UNIVERSITY OF ILORIN

THE TWO HUNDRED AND NINETIETH (290TH) INAUGURAL LECTURE

"THE QUEST AND CONQUEST OF COMMUNITY EYE CARE: MINDING THE GAPS"

By

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DEPARTMENT OF OPHTHALMOLOGY,
FACULTY OF CLINICAL SCIENCES,
COLLEGE OF HEALTH SCIENCES,
UNIVERSITY OF ILORIN, NIGERIA

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The Vice-Chancellor

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Heads of other Departments and Units,
Head of Department, Clinical and Non-Clinical Staff of UITH,
My Lords Spiritual and Temporal,
Distinguished Invited Guests,
Members of my Nuclear and Extended Families,
Great Students of the University of Ilorin, and especially of the College of Health Sciences,
Gentlemen of the Print and Electronic Media,
Distinguished Ladies and Gentlemen.

Preamble

The Vice-Chancellor, Sir, distinguished guests; it is a rare honour and privilege for me to deliver the 290th Inaugural Lecture of our great University. For me, today is doubly special because it coincides with my birthday, October 2nd, 1967. What better gift could I receive than this moment? I acknowledge my Creator, the Almighty God, the Giver and Sustainer of life. As Romans 8:30 declares: "Those he predestined, he also called; those he called, he also justified; those he justified, he also glorified." This is my testimony. To Him alone be the glory.

This lecture is the third from the Department of Ophthalmology, following Professor Abdulrahman Olarongbe Mahmoud's in March 2012 "*The Sights and Rights of the Blind"*, and Professor Ademola Popoola's in June 2023 "*Illusion to Vision: A Symphony of Trial and Triumph of Child Eye Health"*. By God's grace, I carry that torch forward today.

My name is Grace, and truly, I am a product of grace. I lost my father, Joseph Alalade Ayorinde, before my first birthday and was raised by my prayerful, resilient mother, Madam Sarah Oladeibo Ayorinde, my role model in faith and determination. I attended six different primary schools before finishing at Igosun LGEA, where grace singled me out as head girl and multiple prize winner. Secondary school at Oyun Baptist High School, Ijagbo, almost ended at the start. After my first year, fees rose to ₦135 per term, and continuing seemed impossible. Two people rescued my dream. My late aunt, Mrs. Elizabeth Adegoke, who took me into her home in Offa, I trekked the 5km journey to and fro, a rugged preparation for my future work, including community eye care service. My English teacher, Dcn M.O. Titiloye, later volunteered to take me to school daily in the 4th year. With God's help and the support of these two people, I graduated as the head girl, best overall student, and winner of multiple subject prizes, including Mathematics, English, Biology, Physics, and Geography. Oyun Baptist High School groomed me for drama, debates, news casting, and quizzes, where I proudly represented my school on several occasions. I thank all my teachers and mentors, some of whom are here seated today.

At Ahmadu Bello University, Zaria, the medical school presented further challenges, no textbooks of my own and almost no notebooks. Yet, providence saw me through. I graduated in 1991 with the Albar Award for the best graduating medical student, and the best prizes in Pediatrics, Community Medicine, Surgery, and Obstetrics & Gynaecology. My eldest sister, Mrs. Oyeleke Felicia, you stood in as mother, father, and sister. To you, I remain deeply grateful. Initially, I leaned towards general surgery and was encouraged to g into O&G by scholarships from

the ‘’Women in Nigeria’’ group and my teachers, especially Dr. Musa. A turning point came after an exhausting 72-hour emergency duty. Dr. Musa advised me to follow my convictions. My heart resonated with Ophthalmology after witnessing the finesse of Professor Adenike Abiose. Here was a specialty where I could merge community service, precision surgery, and even my passion for singing, which had earned me the nickname “Singing Surgeon.” I later got called into Christian movie acting. I am privileged to have acted in over 150 movies; this has strengthened my skills in storytelling and health education for eye care.

I began residency training in Ophthalmology on December 10, 1993, as a medical officer at UITH, with Dr. Dupe Ademola Popoola and Dr. Kolawole Ogundimu. At the time, UITH was not accredited for postgraduate training, so we rotated across Ibadan, Kaduna, and Lagos. I remain grateful to Professor Olurotimi Fakeye, who played a vital role in ensuring we obtained the needed training, and to Professor Owoeye, who once told me at the verge of being left behind, “Adepoju, find a place also, I will single-handedly run the department.” That sacrifice paved my way forward, I am grateful. I also owe much to Professor Victoria Pam, whose mentorship at Guinness Eye Hospital, Kaduna, helped me win the Dr. Oyin Olurin Prize for best candidate in the Part 1 FMCOph examination of the National Postgraduate Medical College of Nigeria. Prof Pam remains not only my mentor, but also my role model, my friend, a senior sister, and a mother figure.

I joined the University of Ilorin in 2001 as a Lecturer and became a professor in 2014. Today, I stand before you not merely to present the science of community eye care, but to share the soul of the work, a journey of light amidst darkness, of hope in the shadow of despair. A journey in uncharted waters, fueled by a quest to address the millions of rural community dwellers, who do not have access to care. I will present on the conquest, highlighting the gaps that exist in the eye care system in Nigeria, and how we have focused on minding these gaps.

An inaugural lecture is not merely a tradition, it is a celebration of academic pursuit, a testimony of expertise, and an opportunity to inspire, particularly the younger ones that your background should never hold you back.

Introduction

A memorable event was during the M.Sc. programme, we visited the Noor Restaurant in the UK, where blind staff members ran all activities. We were blindfolded, served meals, and later asked to identify what we had eaten, none of us got the correct answer, revealing how powerful vision is and how daunting life becomes without it. This experience as brief as it was, gave me an understanding of the challenges of the blind, and strengthened my resolve to fight avoidable blindness. The eye acts like a camera, but the actual picture we "see" is formed in the brain. The eye, as part of the central nervous system, captures visual information, while the brain, through complex retinotopic mapping and inter- and intra-cortical connections, projects the final visual experience.

