SIGHTREACH:
AN EYE CARE PROGRAM
FOR THE UNDERSERVED AND CHILDREN

MATCHING GRANT
SECOND ANNUAL PROGRESS REPORT
January 1, 1996 to June 30, 1996

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Submitted by:

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ACRONYMS

AAO	American Academy of Ophthalmology
APO	Asociación Panamericano de Oftalmólogia
CBM	Christoffel Blindenmission
DIP	Detailed implementation plan
FUDEM	Fundación para el Desarollo de la Mujer Salvadoreña
HH	Health for Humanity
HSA	Health Surveillance Assistant
ICEH	International Centre for Eye Health
IEF	International Eye Foundation
IOL	Intraocular lens
ITP	Itinerate Teachers Program
MG	Matching Grant
MOH	Ministry of Health
MOE	Ministry of Education
NCBD	National Committee for the Blind and Deaf
NCPB	National Committee for the Prevention of Blindness
NGO	Non-governmental organization
OMA	Ophthalmic Medical Assistant
PAHO	Pan American Health Organization
PEC	Primary Eye Care
PVC	Private Voluntary Cooperation (USAID Office of)
ROP	Retinopathy of prematurity
TEM	Traditional eye medicines
TH	Traditional healers
USAID	United States Agency for International Development
WHO\PBL	World Health Organization\Prevention of Blindness

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I. BACKGROUND

The IEF has chosen to report the 1996 activities for the Matching Grant Program, "SIGHTREACH: An Eye Care Program for the Underserved and Children,"in two bi-annual reports. The following is the first bi-annual report for 1996, covering the six month period from January, 1996 to June 30, 1996. The **SightReach** program is composed of two separate but related components (ResPack and ChildSight). The report discusses achievements and problems by objective, supported by additional documentation as attachments.

A. Program Description

Component One: ResPack

This component seeks to redress an acute imbalance of eye care services in Latin America; it is currently being implemented in Guatemala, Honduras, El Salvador, and Ecuador. The objective of this program is to provide young, Latin American ophthalmologists with an incentive to work in rural areas, or smaller cities and peri-urban communities, where no eye care services are currently available. Rural populations and residents of smaller cities in much of Latin America have little or no access to eye care services in spite of having a significant number of ophthalmologists. The reason for this lies in the fact that 95% of the ophthalmologists in Latin America live and work in major urban centers. Younger doctors and recently graduated residents rarely have enough money to buy a complete set of equipment to open a private practice, nor can they compete with the large number of older ophthalmologists who have well-established practices in the cities. Thus, we find many younger ophthalmologists working part-time for urban hospitals and/or other doctors at low wages.

The IEF has put together a comprehensive package of ophthalmic equipment that enables these young doctors to go into private practice in under-served areas. The IEF makes this package available for purchase for selected ophthalmologists who are willing to work in rural areas, smaller cities, or poor peri-urban areas, where there are no eye care services. The basic optional items has been available for approximately $5,000. The IEF provides support in terms of donations of medical and surgical supplies to those doctors who provide free care to the most needy segment of the local population. To assist these physicians in developing successful private enterprises, the IEF provides training in ophthalmology clinic management and equipment maintenance and repair.

In summary, the IEF feels that this project offers a viable solution to the imbalance of eye care in Latin America in a long-term, sustainable fashion, because it provides a practical incentive to provide services in under-served areas and promotes private enterprise. It also encourages these young doctors to devote a small part of their time to provide free services to community projects and to those individuals who cannot afford eye care.

Component Two: ChildSight

This component is a Congressionally earmarked initiative which seeks to enhance the technical and service abilities of Ministries of Health and non-governmental organizations in six countries to provide sight restoring operations and general eye care services for visually impaired children. The WHO estimates that 1.5 million children are blind in the world due to a variety of etiologies. Many of these children are housed in blind schools or shelters. However, the vast majority of these children are cared for by family members at home, never having the chance to be seen by a general health worker. Most of those who are seen by a general health worker are not referred due to a lack of understanding of what could be done or where children should be sent.

Through the use of existing IEF field infrastructure and staff, and partner NGOs, this project seeks out visually impaired children; provides sight restoring operations where appropriate; and provides primary, secondary, and tertiary training in pediatric ophthalmology. The objectives of the project include 1) determining the leading causes of childhood blindness in blind schools using a standardized survey method, 2) conducting workshops for general medical and health personnel and NGOs in the recognition and referral of blind and visually impaired children, and 3) strengthening the capacity of tertiary ophthalmic centers to perform pediatric surgery in infants and children through technical training and improvement of surgical instrumentation and equipment.

IEF is administering the SightReach program in six countries where IEF currently has infrastructure in place and where eye care is needed. Two countries in each of three geographic regions of the world were chosen to be included. In Latin America, IEF has strong field offices in both Guatemala and Honduras operating in vitamin A, onchocerciasis and eye care projects. In Africa, IEF has a long history of support for eye care projects in Malawi and has also begun new activities in the recently independent country of Eritrea. In eastern Europe, IEF has concluded five successful years of an eye care program in Bulgaria, and formalized its contacts in Albania with the start of the current program.

B. Program Objectives

The program objectives are as follows:

Component One: ResPack (Guatemala, Honduras, El Salvador, Ecuador)

1. Provide ophthalmologists with access to equipment, enabling them to establish practices in under-served areas (3-5 per year in each country)

2. Provide training to participants in ophthalmology clinic management, and equipment maintenance and repair (3-5 participants per year in each country)

3. Increase outreach of eye care services to Underserved areas through community eye care services

Component Two: ChildSight (Guatemala, Honduras, Albania, Malawi, Eritrea)

1. Complete one survey of the children in the schools for the blind in each country; analyze and disseminate the results

2. Conduct four workshops in each country for nurses, physicians, and community health workers on identification of ocular conditions in children, treatment, and referral

3. Strengthen the capacity to perform pediatric ophthalmology and surgery at tertiary centers through the provision of training, equipment, and supplies.

II. OVERVIEW OF YEAR TO DATE

A. Comparison of actual accomplishments with objectives

Component One: ResPack:

Objective 1: Provide ophthalmologists with access to equipment, enabling them to establish practices in under-served areas (3-5 per year in each country).

In Guatemala, two new ResPack clinics were opened during this reporting period. Dr. Maria Eugenia Sanchez, an ophthalmologist trained in pediatric ophthalmology through the ChildSight component, has opened her clinic in San Marcos. Located 5 hours from Guatemala City near the Mexican border, the region is very lacking in medical services. In the first 4 months she has attended 200 patients. Dr. Paul Cifuentes, a participant trained in Guatemala but originally destined for his native Honduras, has decided to stay in Guatemala. He has opened his ResPack clinic in Barbarena, Santa Rosa. This makes a total of 6 established clinics to date.

In Honduras, one new ResPack clinic was opened. Dr. Doris Alvarado, the president of Honduras's National Committee for the Prevention of Blindness, opened her clinic in Colonia 21, Tegucigalpa. In addition, a new candidate, Dr. Claudia Silva Solomon, has been accepted to the program. She is due to move to Siguatepeque in January 1997.

In El Salvador, we have accepted our first participant to work in Sonsonate, located in the west, 2 hours from the capital. He is currently in the process of procuring a loan for his equipment and expects to open his clinic in August 1996.

In Ecuador, three of the participants have established their clinics: Jorge Rivera in Sangloquí; Rosemary Gaumán in Loja; and Manuel Alvarez in Machachi. All of the above doctors are part of medical "centers" where other doctors have their offices located. This situation has proved to be extremely beneficial for the initiation of their practices. The residents have a central location to go when they are in need of care. Patients seeing other doctors become aware that there is an ophthalmologist in town, and the other doctors in the center refer their patients to them. There exists a very cooperative relationship at the centers and they all help each other out.

Two other participants have sites selected and are in the process of establishing their clinics . Dr. Victor Carrión will be opening his clinic in Calderon, a marginal barrio of Quito, and Dr. Jose Viteri will be located in Chillogallo, located south of Quito.

A total of three participants have changed the site of their clinics from those for which they were originally accepted. Please see attachment A, letters stating reasons for change of clinic site. Manuel Alvarez was originally destined for the coast, that being his home. Unfortunately, his son suffered a severe bicycle accident in which his foot was nearly amputated. Because of this,

his family must stay near rehabilitation facilities for the next two years so that the child may recuperate. Victor Carrión was originally bound for a town near Loja. Having studied his postgraduate at the Social Security Hospital, he is bound by the government to serve 4 years in a government institution. Originally assigned to Loja, Carrión's orders were switched by the Seguro Social to a hospital in Quito. Our representative in Ecuador, Dr. Roberto Proaño aided in the relocation to an appropriate site. For maps of the ResPack clinic sites, please see attachment B.

Country	No.	Participant Name	Accepted	Basic	Micro-scope	Pract. est	Pop. Served
GUATEMALA	1	Orlando Oliva	x	x	x	9/94	200,000
	2	Sidney Morales	x	x	x	1/95	350,000
	3	Gonzalo Cruz	x	x	x	4/95	500,000
	4	Paul Cifuentes	x	x		2/96	250,000
	5	Maria Eugenia Sanchez	x	x		3/96	800,000
	6	Antonio Hernandez	x	x	x	8/95	200,000
HONDURAS	7	Sergio Zuñiga	x	x		2/95	50,000
	8	Jorge Cisneros	x	x		1/95	50,000
	9	Denis Espinal	x	x		12/94	50,000
	10	Ricardo Rivera	x	x		8/95	50,000
	11	Doris Alvarado	x	x		2/96	50,000
	12	Claudia Silva Solomon	x				
	13	Daniela Salinas	x				
	14	Luisa Rojas	x				
	15	Xiomara Garay	x				
	16	Daphne López	x				
ECUADOR	17	Rosemary Guamán	x	x		5/96	120,000
	18	José Viteri	x	x			
	19	Victor Carrión	x	x			50,000
	20	Jorge Rivera	x	x		6/95	150,000
	21	Graciela Ruiz	x				27,000
	22	Manuel Alvarez	x	x	x	3/96	50,000

Objective 2: Provide training in ophthalmology clinic management and equipment maintenance and repair.

In this reporting period we have held two training workshops. In February 1996 a training in **ophthalmology practice management** was held in Honduras for the ResPack participants for Guatemala, Honduras, and our participant from El Salvador. Dr. Batlle discussed the administration of the ophthalmic clinic and how to establish a successful clinic while fulfilling the social responsibilities of an ophthalmologist. Some of the issues raised included: the lack of access to affordable surgical supplies, community outreach and education as a form of publicity and promotion, unavailability of reasonable financing for purchase of equipment, and the conflicts experienced in leaving the capitals to practice ophthalmology. This training included a round-table discussion where each ophthalmologist shared their experiences. This was a very insightful experience where each told of trials, errors, and the growth of their clinics. All had interesting ideas to share with others. Every doctor present was very pleased with the present state of his ResPack practice. Many doctors' practices started out slowly at first, but all have grown into successful enterprises. It was very clear in the discussions that these ophthalmologists possess a healthy community spirit and are an asset to these communities. Please see attachment C, Report on Practice Management workshop.

IEF would like to institutionalize these trainings with the Pan American Association of Ophthalmology (APO) to insure continued access of these valuable courses to Latin American Ophthalmologists beyond the life of the ResPack program. IEF participated in the Regional Meeting of the Pan-American Association of Ophthalmology from May 2-4, 1996 in Costa Rica with the goal of seeking support from the APO. Dr. Batlle gave his presentation for the **practice management workshop** as a means to the aforementioned end, but also served to inspire the participants to do community service and introduce the ResPack program to Latin American ophthalmologist from Central and South America. The president of APO, Dr. Francisco Martinez Castro, was very excited by the ResPack program and the initiative taken by IEF in working with young ophthalmologists and encouraging them to serve the rural population. He extended invitations to participate in both the IAPB Congresses of both Brasil and Cancún. Please see Attachment D, Trip report-Ellen Parietti-Regional Meeting of the PanAmerican Association of Ophthalmology, Costa Rica, May 2-7, 1996 and Attachment E, Reporte del Congreso Regional Panamericano de Oftalmólogia, Orlando Oliva. IEF was approached by many Latin American ophthalmologists who had interest in bringing the ResPack program to their countries. Some of these doctors were young ophthalmologists who wanted to participate themselves and others were heads of ophthalmology post-graduate programs whose residents are involved in community outreach and would be interested in the program.

