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The peculiar challenges of blindness prevention in Nigeria: A review article

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Abstract
Aim: to describe the challenges peculiar to Nigeria in the implementation of vision 2020: the right to sight and to proffer solutions as to the way forward
Method: a review of the recently completed national blindness survey, current literature, and the advocacy experience of the Ophthalmological Society of Nigeria.
Findings: the prevalence of blindness in Nigeria is 0.78%. Over 43% of these are blind from cataracts and a further 9% from uncorrected aphakia or complications of couching. 50% of all cataract interventions are carried out by itinerant couchers. Other major causes of blindness are glaucoma (16%) corneal opacities (12%), trachoma (4%), optic atrophy (3%) onchocerciasis (1%) and macular disease (1%). 70% of these are either preventable or reversible. Nigeria has a relatively favourable ophthalmologist/population ratio of about 2.8 per million, but has a low Cataract surgical rate of 300 per million per year. The reasons for this include a lack of ownership of blindness prevention programs, a lack of political will and parlous state of funding for vision 2020. There is an abdication of responsibility for both training and services on the part of government to the International Non-Governmental organisations. Teaching hospitals no longer generate enough patient surgical load to support training. We estimate it would cost N8.5 billion ($56.8 million) to sustain the WHO recommended Cataract Surgical Rate of 3000 per million per year in Nigeria.
Conclusions: Nigeria is not headed in the direction of meeting Vision 2020 targets. Advocacy involving funding through the MDGs, needs to be intensified.

Key words: *Blindness prevention, Nigeria, vision 2020.*

Résumé
Pour décrire les défis réguliers au Nigeria sur l'implémentation de la vision 2020: le droit à la vision et d'apporter les solutions ; La revue de la surveillance de la cécité national, la littérature courante et l'expérience de la Société Ophtalmologique au Nigeria. Les résultats montrent que le taux de cécité au Nigeria est de 0.78%. Plus de 43% sont cause par les cataractes et en plus de 9% de l'aphasie non corrigée ou complications. 50% des cas d'intervention de cataracte sont faite par des praticiens itinérants. D'autres causes majeurs d'aveuglée sont le glaucome (16%), les opacités cornières (12%), trachome (4%), l'atrophie optique (3%), onchocercose (1%) et la maladie maculaire (1%). 70% des cas étaient preventables ou réversibles. Nigeria a une proportion ophtalmologiste/population relativement favorable d'environ 2.8 par million, mais des taux de chirurgies de cataracte faibles de 300 par million par an. Les raisons de ceci inclus le manque de programmes de prévention de la cécité, manqué de la volonté politique et de fond maigre de l'état de la vision 2020. Il y a un manque de responsabilité dans la formation et les services de la part du gouvernement aux organisations internationales non-gouvernementales. Les centres hospitaliers ne génèrent plus assez de fond des cas de chirurgie pour supporter la formation. Nous estimons un cout de N8.5 billion ($56.8 million) pour supporter les soins de la chirurgie de la cataracte recommandée par OMS de 3000 par millions par an au Nigeria. En conclusion, Le Nigeria, avance pas dans la direction de joindre les objectifs de la vision 2020. La recherche des financements par les MDGs, doit être intensifiée.

Introduction

Blindness remains a major problem of pubic health significance in Nigeria. The recent national survey on blindness estimates an overal prevalence of 0.78%, nationwide [1, 2, 3].

Initiated by the Federal Ministry of Health, the survey was supported by Sight-Savers International (SSI) and provides important data which had previously been lacking about the number of people in Nigeria who are blind and visually impaired and the causes of their visual loss. The findings in the survey demonstrated an urgent need for practical steps to reduce the burden of blindness and visual

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impairment. In this communication we wish to briefly address the challenges that face us in Nigeria as we attempt to meet the goals of vision 2020 which is to eliminate the causes of avoidable blindness by the year 2020.