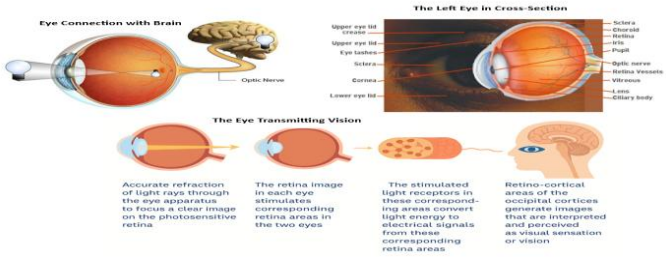

Fig 1: The Eye Connections, Structures, and their Functioning

The exact "location" of this visual screen in the brain remains unclear. The eye is a complex organ; the complexity of sight is a reflection of God's wondrous design. Only He fully understands how our eyes and minds come together to create the gift of vision. Vision is the primary function, but the eye also contributes to beauty and aesthetics. Perceived vision influences the sleep-wake cycle, communication, movement, and emotional responses. Clear vision is thus essential to life and the quality of it.

Blindness and Avoidable Blindness

The visual acuity is a simple test to assess how well an eye is seeing, usually tested one eye at a time. A normal visual acuity tested at 6m, is 6/6. This means what the eye should see at 6m is seen at that distant. There are different categories of visual impairment. Blindness is defined as presenting vision of less than 3 meters in the better eye. In the absence of appropriate vision chart, inability to count fingers in daylight at a distance of 3 meters (World Health Organization [WHO], 2023). Visual impairment is classified into; mild, moderate, and severe. Persons with mild impairment have visual acuity better than 6/18, while moderate impaired people have visual acuity of worse than 6/18 but better than 6/60. This grading provides a quantifiable measure of how well a person can see and is a key component in assessing and monitoring eye health. It refers to the sharpness or clarity of vision. Its significance is on baseline assessment of vision, diagnosis of eye conditions, determining treatment needs, monitoring progress or deterioration and has legal and occupational relevance

Grade	**Snellen (6/6 or 20/20 Equivalent)**	**Interpretation**
Normal	6/6 (20/20)	No visual impairment
Mild	6/12 to 6/18	Minor impairment, often correctable
Moderate	6/24 to 6/60	Significant difficulty; may need medical/surgical care
Severe	3/60 to 6/60	Legally blind in some regions
Profound	<3/60	Very limited vision
Near blindness	Light perception only	Can detect light, but no usable vision
Total blindness	No light perception	Complete vision loss

Globally, over 2.2 billion people live with visual impairment, 43.3 million of whom are blind. Ninety percent (90%) of blind people live in low- and middle-income countries (World Health Organization [WHO], 2023a). The common causes of Blindness are Cataract, Uncorrected refractive errors, Glaucoma and others listed below, 80% of these are avoidable causes.

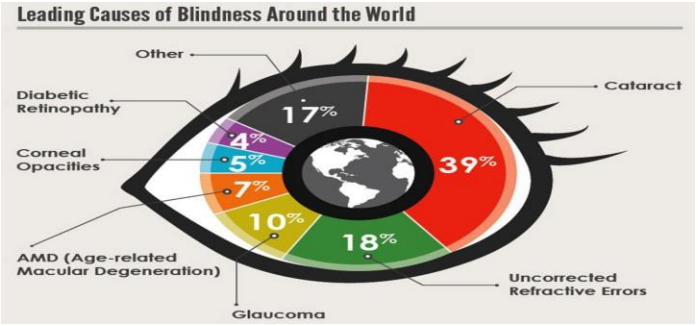

Fig 2: The Global Vision Database, 2016

In Nigeria, 0.78% of the population is blind, cataracts accounted for 43% of cases, and 80% of these are avoidable (preventable or treatable), while the majority live in underserved rural areas (Abdul, 2009). These statistics are not numbers; they are people whose potential is dimmed by avoidable blindness. Avoidable Blindness is either preventable or treatable. Preventable from measles by vaccination, diabetes and hypertension by adequate sugar and blood pressure control, from trauma and foreign bodies by appropriate precautionary measures, and Glaucoma by early detection and treatment. Treatable blindness is such that vision can be easily restored with available treatments, as in cases of cataract surgery, refractive error correction. The burden of avoidable blindness kills, incapacitates, lowers the quality of life, drives poverty, and causes dependence.

There are several risk factors for blindness. An aging world brings with it a predictable increase in age-related eye conditions, particularly cataracts, glaucoma, and age-related macular degeneration (AMD). The lengthening of human lifespans means more people are living long enough to experience these chronic sight-threatening diseases. **Adepoju** *et al*. (2005) found higher ocular morbidity and blindness among persons above 60 years. The burden of vision loss is not carried equally; it is heavily skewed by gender. Women and girls face a disproportionate risk, often due to a complex web of cultural, social, and economic factors that limit their access to timely and effective eye care. They may be less likely to have the financial independence to seek treatment or the social agency to priotise their own health needs over others. **Adepoju** *et al*. (2022) found more men present for services than women, even at free or subsided services.

Beyond the biological and social realities, eye health is fundamentally tied to an individual's circumstances. Poverty and illiteracy form a vicious cycle, where a lack of education can lead to poorer health choices and an inability to understand the importance of eye care, while vision loss itself can perpetuate poverty by hindering a person's ability to work (Omolase *et al*., 2007). Ayanniyi and **Adepoju** (2009) found poverty and illiteracy as high risk factors for non-uptake of orthodox eye care. Geography also plays a critical role. For those living in rural areas, the scarcity of eye care facilities is a significant barrier. Long distances to clinics, poor referral systems, and a lack of trained professionals often mean that a simple, treatable condition can progress into irreversible blindness, (Omolase *et al*., 2007). **Adepoju** *et al*. (2011) and **Adepoju** *et al*. (2014) reported that majority of the eye care centres and human resources located at the urban cities.

This geographic and economic disparity often leads to late presentation for treatment. When a person finally seeks care, it's often because their condition has become debilitating. This delay is typically a result of multiple factors: the high cost of

treatment, deeply ingrained cultural beliefs about illness, or simply a lack of awareness that their condition is treatable. In some cases, the very act of earning a living can threaten sight. Occupational hazards, such as those faced by farmers' exposure to harsh sunlight or miners working in industry, dangerous conditions, can lead to irreversible eye damage. Workplace related-accident and injuries were reported (**Adepoju** *et al*., 2007). However, well-intentioned but harmful practices are another cause of vision loss. The use of traditional eye medicines, self-medicating with unproven remedies, or the misuse of steroids can cause severe damage. Such practices highlight the urgent need for better public health education and access to safe, regulated medical care.