Ecuador participated in its first **equipment maintenance and repair training** June 1, 1996. All of the participants from Ecuador attended the workshop held in Sangloquí with Javier Prada, of Optica Vision, Costa Rica. In addition to conducting the workshop, Prada diagnosed the problems many of the participants encountered with their equipment, and in many cases was able to administer repairs. Manuals containing instructions for repair of the lensometer, slit lamp,

phoroptor, and keratometer were distributed along with a video on the steps involved in the maintenance and repair of the slit lamp. The ophthalmology practice management training is scheduled for August 30 and 31st, 1996. Please see Attachment F & G, Trip reports by Ellen Parietti and Orlando Oliva, Ecuador, May 29 to 7th.

Objective 3: Increase Outreach of Eye Care Services

In the February's 1996 Practice Management Workshop conducted in Honduras, outreach activities were discussed at length. It was very clear that the doctors who participate in community outreach enjoy a greater volume of patients and practice their skills more. Many of the participants have conducted different activities and they were able to share them at the round table discussion. The outreach activities of Jorge Cisneros of Choluteca, Honduras were quite impressive and served to inspire the other participants to work with local schools and teachers. He also encouraged them to seek air time with local radio and television programs discussing ocular health and the prevention of blindness.

Previously unable to perform surgeries due to lack of a microscope, IEF HQ contributed $4000 received as a donation towards the purchase of a coaxial microscope for Dr. Cisneros. Jorge received the scope in late May 1996 and has been operating on the backlog of cataract patients in Choluteca. Aside from attending to many patients with few resources in the Catholic hospital San Francisco de Asis, he has also arranged for a Lions SightFirst campaign to take place in December 1996 with 100 patients. See attachments H, Jorge Cisneros Outreach Activities.

IEF has been working towards putting together cataract kits to enable our ResPack doctors to cataract kit. Unfortunately, the process has been slowed because major US pharmaceutical companies have been been unable to lend the support for the project due to decreased product excesses. However, it has been possible to secure some donations, and we will have enough intraocular lenses and viscoelastic to furnish material for a pilot project involving 100 patients.

IEF Honduras has produced Snellen charts for distribution amongst the ResPack participants. The participants expressed a desire to distribute Snellen charts amongst teachers in their communities so they can screen students in the schools.

The participants in Ecuador have been very successful in conducting "camps" where they go out to a rural area and attend to indigent patients at a low cost. Two of the three doctors who have established their clinics participate in such outreach activities (Manuel Alvarez and Rosemary Guamán). Working with the other doctors with offices in their buildings, they travel to outlying areas and offer a wide array of services. Working in a group cuts down the overhead costs of such excursions, and in general eases the process. See Attachment I, Report for June, 1996, Rosemary Guamán. While doing their outreach they are increasing their client base. Jorge Rivera is working as part of a community medical center which attends the community of Sangoloquí. Located in an agricultural area, there are many indigent patients. The work the doctors do there and the dedication they exhibit is truly moving. IEF HQ has been able to

support community outreach with donations of pharmaceutical and surgical supplies sought from US corporations. These donations are given to program participants as all receive patients of very low resources.

COMPONENT #1: ResPack
Second Annual Report Period -- Sep. 1st, 1994 - Dec. 31st, 1995 -- Cumulative Progress

Project Goals: 1. To expand the availability of and access to eye care services by facilitating young ophthalmologists to establish practices in under-served areas.

Objectives	Progress	Constraints	Third year
1. Provide access to equipment packages Guatemala Honduras Ecuador El Salvador	 6 participants; 6 estab. practices 10 participants; 5 estab. practices 6 participants; 3 estab. practices 1 participant; 0 estab. practices	difficulty raising funding, commercial credit not possible, customs charges high, fierce competition among ophthalmologists	continue enrolling; 2 ophthalmologists continue enrolling; 2 ophthalmologists continue enrolling; 3 ophthalmologists continue enrolling; 3 ophthalmologists Total participant 30
2. Provide training: practice mgt. (PM) & equipment maintenance (EM). Guatemala Honduras Ecuador El Salvador	 comp. PM x 2; EM x 2 comp. PM x 2; EM x 2 EM x1 PM x1	-PM tr. needed revisions to meet information needs of participants. -availability of consultant	continue PM & EM course development; institutionalize PM, EM courses. conduct courses conduct courses
3. Increase outreach of eye care services Guatemala Honduras Ecuador El Salvador	outreach conducted; cataract campaigns some outreach conducted; educational outreach & campaigns conducted start-up phases;	unfamiliar with outreach activities; community ability to pay for services; need for materials for surgery	investigate market survey; develop IEC materials for promotion; support follow-up of ChildSight screening with secondary screening/referrals

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Component Two: ChildSight:

Objective 1: Conduct surveys of the children in blind schools.

Surveys of the blind schools were completed in Guatemala and Honduras during the first year of the project. The results for Honduras were entered into the WHO/PBL Eye Examination Record for Children with Blindness and Low Vision database, and a report produced.

Data for Guatemala has been analyzed and compiled into a report. (Please see Attachment J, Results of Blind School Study Guatemala 1994.) Due to discrepancies which were apparent in the original data collection, our representation in Guatemala now feels that this data may not be accurate. It has been decided that a follow-up which would check on recommended interventions and newly matriculated students will also include a second screening for all of the children in the Santa Lucia Blind School. This second screening will be conducted by Maria Eugenia Sanchez, the ophthalmologist who received pediatric ophthalmology training through the ChildSight program last year. (See attachment K, Assesment of Guatemala Blind School .)

In Malawi, children previously identified in blind school surveys as potentially benefitting from surgery or refraction remain to be transported to tertiary centers for treatment. (QECH Queen Elizabeth Central Hospital or KCH.) IEF is committed to paying the costs of transporting these individuals from their homes to surgery sites. Grace Funsani, the Eye Care Coordinator is responsible for the follow-up of referrals. All existing referrals are in a computer data base.

Lions SightFirst Eye Hospital presented a proposal to the "Seeing 2000" program to increase the number of pediatric eye surgery they are able to perform. Dr. Moses Chirambo is the project director, and will involve health workers trained by the ChildSight program.

Objective 2: Conduct workshops on identification of ocular conditions in children, treatment, and referral.

As reported in the previous annual report, the workshops on the screening and detection of ocular conditions for health personnel and school teachers in Guatemala and Honduras were held in October 1994.

In Honduras, the training of special education teachers held by IEF\Honduras has proved to be very successful. The teachers submitted the results from their screening data and the Ministry of Education's computation department processed the data. IEF Honduras's Marylena Arita then used this data to form a report delineating the areas of greatest need and an evaluation of the screening process. Please see attachment L, "Informe de Resultados de Evaluacion de Agudeza Visual de Los Niños de Primer Grado de las Escuelas con Aula Recurso Educacion Especial." Priorities were established based on the findings of the report. Brigades have been held in areas of need by the National Committee for the Prevention of Blindness and by Optometrists from the University of Montreal. Then NCPB obtained donations from local restaurants to feed the

optometrists and local families housed them. These optometrists attended patients in 5 different communities. Please see attachment M, Advances de Actividades del Comite.

As discussed later in this report, the ChildSight screenings have had greatly raised the awareness of the importance of visual screening of children. Thanks to actions of IEF Honduras Country Director Raúl Gómez, the president of the Republic of Honduras has made it a law that all first graders be screened for their visual acuity. The IEF Honduras staff and the above mentioned report on the results of the screenings conducted by special education teachers will be key for planning the implementation of this national law.

In Guatemala, workshops held for health professionals from the Ministry of Health (MOH) were held along with rural health workers associated with local NGOs. Administration of screenings, however, were not dictated by the IEF and participants were not obliged to conduct activities. Although some organizations did hold screenings, many did not. When IEF Guatemala tried to collect data on screenings conducted, they encountered difficulties. Please see Attachment N, Talleres de ChildSight. The group of community health promoters in IEF's Coban project did conduct screenings. Over 500 people were identified as needing follow-up services. Martha Burdick de Piedrasanta, IEF's country director arranged for an eye camp to be conducted by the Robles Hospital. One doctor made the trip to Coban and 129 patients from 38 different communities were seen in October of 1995. Unfortunately, no other ophthalmologist is able to make the trip to Coban until July and many people remain to be seen. IEF has decided to resolve a manner in which these people can be cared for, and concentrate further screening workshops in areas where ResPack doctors reside so the people identified with visual needs can have a reference spot. These training are scheduled for November.

In Albania, the first national conference on the prevention of blindness was held in Tirana. This activity had been recommended in the previous reporting by Eun-Joo Chang, consultant, to orient the ophthalmic community to a community-based approach to blindness prevention. See Attachment O, First National Conference on the Prevention of Blindness, February 13-14, 1996, Tirana, Albania.

The second and third workshops will be held back-to-back in April 1996 and the district workshop held in June 1996.

For a second year IEF will be coordinating activities with Health for Humanity (HH) to equip regional hospitals through funding from the Soros Foundations' Open Society for Albania. IEF will assist HH in the identification and purchase of the equipment for the referral sites and in shipping the equipment to Tirana. This particular project, which seeks funding for an additional three years from the Soros foundation to expand these activities, and the ChildSight project are envisioned to be part of one national plan.

In Bulgaria, The first of four workshops for non-ophthalmologists was held in the last reporting period from 13-15 December 1995. See Attachment P, Summary of the first course for Non-

Ophthalmologistt in Bulgaria, Stara Zagora, December 1995 and description of the video of this event. This three-day workshop for neonatalogists emphasized education on retinopathy of prematurity (ROP). The second workshop will be held in Pleven July 11-13, 1996.

In Malawi, Karen Van Dijk conducted a follow-up training of 1 1/2 days to the 7 O.M.A.s (Ophthalmic Medical Assistants) trained in refraction and low vision in May 1996. Emphasis was placed upon the prescription of magnification glasses. Rosemary Lowdon will be contracted to assess training effectiveness and needs of OMAs and HSAs (Health Surveillance Assistants.) After this assessment, IEF will continue to support training for HSAs in Nchalo and Ngabu, and will support partial costs of training for OMAs in the southern region scheduled for September 1996.

Evaluation of children in the ITP (Itinerant Teacher Programs) have started only recently due to two problems. First, the distance from mobile OMAs trained in low vision and second, not all OMAs have received training in low vision. This will improve as those OMAs will receive their scheduled low vision and refraction training. The goal is to assess all the children in the ITPs this year. Remaining ChildSight funds will be used to print referral slips, screening forms, Snellen charts, and the training curriculum developed by Karin van Dijk. See Attachment Q, Vision Screening and Primary Eye Care, Karen van Dijk. Statistics on the children who have been evaluated through this program are found in Attachment R, Report of Low Vision Related Activities, Malawi, January - April 1996.

The Ministry of Health in Eritrea has yet to sign a country agreement with IEF. This has hampered our ability to implement workshops and training.

Objective 3: Strengthen tertiary centers capability in pediatric ophthalmology.

In Honduras & Guatemala it has been difficult to identify appropriate candidates to travel to India for the period of several months to receive pediatric ophthalmology training in Aravind Hospital. Difficulties stem from both the time commitment involved, and the need for fluency in English. Hands-on training at other Latin American institutions is not desired by these ophthalmologist because procedures practiced in some Latin American countries are perceived as controversial in others. Dr. Maynard Wheeler, a Spanish speaking pediatric ophthalmologist has offered to make the visits and are programmed for January 1997.

Dr. John O'Neill visited the Berhan Eye Hospital in Eritrea in the capacity of visiting pediatric ophthalmologist. Dr. O'Neill presented several lectures on pediatric ophthalmologic problems surgical techniques in the Berhan Eye Hospital to the hospital staff and senior ophthalmic technicians. Dr. O'Neill was so impressed with the medical personnel at the Berhan Eye Hospital and the conditions they work under that he was moved to seek assistance for them in obtaining a vehicle and needed surgical supplies. The W. O'Neill Foundation of Bethesda, Maryland made a contribution of $50,000 towards these needed things. Please see attachment S, Trip Report, John O'Neill, Eritrea, January 12-February 4, 1996.

COMPONENT #2: ChildSight -- Second Annual Report Period -- Sep. 1st, 1994 - Dec. 31st, 1995 -- Cumulative Progress

Project Goals: 1. Enhance the system for identification, treatment and referral of children who can be helped by ocular surgery.

