

## **Abstract:**

For a long time, it has been generally assumed that the level of blindness and need for prevention of blindness services in Africa is too high and there is no justification for committing the little available resources in conducting community based surveys. Blindness surveys are relatively expensive in the short term but cost-effective in the long term. Exaggeration on the burden of blindness and visual impairment when planning may lead to wastage of scarce resources while underestimation may deny essential services to needy communities. Evidence from recent district surveys conducted in Kenya indicate that this general assumption may no longer be applicable and hence the need for more accurate baseline data before implementation of community interventions in the country; and probably in Africa. The global estimates we have been using may no longer be accurate. The only national blindness survey data we have since the inception of the Kenya Ophthalmic Programme (KOP) in 1956 was collected in the 1980s.<sup>1</sup> Results of two recent rapid assessments of avoidable blindness (RAAB) conducted in Nakuru<sup>2</sup> and Kericho-Bomet-Bureti comprehensive eye services (CES) project and one rapid assessment cataract surgical services (RACSS) conducted in Embu and published in this journal (East Afr. Ophthalmol. J 2006; 13(3)) estimated the prevalence of blindness in people aged >50 years at 2% in all the surveyed districts. This is much lower than the planning estimate of between 5% and 9% previously assumed. Blindness due to age related cataract was found to be lower than previously thought but the proportion of patients with good surgical outcome was low. Cataract surgical coverage (CSC) for cataract bilaterally blind people was also found to be high which implies that we should now give more emphasis to improvement of our cataract surgical outcomes as we increase our cataract surgical rates (CSR). Inadequate continuing skills update training, lack of biometry equipment (majority of eye clinics still implant standard intraocular power) and vitrectomy machines (poor vitreous loss management) are among the short term handicaps which need to be addressed. A survey conducted in Kibera slums in 2002 indicated that even the overall prevalence of blindness (0.6%) may be lower than the national average (0.7%) and the VISION 2020 estimate (1%) the KOP has been using for strategic planning. The authors of this article and others have just finalized an eye disease and blindness survey in Kibera and Dagoretti Divisions of Nairobi which form the Sight Savers supported Nairobi CES project area. The preliminary report estimates the prevalence of blindness at 0.1%. We hope that ongoing surveys in Nairobi City and several rural districts plus regular schools and schools for the blind will provide valuable additional information. The findings of phase I and the ongoing phase II Kenya national trachoma survey (and in other endemic countries of Africa) indicate that this forgotten tropical disease which is “a manifestation of poverty through the eyes” is still a public health problem<sup>4</sup>. In some districts of Kenya, the prevalence is higher than previously assumed while in some previously assumed endemic districts (like Meru North and greater Laikipia); the prevalence has been found not to be a public health problem. The WHO forecasts a downward trend of blindness due to infectious causes like trachoma. The recent evidence makes us conclude that the trend may be different in Kenya and probably in Africa.<sup>6</sup> Information from colleagues from other parts of Africa including Tanzania, Ethiopia, Niger, Nigeria and Eritrea among others carry the same message: Trachoma is a public health problem among very poor communities of Africa. The recommended treatment for districts where active trachoma is endemic is mass azithromycin distribution in the whole population excluding children below one year and pregnant mothers. Evidence from the National survey conducted in Tanzania and published in this journal (East Afr. Ophthalmol. J 2006; 13(3)), indicates that this practice of

excluding children below one year during azithromycin mass distribution may leave a significant source of active infection in the treated communities. There are many barriers to utilization of eye care services but top on the list is the community member's inability to pay for services. Economical use of little available resources is important so that one can serve more people within a fixed budget. To be able to do this, we need accurate facts during planning for prevention of blindness.<sup>2,7,8</sup> It is our humble submission that we need accurate scientific data and not "common knowledge" in eye care project planning in Kenya to avoid wastage of resources and denying funding to the very poor communities.