Finally, daily habits contribute significantly to eye health. Lifestyle factors like smoking, poor diet lacking in essential nutrients, and excessive alcohol consumption have all been linked to an increased risk of developing serious eye diseases. These are behaviors that, while seemingly disconnected from the eyes, impact the entire body's health, including the delicate structures of vision.

Challenges to Eye Care in Nigeria

1. Shortage and misdistribution of skilled eye care workers, worsened by "*Japa*" syndrome, (**Adepoju** *et al*., 2011).
2. Poor infrastructure, lack of diagnostic and surgical facilities.
3. Geographical, sociocultural, and logistical barriers to service.
4. Inadequate training, limited technology, and high equipment costs.
5. Rising insecurity.
6. Weak integration of primary eye care into primary health care.

Community eye care is a people-centered subspecialty care, focusing on primary prevention (education, vaccination,

vitamin A, eye safety measures), and secondary prevention (early detection via screening, treatment before blindness occurs, and treating avoidable causes), as well as rehabilitation, awareness campaigns, and advocacy, all of which are at the population level. Ophthalmologists, optometrists, technicians, nurses, general physicians, support staff, community members, and partners all work together as a team to serve in community eye care.

- Ophthalmologists – medical doctors with specialization in medical, surgical, and optical eye care.

- Optometrists – refraction and prescription of glasses.

Fig 3: Community Eye Health Care Team

Communities are target populations with shared needs, culture, and beliefs, reached through interventions. They have unique phenotypic or typological features, some hospitable, others hostile; some collectivist, others individualist; some fearful, others resilient, often with a mix of these characteristics. Sojourn into community eye care services revealed poor access to care with several documented bizarre ocular conditions and several cases of bilateral blindness from avoidable causes such as cataract are common encounters typified by few examples in Figure 4:

Fig. 4: Bizarre Eye Findings found in the Community

The Vice-Chancellor Sir, permit me to conclude this segment with these community works:

1. The audience, have you had an eye check this year? Everyone is mandated to check their eyes at least once every year; early detection saves vision.
2. Kindly cover one eye, observe your sight, open and cover the other, if vision differs, narrower in one or if your vision is poor in both eyes, get help immediately after this lecture.

My Contributions

The eye, small yet powerful organ, has fascinated me and served as a window through which I have contributed to improving human health and dignity. Blindness remains one of the most dreaded disabilities, yet most of it is avoidable, a friend once called this "Avoidable Blunder!" Nigeria reflects this global challenge: despite advances in surgery, training, and policy, cataract and other preventable causes still account for high levels of blindness. Distinguished guests, my life experiences, including discovering purpose through challenges, prepared me to see the need and to serve the community. To better understand and address blindness at the Community level, I pursued a Certificate in Community Eye Health at the Groote Schuur, University of Cape Town, and a Master's at the London School of Hygiene and Tropical Medicine. I further refined my cataract surgery skills at Aravind Eye Hospital in India, a global model for delivering affordable, high-quality care.

Fig 5: The Three Sharpening Schools

In our study at a school for the blind, **Adepoju** *et al*. (2006) found blindness was avoidable in 77.5% of cases. Major causes were corneal disease, cataract, and glaucoma. Most were blind from childhood, half of the before age 1, highlighting the urgent need for prevention and early care. A one-year cross-sectional study at UITH by **Adepoju** *et al*. (2005) showed the commonest eye diseases to be allergic conjunctivitis, refractive error, cataract, and glaucoma. These avoidable conditions can largely be addressed at primary and secondary care levels, leaving consultants to manage complex cases at the tertiary care. In another study of elderly patients by Abdulraheem and **Adepoju** *et al*. (2007), cataract and glaucoma were found as the leading causes of blindness; one out of the adult cases was bilaterally blind.

Among commercial intercity drivers in Ilorin, **Adepoju** *et al*. (2008), found common conditions like presbyopia, conjunctivitis, ocular hypertension, cataract, and refractive error. One of the profound findings was about 10% of the drivers had severe visual impairment and found few legally blind drivers still on the wheel. In one of our community outreach journeys early in the morning, a trusted driver who takes us for community outreaches was driving and entering all the gutters and potholes. He was discovered to have cataract blindness in both eyes, nearly causing a disaster. He was later successfully operated. This underscores the urgent need for mandatory vision tests at driver licensing and renewals.

Cataract remains a key global indicator of eye care service. At the 74th World Health Assembly (2021), World Health Organisation [WHO], (2022b) set targets that a 30%

increase in effective cataract surgery coverage and a 40% rise in refractive error correction should be achieved by 2030. Yet these remain far off. Developed nations like the USA and UK achieve high cataract surgical rates (4,000-6,000/million), while India and Pakistan have made significant progress, nearing the WHO's target of ~3,000/million. Low-income Countries often have <500. The National estimate for Nigeria is 300 (Foster, 2000). **Adepoju** *et al*. (2014), in their study on *Cataract Surgical Services in Kwara State*, revealed a complex landscape, characterised by notable strengths as well as significant challenges. While the state has a fairly adequate number of eye care workers, infrastructure, and equipment, the poor distribution of facilities and human resources was a major barrier to care. Out of 14 surgical centers reported, nine of which were base hospitals were all located in urban centre, 80 % of them situated in Ilorin central where only a third portion of the population lives, creating a significant imbalance in access to care for the more widely distributed rural population.

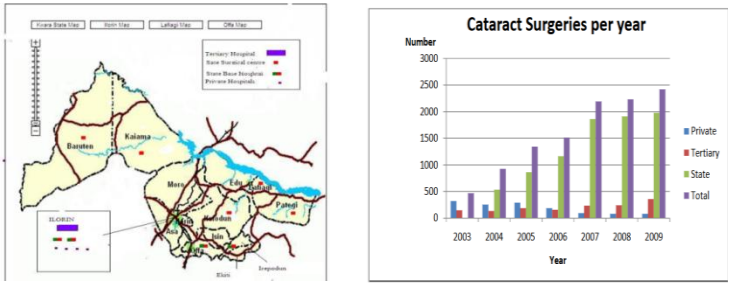

Fig 6: Cataract Surgical Services in Kwara State

Despite these issues, the cataract surgical rate (CSR) increased from 218 in 2003 to 2,417 in 2009. However, this figure is still far below the 4,000-6,000 target needed to effectively eliminate blindness caused by cataracts, and the state's total backlog is estimated at 7,227 cataract-blind individuals. The study identified the main constraints to

improving cataract services, distance to service points, low level of awareness of treatment, and efficiency issues in the hospitals, such as long waiting times and complicated payment processes. Additionally, a poor staff mix and the high cost and fear of surgery for patients are significant deterrents.