2. Upgrade the abilities of the tertiary centers to conduct pediatric ophthalmology.

Objectives	Progress	Constraints	Third year
1. Complete surveys		completed by:	
Albania	completed (3/94)	C. Gilbert	examine new students
Bulgaria	completed (9/95)	S. Lewallen	examine new students
Eritrea	completed (1/95)	Eckstein	examine new students
Malawi	completed (3/94)	Lewallen/Courtright	F.U. on id. students
Guatemala	completed (5/94)	F. Hermes	none
Honduras	completed (2/95)	F. Hermes/Benavides	examine new students
			all: write article/presentation
2. Conduct 4 workshops			
Albania	comp. #1(2/96)	organizational	#1-4 (2/95)
Bulgaria	comp. #1(12/95)	political	#2-4) (4-6/95)
Eritrea	none	country agreement	#1-4 pending country agreement
Malawi	comp. #1(6/95)#2(7/96)#3(10/95)#4(11/95)	none	additional follow-up
Guatemala	comp. #1-4 (2/95)	none	F.U. secondary screening of identified
Honduras	comp. #1-4 (10/94) #5-8(3-4/95)	none	children\campaigns\with ResPack Drs.
3. Strengthen tertiary centers/			
Albania	Beci/Kearnan/Levinson	coordination HH	Kearnan (2)
Bulgaria	Miller/Day		Miller/Day
Eritrea	O'Neill		O'Neill (1)
Malawi	Steinkuller		to be determined
Guatemala	Maria Eugenia Sanchez (India)	availability of worthy	create a self-sustaining eye glass workshop
Honduras	candidates under consideration	candidates willing to travel	ophthalmologist to India

B. Technical support

The following technical support was received during this reporting year:

- Dr. Clare Gilbert has continued to provide support in the analysis of the WHO/PBL blind school surveys.

- Dr. Juan Carlos Silva, Regional Advisor for the PAHO's Prevention of Blindness efforts in Columbia is collaborating with IEF Honduras in plans to set up a self-sufficient eye glass workshop in Tegucigalpa.

-Dr. Frederick Griffith of the International Federation of Eye Banks (IFEB) is working with IEF Honduras and the National Committee for the Prevention of Blindness on the establishment of an eye bank in Tegucigalpa.

- Juan Batlle, M.D., of the Dominican Republic was hired as an instructor for the workshops on ophthalmology clinic management in February 1996 in Honduras, and again in May 1996 for the Regional APO Conference in Costa Rica.

-Javier Prada of Optica Vision, Costa Rica provided the instruction for our equipment maintenance and repair workshop in Ecuador in June 1996.

- The National Committee for the Blind and Deaf (NCBD) in Guatemala has collaborated by conducting secondary screening for children identified in ChildSight screenings and other prevention of blindness activities.

-The National Committee to Prevent Blindness in Honduras has supported ChildSight activities by arranging accommodations for doctors conducting secondary screening for children throughout the country. The Committee has also been very active in steps toward the establishment of a self-sufficient eye glass factory and an eye bank in Tegucigalpa.

-Dr. John O'Neill visited Eritrea to provide training in pediatric ophthalmology.

-Dr. Daniel Forlhomme of the University of Montreal and his optometry students traveled to Honduras and participated in eye camps where children from ChildSight screenings were given secondary screenings and glasses.

C. Linkages Made Between the Program, Members of the Ophthalmic Community, the Ministry of Health and Other Institutions

Meetings have been held with IEF staff and the directors of the ophthalmology residency programs in Guatemala, Honduras, Ecuador, and El Salvador along with residents and individual ophthalmologists to encourage participation in the program.

Collaborating organizations for participation in the ResPack Program are Hospital Roosevelt (Guatemala), Hospital Rodolfo Robles V. (Guatemala), Hospital San Felipe (Honduras), Hospital Voz Andes (Ecuador), FUDEM-Fundación para el Desarrollo de la Mujer Salvadoreña (El Salvador), Hospital Rosales (El Salvador), and individual ophthalmologists from both Guatemala and Honduras. During the last visit to Ecuador in June, IEF staff met with other members of the Ecuadorian Ophthalmology community who were very supportive of the ResPack program and its goals. Dra. Delia de Guerra, president of the Central Ecuador Association of Ophthalmology, met with Ellen Parietti and Orlando Oliva offering unlimited support to the ResPack participants and ResPack.

Companies with which we have a relationship for the procurement of equipment are KOWA Optimed, Inc.; Keeler Instruments, Inc.; SkyLine Medical, Inc.; Welch Allyn, Inc.; Volk Optical; Ocular Instruments; ScanOptics; Echo Medical Instruments; and InterMed Sales Corp. Companies with which we have a relationship for receipt of in-kind donations include Alcon Laboratories, Inc.; Merck & Co., Inc.; Allergan Pharmaceutical; IOLAB Corporation; KABI-Pharmacia; Ethicon; Rafi Systems Inc; Carl Zeiss, Inc; and individual donors.

D. New Professional Staff

There have been no changes in professional staff in this reporting period.

E. Evaluation

There has been no evaluation conducted in this time period.

III. CHANGES MADE IN PROGRAM DESIGN

In March, IEF requested a two year no-cost extension from USAID to allow for completion and a furthering of the SightReach program's objectives. IEF feels that in the process of completing the objectives outlined in the DIP we have learned lessons that, integrated into our programming, will greatly increase its sustainability. This request was granted and will extends the SightReach program until August 1998.

IV. CONSTRAINTS, UNEXPECTED BENEFITS, AND LESSONS LEARNED

A. Component One

Constraints:

Prices of equipment have continued to rise over time. It is is increasingly difficult to keep the price of the basic package at $5000. The current price is now at $5400. Some of the equipment originally included in this package, specifically Khosla products, has proven to be of low quality.

In addition to the fact that prices increased, the equipment is very prone to breakage. Equipment of higher quality has replaced the problematic Khosla products resulting in a more expensive price, but better quality package.

Repairs of Equipment: Sometimes even the highest quality equipment needs repair. Ophthalmologists are faced with two choices: send the equipment back to the manufacturer for repair and face a long delay where they they will be without their equipment, or bring the equipment to a local electrician with hopes that repairs can be made and a rapid return of the equipment. The workshops of these local electricians are notoriously filthy and without exception a shambles. Please see Attachment T, photograph of electrician's workshop in Loja, Ecuador.

Convenio: The agreement signed upon entrance into the ResPack program is not legally binding. We have no recourse if people do not open their ResPack clinics or proceed to locate their equipment in a place where it is not in use. IEF personnel have found it difficult to enforce our policies without being able to take legal action. Two participants in Honduras were obliged to close their Respack clinics temporarily, Ricardo Rivera in La Entrada de Copan, and Sergio Zuniga en Colonia 21. Sergio Zuñiga was forced to vacate his clinic (located in a poly-clinca) due to the wishes of the building's owner to replace him with doctor that kept more patients overnight, thereby earning more money. Dr. Zuñiga is attending patients at another Res-pack clinic, and he feels he is fulfilling his commitment to IEF while looking to re-open his own. Ricardo Rivera reported that he was losing money by keeping his ResPack clinic open, that not enough patients were arriving. Both of these closures took place in February and the clinics have yet to re-open. Dr. Gomez, IEF/Honduras Country Director has no power to force them to do so.

Country Limitations: Due to the fact that ResPack is only approved in 4 countries, we have had to refuse many interested ophthalmologists the opportunity of participating in the program. As participation in the ResPack program truly is not for every ophthalmologist, IEF would truly like to include those doctors who show a clear desire to work in underserved areas. We are at the point in Honduras and Guatemala where the people genuinely interested in establishing their clinics in underserved areas have already entered the program. We would like to be able to support ophthalmologists working in rural areas of other Latin American countries who are working without sufficient equipment. IEF has met several deserving ophthalmologists from Latin America whom we would like to include in ResPack. See Attachment U, letters expressing interest in the ResPack program.

Benefits:

Donations: IEF HQ received a $4000 donation from an ophthalmologist from Texas, Dr. Ronald Antinone, for use in the ResPack program. This money was put towards the purchase of a coaxial operating microscope for Jorge Cisneros, ResPack ophthalmologist located in Choluteca, Honduras. See attachment I, Jorge Cisneros Outreach Activities for a photograph

of Dr. Cisneros, the donated microscope, and his first patient.

Sustainability of Programming: Javier Prada, who has also worked with us on our equipment maintenance and repair workshops has provided assistance in helping us in our goal to institutionalize the workshops with the Pan American Academy of Ophthalmology. He assisted in communication with the organizing committee. Dr. Francisco Martinez Castro, President of the Pan-American Association of Ophthalmologists is very interested in arranging the implementation of ResPack workshops on a continuing basis.

Lessons Learned:

Partnerships with other specialists: In Ecuador, the ophthalmologists who set up their clinics with other doctors or specialists benefit greatly from the relationship. Their offices are a reference point for health care. They make campaigns into rural areas together, attracting many patients by offering a broad range of services. This makes such ventures very cost effective as they share the incurred costs. Advertising costs for the center are also shared among all specialists, and they refer their patients to other doctors within the center.

Purchase of Equipment: When procuring equipment manufactured outside of the United States for use in another foreign country, import taxes for the US can be avoided by arranging for direct shipment to the recipient.

B. Component Two

Constraints:

Personnel from the Ministry of Health and other NGOs were not obliged to conduct training with the skills they acquired in the ChildSight workshops. As a result, many of these people did not take the initiative to conduct any activities.

Benefits:

Law Requiring Screening for Schoolchildren in Honduras: Dr. Raúl Gomez, IEF Honduras Country Director, has been instrumental in gaining the passage of a law requiring that all first graders receive a test of their visual acuity. IEF Honduras will be key in implementing the national strategy for the training of necessary personnel.

Grant Generated for Berhan Eye Hospital Medical Staff: Dr. John O'Neill's visit to Eritrea inspired him to seek funding for a vehicle and other necessary medical equipment to improve facilities for the medical team. He succeeded in acquiring a $50,000 grant from the W. O'NEILL foundation for these purposes.

Television Appearances: In Honduras, two representatives of IEF, Dr. Raúl Gomez, the

Country Director, and Dra. Marylena Arita, made appearances on a televised community service program, "Abriendo Brecha." Dr. Gómez discussed a conference he attended at the Carter Center, (Children First) and how it related to IEF's in-country activities. Dra. Marylena Arita discussed the visit of Canadian Optometrists to various Honduran communities.

Lessons Learned:

Collaboration of teachers: IEF Guatemala has found it more rewarding to work with teachers than MOH personnel or health workers in the ChildSight screening workshops because of their continuing relationship with the children screened. The teachers have proven to be very motivated and have an interest in the well being of their students. The organizational structure of the Ministry of Education has proven to be of great importance in the follow-up of screenings that were conducted. Every teacher is under the authority of the MOE and must comply with the orders of the Minister. The MOE required their teachers to screen their students and to check if they received any follow-up care. All of this data was collected from the MOE in a relatively simple fashion.

Requirements for participants: When offering a training, the participants (or the organization they work for) should agree to do something with the training. (Guatemala -MOH personnel.)

V. OTHER ACTIVITIES

A. APO: The IEF sponsored the attendance of ResPack ophthalmologists Jorge Rivera of Ecuador and Mario León Gómez of Honduras to the regional meeting of the Asociación Pan-americana de Oftalmologia in San Jose, Cost Rica May 2-5, 1996. The doctors helped represent IEF and the ResPack program in the conference.

B. LOW COST EYE GLASS FACTORY: The National Committee for the Prevention of Blindness (NCPB), Honduras continues to work diligently with Juan Carlos Silva, the Regional Advisor to the Pan American Health Organization (PAHO) to establish a self-sufficient primary eye care project. Project Officer Ellen Parietti had the opportunity to visit the project in Bogota, Colombia and discussed the steps involved with setting up the laboratory. Please see Attachment V, Ellen Parietti, Bogota, June 7, 1996. PAHO works with a Sonoma, California based NGO, Help the World See, on low cost spectacle projects. Dr. Wayne Cannon, an optometrist and Executive Director of Help the World See, visited Honduras's NCPB to evaluate the feasibility of establishing a self-sufficient eye glass factory in conjunction with the NCPB and PAHO. Dr. Cannon was very impressed with the enthusiasm and competence of the National Committee as well as the prospects for a successful project. This visit along with the recommendation from the PAHO has moved him to pledge to raise money for the Honduras project. The National Committee needs to reach an agreement with the government where they have support from the Ministry of Health, and the money raised from the project will be re-invested in eye care and not used for any other purpose. This facility will be key in meeting the need for low cost spectacles generated by ChildSight screenings conducted throughout the country. These needs

will increase greatly with the nation-wide institutionalization of screening first graders recently mandated by the government, and as awareness of the availability of low cost spectacles spread. Please see attachment M, Informe Sobre Los Advances del Comité Naciónal de Ceguera.

