

Eye health in Kenya: 50 years on, what have we to show for it?

Though contemporary recorded history gives a lot of prominence to the rise and development of ophthalmology in western civilization, the birthplace of ophthalmology is arguably in Africa. There is archaeological evidence of an oculist in the Egyptian court as early as 2500BC. Egyptian papyrus records from 1600BC have an entire section devoted to eye disease and couching was already being practiced. Ophthalmology has evolved from these early descriptions of eye conditions, through the elucidation of ocular anatomy and to interventions to improve and even restore eye health.

In Kenya, the first contemporary providers of eye care were opticians that came over from India with the building of the railway in the 1900s. However, co-ordinated eye care as we recognize it today began as an initiative of the Royal Commonwealth Society for the Blind (1950 to date - currently operating as Sight savers) and supplemented by Sight by Wings (started in 1971). The Kenya Society for the Blind (KSB) was the local implementing partner for the Royal Commonwealth Society for the Blind. These organizations would bring in doctors from abroad to provide eye care particularly in the rural areas. Essentially eye health care provision was provided by private healthcare sector players in the *de facto* vacuum left by both the colonial and post-independence governments. This may explain why eye health is to date still viewed by many as an adjunct to health in general and not of primary concern.

When eye care service is mostly provided by the private sector, reach to the general population is limited and it is perceived to be a special service to be accessed only by the select few. Where the poor, remote and socially disadvantaged persons accessed eye care, it was provided by the 'not-for-profit' private sector players, which further propagates the idea that it is not a service to be accessed by all. It is viewed as a gift or favour by those providing the service. It also has played a role in creating the culture whereby the general Kenyan population has low willingness to pay for eye care services as they are deemed to be free services. This has implications on health financing and sustainability of eye care programs.

Even with the government's entry into the provision of eye care services, the field was and still is heavily influenced by private sector for profit and not-for-profit. Most professional eye care services are mostly found in urban areas and in regions where the not-for-profit organisations or social entrepreneurs have had an interest. This may have contributed to the beginning of a skewed distribution of eye care services, both in terms of infrastructure and personnel.

By the time the first Kenyan ophthalmologist, Professor Henry Adala, began his training in 1974, there were three ophthalmologists in the country, who were located in Nairobi and Kisumu. This number grew to 10

by 1980, most being ophthalmologists trained abroad. The start of the Department of Ophthalmology in the University of Nairobi in 1978 contributed to an increase in the number of ophthalmologists and may be seen as the official start of government participation in provision of eye health services. This was further enhanced by the setting up of the Kenya Ophthalmic Program (KOP) by the government in 1980 to coordinate eye health activities in the whole country. In 2002, KOP was upgraded to a full Division of Ophthalmic Services (DOS) of the Ministry of Health (MOH) with several national programmes. DOS is currently known as the Unit of Ophthalmic Services (OSU) which serves as Secretariat for the National Inter-agency Coordinating Committee for Eye Health. The first KOP coordinator was Dr. Walia Dharminder Singh and the founder Head of DOS was Prof. Jefitha Karimurio.

With time it was realised that the rate of training of ophthalmologists could not keep up with the need for eye care services. As part of the effort to provide adequate and accessible eye care, training of mid-level ophthalmic care officers began. Notably, Dr Mark Wood and Dr David Yorston working at Kikuyu Eye Unit were instrumental in starting short courses that trained ophthalmic nurses and ophthalmic assistants in the 1980s. The Kenya Medical Training College also contributed to the increase in human resource for eye health by training of ophthalmic clinical officers and cataract surgeons from 1986 and later ophthalmic nurses, optometrists and even low vision specialists. At present Masinde Muliro University of Science and Technology also trains optometrists.

There has been a steady increase in the numbers of eye healthcare professionals in the years since then which is commendable. However, despite the good progress, the World Health Organization recommended ratios of each cadre to the population have not been realised to date. There is need to rethink the composition of eye healthcare professionals in terms of numbers, cadres distribution and methods of training, if Kenya is ever to attain these VISION 2020 ideals.

As we move into the next half century of independence, we should pause, look at where we have come from and take stock. What have been our triumphs? Can we celebrate these? What oversights have we made? What lessons can we learn from them? What do we want the next 50 years to look like? What steps do we need to take to realise these dreams?

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