Adepoju *et al*. (2012) identified such barriers as high costs, poor access to surgical centers, low staff motivation, and lack of patient awareness or support as barriers to service. Many do not know where to go, cannot afford surgery, or lack accompaniment, factors keeping cataract blindness a persistent challenge. Ayaniyi and **Adepoju** (2009) studied 23 hospitals in Nigeria and Ghana, exploring strategies to increase the CSR. The most popular idea was offering rural allowances to encourage ophthalmologists to work in underserved areas. Omolase and **Adepoju** (2007) examined the eye care preferences among rural Nigerians in Afon community, established that of those interviewed chose Orthodox treatments as their preferred option, although there was no presence of an eye clinic, and several had to commute to Ilorin, about 15 km away.

Adepoju *et al*. (2007) identified barriers to accessing care to be primarily financial cost. We recommend reducing both direct and indirect costs of eye care for rural populations and providing better public health information. Using these findings, we launched advocacy for sponsorship from the philanthropists and the management of UITH, we secured subsidised costs of care for community-sourced patients, a practice that is still ongoing. (Olatunji & **Adepoju** *et al*., 2015), showed that while blindness is often preventable, local beliefs, such as aged people can be acceptably blind, or as supernatural punishment.

Community-based care is vital but complex. Regarding traditional healers, a study co-authored (Omolase & **Adepoju** *et al*., 2007), conducted in Afon, majority of inhabitants and all 32 traditional healers interviewed supported collaboration with ophthalmologists, however medical professionals interviewed during a conference were not in support. Since many rural patients visit healers first due to accessibility and affordability,

partnership is essential. Our later collaboration with healers improved referrals and reduced harmful practices. Collectively, these findings have guided service provision, partnerships, training, and health messaging to address Nigeria's pressing eye care needs. Preventing blindness is both medical and socio-economic; restoring sight restores independence, education, and productivity, breaking poverty cycles.

Reduction of Blindness from Cataract

A defining part of my career has been cataract surgery, through which I have restored vision, advanced surgical methods, trained the next generation, and shaped public health policy. Reflecting on my growth in treating avoidable blindness from cataract, I recall starting cataract surgery with the only option to us being intracapsular cataract extraction (ICCE) with ACIOL. Determined to move up to an advanced method of treatment, I trained at a Maja Hospital in ECCIOL during weekends' off-call. On returning, with Professor Owoeye's support, I introduced ECCE-IOL surgery in my institution. Our first cases were successful, freeing patients from the thick "*Oju Igo*" glasses, a benefit later confirmed in a study (**Adepoju** *et al*., 2004). We affirmed global evidence of cataract surgery's effectiveness in restoring sight and quality of life.

A major challenge at the start was operating microscopes to be able to do micro-surgery at the community level. The base hospital has limited number of microscope, this is still a limitation at the moment. I adapted an old microscope purchased for ₦40,000; its design appears to be originally meant to clean instruments.

Fig 7: Sequence of Improved Microscope

The adapted microscope was modified by changing the bulb holder to a brighter and available bulb, constructing a stand, improving the weight and widening the base to accommodate the angulations, the base, and upgrading the coil, and stepping down. Remarkably, this improvised instrument has been used in over 10,000 cataract surgeries at different community outreach programmes. Through cataract surgery, I have learned that there is always room for improvement. I was not born in the era of couching, an outdated, ineffective method still unfortunately practiced despite poor outcomes. I witnessed the development of ICCE, trained in it, and with colleagues transitioned to ECCE-PC IOL, later to SICS and Phacoemulsification.

Seeking further training, I went to Aravind Eye Hospital, India. Initially restricted to ECCE, I eventually gained access to Small Incision Cataract Surgery (SICS) training after persistent advocacy. Returning home, I taught SICS, which became the dominant local technique due to its speed, effectiveness, and suitability for outreach in low-resource settings. I later pursued Phacoemulsification, a more technical and steep learning process, investing personally in equipment. I have now performed over 50 Phaco surgeries and even introduced the technique in rural communities. Advances like femtosecond laser-assisted cataract surgery (FLACS) continue to shape the future; there is always a next level of cataract surgery.

Monsudi and **Adepoju** (2012) established that quality of life of operated patients improves after cataract surgery. Yet, many still live and die with cataract blindness, a needless avoidable blindness. In one of our studies few years later, Olokoba and **Adepoju** *et al*. (2016) showed the percentage contribution to blindness from cataract is, reducing from improved service coverage, while the prevalence of bilateral cataract blindness was 1.6%, a marked drop from 6.5% at the start of community outreach. Recognising early the challenge of unavailable biometry and, as a stopgap **Adepoju** *et al* (2006) calculated the average IOL power needed, the study gave a range of 20D-22D, which we used to provide services in rural areas for

several years. We now perform biometric calculations in the hinterland, though equipment numbers remain below benchmark. According to Shaheen *et al.* (2008), 112 ophthalmologists from the International Research Group contributed data on 11,048 cataract patients, published in the *World Health Bulletin*. Preoperative Visual Acuity at surgery of less than 6/60 was fund in about half of all surgeries from developing countries as against less than 1% in developed countries. We now record earlier visual acuity at cataract surgery, reflecting better techniques, improved outcomes, and rehabilitation.

The Vice-Chancellor Sir, our Cataract surgeries have remarkably increased, with over 20,000 cataract surgeries performed across communities and hospitals. This effort was recognized with the XOVA Award by Novartis International to deliver 1,200 surgeries in a year concluded in January 2025. We have also trained Cataract Finders, Friends of the Eyes, CHEWs, and community health workers to detect and refer cataract-blind patients. In addition, numerous cataract education programmes have been conducted via radio, TV, village squares, community forums, and online platforms. Mr. Vice Chancellor, permit me to Mr. and Mrs. Cataract, the conquest is still on, until no one is needlessly blind from the commonest cause of avoidable blindness. We made a film titled *You Are My Eye* (2011), a health education film on cataracts. This film received an award from the Ophthalmology Society of Nigeria and the African Ophthalmology Council in 2011, was viewed by more than 10million, and was shown in 27 TV stations in Nigeria and Africa.