C: EYE BANK: The National Committee for the Prevention of Blindness in Honduras has is receiving the support of the International Federation of Eye Banks. Dr. Raúl Gomez, IEF/ Honduras Director visited the IFEB with Victoria Sheffield during a visit to the Washington area. Dr. Frederick Griffith communicated the pre-requisites for IFEB support of the project, and the NCPB has been working quickly to complete them. An area of the San Felipe hospital has been allocated to the Eye Bank and has met with IFEB requirements. As soon as presidential backing is obtained (this is expected), furbishment of the area and training of personnel can begin.

D. WORLD BANK VISIT: Program Officer Ellen Parietti and Dr. Orlando Oliva visited with the World Bank's regional NGO liaison officer, Mario Marroquín Rivera, while attending the APO regional conference in San José, Costa Rica. IEF is interested in being part of the World Bank's new initiative on NGO cooperation. The World Bank, appreciating the experience accrued from years of working internationally, has professed a desire to integrate the perspectives of NGOs into their policies and programming. The purpose of this visit was to register our organization with the World Bank for purposes of the above mentioned collaboration and to explore the possibility of financing. Mr. Marroquín was very frank with us, telling us not to get our hopes up. He said that while it is a goal to integrate the experience of NGOs into World Bank projects, it is still a very new idea not yet a reality. Current World Bank projects were approved years before NGO cooperation became a priority, so many projects currently do not feel inclined to work with NGOs. Those projects with even very limited NGO involvement comprise less than 5% of World Bank activities. Mr. Marroquín did, however encourage to maintain contact as this mentality will change as new projects get funded. Please see Attachments F & G, Trip Reports, Ellen Parietti and Orlando Oliva, Costa Rica.

E. BUYERS GUIDE: IEF Guatemala's Dr. Orlando Oliva translated the American Academy of Ophthalmology's Buyer's Guide to the Purchase of Ophthalmic Equipment to Spanish to help ophthalmologists and institutions in Latin America protect themselves when purchasing ophthalmic equipment. The AAO will continue to distribute the publication through their Committee on International Ophthalmology, and will provide copies for IEF's ResPack program and Seeing 2000's Spanish speaking institutions for whom it will be invaluable.

VI. BUDGET REVIEW

A two year no-cost extension was granted for the SightReach program.

Expenditure of the Headquarters (regional) budget is on track with approximately 75% of the USAID budget spent through June 30, 1996. The remaining portion of the USAID budget is sufficient for the remainder of the project, as funds will be rebudgeted to allow for the two year no-cost extension granted by USAID.

Expenditure of the field budget is underspent with approximately 26% of the budget spent through June 30, 1996. There have been minimal expenses from El Salvador and Eritrea due to start-up problems, and smaller than anticipated expenses in Albania, Bulgaria, and Ecuador.

The expenditure of combined headquarters and field budgets is underspent with approximately 50% of the USAID budget spent through June 30, 1996. IEF has met match requirements, and with the no-cost grant extension is able to continue program activities through mid 1998.

Please see Attachment X, pipeline analysis for this reporting period.

VIII. ATTACHMENTS

A. Letters from participants stating reasons for changing sites
B. Maps of Respack Clinic Sites
C. Report on Practice Management Workshop, Tegucigalpa, Honduras February 2-5,1996
D. Trip Report, Ellen Parietti, Regional Meeting of the Pan-American Association of Ophthalmology, Costa Rica, May 2-7, 1996
E. Reporte del Congreso Regional Panamericano de Oftalmologia, Orlando Oliva
F. Trip Report, Ellen Parietti, Ecuador May 29 to June 7th, 1996
G. Reporte del Viaje a Ecuador, Orlando Oliva, 29 mayo - 7 junio, 1996
H. Jorge Cisneros Outreach Activities
I. Monthy Report for Rosemary Guamán
J. Results of Blind School Survey, Guatemala
K. Assessment of Guatemala Blind School Survey Data
L. "Informe de Resultados de Evaluacion de Agudeza Visual de Los Niños de Primer Grado de las Escuelas con Aula Recurso Educacion Especial"
M. Informe Sobre Los Advances de Actividades del Comité Nacional de la Prevención de Ceguera
N. Screening Activities by Child Sight Workshop Participants
O. First National Conference on the Prevention of Blindness, February 13-14, 1996, Tirana, Albania
P. Summary of the first course for Non-Opthalmologist in Bulgaria, Stara Zagora, December 1995 and description of the video of this event
Q. Manual Visions Screening and Primary Eye Care, Karen Van Dijk
R. Report of Low Vision Related Activities, Malawi, Jan-April 1996
S. Trip Report, John M. Barrows, Malawi, June 19-27, 1996
T. Trip Report, John F. O'Neill, Asmara, Eritrea, January 12-February 4, 1996
U. Photograph of electrician's workshop in Loja, Ecuador
V. Letters expressing interest in participating in ResPack program
W. Trip Report, Ellen Parietti, Bogota, Colombia
X. Budget Pipeline

ATTACHMENT A

LETTERS FROM PARTICIPANTS STATING THEIR REASONS FOR CHANGING SITES

Dr. Roberto Proaño S.
CIRUJANO OFTALMOLOGO
América 5504 Centro Comercial
La "Y" Tel.

Quito, Agosto 19 de 1996

Señorita
Helen Parfett
FAX: 301-986-1876

Apreciada Helen:

Me es grato dirigirme a usted en primer lugar para hacerle llegar un atento saludo, luego para comunicarle que los Doctores Manuel Alvarez Rosemary Guamán y José Viteri por razones de su BECA se han visto la necesidad de cambiar de lugar sus consultorios. Así la Doctora Rosemary Guamán está en Loja, el Doctor Manuel Alvarez en Machachi y el Doctor Jose Viteri en Chilogallo.

Es importante señalar que dichos cambios se han realizado manteniéndo nos fieles con la filosofía de INTERNATIONAL EYE FOUNDATION acerca de prestar servicios a los lugares donde no hay oftalmólogo.

Proximamente le haré conocer más detalles.

Cordialmente,

DR. ROBERTO PROAÑO SANTANA

Guatemala 25 de Junio de 1996

Doctor
Orlando Oliva
Internacional de Ojo -
Guatemala.

Distinguido Doctor:

La presente es para hacer formal petición por escrito, lo solicitado verbalmente a la Intenational Eye Foundation en su última reunión de Tegucigalpa-Zamorano, Honduras la cual consiste en el traslado de clínica oftalmológica de Talanga , Honduras, en donde hice la solicitud original para Barberena, Santa Rosa, Guatemala, lugar que llena perfectamente los requisitos de ser area rural y que no cuenta con servicio de Oftalmología en toda esa zona sur-oriental .

La presente la justifico en cambios radicales en el curso de mi familia, la cual hemos decidido residir permanentemente en Guatemala, en donde creo puedo ofrecer a mi familia mejores oportunidades. Debo aclarar que mi Persona, es Guatemlateco de origen y hondureño por nacionlización ; y luego de terminar mis estudios de especialización vi muy complicado otro traslado ya que mi familia (nucleo) es grande esposa y tres hijos.

Sin otro particular, y agradeciendo de antemano su atención,

Atentamente,

Dr. Paul Cifuentes

30 av. B 1-74 zona 7 Utatlaán 1 Guatemala.

25

Loja, 17 de Julio de 1996

INTERNATIONAL EYE FOUNDATION

Ellen Paretti. MPH.

Program Officer

Me es grato dirigirme a Uds. para informarles que el consultorio de OFTALMOLOGIA está funcionando aproximadamente dos meses , estamos realizando visitas los fines de semana a los diferentes cantones se esta aciendo labor social , el día 14 de Julio estuvimos en el canton Catamayo (LA TOMA) se atendio a 40 pacientes ;
Además me permito informarles que el lugar de atención OFTALMOLOGICA que estaba planificado en la Toma lo cambie por las siguientes razones

1.- La poblacion de Loja tiene aproximadamente 110.000habitantes la Provincia 190.000 habitantes a la fecha actual contamos con4 OFTALMOLOGOS EN LA CIUDAD DE LOJA ; al estar con mi consultorio en La Ciudad De Loja puedo cubrir los barios URBANO MARGINALES como el Valle, Pradera, Plateado , incluso megustaria hacer atención en una UNIDAD MOVIL ; por mis limitaciones economicas me es imposible que se realize este proyecto tempranamente ya que estoy iniciandome recien la especialidad ; si ustedes me ayudarián hacer este objetivo realidad la poblacion de Loja se lo agradeceria.

2.- Considero Loja un sitio ideal para hacer el desplasamiento a las diferentes cantones de La Provincia De Loja ya que en La Ciudad contamos con todos los servicios basicos de comunicación .

3.- Al dejar mi consultorio en el Canton Catamayo (LA TOMA) que se encuentra a 90 km de Loja me tocaria dejárlo al consultorio sin la proteccion necesaria .

4.- El Canton Catamayo (LA TOMA) se considera zona conflictiva y al producirse un asalto me quedaria sin los instrumentos de trabajo que me atocado mucho tratar de reunir para comprar el 1º paquete.

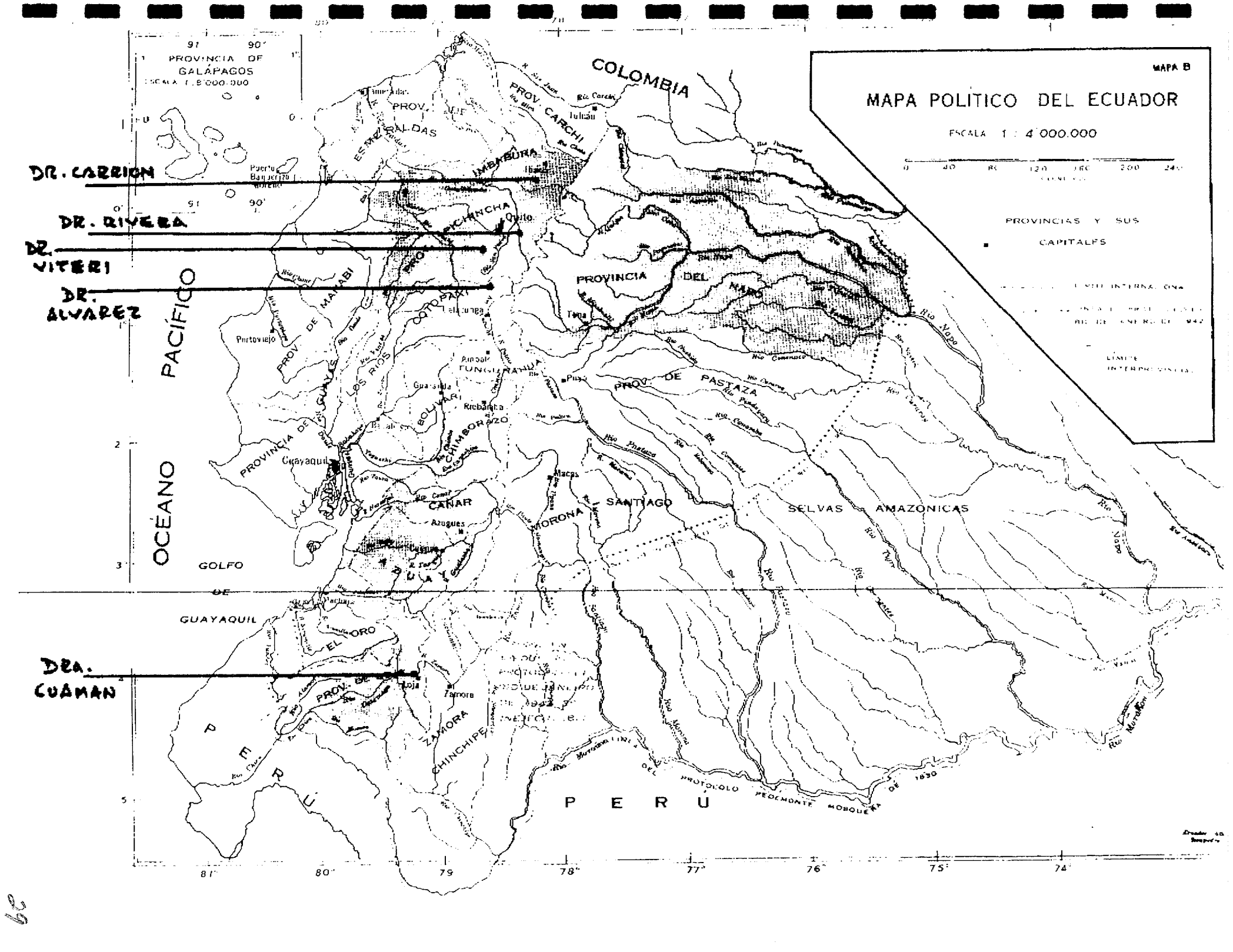
5.- Soy una profesional de pocos recursos economicos ya que estamos partiendo nuevamente con mi familia en el trabajo en la Ciudad de

