

# From Clinical Ophthalmology to Sustainable Community Eye Health Care

## The Vision, the Mission and the Beatitude

The Fourth Theodore Okechukwu Memorial Lecture  
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- *To have eyes is good, especially if they look good  
But to see with them is the real thing to do*
- *To have sight is good, if we perceive and value it  
And by it, insight, hindsight and foresight too*
- *Yet with no eyes or sight at first, insight and else are hard  
To have insight, hindsight and foresight is real good*
- *To have eyes, all the sights and vision is very good  
But to have all that and mission, fulfilled, is beatitude!*

The thoughts that came to me as I considered the invitation to give this lecture are best summarized by the above four verses. I hope that their full meaning will become evident as we go along.

I received the invitation to present this lecture just three weeks to the date of presentation. Was I stressed by it? Of course, I was! My first reaction was to turn down the invitation, but when I thought of those who had invited me and the person who the lecture was in memory of, I had to accept. It may delight you to learn of the pathway to that decision and the eustress that your invitation has produced since then.

### MY OPHTHALMOLOGICAL ANTECEDENTS

Dr. Theodore Okechukwu, in whose memory this lecture is being given, was already an elderly man by the time I knew him. Personally, I did not come in contact with him professionally, but my colleagues and I had learnt that he was one of the pioneer ophthalmologists in Eastern Nigeria,<sup>1</sup> along with others such as Professor Herbert Kodilinye and Dr. Onwumere, the pioneer ophthalmic private practitioner of the old Eastern

Nigeria. However, Dr. Okechukwu was different. He spearheaded the development of ophthalmological care in the public health service of that region. Public health was later to become my primary area of interest in medicine as a profession. On his return to Nigeria after his overseas training, Dr. Okechukwu started work in Lagos before moving to the East. He also made a brief foray into practice at 'our very own and apex' University College Hospital, Ibadan, when national duty required him to do so.

Dr. Okechukwu came from my maternal ancestral hometown and village (indeed, my grand maternal *umunna* of Umuehim) of Ukpok and therefore we shared some of the same genes! His fame did not only stem from his popularity as a pioneer but from the fact that his achievements have inspired so many young people (at home and in diaspora). It is reported that by far, ophthalmology has remained, relatively speaking, the most popular medical specialty among Dr. Okechukwu's Ukpok townfolk who ended up in the medical profession.

As a medical student, I was taught by two ophthalmologists whose professional excellence has remained memorable to me. Professor Oyin Olurin was an elegant ophthalmic surgeon and good speaker at surgical grand rounds. Professor 'Bopo' Osuntokun was the delicate and maternal teacher whose gentle surgical and clinical care made ophthalmology 'homely' and interesting to learn. This was all before I became a physician in my own right.

As a National Youth Service Corps doctor, when I learnt that I was to be involved in mobile health services, I sought for records of Nigerian experience in such work. The one, and indeed the only published work of personal involvement I found in this regard was the mobile ophthalmological eye care work in which Professor Ayanru was involved in the then Bendel State of Nigeria.<sup>2,3</sup> As a result of my involvement in community mobile clinical services, I developed a keen interest in public health and community medicine, and so, after my service year, I returned to the University College Hospital, Ibadan to specialize in this field. It was then that I came in direct personal contact with the ophthalmologists who left me with the deep impressions that make giving this lecture a delight.

Dr. BGK Ajayi was then a senior registrar in ophthalmology and president of the Association of Resident Doctors of UCH. I served with him as the public relations officer of the same association when I entered into the residency programme. The association at that time not only strove for the highest ethical standards in medical care by resident doctors but also looked after the professional interests of doctors without too much friction with anybody. I was also with him at the post-war resuscitation of the Guild of Catholic Physicians of Ibadan, an association meant to promote the highest ethical and holistic medical standards in the provision of services by doctors, whether individually or corporately. I have since followed his exploits in starting the first full-fledged missionary eye hospital in Nigeria in the Ijebu-Ode Diocese of the Catholic Church. That hospital, as some of you may know, is involved in a lot of primary and community eye care services and has received both national and international recognition for the training it gives to various eye care personnel.