This article will be approached from the following points of view:

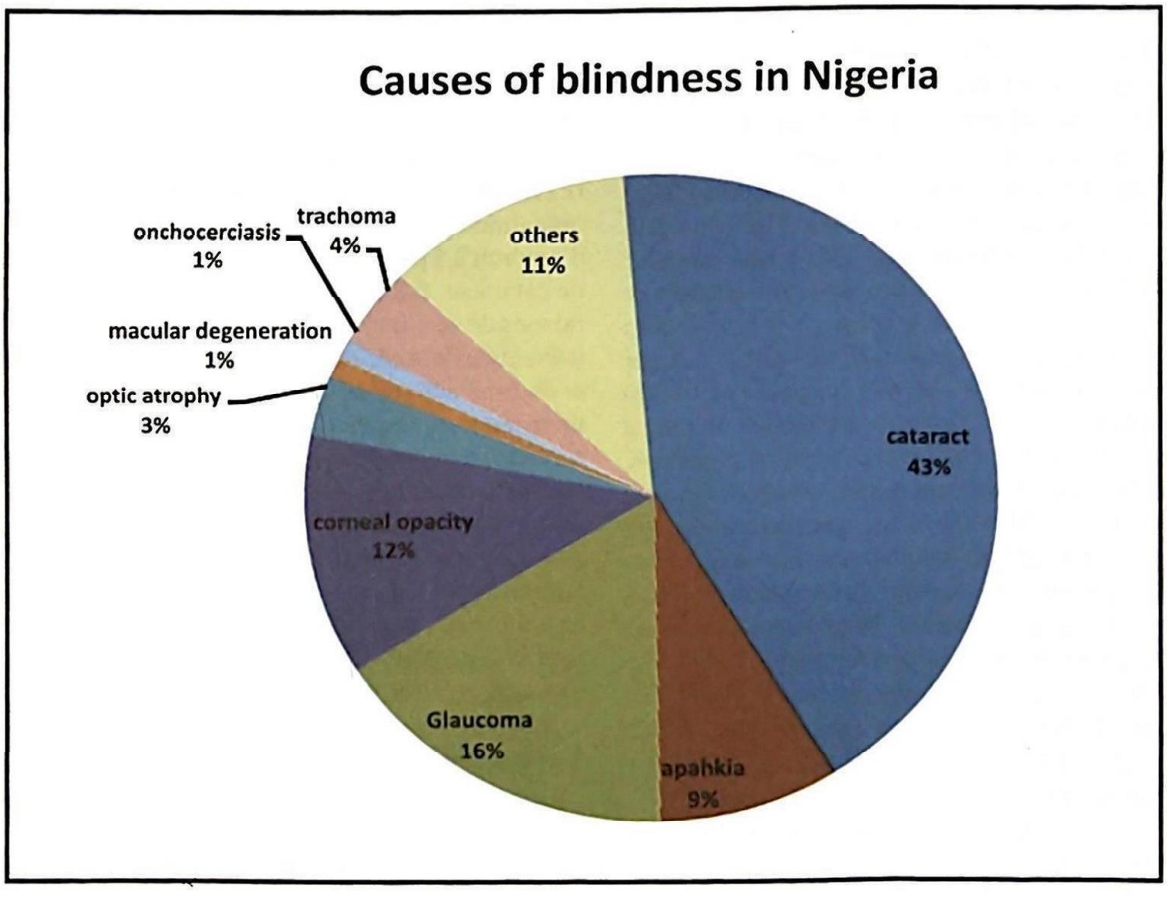
1. What is the present position with regards to blindness in Nigeria? (Major causes and distribution)
2. Who is involved in blindness prevention in Nigeria and what is their level of involvement?
3. What steps have been taken so far to prevent/ reduce blindness and how successful have these steps been in relation to what the goals should be?
4. How can we move forward from here? How can blindness prevention compete with other more 'attractive' health interventions such as HIV/AIDS AND MALARIA?

The key findings of the survey are as follows

The overall prevalence of blindness is 0.78%. With a population of over 140 million, this suggests that over 1 million Nigerians are blind and over 3 million are visually handicapped. Furthermore, 42 out of every 1000 adults aged 40 and above are blind. Overall, two out of three Nigerians are blind from causes which could be avoided such as cataract which is the single commonest cause of blindness

Blindness is almost three times more common in the dry northern areas (the Sahel) than in southern delta areas. The survey further found that Illiterate participants were twice as likely to be blind as those who were literate

Fig.1: Causes of blindness in Nigeria based on the recent National blindness survey.