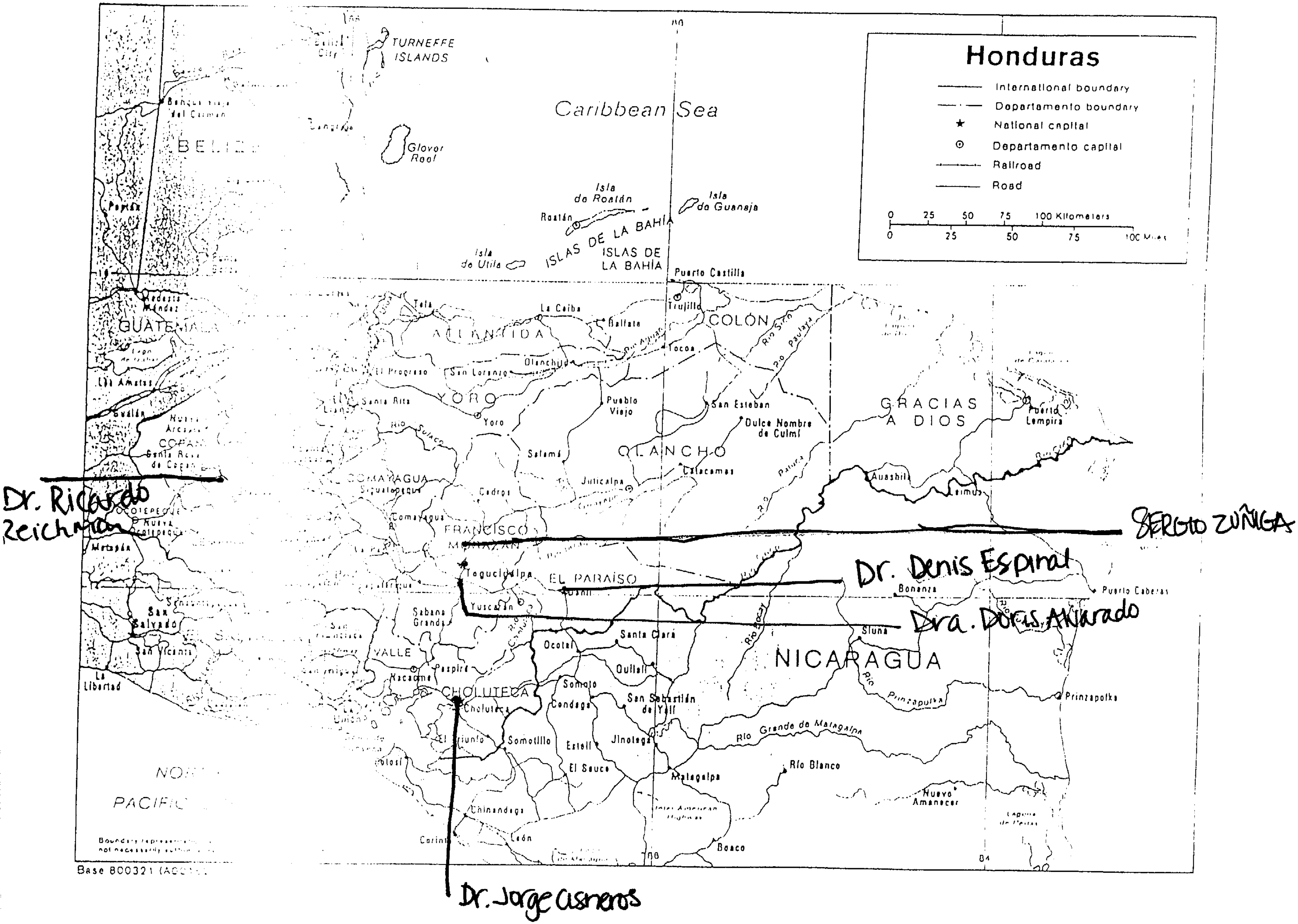
6.- Esperando se tome encuenta mis razones del cambio de lugar me suscribo de ustedes atentamente .

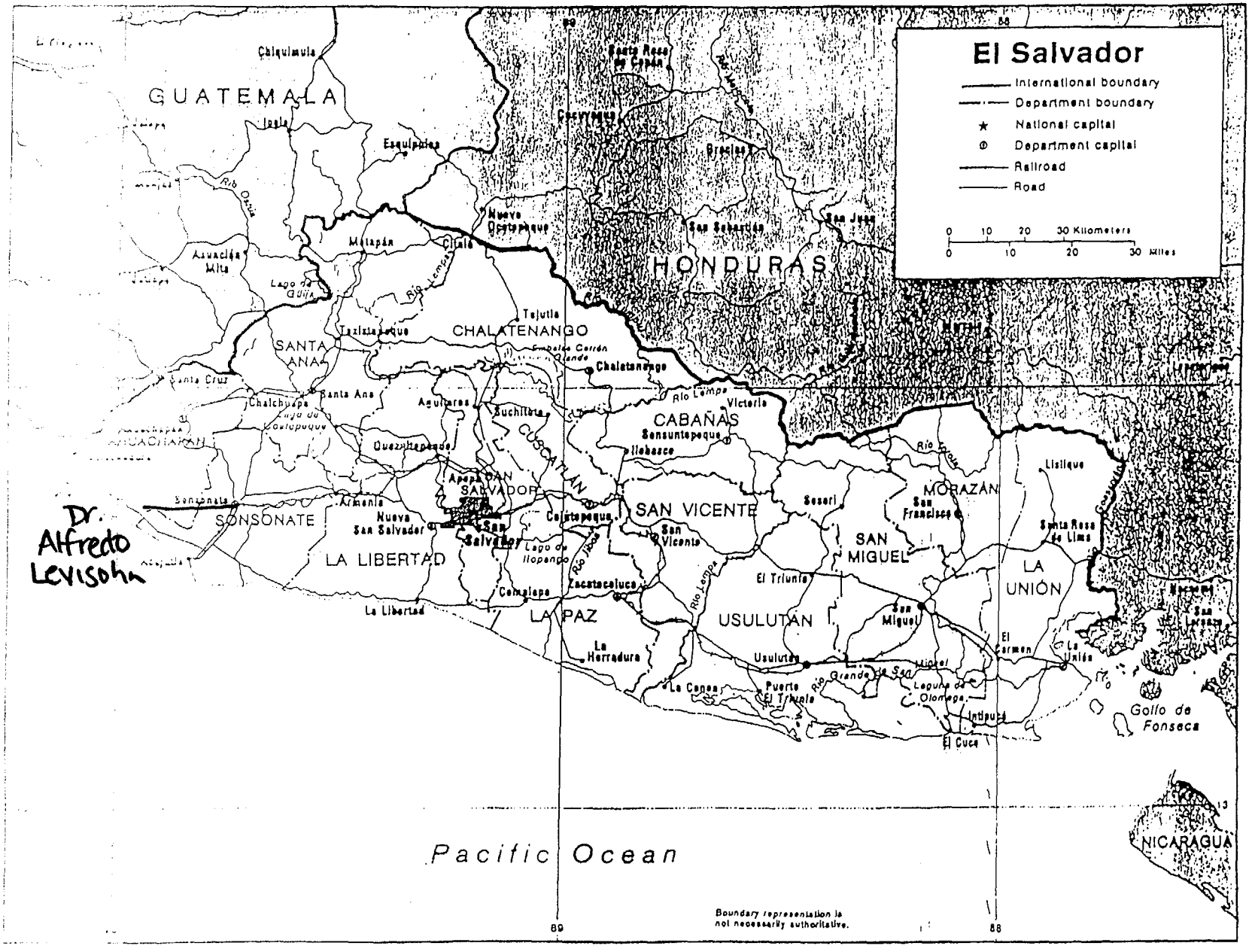
Dra. Rosemary Guzmán
POSTG. ESPECIALIDAD
CODIGO C.M.L. 6

ATTACHMENT B

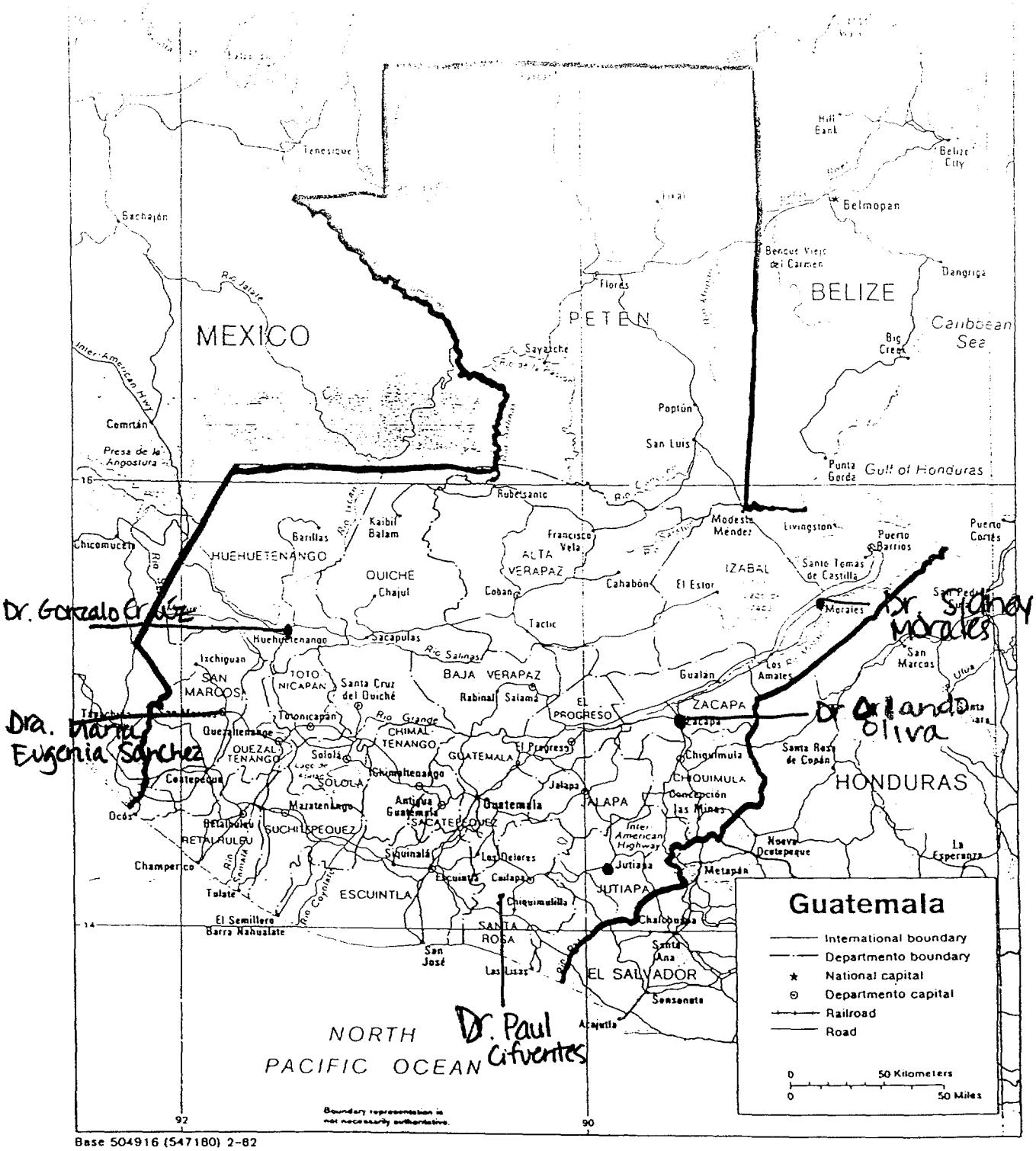
MAPS OF RESPACK CLINIC SITES


MAPA B
MAPA POLITICO DEL ECUADOR
ESCALA 1 : 4'000.000
PROVINCIAS Y SUS
CAPITALES
PROVINCIA DE GALÁPAGOS
COLOMBIA
PROV. DE ESMERALDAS
PROV. DE CARCHI
IMBABURA
PICHINCHA
Quito
PROVINCIA DEL NAPO
Río Napo
PROV. DE MANABI
COTOPAXI
PROV. DE PASTAZA
PROVINCIA DEL GUAYAS
LOS RIOS
BOLIVAR
CHIMBORAZO
Guayaquil
CAÑAR
MORONA SANTIAGO
SELVAS AMAZONICAS
OCÉANO PACÍFICO
GOLFO DE GUAYAQUIL
EL ORO
Loja
ZAMORA CHINCHIPE
PERU
DR. CARRION
DR. RIVERA
DR. VITERI
DR. ALVAREZ
DRA. CUAMAN