Contribution on Glaucoma

Glaucoma, the *"silent thief of sight"*, leads to gradual visual field loss and, if untreated, results in irreversible blindness. Frequently asymptomatic in its early stages, glaucoma is a leading cause of preventable blindness worldwide, though common in older adults, it can occur at any age. In a study of 208 patients, Adekoya and **Adepoju** *et al.* (2015) found that the major bane in glaucoma treatment was late presentation was

largely due to poor awareness. At diagnosis, a quarter of patients already had visual impairment, and 15.5% were legally blind in their better eye. Other issues were poor compliance with treatment, limited equipment, high drug costs, counterfeit medications, and reluctance toward surgery. Adekoya and **Adepoju** *et al.* (2013) found that there were sufficient ophthalmologists and nurses in Lagos State, but shortages of equipment technicians and low-vision therapists. About half of the government hospital equipment was not functional while all privately owned equipment was functional, with particularly low access to essential tools like visual field analyzers and pachymeters. These findings underscore the urgent need for increased funding, better equipment, affordable medications, and coordinated stakeholder efforts to strengthen glaucoma care in Nigeria.

Our contributions to the Glaucoma care centred around, distribution of widely circulated eye health leaflets, production of the eye health film "The Still Water" which was widely viewed, Serial TV and radio eye health lectures, development of a local fundus camera for community-level detection of cupped disc. We need to further conquer glaucoma blindness by ensuring good knowledge of the disease in the community, encouraging early presentation, and strict compliance with care to reduce glaucoma blindness. The regular play out is late presentation when blindness that is irreversible has occurred. A similar scenario is typified by Mr. A.Y., first seen in 2012, was diagnosed with glaucoma, defaulted from follow-up after one visit, and returned nine years later, blind in both eyes. This avoidable blunder must stop.

Pediatric glaucoma requires special attention, with early intervention being critical to preserving vision. Normative studies (Olatunji & **Adepoju**, 2014; Olatunji & **Adepoju**, 2016) established corneal diameter and intraocular pressure ranges for Nigerian newborns, providing key diagnostic tools. Faced with limited resources, we improvised a trabeculotomy using a 27-gauge needle, enabling sight-saving surgery in rural settings, a

practical example of innovation driven by necessity. A one-week-old baby was successfully treated and is now ten years old and healthy.

Contributions on Cornea Ulcers

Corneal ulceration is a major cause of avoidable blindness and visual impairment worldwide. A retrospective study at the University of Ilorin Teaching Hospital (**Adepoju** *et al*., 2023) and a national corneal ulcer profiling study under review highlight its prevalence, often linked to occupational hazards among farmers and traders. Timely intervention is crucial to prevent vision loss and restore sight. The findings revealed late presentations by patients, over-the-counter medications, use of several injurious substances and herbs as core risk factors.

Fig. 8: Commonly used Traditional Eye Medications & Aftermaths

To reduce the high number of corneal ulcers and perforations seen at the hospital, Adekoya and **Adepoju** *et al*. (2014) focused on how to minimising cornea scarring caused by harmful traditional eye medications. The work contributed to the understanding of this issue and recommended a comprehensive, multi-faceted approach. The strategies proposed focus on the community level including community diagnosis to understand specific local practices, health education to inform people about the dangers of these remedies, involvement of community members in finding lasting solution to the menace. The study highlighted the importance of integrating basic eye care into the community's primary healthcare system.

Finally, we suggested collaboration with traditional healers to help modify or discourage harmful practices from within the community itself. As part of primary prevention, which involves health education, we created posters and several health information materials to educate the community. In tertiary prevention, we are evaluating the production, storage, and use of Amniotic Membrane Transplantation in managing corneal ulcers. Combining health education, early diagnosis, and these interventions can significantly reduce blindness from corneal ulcers.

Contribution to Ocular Injury

Ocular injuries are the leading cause of uniocular blindness and a common emergency in eye care. I recall a case involving a young Fulani headman with a ruptured right eye and three weeks later, a ruptured left eye from a cow horn injury. And a young lady beaten by his brothers, both had avoidable blindness from a preventable cause. **Adepoju** *et al*. (2020) highlighted global prevalence of ocular injury, documented, male preponderance, and bimodal age distribution (18-44 and ≥60 years). Common causes include occupational, domestic, road traffic accidents, and assaults. Outcomes depend on injury extent and treatment promptness. Preventive measures, health promotion, education, legislation, and advocacy, are crucial.

Chemical eye injuries were reviewed retrospectively by **Adepoju** *et al*. (2007) with findings showing that most injuries were accidental, primarily work-related, while a third was from assault, leading to bilateral blindness. Acids and alkalis were the main agents. Findings underscore the need for improved occupational health policies and better institutional preparedness for ocular burns.

Fig. 9: Severe Eye Damage Following Blunt Trauma and Chemical Eye Injury

Adepoju *et al*. *(*2014) demonstrated that ocular injury remains a significant cause of monocular visual impairment and blindness, with a notable impact on bilateral cases. A 15-year retrospective study at the University of Ilorin Teaching Hospital (1997–2012) examined the causes, risk factors, psychosocial effects, and preventive measures of bilateral blindness from ocular injury. Males were three times more likely to have ocular injury; chemical injury from car battery water was the leading cause. These findings highlight chemical injury as a preventable cause of bilateral blindness, reinforcing the need for education and legislation. In addition to numerous lectures and seminars, we produced a book, *Stop the Madness*, and a widely circulated film on ocular injury. Also, an eye health film on ocular injuries in Feyi Adepoju *YouTube.*

Contributions to Community Engagement and Community Outreaches

The proportion of people needing eye care who present to hospitals is low, as most facilities are in urban centers. Many at the community level have poor or no access, including those in urban slums. The community experience also revealed groups who are well to do but for logistic reasons resort to medical tourism, but communities are not helpless. They hold within them resilience, goodwill, and capacity. With the right guidance and support, they can become powerful partners in preserving vision and preventing blindness. I have learned through experience that sight is far more than just vision; it is dignity, independence, opportunity, and hope. When sight is restored, the ripple effect touches families, strengthens communities, and reshapes futures, across generations, from the rural villager to the urban policymaker.

Sojourn in community eye care was largely by mercy and grace. At the time, community practice was new, and the culture was to wait in hospitals for patients. A respected senior once told me, *"Why go to the community? Patients should come to us!"* Mr. Vice-Chancellor, we changed that culture. Community outreach later became a main source of cataract

patients for base hospital surgeries. We developed innovative solutions, including: production of local torches used as penlights, constructed locally made table stands and pinholes, built Snellen charts constructed from wood, later aluminum, Improvised refraction lenses from broken frames stacked in different powers, modified a microscope previously discussed, in use until 2015, constructed a small portable fundus camera, now being upgraded toward a non-mydriatic model.