Soon after, at the same UCH Ibadan, I served as consultant epidemiological assistant to Dr. SNN Nwosu in his research into occupational eye health for his FMCoph dissertation. I was also not far from Dr. Ajayi and Professor Osuntokun's influences. Professor Nwosu has since promoted interest not only in occupational eye care but also in other preventive, social, rehabilitative and primary eye care, the very kernel of my discussion today. He has advanced primary eye care in the same eastern Nigeria where Dr. Okechukwu made his mark!

Dr. Charles Bekibele, as senior registrar in UCH, joined me in the study of occupational ophthalmology.

His desire was to develop a programme in primary eye care training for doctors in residency or other training in occupational medicine in Nigeria.<sup>4</sup> Dr. Bekibele has since become more and more involved in missionary eye care and various other community eye care programmes. Dr. AO Ashaye was the consultant ophthalmologist who worked with Dr. Bekibele and I in that occupational ophthalmology study. We have since worked together on another of such studies in an industry as well as on other preventive and community eye care work.<sup>5</sup>

Later, my work with the Tropical Disease Research (TDR) programme of the World Health Organization in onchocerciasis control brought me in contact with Professor Abiose, who provided the location for one of our pan-African group workshops at her centre in Kaduna. That work led to the production of the first TDR monograph series based on the burden of onchocercal skin disease.<sup>6</sup> That work has since given birth to the African Programme on Onchocerciasis Control (APOC) which superseded the erstwhile Onchocerciasis Control Programme (OCP) which involved only the countries around the Upper Volta River in West Africa alone. Her work on eye care in onchocerciasis, one of the prominent diseases of your international Vision 2020, is fairly well known to most of you.

I have given some of these antecedents (there are many others), not only to show you why it was my delight to accept to come and share some insights with you, but also to let you see that the leadership which Dr. Okechukwu showed in ophthalmology in public health services in Nigeria and which is the reason for this lecture has not died. Indeed, it has grown, matured and is flowering. Many of you here, as ophthalmologists after his time, have imbibed that leadership and are showing it by not limiting yourselves to mere bedside ophthalmology, but extending your services to public health in all its ramifications; the very substance of my lecture. That is what medicine has called us to do, as we shall all see shortly.<sup>7,8</sup> Secondary and tertiary health care services and personnel, even though not substantively involved in PHC, must be reorganized and re-orientated to provide the PHC support system, without which PHC itself will not succeed!<sup>8</sup>

#### **YOUR PAST MEMORIAL LECTURERS**

The other thing that delighted me when I received your invitation was the calibre of the past lecturers in this series. Of the three lecturers, two were my teachers who have shared and continue to share my interest in medical education and the appropriate organization of Nigerian health services. Dr. Adeoye Adeniyi, the 2<sup>nd</sup> memorial lecturer,<sup>9</sup> was my teacher in paediatrics before he left Ibadan to become Professor of paediatrics at Ilorin. He continues to benefit us all at the National Postgraduate Medical College of Nigeria in the docimology

programme. Dr. Ed 'B Attah, the 3<sup>rd</sup> memorial lecturer,<sup>1</sup> was my teacher in pathology at Ibadan. He moved to Ahmadu Bello University, Zaria, where he became a professor and later on to the University of Calabar. His constant interest in medical education, especially in properly organized health services, is evident in the substance of that 3<sup>rd</sup> lecture as well as in the lecture he gave at the 2001 convocation of the National Postgraduate Medical College of Nigeria.<sup>10</sup> It should, therefore, not surprise anybody that it is my delight to be included in this group of illustrious people.

#### FROM CLINICAL OPHTHALMOLOGY TO PRIMARY EYE CARE

From the title of my presentation as well as the associations I have explained above, it should be clear to you that I intend to commend Nigerian ophthalmologists, not only for looking after people's eyes but for showing, in word and action, that they themselves have and look after their own eyes very well. So, they have good eyes, they see with them, they have insight, hindsight (as exemplified in this lecture series) and foresight. They have applied their foresight to the things that they are doing for the future health of the communities they serve.

As you all know, since the 1970s, there has been a movement (or indeed, several movements), in the medical and health professions as well as the entire concerned public health community, to make all medical and health care public-health oriented, instead of being locked up in over-individualized clinical care.<sup>11</sup> What this means is that in the practice of all clinical medicine practitioners should be mindful of its preventative, social, rehabilitative, public and community health dimensions. In that way, they will not only be cost effective but will ensure better health and well-being in the individuals and communities they serve. This movement in the medical care paradigm can be likened to having eyes, seeing with them and thereby also developing insight into the events that happen around one.