The survey indicates that 486,000 adults across the country are in immediate need of cataract surgery, a straightforward operation lasting a matter of minutes, which the World Bank has described as "one of the most cost-effective surgical interventions". Other important causes of blindness were glaucoma, corneal scarring and poor procedures for cataract surgery. Onchocerciasis, or river blindness, and trachoma together accounted for five percent of blindness.
Some more specific findings are as follows (fig.1):

- 3,920,000 are estimated to be visually impaired from all causes
- Of these, 1,480,000 (37%) are handicapped from uncorrected Refractive errors
- 1,050,000 are blind from all causes (overall prevalence is 0.78%).
- 500,000 are blind from cataracts (42.9%)
- 16.3% are blind from Glaucoma
- 12% are blind from Corneal opacity
- 8.4% are blind from Uncorrected aphakia (couched patients included)
- 3% are blind from Optic atrophy
- 1% from Macular degeneration
- 1% from Onchocerciasis
- 4% from Trachoma

Therefore cataract and uncorrected aphakia together are responsible for 51.3% of all blindness in the country. It was also observed during the survey that about half of the cataract interventions being carried out in the country, particularly in the North, were been done by traditional couchers. During couching an instrument is used to dislocate the opaque lens away from the pupil, into the back of the eye but this is often associated with complications. The reasons for this are conjectural but probably include that the couchers are itinerant, accessible, and culturally more identified with the patients. Cost may not necessarily have been a major factor because these patients do pay for the procedures, sometimes up to N40, 000.00 (about $266) per procedure, twice what they would have had to pay in the typical government hospital. With the publication of the results, it became obvious that something had to be done to reduce the burden of blindness, especially from cataract.

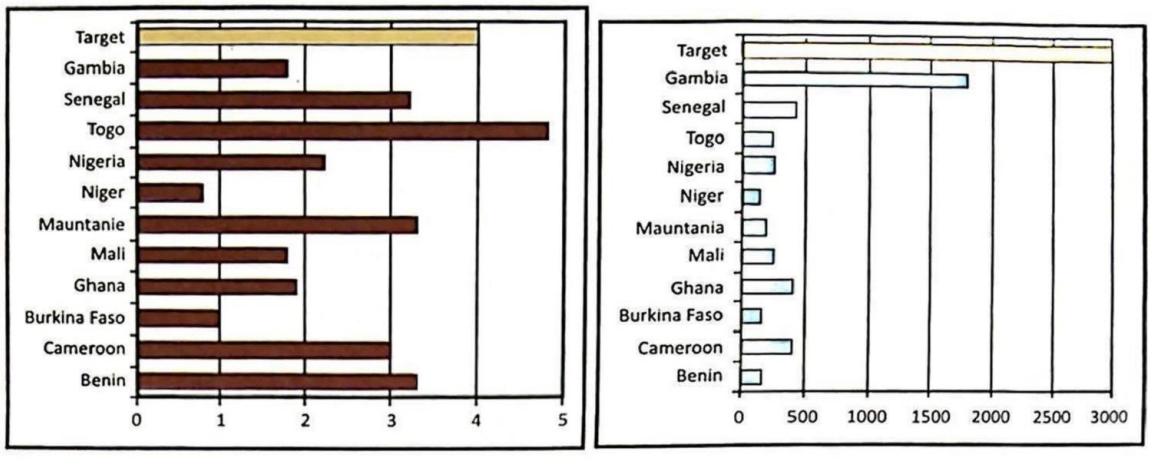
There is obviously therefore a cataract backlog, as already recognised by some Nigerian authors [4]. Comparing the National Blindness survey findings with the earliest blindness surveys carried out in Nigeria in the 1950s[5] there appear to be some obvious changes in the pattern of aetiology of blindness as follows:

- A decline in the relative importance of trachoma which used to account for between 21-43% varying with the specific areas. This had been alluded to by earlier workers [6]. A similar decline was reported in the Gambia[7].
- A decline in the overall blindness and morbidity from onchocerciasis due to the relative success of the ivermectin distribution programs supported by the National Onchocerciasis Control Program and the African Program for onchocerciasis control [8,9].
- 'Newly emergent' diseases such as diabetic eye disease [10], age related macular dystrophies and retinopathy of prematurity[11]

What blindness prevention activities are going on in Nigeria concerning the major diseases identified in the survey? Cataracts are obviously our biggest problem. However before more is said about cataract, a few things need to be noted about other major blinding conditions.

Next to cataracts, glaucoma causes 16.3% of the blindness. Glaucoma is known to run a more aggressive course in blacks [12] and this compounds a situation where mechanisms are not in place for early detection and treatment. Even when the condition is diagnosed, typically incidentally or when one eye has become blind, treatment can be challenging: cost of medical treatment, particularly with the newer prostaglandin analogues, is high relative to the average earning power. Compliance is therefore a problem [13]. Anecdotal evidence also suggests that many of these medications become less effective with the passage of time [14]. Surgical interventions are also fraught in the African: the procedure is not always acceptable in view of the fact that it is not associated with dramatic improvement in the vision, and may in fact cause a worsening [15]. Secondly the failure rate of surgical blebs even with Mitomycin C trabeculectomy, is still high in the African eye. In an audit of trabeculectomies over a one year period at the Good Hope hospital, Chiang [16] found that about 35% of patients of African-Caribbean descent required needling revision of the bleb within one year of the surgery. Therefore reduction of blindness from glaucoma is challenging.