Honduras
International boundary
Departamento boundary
National capital
Departamento capital
Railroad
Road
0 25 50 75 100 Kilometers
0 25 50 75 100 Miles
Caribbean Sea
TURNEFFE ISLANDS
Glover Reef
Isla de Roatán
Isla de Guanaja
Roatán
ISLAS DE LA BAHÍA
Isla de Utila
Puerto Castilla
Trujillo
La Ceiba
Tela
ATLÁNTIDA
COLÓN
Olanchito
Tocoa
El Progreso
San Lorenzo
YORO
Yoro
Santa Rita
Pueblo Viejo
San Esteban
Dulce Nombre de Culmí
GRACIAS A DIOS
Puerto Lempira
OLANCHO
Salamá
Juticalpa
Catacamas
Auashila
COMAYAGUA
Comayagua
Cedros
FRANCISCO MORAZÁN
Tegucigalpa
EL PARAÍSO
Yuscarán
Sabana Grande
VALLE
Nacaome
Pespire
CHOLUTECA
Choluteca
El Triunfo
Santa Clara
Ocotal
Quilalí
Somoto
Condega
San Sebastián de Yalí
Somotillo
Estelí
Jinotega
El Sauce
Matagalpa
Chinandega
León
Corinto
Boaco
NICARAGUA
Río Grande de Matagalpa
Río Blanco
Siuna
Bonanza
Puerto Cabezas
Prinzapolka
Río Prinzapolka
Nuevo Amanecer
BELIZE
GUATEMALA
COPÁN
Santa Rosa de Copán
OCOTEPEQUE
Nueva Ocotepeque
San Salvador
San Vicente
La Libertad
NORTH PACIFIC
Base 800321
Dr. Ricardo Reichman
SERGIO ZUÑIGA
Dr. Denis Espinal
Dra. Doris Alvarado
Dr. Jorge Cisneros



Dr. Alfredo Levisohn


Dr. Gonzalo Cruz
Dra. Maria Eugenia Sanchez
Dr. Paul Cifuentes
Dr. Orlando Oliva
Dr. Sydney Morales
MEXICO
BELIZE
PETEN
HUEHUETENANGO
QUICHE
ALTA VERAPAZ
BAJA VERAPAZ
IZABAL
ZACAPA
CHIMALTENANGO
GUATEMALA
SOLOLA
TOTONICAPAN
QUEZALTENANGO
SAN MARCOS
RETALHULEU
SUCHITEPEQUEZ
ESCUINTLA
SANTA ROSA
JUTIAPA
JALAPA
CHIQUIMULA
EL PROGRESO
HONDURAS
EL SALVADOR
Caribbean Sea
Gulf of Honduras
NORTH PACIFIC OCEAN
Guatemala
International boundary
Department boundary
National capital
Department capital
Railroad
Road
50 Kilometers
50 Miles
Boundary representation is not necessarily authoritative.
Base 504916 (547180) 2-82

ATTACHMENT C

REPORT ON PRACTICE MANAGEMENT WORKSHOP, TEGUCIGALPA, HONDURAS FEBRUARY 2-5, 1996

CLINIC MANAGEMENT WORKSHOP
HONDURAS
FEBRUARY 3-4, 1996

This, the second clinic management workshop to be held by IEF was held in Honduras at the Zamorano Agricultural School. Guatemalan participants in the program were flown in so there could be a discussion as to the relative progress of the individuals.

First Dr. Juan Battle gave a presentation entitled "Prevention of Blindness" familiarizing all of the participants with the problem of blindness on a world scale. He then talked about how cost-effective cataract surgeries can be effected in order to ameliorate this problem.

Later he showed how the Dominican Republic organized their national blindness survey and the support they received to accomplish it. This led to his discussion on the National Plan for Blindness Prevention and the activities of the Elias Santana Hospital (Center of Christian Medical Services) where the doctors (including Dr. Batlle) perform surgeries and give care to indigent patients.

After lunch, Juan Batlle talked about some general administrative issues which would help avoid problems at the beginning of a project. (Slides are in HQ.) In addition, he presented a system of checks and balances for the financial administration of a clinic to make sure the patient was being charged the correct amount by the administrator.)

As a warm-up to the round table in which each participant talked about their experiences in their clinics, Juan talked about the responsibilities of the ophthalmologist has to society.

ROUND TABLE:

Antonio Hernandez- He has set up his ResPack clinic in Jutiapa, roughly 5 hours from Guatemala City. He sees roughly 90 patients and performs about 2 cataract surgeries per month. He talked about the difficulties he encountered with procuring a loan to buy the basic package, then he had to pay taxes upon the arrival of the equipment, talked about his work with the Lions Club in Jutiapa, where they give him all the consumables, they pay an operating room, and they paid him $35 for every operation that he did. Through another organization he obtained the money for his surgical microscope in exchange for preforming 250 cataract surgeries.

He said that he would like a Lions-like arrangement but with the IEF. (That we pay his consumables, and a fee for every surgery that he performs on indigent patients.) The Lions Club is sponsoring a Mega Project in the Dominican Republic based on this model. This would help him in Peten, were he lacks money for his consumables, and in Jutiapa.

Gonzalo Cruz- He very much liked the idea of the cataract kit. He is very encouraged about his ResPack clinic on the whole. He has it situated within his father's optical shop.

He has been working during the week in the capital, and every week he makes the 5 hour trip out to Huehuetenango to his ResPack clinic. His father always has appointments lined up from his patients in the optica. He has been attending about 15-20 patients per week. Dr. Cruz and his father have just moved their clinic into a new building which has a room that can be used as an operating room. He has about 20-30 people scheduled for cataract surgery for when he prepares the operating room. A cataract kit could facilitate his operating on indigent patients.

Edy de la Cerda-He is an ophthalmologist who had met John Cheatham while still a resident at the Roosevelt hospital in Guatemala City. He had always had a small consultation at home in which to attend to neighborhood people and family, but really didn't charge too many people and certainly didn't make much money. John Cheatham asked him if he might not like to set up a clinic in a rural area of Guatemala with his help. He moved out to Chimaltenango, (about 1 hour from the capital) and was attending patients at first just a few days a week. His father served as his publicist and secretary, luring people into the clinic by the distribution of flyers, etc. The first year was sort of hard, but his practice began to grow. After several months, his father passed away. Following this event, he decided to move his home to Chimaltenango. He helps a lot of poor people, and it is very clear due to his patient style and calm attitude he enjoys this work. He is able to perform cataract operations at a very low cost about $90 due to the support he receives from John Cheatham. He can use an operating room and consumables without cost. He performs about 5 per month in this fashion. Edy served very well to illustrate some of the doubts common to ophthalmologists opening their own clinics.

Orlando Oliva-Orlando is happy with his experience thus far. He attends his ResPack clinic in Zacapa, 2 hours east of the capitol, every Friday and Saturday. He sees between 15-20 patients per weekend. Thus far has performed 8 cataracts operations and roughtly the same number of ptergigiums. His clinic is self-sufficient and the profits allow him to pay off his loan he took out to pay the equipment. He thinks that if he were a little better known he would get many more patients. He would like IEF to become involved in helping participants with publicity.

Denis Espinal-He expressed satisfaction at his clinic's progress. He has located it in Danli, where he lives on a farm. He works at a private clinic and at the Hospital San Felipe. He does not have a surgical microscope and the does not seem to think that one is necessary for his ResPack clinic. He refers all of his cataract patients to the Hospital San Felipe where a surgery only costs $30. He attends patients in his ResPack clinic on weekends, totaling about 12-30 per week.

Paul Cifuentes-Previously Paul had said that he would open his clinic in Honduras after he finished studying in Guatemala. (He is Honduran.) After finishing his studies, he encountered some delay in returning, and now he states that he will set up his clinic in Barbarena, Santa Rosa, about 1 hour from the capital. He says that he will have the clinic open within the next three weeks.

Jorge Cisneros-Located in Choluteca, Jorge Cisneros attends his ResPack clinic all week. It is about a 2 1/2 hour ride from Tegucigalpa. He sees about 130 patients per month, but has not

been able to perform surgeries due to the fact that he does not have a microscope. He has given training to various teachers in the community so that they may screen their students. He has also given community talks on ocular health and appeared on radio and television shows talking about the same.

Sidney Morales had family problems and had to cancel at the last moment. He is doing quite well and carrying performing a lot of charity work. He also benefits a great deal from the help of Dr. John Cheatham. He performs about 60 surgeries a month.

Sergio Zuñiga could not attend due to the fact that his pregnant wife was having premature contractions. He had to vacate his ResPack clinic due to the wishes of the owner of the office building in which he had his office. (The owner wished to have the space filled by someone who would hospitalize patients.) He had been doing well, seeing about 10 patients per weekend, and working both in a private clinic and at the Hospital San Felipe.
(Sergio came to meet with Orlando and Ellen the day after the workshop and expressed his intention to re-open his ResPack site immediately. He stated that he was very happy with the way his practice had been growing and was experiencing no problems.)

Ricardo Rivera -He did not attend the workshop. He had been working weekends in La Entrada de Copan. He had been seeing roughly 15 patients per week before late November and December hit, in which he did not have many patients at all. One of the contributing factors to this was that doctors from a private clinic at which he works, Santa Lucia, conducted an eye camp in which they were seeing patients and giving eye glasses at a lower price than he did in his ResPack clinic. He feared that these patients would arrive in his clinic not wanting to pay his rates, so he did not participate. He said that for the past two months his ResPack clinic was operating at a loss. He closed his ResPack clinic in the month of January.

Dra. Doris Alvarado- Has yet to open her ResPack clinic although she has had her equipment due to a pregnancy. She had originally been scheduled for....but now would like to open her clinic in the Colonia Kennedy of Tegucigalpa, a marginal area.

CONCLUSIONS, RECOMMENDATIONS & PLAN OF ACTION

Conclusions:

1. Participants should have a lot of patience in waiting for their clinics to grow and be successful. Slowly their clientel grows, and will they achieve success.

2. There is a low demand for cataract surgery compared to other countries. This may be due to several factors: a general fear or distrust of strangers, an unawareness of the benefits, past eye camps which have left people with complications, etc.

3. The only way that cataract operations will become more common and acceptance will grow, increasing demand, is if the price can be lowered to about $100. That way people who would be open to cataract operation can afford it, and spead word of the benefits.

4. Currently the ResPack participants operating independently cannot perform a cataract operation at $100 without taking a loss.

5. To arrive at the price of $100 for a surgery, we need to somehow subsidize these initial surgeries for indigent patients (the docs would donate their time.)

6. There are a lot of barriers to people leaving the capital. These include:
a) a hesitancy to leave teaching institutions where they may be performing surgeries.
b) a hesitancy to leave family
c) " school for children
d) women's husbands may work in the capital.
e) if single, women may not like to go out.

Recommendations:

1. Involve only people that demonstrate a true vocation for working in underserved areas.

2. It's recommendable that the ophthalmologists training to local teachers so that they may screen their students and then give referrals.

3. Continue to look for some form of financing for the people that have still been unable to purchase their basic packages.

4. The patients should always be charged something even if it is negligible so that they appreciate the service.

5. Participants need to be creative in the ways in which they increase the utilization of their services: community education, radio talk shows and pamphlets about ocular health.

6. Juan Batlle: The IEF make an operating room available to the ResPack Drs. so that they could operate at a lower cost.

7. JB: Edy and maybe other ResPack candidates form a foundation in their sites.... give themselves a salary, and be able to get donations, etc.

8. Find a way to include doctors that are already working outside of the capital. If they already have their basic equipment, they should be permitted to purchase a microscope, etc.

Plans of Action:

1. Investigate the possibility of putting together a "cataract kit" with an IOL, viscoelastic, suture, patches, eye shield, 2 pairs of gloves, 6-0 silk and 10-0 Nylon, BSS, pilocarpina, tape,

2 10 ml bottles of tobradex (Alcon) Bajante de Suero (iv tubing) sterile drape (3M) 10cc syringe, a 5 cc, 3cc, 1cc, B&D , 64 beaver blade and a 75 beaver, xylocane and (1or2%) 0.75% marcane or bupivacaina 10 mls. Weck sell sponges 1 package no more than 60 or 80 dollars.....dilating drops..