However, the medical and health professions have moved this paradigm a little further and now talk about community-oriented and *community-based* medical and health sciences education and services. Experiences around the world show that so far, only four areas of the medical and health sciences and specializations (other than the inherently community-bound disciplines of community medicine and community nursing and the inherently community-oriented specialty of general medical practice or family medicine) have developed this desired movement in the professions. These areas are: community paediatrics and child health, dental public health and community dentistry, mental health and community psychiatry, and community physical rehabilitation. Worldwide, however, it is only in

community dentistry that auxiliaries have been trained who work with community health professionals – viz, dental therapists, hygienists and aids/nurses. In a few countries, community rehabilitative assistants have been trained and these work with community nurses and medical officers, as the case may be, for holistic health care delivery requiring elementary physical rehabilitation.<sup>12</sup> It is important to note that in all these situations, these auxiliaries hardly need to be supervised by the professional specialists in the full-time clinical disciplines which they represent within the PHC system, but they are invariably supervised by the medical officers of health in those communities. The community nurses not only learn to substitute for these auxiliaries but indeed continue the work the auxiliaries have started when they leave. Community nurses are the only professional community health workers that countries that are seriously interested in the health of their people have been able to train, post and adequately maintain; one nurse for 2,000 to 7,000 people, depending on the population density.<sup>12</sup> Such community nurses usually work at least 3 days out of their 5-day working week in such communities and only 1 and a half or 2 days in the static health facility (health centre, district hospital or district nursing centre/health clinic) in which they are based. Such single specialty practices and auxiliaries continue to be part of the vertical public health organization even when they are prefixed 'community'; and are only truly 'community' to the extent to which they dovetail into the holistic healthcare delivery of the community health professionals, who must learn every aspect of primary care in all the health and medical disciplines and carry them out to the best of their ability.

In situations where professional community health work is truly established, and tertiary health care personnel complete their centre-based secondary, tertiary, preventative or vertical public health, or the foray/quick-fix or 'primary/community health' care training programme, a notification thereof is usually sent to the medical officer of health. Copies of the notification are sent to the nursing sister or superintendent responsible for community nursing care in the LGA as well as the community nurse (zonal or district) responsible for community nursing care in a patient's community. Such a nurse, sister, or MOH will put such a subject's name in the particular at-risk health register of the respective office or community. The community nurse would usually visit the said subject within the shortest possible time to ascertain that the subject understands the nature of his/her illness and the follow-up programme for such a condition, and that there is a family member who also understands the case and will help the subject comply with the treatment or otherwise report any problems to the community nurse for assured continuity of care.

Currently, Nigeria has enough doctors to provide MOHs to all her 744 LGAs and more, 774 LGA community health sisters or superintendents, and the at least 15,000 community nurses that will be needed to provide complete community nursing care for the whole country. Such complete community nursing care will only be possible if we develop the necessary political will and health system reforms and support. The auxiliary community health workers (community health officers and community health extension workers being trained in the country currently) can be used to supplement proper community health work only when the health system has first been put in place; but not in spite of or against the current reality. In addition, the National Youth Service doctors and nurses can also be used to strengthen and supplement these services if the NYSC, the state and the LGA administration are educated and provide what it will take to do this, especially in terms of community-based accommodation, co-operation, transportation, and most importantly, a functional PHC system with the essential drug supply.<sup>2,12</sup>

#### **THE UNIQUENESS OF OPHTHALMOLOGY IN THE MODERN HEALTH SERVICES PARADIGM**

Even though every medical and health profession would seem to be well involved in the modern health services paradigm, i.e., from the previously curation-only mode to prevention, socialized services, (vertical) public health, community-oriented health and (holistic, all-diseases, all-persons-serving, fully preventive and curative) community-based health care, ophthalmology would seem to have beaten them all on a global level. Vision 2020 is an international health programme which, to my knowledge, is one of a kind in terms of being engineered by the professionals in that specialty of medicine.<sup>13</sup> By targeting 5 relatively easily preventable causes of blindness around the world to be eliminated or reasonably controlled/prevented by the year 2020, ophthalmologists are surely giving the rest of the health professions and specialties the challenge of their lives! The priority diseases targeted for this purpose are:

- Cataract
- Trachoma
- Childhood blindness
- Refractive errors
- Onchocerciasis

Community medicine shares many common grounds with you in virtually all these subject matters.