Non-onchocercal corneal opacities in Nigeria are often due to a combination of vitamin A deficiency and other nutritional factors [17], measles, ophthalmia neonatorum, [18] and trauma. The survey found corneal opacities responsible for 12% of blindness in general. Reducing blindness from corneal opacities would entail a combination of primary preventive measures such as an increase in measles immunization coverage, improvements in perinatal care, nutritional education and poverty alleviation.



X-AXIS LEFT GRAPH- NUMBER OF OPHTHALMOLOGISTS PER MILLION POPULATION.

X-AXIS RIGHT GRAPH- CATARACT SURGICAL RATE PER MILLION POPULATION PER YEAR.

(MODIFIED FROM A PRESENTATION BY DANIEL ETY' ALE, WHO BLINDNESS PREVENTION PROGRAMME).

Figure 2. Ophthalmologists per million compared with Cataract Surgical Rate (CSR) in selected West African countries. CSR rates are dynamic and there have been increases in the rates in Ghana after introduction of National health Scheme, and also in Nigeria due to intensified activities in certain NGO and faith based facilities.

Trachoma which is responsible for 4% of the blindness is a major cause of concern. Trachoma constitutes a public health problem essentially in the northern half of the country. This therefore caused the setting up of the Trachoma Task Force in 2001 [19].

The northern half of Nigeria lies in the WHO-identified 'trachoma belt' as it shares a northern boundary with the Republic of Niger where high trachoma prevalence (45.7% in Maradi, 28.6% in Dosso and 37.7% in Zinder provinces) has been reported [20].

Trachoma contributes significantly to the overall burden of blindness in Nigeria. International Non-Governmental Organizations (INGOs) namely Helen Keller International (HKI), The Carter Centre, Sight savers International (SSI) and Christoffel Blindenmission (CBM), have been collaborating with government to control trachoma using the WHO recommended Surgery, Antibiotics, Facial cleanliness and Environmental change (SAFE) strategy. The activities are integrated in to the Primary Health Care (PHC) system .The results of the various surveys and assessments showed that both active and blinding in most parts of Northern Nigeria. The prevalence of active trachoma ranges from 5% in the North Central states (mainly within Savannah vegetation) to over 50% in the far Northern states (North East and North West), which in addition to the relatively poor social, infrastructure and economic underdevelopment of the far north are factors implicated in the high transmission and hence the high prevalence of trachoma [21, 22].

Optic atrophy was identified as a cause of visual loss in 3% of cases. Apart from optic atrophy related to onchocerciasis, other factors have been identified as associated [23,24,25] . Some of the non-onchocercal causes identified in these studies included intracranial and intraorbital tumours, trauma, nutritional factors (such as cyanide-cassava particularly in the Rivers state study), hydrocephalus, (particularly in the Oluleye *et al* study which was carried out in a neurosurgical referral centre) retinitis pigmentosa, seizure disorders and birth asphyxia. In the Oluleye group study, aetiology was ascribable in only 38% of cases.

Onchocerciasis was responsible for blindness in 1% of cases nationwide. However there are always

pockets of high endemicity [24]. Control measures being undertaken by the National Onchocerciasis Control Project (NOCP) is mainly geared towards ivermectin distribution by Community based distributors (CBD) (Community Directed Treatment with Ivermectin). Onchocerciasis is estimated to be responsible for over 200,000 blind persons in Nigeria. The disease is endemic in all 6 zones of the country, but occurs in very low prevalence in Bayelsa, Lagos, Katsina and Rivers States [26]. Systematic ivermectin distribution started in 1991 and APOC assistance was introduced in 1997. Over 30 thousand communities are now under treatment with a therapeutic coverage of about 77%. Compared to placebo, studies have shown an impact in the reduction of optic nerve disease from ivermectin [27]. The control of the disease is implemented by the NOCP with assistance from APOC, UN agencies and NGDOs.

Macular degeneration has emerged as an important cause of blindness and visual impairment being found in 1% of the population in the National survey. Age related macular degeneration is now more frequently encountered in Nigerian eye clinics [28] Macular disease is also found in association with diabetes [29] and chloroquine toxicity [30]. A so called crystalline maculopathy has also been described in West Africans in elderly Igbo patients from south eastern Nigeria although this does not often lead to blindness [31].