1000 kits a year.....$60 for $60,000

2. Expand into other countries in order to include only doctors who truly have an interest in working outside of the capital.

ATTACHMENT D

TRIP REPORTS, ELLEN PARIETTI, REGIONAL MEETING OF THE PAN - AMERICAN ASSOCIATION OF OPHTHALMOLOGY, COSTA RICA, MAY 2-7, 1996

TRIP REPORT
REGIONAL MEETING OF THE PANAMERICAN ASSOCIATION OF OPHTHALMOLOGY
COSTA RICA: MAY 2-7, 1996
Ellen M. Parietti

OBJECTIVES:

1. Present the practice management instruction given by Dr. Juan Batlle to the Panamerican Association of Ophthalmology (APO) with the goal to have both ResPack trainings (practice management and equipment maintenance) instituted with the association. The intention is to expand the courses to reach opthalmologists outside the geographic and temporal limits of the ResPack program.

2. Meet with Dr. Francisco Martinez Castro, Executive Director of the Pan-American Association of Ophthalmology to discuss the above and other ways of collaborating with the APO.

3. Increase the visibility of IEF's programs in Latin America, and seek collaboration from local ophthalmologists.

4. Explore possibilities of donation/purchase of low cost products to form the cataract kits.

5. Visit Regional NGO liaison in San José office of the World Bank.

ACTIVITIES REALIZED:

I. Dr. Batlle's presentation: Dr. Battle was scheduled to give a presentation at 8:00am on Thursday, May 2nd entitled: Management of the Ophthalmic Practice: The Real Situation. Due, however, to weather conditions in Miami, Dr. Batlle was unable to arrive in San José until 1:00pm that day. As a consequence, the original time slot of 4 hours was reduced to a 1 hour slot. He apologized for his delay, and he explained that the International Eye Foundation incorporated this and other talks into the practice management workshop given as part of the ResPack program. He then called on Orlando Oliva to introduce the program and explain how we want it institutionalized with the Pan-American Association of Ophthalmology. Dr. Batlle presented the Dominican Republic's national survey of blindness and diabetes, the results, and responses taken. A transcript of this talk as well as his other talks included in his workshop are to be forwarded to this office in late May of this year. At the end of his talk, Dr. Francisco Martinez, the President of APO, stood to congratulate Dr. Batlle on his work, the IEF on our initiative in setting up the program. Dr. Martinez sees it as imperative for the future of ophthalmology to involve young doctors in rural and "needy" populations.

II. Meeting with Dr. Francisco Martinez Castro, Executive Director of the Pan-American Association of Ophthalmology. Dr. Martinez is a very charismatic man who clearly is motivated to wake up the older generation of ophthalmologists who have been content to sit back and deny they have a problem with the distribution of eye care in their countries. He congratulated the IEF on their initiative with the ResPack program and wants to support us in our work. He is very aware of the mentality of many of the older, established ophthalmologists in Latin America who would rather fight for prestige than work together to actually prevent blindness. He wants to encourage the new generation of ophthalmologists to pay attention to the plight of their nation as a whole. He would like to have the Pan-American Association of Ophthalmology associated with the ResPack program in order to assure its existence after the SightReach program, but also as a way to give it prestige and make it a desireable activity for young opthalmologists to get involved with. This association would also be a way of making the "convenio" that they sign somewhat more binding in that it will be affiliated with their professional association. He wants very much for us to attend a meeting scheduled in São Paulo and next year's APO convention in Cancun.

He is aware of the bordom people associate with "Prevention of Blindness." To change the image of this committee, he proposed to change the name of the "Prevención de Ceguera" to "Servicios Humanitarios a la Comunidad." This comite would consist of representatives from each national association, representatives from sub-specialties, and representatives from NGOs. For the congress, Dr. Martinez has a scheme in place to force people to listen to prevention of blindness activities at conferences by having 5 minutes at the start of every presentation. Since most doctors perfer to attend presentations on new procedures, they will still receive news on prevention of blindness.

POSSIBILITIES DISCUSSED:

1. Making the ResPack program "sponsored" or endorsed by the Pan-American Association of Ophthalmology so as to a) make it more prestigous and desireable in the eye of Latin American ophthalmologists b) perhaps make them less likely to break the terms of the convenio.

2. Selecting the appropriate audience was for our message was discussed. Juan Batlle didn't present the usual "ResPack Practice Management Workshop" due not only to time limitations, but also to more appropriately address an audience composed by 80% of older, established, rich ophthalmologists. A small percentage of those present were younger, but these younger, recently graduated doctors cannot usually afford to attend larger regional meetings. These younger doctors as well as all residents, do, however, attend national meetings held in their own countries. The larger meetings are very effective in showing important older doctors (perhaps heads of residency programs, etc.) our ideas, and hopefully get collaboration. We we hope to capacitate the younger ResPack doctors to be able to hold these lectures in the smaller national meetings.

3. Use the Boletín Oftalmológico Pan-Americano (put out by the APO) to raise consciousness about the issue of rural access to ophthalmic care.

III. Meetings with IEF invitees:

1. Dr. Mario Leon Gomez (Honduras) brought me the report prepared by Marylena on the results of ChildSight screenings, and a disk with the data from Honduras blind school data. He also let me know that the A-Scan donated by the IEF to the San Felipe Hospital was unusable due to the fact that the image generated onto the screen would not freeze, and therefore not print. I spoke with Brian Johnson upon return, and he said it was most probably a "software problem."

2. Dr. Jorge Rivera (Ecuador) expressed dissatisfaction with his Khosla lensometer. It arrived mal-adjusted, as did everyone elses. He cannot use it. He wants to return it and get another one.....like the one Javier Prada will quote us on; also available through Optimetrics.

3. Dr. Orlando Oliva delivered the data on the number of surgeries performed on children at Roosevelt and Robles hospitals. In addition, he turned in a record of the surgeries that he performed at his ResPack clinic.

IV. Meetings with Doctor interested in starting ResPack programs in their countries

Dra. Ines Duran-Panama. This young woman sought us out to speak about the possibility of us opening a ResPack program in Panamá. She trained in Peru with Dr. Contreras and so was trained with a "prevention of blindness" mentality. Currently she is the only ophthalmologist serving 300,000 people in Santiago de Veraguas, located 250km from the captital. Her family is from Santiago, and she has a salaried position from the government there. However, the equipment is severely lacking, as are pharmaceuticals and materials for surgery. Dra. Duran's father is Peruvian, as is her husband. She would like to become a pediatric ophthalmologist. (Her husband is the area's only neonatologist.) (507) 998-0987

Dra. Maria Jose Cordoba-Nicaragua. She is the director of the country's only residency program, the "Centro Nacional de Oftalmologia," which currently has 14 residents. Dra. Cordoba met Dr. Batlle at a course given in Puerto Rico. She was very impressed with him and his efforts in the field of community health, and said he was her inspiration to do similar things in Nicaragua. She has accomplished a lot in prevention of blindness herself and was asked to be the director of the residency program because of her focus of community ophthalmology. Within the residency program, she in turn trains the residents with this consciousness, and many plan to work outside of the capital. She sees a lot of potential interest in the program among her residents. ***update: she has faxed me with the names of 5 of her residents who wish to participate in ResPack.

Dra. Sioni Rojas A.-Costa Rica She is an associate in an ophthalmology clinic in the capital currently. She is interested in collaborating with us in some way, but was not immediately interested in setting up clinic outside of the capital; perhaps in the future after she earns and saves some money.

V. Meetings with Central American Representatives of Pharmaceutical Representatives

1. Ciba Vision: Gustavo Ochoa- Director of Latin America and the Caribbean. He is from the Regional office in Quito, Ecuador. He is the highest ranking official in the area, and so would be the one to authorize donations. I explained to him the ResPack program and the hope of getting donations or buying at cost to do a pilot project consisting of approximately 200 cataract kits. He was seemed very supportive and said he would investigate the possibilities of helping us with donations or at least at cost. We agreed that I would send him information on SightReach/ResPack and the idea of the cataract kit. He in turn would find out what he could help out with. We will have an appointment when I go to Quito.

2. CibaVision's Joaquín Ernesto Mejía- San Salvador, El Salvador. He expressed great willingness to help out with any sort of programs that might need product support in El Salvador. He presented me to Gustavo, his boss and was very kind in helping me generate interest with him.

3. Alcon-Roberto Quezada. I spoke with him about the cataract kit, gifts in kind in general, etc. He is located in Guatemala City and assured me that we need only request assistance. (Orlando has, but hasn't received any.) Next time I am in Guatemala I will meet with him as well. I asked him about the possibility of putting information into the Boletín Pan-Americano de Oftalmológico. He gave me the name of Ramiro Fallacé as the person who would be able to give me more information about this.

SUGGESTIONS:

1. Obtain a listing from APO of all of the current information regarding national associations of ophthalmology throughout Latin America and communicate directly with current presidents in project countries. I believe this would facilitate communication and possibly ease the perception of "unfair competion" held by older ophthalmologists toward ResPack participants. Currently we don't receive much support from these organizations, so we can only improve relations. Make an effort especially in El Salvador and Ecuador.

2. Encourage a relationship with field offices/ collaborating ophthalmologists with Latin American offices of pharmaceutical companies. Visit contacts made during conference while in country along with local reps/docs.

3. Investigate with Cathy Bowes the possibility of working with highly motivated people in countries outside those officially included in the SightReach program who are working in rural areas without sufficient equipment. Dr. Maria Jose Cordova [director of the national residency program in the Centro Nacional de Oftalmologia] in

Nicaragua, Dr. Ines Duran de Saavedra in Panama)

4. Utilize the Boletín Oftalmologico Panamericano to publicize upcoming IEF initiatives, activities, ResPack activities, etc.

5. Put together notes on Dr. Juan Batlle's lectures on the establishment of a national plan for the prevention of blindness, practice management, low cost cataract surgery,etc. Capacitate participating ophthalmologists to present this lecture at meetings.

ATTACHMENT E

REPORTE DEL CONGRESO REGIONAL PANAMERICANO DE OFTALMOLOGIA, ORLANDO OLIVA

REPORTE DE VIAJE A COSTA RICA
CONGRESO REGIONAL PANAMERICANO DE OFTALMOLOGIA
1 - 7 DE MAYO DE 1996

JUEVES 2

La presentación del Dr. Juan Battle por parte de IEF con el tema Manejo de la Práctica Oftalmológica: La Situación Real estaba programada para darse durante la mañana para iniciar las actividades del Congreso a las 8:30 horas, sin embargo, por problemas con su vuelo en Miami el Dr. Battle pudo arrivar a Costa Rica hasta el medio día y no el día anterior como estaba planificado. Al final de la tarde a las 18:00 horas el Dr. Battle pudo hacer su presentación, previo a lo cual me llamó al frente e hice una breve explicación de lo que es el programa Sightreach y lo que actualmente se está desarrollando en los países donde está el programa, luego el Dr. Battle presentó la estadística sobre ceguera y diabetes que se efectuó a nivel nacional en la República Dominicana. Al final de su intervención, el Dr. Francisco Martínez Castro, presidente de la APAO, tomó la palabra y felicitó tanto al Dr. Battle como a IEF por esta presentación y además por el Programa Sightreach que le parece una excelente idea para tratar de ayudar a resolver los problemas de ceguera en América Latina.

VIERNES 3 Y SABADO 4

Asistencia a las diferentes conferencias científicas del congreso y además tuvimos la oportunidad de entrevistamos con diferentes personas:

1. Dra. Sonia Cerna: es residente de tercer año en el Hospital Rodolfo Robles, es colombiana y está muy interesada en el programa para participar a su retorno a Colombia si es posible.

2. Dr. Francisco Martínez Castro: Director Ejecutivo de la Asociación Panamericana de Oftalmología, se mostró muy interesado en el Programa Sightreach ya que según él es una forma viable para resolver los problemas de ceguera en América Latina, piensa que somos los jóvenes quienes debemos jugar un papel protagónico en este aspecto y desea tratar de concientizar a oftalmólogos de épocas anteriores para que participen en actividades de prevención de Ceguera. Le pareció una excelente idea el curso de manejo gerencial de la práctica oftalmológica para los participantes del programa y dijo que le gustaría mucho que el curso se pudiera replicar en conjunto con la APAO, tiene mucho interés en que haya representación de IEF en el XI Congreso Brasileño y I Congreso Panamericano de Prevención de Ceguera a realizarse en Sao

Pablo, Brasil del 4-7 de Septiembre de este año así como de que participemos en el congreso Panamericano de Oftalmología que se celebrará en Marzo de 1997 en Cancún, México.