#### **THE SUCCESS OF NIGERIAN OPHTHALMOLOGISTS**

Nigerian ophthalmologists have definitely not lagged behind their international colleagues and have kept up with trends in the modern health care delivery paradigms. For example, even in countries that are notably quite advanced in the modern PHC framework

for health services (e.g., Fiji), with no less than 12 practice areas (instead of the original 8 listed in the Alma-Ata document), primary eye care is not yet on that list. In Nigeria, however, at our last encounter with the National Primary Health Care Development Agency, we learnt that primary eye care is now listed as the 11<sup>th</sup> minimum service content of Nigerian PHC – thanks to the ophthalmologists in Nigeria! Who says that your hindsight has not produced foresight?

#### **TO COMPLETE THE MISSION OF HOLISTIC HEALTH CARE: Sustainable Community Eye Health**

There can be no doubt that the spirit behind the leading position of ophthalmologists in the modern community-orientation of their health services is the innate human hunger for holistic health care. In a country where the actual professional community health care specializations of community medicine and nursing are so severely undermined, it will be in their interest to see that such abuses are abated. In the absence of such professional development, all these vertical 'community' or 'primary' health care will only end up as forays into communities without the professional custodians of the people's health to ensure that any possible good done by those forays are maintained and perhaps, even fostered in the interval between the forays! Such properly established statutory health care is the basis of any sustainable health care in a country such as Nigeria.

One should not stop this discussion at the necessity to dovetail all vertical community health work to the normal total/horizontal community health work where alone it is bound to produce a holistic health care. One must talk of the entire health care pyramid. All single organ or single demographic group health specializations and practices belong essentially to the tertiary health care system. Between them and primary health care is secondary health care, whose kernel is specialist general medical practice or family medicine. In Nigeria, that part of the health care system is also neglected or even consciously undermined within the public health services. People who specialize therein, because of neglect within the public health services (coupled with poor remuneration, conditions of rural life and general service), readily move to private medical practice. If health services are to become properly developed and staffed, and therefore sustainable, truly progressive minds within the health professions would do well to contribute, individually and corporately, to returning these specializations to their rightful places, and give them the proper appreciation and treatment they deserve.

#### **BUILDING BRIDGES TOWARDS VISION 2020**

If Nigerian ophthalmologists join in the restoration or attainment of the required wholesome and sustainable health system, their leadership in the modern health care

paradigm will not only become insightful in every way, but truly visionary, with a mission that will surely be accomplished to their patients, society and their fulfillment. Thus, the theme of your congress this year is apt – 'Building bridges towards Vision 2020'. I propose 4 such bridges (which should be stronger than such other Nigerian bridges) between the following:

- the policy makers and politicians and our medical and health professionals
- all clinical medicine and vertical public health
- all vertical public health and primary care (general medical practice or family medicine)
- primary medical care and primary health care (community medicine and nursing)

In this regard, your specialty of medicine has indeed been very exceptional and exemplary as all my discussions here have shown. We can rightly expect that you will still do more.

**TO CONCLUDE**

Dr. Okechukwu helped to put ophthalmological care on the public health agenda of the Eastern Region in pre-independence Nigeria, and in many ways in Nigeria as a whole, having started his specialist service in Lagos, and with forays into Ibadan, even when he had settled down in the East. He also ended up, post-retirement, in private ophthalmological practice and primary eye care in his village and hometown – making a full tour and turn of medical practice. By establishing this lecture series in his honour, you show hindsight for what is noble and worthy of emulation. By your leadership, individually and corporately, in moving ophthalmological care further afield than he did, into preventative, occupational, rehabilitative, social, community and vertical primary eye care, you show foresight and vision. In joining your international colleagues in the Vision 2020 agenda, you show a sense of mission.

However, in order for that mission to be well established in Nigeria, your services should not end up in exciting forays into communities for these services in a vertical public/community health service not dovetailed into the normal/statutory horizontal community health care system or one that hardly exists. In helping to establish in this country, a proper health care pyramid, with the primary professional community health and secondary health care workers needed in place, you will create the enabling environment for the true fulfillment of your vision and mission of sustainable community eye care and eye health. I feel fairly

confident that you will expand your vision that much and that the overall theme of this conference 'building bridges' would be accomplished.

I thank you for your invitation and your esteemed audience.

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