Uncorrected refractive errors account for a further 1% of blindness, and a very high proportion of the visually disabled (37%). This suggests that optometric services need to be extended to the rural areas. Even though Nigeria now boasts of over 2000 optometrists and increasing, there is an obvious mal-distribution with a bias to urban areas associated with a lack of incentive to work in rural areas.

The cataract backlog: obviously cataracts and aphakia are responsible for the over 50% of blindness. It is estimated that there is a backlog of over 2 million people needing cataract surgery in Nigeria. Over 70% of this population resides in the rural areas. However there are two key points which are peculiar to Nigeria (see figure 2)

- Nigeria has a low cataract surgical rate (CSR) estimated at between 200 to 400 cases per million per year [32].
- Nigeria has met up to 60% of the WHO recommended need for ophthalmologists, there being about 500 ophthalmologists (Fellows of post graduate medical colleges and diplomates of the West African College of Surgeons working in various hospitals). WHO recommends a ratio of at least 4 ophthalmologists per million population, and the ratio in Nigeria approaches 2.8 per million at present.

This suggests that the problem is more of an underutilisation of the existing manpower.

The objectives of Cataract Blindness Control in Nigeria must therefore be:

1. To keep up with the incidence of cataract blindness by increasing the CSR (Cataract surgical rate) from the present level of less than 300 in most zones of the country to at least 2000 per million population. This may translate to about 260,000 cataract surgeries per year for the country.
2. To increase the uptake of cataract services by improving the quality of cataract surgeries performed in the country to achieve good results in at least 90% of cataract surgeries in keeping with WHO guidelines [33,34].
3. To increase the quantity and improve the quality of training of ophthalmologists and supporting mid-level eye personnel in the context of eye care teams and more efficient use of personnel.
4. To improve the productivity of existing surgeons and surgical teams to achieve a desirable output of a minimum cataract surgeries per surgical team. If there are 500 ophthalmic surgeons and 260,000 procedures to do per year, each surgeon will have to be doing over 500 procedures per year. This will be in base hospitals and with the use of outreach and camp strategies.
5. To advocate for user charges system which does not deny services to the cataract blind and the elderly by using the national health insurance scheme, poverty reduction and other such schemes.
6. To advocate that quality intraocular lens and other essential consumables are available at the point of need
7. To appropriately redistribute/deploy and equip eye care teams i.e. ophthalmologists, nurses for an efficient cataract management service in the country.

How Nigeria has addressed cataract blindness thus far

1. Eye camps

   These have been short term, intensive and high publicity events performed by health care providers and supported by NGOs, political figures, philanthropists, state and local governments etc. They happen parallel to and usually outside the health system.

2. "Free" Services
   These are services labelled free in which surgery may be free to the patient, a major incentive for uptake. The patients still bear non surgery costs. The full actual costs are met by the many and varied donors, internal and external.

3. Health Services
   Within the health system where majority of the members of the eye care team including ophthalmologists are located, the performance in cataract surgery is disappointingly low across the country; as low as 30 per surgeon per year in the teaching hospitals.

Table 1: The international Non-Governmental Development Organisations active in Nigeria and their areas of operation/service focus.

NGDOs	States where operational	Activities
Christoffel Blinden VISION 2020Support Programme	Kano, Yobe, Jigawa and Federal Capital Territory (FCT)	Mectizan distribution, Primary Eye Training, Vitamin A supplementation, Low Vision Services; Cataract services; Surgical support services
Eye Foundation	Lagos, on ad-hoc basis to other 36 states and FCT	Clinical Activities Surgical Outreach activities HRD of Ophthalmologists
Eye Care Africa	Akwa-Ibom, Cross-River, Edo, Delta, Imo, Abia, Ondo.	Surgical Outreach Vit. A distribution (Human Resource Development HRD) Research into local causes of Blindness.
Carter Centre(formerly Global 2000)	Nasarawa, Plateau, Edo, Delta, Anambra, Enugu, Imo, Ebonyi, Abia	Mectizan Distribution Trachoma control Management Training Lymphatic filariasis
Helen Keller International (HKI)	Adamawa,Borno,Akwa-Ibom	Mectizan Distribution Trachoma Control Vit.A supplementation
Mission To Save The Helpless (MITOSATH)	Taraba	Mectizan distribution
Rotary International	Nation wide	National Immunization Programme, Mectizan distribution
Sight savers International	Cross-Rivers, Kaduna, Kwara, Kogi, Kebbi, Sokoto and Zamfara	Cataract Services Mectizan distribution Trachoma Control HRD of eye care workers Vit.A Supplementation Support to Tertiary institutions
UNICEF	Bauchi, Benue, Cross-River, Gombe, Niger, Ondo, Ebonyi	Mectizan Distribution
Youth Care	Cross-River	Vision Screening
International Council for Eye Education	Cross –River, Akwa-Ibom	Vision Screening, Optical Services HRD for Optometrists and other eyecare workers
Netherlands Leprosy Mission	Bauchi,Gombe,Katsina,Borno,Kano, Adamawa,Jigawa,Gombe,Taraba,Benue, Plateau,Nasarawa and Yobe	Leprosy Control Surgical training of Ophthalmic associates
Al Noor Foundation	Adhoc basis according to needs,	Cataract Camps
Al Basaar	Northeast, Northwest zones	HRD
Light and Darkness	Plateau ,Nasarawa	Onchocerciasis Control Cataract Camps, Trachoma Control