In one outreach, when the step-down was forgotten in Ilorin, we powered the operating microscope with a car battery and successfully operated on 13 patients overnight and that became a sometimes go to operate at the community level.

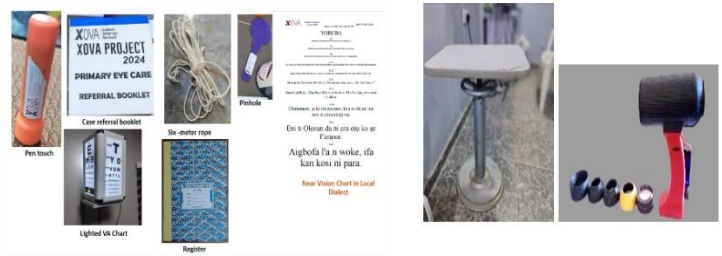

Fig. 10: Innovative Equipment & Tools used for Community Outreach Programmes

Sometimes from movement on bad roads, equipment damage during transit occurs, such as a personal phaco machine recently repaired abroad at great cost. These experiences underscore the need for a dedicated mobile eye hospital Van; if we are not at the level of a Flying Eye Hospital like Orbits, which we have hosted twice in Kwara. The poor state of primary eye care centers was also a challenge; recent government rehabilitation has improved several facilities.

Mr. Vice Chancellor, I have seen firsthand the heavy burden that avoidable blindness places on individuals, families, and communities. Eye care is not just a clinical service but deeply connected to public health and social justice. True impact lies in public health ophthalmology, reaching those who cannot

reach us. To bridge knowledge and access, we provided community eye care in schools, clinics, town halls, farms, village squares, and markets. We targeted welders, chemists, drivers, students, and organisations, people who might never have accessed specialist care. We used every opportunity, World Sight Day, World Glaucoma Week, Diabetes Day, Children's Day, weddings, even funerals, to advance the quest and conquest of community eye care, always keeping our eyes on the gaps.

Fig. 11: Community Outreach Programmes and Engagements with the Stakeholders

Fig. 12: Community-based Outreach Surgical Interventions

Through collaboration with community stakeholders and cross-sector partnerships, my teams have screened and treated thousands of individuals in rural and underserved areas. These efforts have facilitated over 20,000 surgeries, screened over 300,000 persons, and provided glasses to several, restoring vision as well as improving livelihoods, dignity, and hope.

Notably, we have on several occasions operated on siblings and couples on the same day. Early clinical practice exposed me to the stark inequities in eye care: while urban centers had specialised services, rural and underserved populations were largely neglected. This disparity compelled me to look beyond the operating room to public health strategies capable of scaling vision restoration and blindness prevention nationwide.

The divides between urban and rural access, persistent gender inequities, and limited eye care services affirm that community-based outreach is not optional but essential. Guided by this conviction, I have led more than 1,000 community outreaches across Nigeria, including repeated visits to towns and villages in Kwara, Oyo, Ogun, Ondo, Lagos, Niger, and Imo States, screening over 300,000 patients and performing more than 20,000 sight-restoring surgeries. These figures represent lives transformed, families restored, and communities empowered. One outreach in Okigwe, Imo State, required a 13-member team and was conducted under armed security, reflecting the growing challenges of insecurity. A gentle man walked in who had missed our 9:00 a.m. cut-off time, though regulations required he be turned away, mercy prevailed after his 215 km journey. I later found out he was the manager of Kainji dam; he lamented the absence of eye care in his community and the dire need for eye care. He appealed that I come to examine his workers, which marked the beginning of my monthly visit to New Bussa for over 20 years.

This experience highlights the need for people-centered systems, adequate manpower, and accessible eye care. By bringing services closer to underserved groups, especially women and children, and integrating preventive, curative, and rehabilitative care, we can bridge the gap between need and access. The battle against avoidable blindness will be won not in urban hospitals, but in the communities where the burden is greatest. Achieving this requires integrated strategies, where research informs practice, policy supports implementation, and innovations extend care to those in need. Community eye care is

demanding, teams often worked two to three days, delivering what would amount to a month's work in hospital settings. With the support of sponsors and local partners who provided logistics and subsidised consumables, this mission was sustained.

Mr. Vice-Chancellor, allow me to share three experiences that illustrate the transformative power of this work. A deposed Emir from New Bussa, blind in both eyes, regained vision after cataract surgery. At his follow-up visit, he smiled and proudly introduced his new wife, a new chapter enabled by restored sight. In another instance, a two-week-old baby with congenital glaucoma underwent emergency trabeculectomy in a rural community, using an improvised needle. The sight was preserved, and today that boy, now ten, is here in this audience with his mother. Finally, in Offa, a deaf and mute farmer who had gone blind underwent cataract surgery. The morning after, when his sight returned, his joy was so profound that he spoke for the first time.

Fig. 13: A community indigent patient with tumor

This picture is of a young man whose self-esteem had been eroded by a facial mass he carried for years due to a lack of access and funds. With support raised through SEAP, who regularly come to the aid of such individuals, he underwent surgery. Just weeks before I finalized this lecture, he sent me this photo with a short note: *"…back in 2019 and now in 2025."* Another unforgettable story is that of a young woman, bilaterally blind from cataract, which had just given birth. She traveled from a remote community to attend an outreach. After surgery restored her sight, she burst into tears as she saw her baby's face for the very first time.

The list of such stories is endless. The impact of community eye care is as palpable as darkness itself. Yet the need is immense, and the gap between communities and available services remains wide. We must mind the gaps, mend the gaps, and bridge the gaps, and everyone has a role to play. A vital part of community work is advocacy and fundraising. In a multi-community study (2013-2019), Adepoju *et al*. (2022) screened 13,661 individuals across 235 visits in 65 communities in Kwara State. The study found that community-based organizations provided critical financial support, growing from $855 in 2013 to a cumulative $27,250 in 2019. This enabled subsidized care and helped meet outreach goals. However, funding was still insufficient, as services provided fell short of actual need.

