result in the death of an infant or child whose eye disease might have been remedied.

### **Onchocerciasis - Ivermectin campaign**

In optical complication of onchocerciasis, microfilariae migrate into the anterior chamber, and when they die there is a reactive inflammation with keratitis followed by anterior uveitis and choroiditis. Optic atrophy and other complications follow after many years. It usually takes more than three decades of the disease for blindness to occur. Onchocerciasis primarily affects the skin and the subcutaneum and produces considerable dermatological changes, including thickening, roughening and nodules.

The familiar story of the three blind men examining an elephant comes to mind. The ophthalmologist may argue that onchocerciasis is a disease for the dermatologist while the dermatologist argues that the most incapacitating aspect of the disease is the concern of the ophthalmologist. However, in this debilitating disease, the blind and the pachyderm are one and the

same person and there is no lesson whatsoever to be learnt except that humans and societies are better off without such a disease.

There is a curative medicine, ivermectin, for the parasite in humans, but it does not reverse the harm that has already been done to the tissues. Thus, ivermectin serves literally as a 'preventive medicine'. It is administered once a year to all residents of endemic areas, and has received wide acceptance and raised hopes that it will minimize the manifestations and complications of the infection. Ivermectin distribution is often quoted as a good example of community participation in community health care programmes. However, there is another aspect to it. The impact of such mass drug treatment of populations has been the abandonment of programmes on vector eradication, or even attempts at diagnosis. This is something of a dilemma in today's medicine in which investigation and diagnosis are considered the prime factors for the best practice. This mentality has also given rise to the abandonment of stool examination for intestinal parasites. The mood seems to be mass deworming of populations. How this fits into today's picture of medicine is questionable. These attitudes and programmes are brought into countries in which the doctors seem to have gone to sleep and the nations are helpless in reaching important decisions on health issues. The attitude that is now touted as a strategy without an articulated policy apparently comes from despair. Such practice could therefore be referred to as 'medicine of despair'. One might even say, 'desperate medicine'.

This is not to deny the real problem on the ground, i.e., how to eradicate '*Mutu mutu*' the insect vector, *Simulium*. This difficulty would best be dealt with by the medical community being fully informed of the problems and participating in the search for solutions. Twenty-first century medicine is united in the search for evidence for best practice. No impression must be given that an accommodation of default is good in the poorer portions of the world. It was normal to teach medical students and encourage doctors to examine stool. Now, 'desperate medicine' takes the carpet from under the feet without troubling itself with an argument for what it does. There are also some basic questions that could be dealt with. For example, could ivermectin not be produced in the country at a lower cost? If the programme is endogenized, would it not save the cost of travel of the foreign participants?

### **Questions on aspects of community participation**

- ❖ Could ivermectin not be produced in-country at lower cost?
- ❖ International personnel travel, etc. cost
- ❖ 'Mass action brigade' mentality - medicine of despair

- ❖ Policy of containment of disease rather than elimination.

### Refractive errors

Ophthalmology has an adequate answer for refractive errors, however, distances from place of abode to eye test and prescription centres may mean for many, a journey of five or more hours. The cost of dispensed glasses is also a difficulty for many. Therefore, in addition to the technology of refraction, ophthalmologists are in the best position to evolve the best way, in our circumstance, of giving opportunity to the population with refractory errors and defects to see and to read. Two generations ago, the way that Nigerians obtained their glasses was by trying them on and paying for them in the regular township market. Then came the good medical care mentality and prescription glasses. The sale of lenses was accordingly regulated and limited to specialized eye care centres. However, the problems remain for the majority of the population that lives where there are no eye care centres and for whom the cost factor is a problem.

A review of the situation and lessons from the British deregulated glasses market may help here. Following the deregulation of spectacles in the UK, one can now purchase them at pharmacies and other shops. All spectacles are labelled with the lens power, and a person with a prescription buys one of the prescribed power. A person without a prescription tries out the lenses, as was the case many years ago, until he/she finds one that is suitable. In this process, deregulation has resulted in considerable reduction in the cost of spectacles. Deregulation, in this instance, would suit the great majority in Nigeria who are from the low income group.

### The National Eye Centre or Hospital

How is the policy formulation and review to take place? For this purpose, countries set up national eye centres or hospitals. The functions of the National Eye Hospital in Nigeria are research, training and policy development. The supporting NGOs and the Ophthalmological Society of Nigeria are expected to work in partnership with the National Eye Hospital and government to

develop and put in place policies that make primary eye services accessible and affordable to the rural population in programmes that are economically sustainable.

### Confusion of terms and purpose

Some confusion in the use of terms in ophthalmic medicine is observable in Nigeria. Some of this has created difficulty for those in the field that seek to communicate with the public and people in government. The Global Initiative for the Elimination of Avoidable Blindness, Vision 2020 has difficulty being understood because of the confusion with the national economic development programme known as Vision 2010. Indeed the American national programme for eye care is known by the term Vision 2010. Nigeria is a signatory to the global declaration of support for VISION 2020. The confusion is, therefore, uncalled for. Ophthalmology in the country has had to find other terms that will appropriately reflect its goals.

### Conclusion

The ophthalmologists have certainly made a great impact on Nigerian medicine. The great tragedy of blindness in Nigeria and Africa is that in at least 80% of cases, blindness is avoidable. Sustaining the impact of ophthalmology is important as the population is fast increasing. Care in the selection and implementation of programmes and a sustainable approach of partnership with government and people is crucial.

*Avec mes yeux je vois* is basic French meaning, with my eyes I see. It was my intention to speak on basic considerations in medicine as impacted upon by ophthalmology. In West Africa, much of what I have spoken about knows no boundaries.

As we celebrate the memory of Dr. Theodore Okechukwu, I wish to say that there are indeed other dimensions to the eye. For instance, when my father, a pioneer Nigerian agriculturist and large-scale farmer, at over seventy, decided to go back to managing his plantation, he let it be known to his not so agreeable sons, that he was taught in America that:

*The eye of the farmer fattens the cow.*