4. High volume

A few states supported by NGOs have put in place eye care programmes run by Nigerians. Examples are Kwara and Kaduna with Sightsavers international. Fewer still, Nigerian run high volume eye hospitals supported by NGOs which offer comprehensive services prioritising cataract surgery. E.g. ECWA and Christoffel Blinden mission. Other NGOs work within government facilities, where the high volume surgery itself is done exclusively by non Nigerians e.g. Tulsi Chanrai Foundation in Adamawa and Cross River States.

6. Quackery

The survey revealed that across the country, 50% of all cataract interventions is by couching- a practice in ancient Egypt more than 2000 years ago and no longer tolerated within modern health services. The couchers advertise heavily, are itinerant, closer to the people and ready to negotiate terms, which might include deferred payments or payments in kind.

Challenges in terms of funding for cataract surgery.

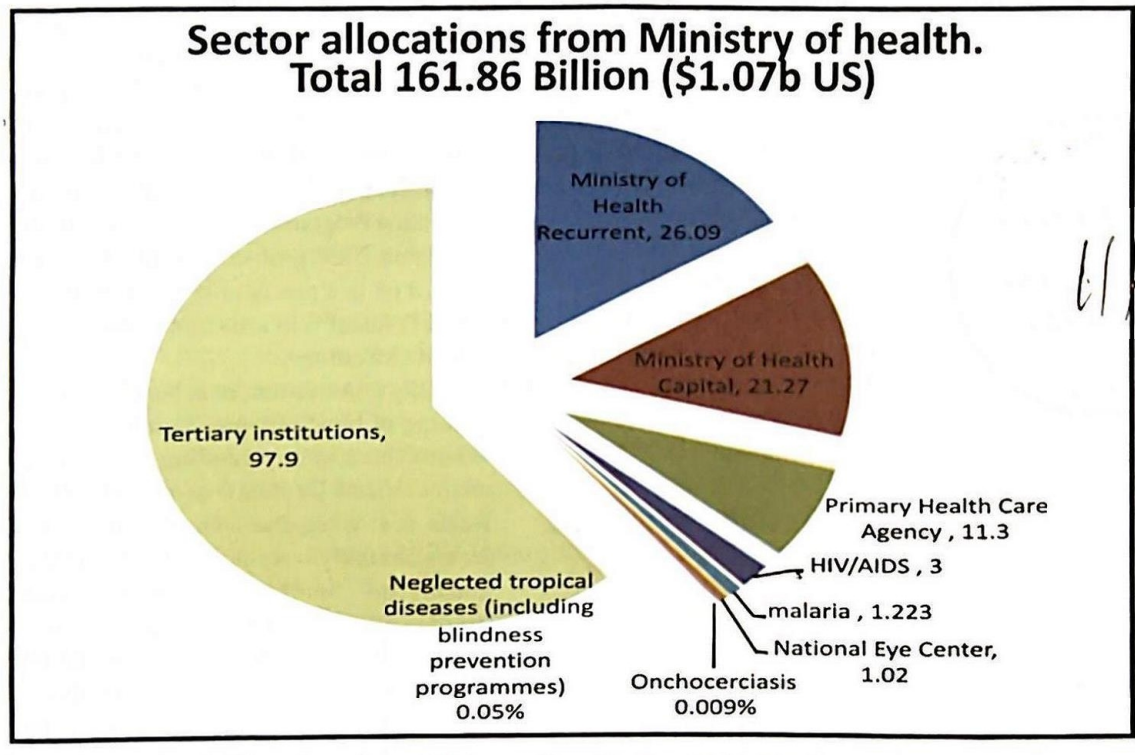


Figure 3. Federal allocations from Ministry of health. Total 161.86 Billion

5 Skills development

In order to deliver a high quality, high volume cataract surgical service, various skills are required across many cadres. An example is surgical skills. To learn and maintain surgical skills, WHO estimates that at least 100 surgeries per surgeon per annum are required. In Nigeria training centres i.e. teaching hospitals, the rate could be as low as 30 per surgeon per annum, And there are no performance targets! This has spun a vicious cycle of the less done, the less taught, the less known, the less done and the abdication of training to the NGO run high volume centres.