Over the years, our community outreaches have been made possible by the generosity of sponsors and partners, including Prof. Lambo, SEAP, former President Goodluck Ebele Jonathan, Alhaji T.J. Fisheries, Pharmacist Bioku, Bioraj Pharmacy, Igbaja Pathfinder, Ebunlomo, Offa Descendant Union of North America (ODUNA), Oro Ago–First Heritage, Femi Areo Ventures, Dr Tale, Engr. Femi Alao, Igbaja Pathfinders, Alhaji Rufai Tajudeen, Oke Ose Association, the Ayorinde Family, MDCAN, MPAC, Senator Oyewo, ARD, Medical Students, Bishop Abioye, among others. These are the true heroes of community eye care.

Health Education on Avoidable Causes of Blindness

Cultural beliefs and traditional practices can be significant barriers to eye care. Health information leaflets and media content were created to help people make informed decisions about their eye health. I have mentioned the three films related to eye health: *You are my Eye*, *Still Water*, which raises awareness about glaucoma, the silent thief of sight, and the third on *Ocular Trauma.* These efforts, combined with my social media campaigns, have helped grow my online audience to over 29,000 subscribers and viewers.

Fig. 14: Sight Education Programmes, and an Online App designed for Visual Acuity

The advocacy efforts also extend to combating harmful traditional practices like couching and other self-medication, including traditional eye medications, which persist despite overwhelming evidence of their dangers. This highlights a critical need for more robust public health education, outreach, and policy enforcement to protect vulnerable communities. Many do not know the difference between types of eye care professionals, opticians, optometrists, and ophthalmologists, or the various causes of blindness and how to prevent them. To address this knowledge gap, we created the *Sighted* programme, *Preserving Vision-Restoring Sight*, a serial television series featuring consultant ophthalmologists and educational segments to raise community awareness. By sharing expert knowledge in an accessible format, the programme has helped bridge critical gaps in public understanding of eye health.

In recognition of these efforts, I have received several awards, including for innovation in blindness prevention and for leadership in human capacity building, both nationally and internationally. The real challenge, however, is not the absence of solutions, but the lack of access to them. Overcoming avoidable blindness demands the collective commitment of all stakeholders to close these gaps and bring care within reach for every community.

Training of Health Workers and Capacity Development

Our research on human resource development for *Vision 2020* (**Adepoju** *et al*., 2011) identified critical gaps in staff mix and the maldistribution of available eye health workers across

Nigeria. In response, we focused on strengthening capacity at every level of eye care. One major emphasis has been the training of health workers at the grassroots. For example, 48 primary health workers were trained to serve as Primary Eye Care Workers across 12 centers in communities such as Esie, Okeho, Erin-Ile, Unity Oke-Ose, Kulende, Alanamu, Tofunmiyo, Offa, Ibadan, Ajase, and Ijagbo. Similar initiatives extended to Community Health Extension Workers in Wawa, where we established community eye care services that have continued for over 20 years in Wawa, New Bussa, and Erin-Ile communities.

To reinforce these efforts, we developed training manuals, published a book on Primary Eye Care, produced instructional flex materials on common eye diseases, and established referral pathways. A unique innovation in these trainings was the use of song as a teaching tool, trainees chorused *"Se o da mo t'o ba ri, Se o da mo t'o ba ri. That is Mr. Cataract…"*, making the recognition and referral of cataract cases both memorable and culturally resonant.

Fig. 15: Communities Primary Eye Care Workers-Trainees

Curriculum Development and Academic Contributions

I had the privilege of developing Nigeria's curriculum for Public Health Ophthalmology, thereby shaping the formal training of future practitioners. I also co-authored a textbook for medical students (Medical Student Textbook of Ophthalmology, with Prof. Pam and Prof. Owoeye) and actively integrated students into community outreaches, where they not only learned but also sponsored programmes as part of their academic projects.

Mentorship and Residency Training

Perhaps the most fulfilling aspect of my journey has been mentoring the next generation of ophthalmologists. As a teacher, examiner, and supervisor, I have sought to build not only skills, but also character, not only knowledge but also compassion. Leadership, I believe, is not about titles but servant hood and influence, and I remain humbled by the privilege to influence lives for good. Over the years, I have supervised 32 dissertations and trained several residents six of whom are professors.

Leadership Development Programmes

I have benefited greatly from international leadership development programmes. I was privileged to be among the pioneering participants of the African Ophthalmology Council Leadership Development Program, later serving as a faculty member and eventually its Head. I was also honored to be the first African ophthalmologist selected for the American Academy of Ophthalmology Leadership Development Programmes, where I received the AAO LDP award. These two experiences were pivotal, shaping my global journey in eye care and strengthening my leadership in the field.

Fig. 16: American Academy leadership Award

Sojourn into Ethics

My journey into ethics began several years ago with my appointment to the UITH Bioethics Committee, where I served for four years before becoming Chair of the Research Ethics Committee. Those eight years proved invaluable, sharpening my knowledge and practice, and expanding my teaching and training in bioethics. This role involved reviewing proposals from students, doctors, consultants, and international collaborators, including clinical trial protocols.

I later became the first Vice-President, and subsequently the President of the Bioethics Society of Nigeria. These positions deepened my understanding of both the scientific and ethical dimensions of research. Reviewing proposals often demanded months of effort, yet broadened my perspective and enriched my scholarship. I remain hopeful that, in the future, such critical work will be formally recognized and rewarded, reflecting its central role in advancing ethical research in Nigeria and beyond. We produced *Ethical Review Guide to Biomedical Research Proposal Writing* and a book titled *Concise Guide on Proposal Writing* published on Amazon and by UNILORIN Press.

International Institutional Collaboration

Through global academic partnerships, I have co-authored with networks such as the WHO and the International Eye Research Network. Together, we examined global trends in preoperative visual acuity and the impact of COVID-19 on ophthalmic surgery in Africa. We documented the significant disruption caused by the COVID-19 pandemic (Ally & **Adepoju** *et al*., 2024) The first year of COVID-19 saw a marked decline in ophthalmic surgeries compared to the preceding year. This reduction was uneven across regions: Southern Africa recorded the steepest fall while West Africa saw a minimal decrease. These findings provided critical evidence for policymakers and health planners on the vulnerabilities of surgical eye care during global crises.

Community Services

Beyond academia and clinical work, I remain deeply committed to community service.

Faith and Service: I served as a Pilgrimage Ambassador, leading groups to Jerusalem and Jordan five times, I was appointed by the Executive Governor of Kwara State as a member of the 12-person Inter-Religious Peace Committee. In my local assembly, the Abundant Life Gospel Church, I have been privileged to serve as Deaconess, Pastor, and later as Reverend. I also hold the office of Provost at the Bible College (ALCOME).