One of the major challenges to the attainment of the required volume is the inability of patients to pay for surgical interventions. Realistically it would cost between N20, 000 to N30, 000 ($130 to $200 US) to deliver a cataract extraction with consumables, fixed costs and labour costs

Between the nineteen sixties and eighties, cataract surgery was free in most secondary and tertiary institutions in the country. In those days the CSR in the country was much higher. With the introduction of fees in our hospitals, we have seen a sharp downturn in the CSR.

Funding for eye care work in Nigeria.

Funding for eye care work in Nigeria has been patchy at best.

A study of the 2010 Federal budget makes interesting reading [35] . The total federal budget was N4. 07 trillion Naira or about $270 billion US. (The Naira exchanges at about 1$ US to N150). Only 34% of this is available to run the ministries, the rest having gone into recurrent budget (49%) debt servicing (13%) and statutory allocations (4%). The Health ministry gets 11% of this 34% (3.7% of the total outlay.) Figure 3 shows how the health ministry budgeted its allocation. The tertiary institutions and ministry of health accounts for over 80%, Primary health care for 11%, and other programmes for less than ten percent. The notable vertical programmes are HIV/AIDS, Malaria, onchocerciasis and the so called Neglected Tropical Diseases (NTDs). The National Blindness Prevention Programme, incorporating Vision 2020, is now within the NTD, which accounts for 0.005% of the health budget! It has to compete with Leprosy, dracunculiasis, Leishmaniasis etc for funding. In practical terms, vision 2020 programs are not funded at present.

From a study carried out by Olowu [36] it was found that, through the Nigerian Programme for the Prevention of Blindness NPPB, only the sums of N712,000 (2005), and N1 million (2006) (About $5000 and $7500 respectively) were accessed from appropriated sums of money. At the state level, with the notable exception of Lagos state and Kaduna state that have been running State eye Care plans for the past few years, Ogun state once budgeted N500, 000 but released nothing, Kogi State budgeted N3 million and released N1.5 million while Kwara State budgeted N5.8 million but released nothing in the years between 2005 and 2008.

The NGOs in the country have picked up the slack, and the governments have virtually abdicated the responsibility for eye care to these NGOs. (See table 1). This is not acceptable because Government ought rightly to take responsibility for her citizens, because NGOs can change policies or pull out at any moment.

Some NGOs have committed significant sums to eye care in Nigeria. For instance, using the 2007 financial year as sentinel, the following organisations spent the sums indicated [35].

- The Carter foundation: N19.4 million for onchocerciasis
- The Carter foundation: N56.2 million for trachoma work.
- MITOSATH (Mission To Save The Helpless): N 10.5 million for general eye work.
- CBM VISION 2020: N34.3 million
- Sight Savers International N5.2 million

To meet the WHO goal of 3000 CSR per million per year, for a population of 142 million Nigerians would cost about N8.5 billion ($56.8 million) assuming each procedure costs about N20, 000 Naira.
(i.e. 3000 X 142 X 20,000.00 = N8,520,000,000.00).
Obviously this is a huge sum of money and is a major challenge for any government. However an incremental approach is probably best in this instance.
In summary the following can be identified as the major challenges in the way of attainment of the lofty goals of "Vision 2020: the right to sight" in Nigeria: (through disease control, Human Resource Development and the development of Infrastructure).