Drama Ministry: My passion for drama began in childhood stage plays and blossomed into a lifelong calling. In 1992, I joined the Victory Drama Group of Abundant Life Gospel Mission and later the All-Nigeria Conference of Evangelical Drama Ministers (ANCEDRAM). Since then, I have acted in nearly 1,500 Christian films and stage ministrations, using storytelling to shape lives and destinies. My recent roles include *Iyalode* in *Abejoye*, as well as parts in *Adekunbi, One Careless Night, Esin Ajeji, Mi o lese, Back to Bethel*, and many others. In 2011, I sought to bridge my drama ministry with my medical profession, leading to innovative productions that combine eye health advocacy with faith-based messages.

Aside from the early years' participation in carols and stage drama in primary schools and at Christmas and Easter celebrations, where yours truly acted as Mary, the mother of Jesus, and the like, those were cherished moments. In 1992, I joined the drama ministry of the church and took part in stage dramas and subsequent film productions. As a member of the Victory drama group and a member of ANCEDRAM, I have acted in over 150 films. The recent: *Abejoye as Iyalode, Adekunbi,* and *VDG Double for Shame*. Other films include *One Careless Night, Esin Ajeji, Miolese,* and *Back to Bethel*. In 2014, I woke up one early morning, and thought to myself. How do I marry my drama ministry and my profession?

Academic and Professional Leadership

- *Past Director, MERU*: International Coordinator for the U6+ Consortium (Two terms)
- *Head of Department* (Twice)
- *UITH*: Leadership roles, including facility development
- *Past Chairman and Vice-Chairman*: Medical and Dental Consultants Association of Nigeria
- *Past Chairman*: Nigerian Public Health Ophthalmology Society
- *President*: Bioethics Society of Nigeria
- *Chairman*: Women Ophthalmologists of Nigeria
- *Faculty Member, Treasurer, and Examiner*: National Postgraduate Medical College of Nigeria
- *Faculty Member and Examiner (Past)*: West African College of Surgeons
- *Member*, American Academy of Ophthalmology
- *Fellow*, International College of Surgeons
- *Member*, Nigerian Institute of Management
- *Internal and External Assessor* for academic promotions to readership and professorial cadre *Reviewer* for local, national, and international journals.

Conclusion

In concluding this lecture, permit me to share a few reflections that have profoundly shaped my journey. Eye care is not only about the patients who find their way to our hospitals; it is equally about the many unseen, unheard, and underserved in our communities. Clinical care remains essential, yet we must remember that less than one in three people who needed our services ever reach us. Every case that walks into the clinic is a reminder of the many more waiting silently in remote villages and urban slums. I stand before you today, deeply grateful, for my critiques, support, my teachers, mentors, collaborators, students, patients, and communities, each of whom has left an indelible mark on my story. I remain committed to the path of service, scholarship, and stewardship.

In the quest and conquest of community eye care, there are gaps, human resources adequacy, distribution and mix, poor access due to distance, cost and other logistic reasons, equipment and infrastructural inadequacy, inadequate training and retraining facilities, poor eye health knowledge. These we minded and mended to ensure improved access to eye care by all and in particular the people at the community level. Together, let us continue to restore vision and renew lives. For me, Preserving Vision, Restoring Sight is not merely a slogan; it is my life's work, my calling, and my charge to all of us. As we look forward, I envision: A Nigeria where no one is needlessly blind from preventable causes; a health system where eye care is seamlessly integrated into primary care; and a future where community-based eye health thrives as a shared responsibility.

Recommendations

Mr. Vice-Chancellor, from my experience in the Quest and Conquest of Community Eye Care Service, I want to make the following strategic recommendations for sustainable eye care:

1. ***Decentralised Services*:** Economic and social development of rural communities should be decentralized to make life in rural areas more attractive to health workers. We must empower local governments, as they are closest to the community, to lead development efforts. While planning can be national, the execution must be local in order to be effective.
2. ***Institutional Adoption*:** Every educational and service institution should adopt one or two nearby communities and be intentional about their development and service delivery.
3. ***Integration of Primary Eye Care*** into the existing primary healthcare system: This is non-negotiable. For inclusivity and comprehensive primary health care delivery at the community level, primary eye care should be integrated into community health services. While the theoretical

groundwork for this initiative has been completed, its implementation is still lagging and must be prioritised.

4. ***Public Awareness and Education*:** There should be the launch of robust campaigns to educate the public on eye health, thereby increasing public awareness and education.
5. ***Fostering Collaboration*:** Effective eye care requires a collaborative effort from all sectors. The government, the governed, the media, corporations, private organizations, NGOs, and individual philanthropists must work together to improve eye care services.
6. ***Continuous Training and Retraining*** of eye care workers are essential. The curriculum should include community eye care and be integrated at all levels of education, from primary to tertiary levels of health care services.
7. ***Individual Philanthropy*:** Individuals are encouraged to support eye care by organising screenings and sponsoring care for indigent persons. Celebrating milestones or honoring loved ones should be done by sponsoring sight-restoring activities rather than being limited to traditional ceremonies.
8. ***Policy Change*:** Implement a public health policy that makes eye care free for persons aged 60 and above, a practice that has proven successful in many other countries.
9. ***Legislation*** against couching, including the moderation and regulation of other harmful traditional eye practices, should be strongly ensured from all concerned stakeholders.

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Eternal Father, I give You praise, glory, and adoration. Where would I be today but for Your unfailing love and care? My life is a testament to Your grace, mercy, and divine guidance. Through every stage, You have carried me, and I return all glory to You. Proverb 20:11

I remember with deep gratitude my parents of blessed memory. My dear mother was a pillar of strength, standing by me, nursing my children, and accompanying me to my examinations. Many of these exams were taken while I was either pregnant or nursing a newborn. I particularly remember the year 2000 when I requested an induction, being heavily pregnant; I feared my belly might distract my examiners. Prof. Fawole Adegboyega, though you didn't warn me how painful induction would be, I forgive you. That young boy is now 24 years old, my beloved "Mr. Fresh Bread," Adepoju Victor. To my senior sister, Mrs. Felicia Oyeleke, you stepped into the role of our parents without hesitation. I remember all the financial sacrifices, the borrowing, the sleepless nights spent worrying over my wellbeing. Thank you for being my covering.

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Thank you all for listening, and God bless you all.

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