- Government not taking ownership of Blindness Prevention Programs. Government has signed the vision 2020 protocol but has not really taken it on in a practical or fiscal sense.
- Lack of Political Will and Commitment on the side of Government.
- Practically non-existent or at best Inadequate funding of blindness prevention programs. Where there is any funding this is often characterized by delay or non-release of funds as at when due. Governments at all levels similarly are not contributing their counterpart funds to NGO run programs.
- Cost of eye care services-Most people cannot afford the cost of accessing the service.
- Inadequate manpower resources. However as noted, Nigeria has met more than 60% or the WHO recommended ophthalmic surgeons need and has indeed exceeded the need for optometrists by a factor of four or more. The problem has more to do with the adequate utilization of the available manpower.
- Infrastructure and Technology inadequate or obsolete- There is gross shortage of Ophthalmic equipments and materials. Existing equipments often breakdown and are poorly maintained. The absence of central procurement processes results in erratic supply of essential consumables especially for cataract surgery. However of recent consumable support services have been set up by CBM in Gwagwalada.
- Refractive error service is inadequate and not properly integrated into existing eye care

programs. Over 2000 optometrists have now been graduated into the system from two schools of optometry in the Universities of Benin and Abia State. The product quality is often less than expected and there is an imbalance in the distribution with most gravitating towards the cities.

- Poor integration of Primary Eye Care into Primary Health Care
- Inconsistent Government Policies and frequent changes in top personnel. By the time a sitting minister has been convinced of the need to act, he is changed. We have had three Ministers of health within the three years of the Yar'Adua/Jonathan government. Also, it is hoped that a senior ophthalmologist within the ministry would be put in charge of blindness prevention. At present, blindness prevention is in the Neglected Tropical Diseases (NTD) division of the epidemiology unit and the NPPB is chaired by an optometrist.
- Inadequate supply of drugs and high cost of essential drugs
- Limited access – About 80% of Nigerians live in the rural areas, whereas most of the eye care centres and the personnel are located in the urban centers.
- Inadequate Community participation
- Lack of standardized Monitoring and Supervision tools.
- Poor cooperation amongst NGDOs and also with Governments

The way forward

Blindness prevention activities are mostly being carried out by NGDOs in the country. This is carried out mostly in hospitals manned by Diplomates in ophthalmology who have generally had a two year structured training in ophthalmology and are then awarded a diploma by the West African College of Surgeons. Government hospitals are manned mostly by Fellows, but they tend to be underutilised. We hope to persuade government to take a more active role in this effort. Advocacy is problematic in Nigeria and government officials are more easily impressed by expatriates from Asia, who run flash in the pan expeditions, rather than well thought out home-grown initiatives.

One such initiative is the SPECS (the Special Program for the Elimination of Cataracts) put forward by the Ophthalmological Society of Nigeria, (OSN) which is a vertical cataract intervention program. This was sold to the former Minister of health before his re-deployment.

The central tenet of the SPECS was (is) to support the ophthalmologists in the various teaching hospitals, where over 50% are based, to carry out more surgery. Few surgeries are being done in the teaching hospitals for various reasons which include the fees asked of the patients and the beurocratic bottlenecks through which they have to navigate. The idea is to get funding through the MDGs department (Millennium Development Goals) to support subsidised/free cataract surgery in the tertiary institutions. The link between the MDGs and blindness prevention has been drawn by Faal and Gilbert [37] who posit that at least seven of the eight goals are linked to blindness prevention. They also posit that the presentation of factual information is germane to getting governments to act by demonstrating that cataract interventions for instance are one of the most cost effective interventions in health care.

Our experience has been that, in the Nigerian context, the mere presentation of facts to decision makers is hardly ever sufficient to influence a decision to commit funds. This is in spite of the fact that we have signed the vision 2020 protocols and have established Vision 2020 committees on paper at the federal as well as state levels. Success comes only when prominent politicians believe they can make political capital from eye care interventions. In Lagos State for instance, former Governor Bola Tinubu gained popularity with the free cataract program, and by distribution of free glasses called 'Jigi Bola' (Bola's glasses). First ladies seeking relevance have also sometimes adopted eye care programs as 'pet projects'. In states where the first ladies have been so persuaded, such as in Delta state, some traction has been experienced in blindness prevention programs. The ministries tend to follow the political winds of change, but will hardly initiate a fresh program or buy into one being sold by a professional body such as the Ophthalmological Society of Nigeria (OSN). Compounding the advocacy conundrum is the 'Vision 2020-20' program of the Yar'Adua-Jonathan regime, which is a political program meant to lift the country into one of the first twenty economies by the year 2020. Vision 2020: the right to side is literally drowned out by the political Vision 2020-20. Advocacy in Nigeria is challenging but we must not give up.

The good news is that with available resources in the country, cataract blindness can and should be eliminated by Nigerians for Nigerians in Nigeria at the average achievable rate of 500 to1000 surgeries per surgeon per annum.

With 500 thousand Nigerians blind and increasing, it is a national emergency and must be dealt with as such. We need some good luck with the new Minister, and hope that by the time we convince him to act on cataracts, he does not have to leave the next day!

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