El mencionó que desea que se cambie el nombre de prevención de Ceguera a algo parecido a Servicios Humanitarios Comunitarios y quiere que haya participación multisectorial, además está pensando en incluir temas cortos de prevención de ceguera entre las conferencias científicas ya que a la mayoría de oftalmólogos no les interesa este tipo de conferencias y tal vez de esta manera las escuchan y toman conciencia del problema.

Hablamos también de la posibilidad de incluir temas del taller de manejo gerencial de la práctica oftalmológica en los boletines informativos que distribuye la APAO con la ayuda de Laboratorios Alcon.

Al Dr. Martínez le interesa que se le incluya a la APAO en el desarrollo del programa Respack y de esta manera se tendría un fuerte apoyo ante las sociedades de oftalmología de los diferentes países y por tanto los participantes tendrían más presión para cumplir con lo establecido en el convenio con IEF.

3. Dr. Jorge Rivera: Comentó que le ha ido muy mal con el Lensómetro Khosla y que no quiere conservarlo.

4. Dra. Inés Durán: Es una doctora panameña interesada en ser partícipe del programa Respack, ella está radicando actualmente a 250 kms de la ciudad de Panamá en Santiago de Veraguas. Ella también tiene interés en Oftalmología Pediátrica.

5. Dra. Sioni Rojas: Oftalmóloga Costaricense que desea tener alguna participación con programas de IEF, no tiene interés en Respack.

6. Joaquín Ernesto Mejía: Representante de Ciba Vision para El Salvador, me ofreció ayuda para cualquier programa que iniciemos en este país.

7. Roberto Quezada: Representante de Alcon para Centroamérica, tiene interés en conocer más acerca de IEF y ver si puede colaborar con nosotros, trataré de contactarlo en Guatemala.

LUNES 6

Fuimos con Ellen a entrevistarnos con el Lic. Mario Marroquín Rivera, Especialista en Análisis Social y ONGs, en las Oficinas Regionales del Banco Mundial para Centroamérica;

para explorar la posibilidad de financiamiento para los diferentes proyectos con que cuenta IEF en la región, sin embargo, el Lic. Marroquín fué bastante claro en su explicación y nos comentó que los fondos se canalizan siempre a través de los gobiernos y que además existen muchas limitaciones para fondos en calidad de GRANTS, nos indicó que podemos intentar obtener algún tipo de fondos en Guatemala por medio del FIS (Fondo de Inversión Social) y que puede haber buenas posibilidades en Nicaragua a través de los PROGRAMAS SECTORIALES DE SALUD Y FISE, nos recomendó conversar con la Lic. Bertha Mayela Quintanilla (Coordinadora general de UCP Tel. 289-7152) o en FISE con el Lic. Carlos Noguera (Tels. 781-665 al 69).

CONCLUSIONES

1. Existe mucho interés en la Asociación Panamericana de Oftalmología en el Programa Respack y en los talleres de manejo gerencial de la práctica oftalmológica.

2. Hay interés por parte de Oftalmólogos jóvenes de otros países latinoaméricanos que no han sido incluidos en el programa Respack (Colombia, Panamá, Nicaragua y otros).

3. Los representantes de casas comerciales internacionales en Centroamérica están interesados en tener relación con IEF.

RECOMENDACIONES

1. Mantener contacto con la APAO para tener su apoyo en el programa Respack y enviar representación a los congresos de Sao Pablo y Cancún.

2. Tratar de expander el programa Respack a otros países latinoamericanos que no gozan de los beneficios del mismo.

3. Mantener contacto con casas comerciales a nivel local para obtener donaciones para las actividades de Sightreach.

ATTACHMENT F

TRIP REPORT, ELLEN PARIETTI, ECUADOR
MAY 29 TO JUNE 7, 1996

ECUADOR
TRIP REPORT
May 30-June 7
Ellen Parietti

Objectives:

1. Realize site visits the the various clinics established by ResPack participants in Ecuador.

2. Hold a workshop on the maintanence and repair of ophthalmic equipment with Javier Prada.

3. Meet with the president of Ecuador's National Ophthalmic Association.

4. Investigate the possibility of interest from other groups of ophthalmologists outside the vozandes group.

5. Interview candidates with interest in enter into the program.

Activities Realized:

SITE VISITS:

1. Jorge Rivera: The equipment maintanence and repair workshop was held in Jorge's clinic because he was given a discount of $200 for the loan of his equipment for this loan. Jorge Rivera installed his clinic in Sangloqui a year ago, as soon as he got his equipment. Sangloqui is located about 45 minutes from Quito. He has opened his clinic in a medical center called "Centro Medico Familiar." This center has 2 family practictioeners, ob/gyn, other specialists. This was opened by a woman who started at the vozandes hospital; the whole staff accepts patients who can not pay as it is a poor area.
The center has contracts with two companies to care for their employees. The employer will pay for the medical attention they receive. (No monthly quote is paid.) They do have agreements with the schools in the area to provide physicals for the children. Jorge Rivera has a good record of all of his patients, and the director of the clinic keeps all of the records in a central place. The center has an hospital area which they are just initiating now. Jorge attends the clinic 3 days a week.....which?
The average charge is???????
How many people on an average per day????
Average median income of the area????
How do you think it is going???? Are the patients arriving there?
Do you do publicity???
What else might you need to do??
Teach teachers to do screenings in local schools.

Manuel Alvarez: He has his clinic in Machachi. He was originally approved for a site on the coast, but his son had a grave accident on his bicycle, and needs to be in rehabilitation for the next year or so. He needs to write a letter to IEF stating the reason for the change of site.

Dr. Alvarez has his site located right on the town square of machachi, located in a center with other doctors. He attends the clinic between 2 and 3 days a week, depending when he has surgeries. Saturday, Sunday, and Monday. These days correspond to the days of the market, so all of the people come to Machachi those days. There is an operating room there that he uses, but has to pay rent. He has the scan optics portable microscope. He was having a problem with the light source. Javier Prada fixed that. In addition, he had a small problem with the slit lamp which Javier also fixed.

He is keeping track of all of his patients in notebooks where each page serves as a file for each person. He annotes what he charges each person. Who accepts the money???

Dr. Victor Carrion was originally accepted into the program with the intention of setting up a site in some area outside of Loja. As he did his post-grad ophthalmology residency in the Social Security hospital, he owes the goverment for his training and therefore must work in their hospital. They changed him from his previously assigned post outside of Loja to a Quito hospital. Dr. Proano then informed him that he needed to choose a site outside of Quito or on the outskirts in an underserved area. He chose Calderon, which Dr. Proano approved as an appropriate site. It is practically part of Quito. Further beyond Calderon, there is not much, about half an hour down the road is the town of Guayllabamba, famous for it's avocados. Another candidate proposed the idea that perhaps this town might be more appropriate. Guayllabamba has a population of 5-10,00000

write up a manual of protocol for our contacts

Wednsday, June 5th: I had made arrangements with Optimetrics to get a Woodlyn's lensometer to replace Jorge Rivera's damaged Khosla lensometer. As our plane was delayed, I arrived after office hours and there was no one from Optimetrics available to bring me the lensometer. I also had a check prepared for InterMed to purchase an applanation tonometer for Rosemary Guaman which she was going to buy with part of the money which was owed to her by the IEF as she had made an overpayment to the IEF. She was to pay a balance of $417. This transaction took place without problem, although our plane arrived an hour and a half late. Carlos Guttierrez waited

for us along with his mother.

I met up in Miami with Orlando Oliva and we arrived without problem into Quito at 10pm. Dr. Proano and Dr. Jorge Rivera were there to pick us up. They dropped us at our hotel.

Thursday, June 6th:

Ximena Velastegui, an ophthalmologist, friend of Orlando, spoke with several residents who had demonstrated an interest in the ResPack program. We met with them in an auditorium within a building where Ximena's familyu has their ophthalmology clinic, called clinica opthalmologica. We met with the following residents:

Name	Post-grad Program	year
Jorge Zurita	Universidad Central	1
Teofilo Gonzalez	Universidad Central	1
Jose Barahona	"	1
Lorena Orquera	"	1
Gustavo Mejia	"	1
Juan Carlos Bastidas	"	1
Juan Villavicencio	"	1
Tania Buzman de Idrovo	Patronato San Jose del Norte	5
Napoleon Orlando Canseco	Hosp. Carlos Andrade Marin	1
Arellolo Janeth	"	1
Amparo Salinas	"	1

The only one who would be immediately interested would be Tania Buzman who will be done with her post-grad within one month. The rest will start their 2nd year of residency within one month. They would therefore be able to apply in their third year. They were interested in knowing if the IEF would help procure retinoscope/opthalmoscopes from Welch Allyn at 50% cost, as Jack Blanks had done in the past. They also wanted to see if we could get the 3 mirror lens, and loupes. I told them I would try to find out about the retino/oopth because they had said it was Welch Allyn's policy to provide this discount. As this would not be part of IEF's programming, we could not dedicate ourselves to finding good buys on these things.

We met with Dra. Delia de Guerra, the president of the Sierra chapter of the Associacion de Oftalmologia Ecuatoriana. Originally this had been planned as a courtesy called, so as to let her know about ResPack and what activities were happening in the country. As it happens, Dr. de Guerra is very involved with young ophthalmologists and residents. She has expressed her availability to help with the promotion of ResPack in Ecuador, and is convinced

of the need for young ophthalmologists to get help in getting established outside of the capital. She is in charge of a foundation called "Fundacion Vista Para Ciegos", located in Quito, very close to her private clinic, which only attends poor people. There the people are charged???? They receive donations of medicines and buy their IOLs from India. Cataract surgery is provided for these people at a very low cost. They also receive reimbursement from a government program called INNFA, institute for children and the family. This leaves the cost of a cataract surgery at only $13 for many people. Every month they take a few of their patients to the Hospital Metropolitana, Quito's nicest hospital, where they are attended to in the same way that paying patients are. She was interested in seeing if IEF could be of some help to their foundation. In the meanwhile, we gave her information to distribute to other residents and young ophthalmologists. She was a very impressive woman who treated her patients very well and was very dedicated to her post of president and tried to bring together as many ophthalmologists in her area as possible for monthly meetings in which they reveiewed recent developments in ophthalmologists.

We went to visit the Fundacion Vista para Ciegos where we met up with Dr. Cabezas, a friend of Orlando's from Roosevelt, who showed us the clinic, their new equipment which had been purchased with money from>>>''

Meeting in the foundation Clinica Optica with interested residents. There were a total of twelve opthalmologists that were interested in the program. In the meeting we presented the IEF and the ResPack program

I tried to contact Dr. Varas from the Fundacion Ophthalmologicio Ecuatoriana in Guayaquil, but he was out of the country and will be until after we have left.

Dr. Ochoa, the head of the Ciba Vision products for Latin America had indicated to me that he would be available to receive me during this trip to Ecuador, but he had to leave the country. The second in charge, Viteri, also had to leave the country unexpectedly.

Tuesday, June 4th: Cuenca. In the state of Azuay. 4 hour bus ride from Loja.

Visit with Dr. Pablo Zeas. He was the first person admitted to the ResPack program when interviewed in Guayaquil with John Barrows and

Diana Schwartz. His application was accepted to establish a clinic in Azoges, about 40 minutes from Cuenca. He reports that he has been unable to raise the money to purchase the basic package. He has, however established a clinic in Azoges along with another doctor with whom he studied in the post-graduate. The two share a consultory with an optical shop in the front, They rotate hours. Although their office has a very nice optical shop in the front, they really don't have much equipment at all.
ORLANDO//lensometer????
They have right now, they just have a keratometer, a trial lens & frame set from Khosla, an ophthalmoscope, what else?? Their goal in the future is to establish a clinic in Cuenca, but maintain in operation the Azoges clinic.

Cuenca is a relatively rich area. Many beautiful houses can be seen throughout the countryside. Dr. Zeas informed us that Cuenca has the most amount of people that go to work in the United States and then send home dollars to Azoges.

Wednsday, June 5th: Cuenca. Orlando and I were on our way to the airport when I saw a clinica with a sign just like the one they had out front of their clinica in Azoges. I ran in and to ask which doctors worked there. The receptionist told me Dr. Torres in the morning, the one that was in the clinic in Azoges, and then Dr. Pablo Zeas in the afternoon. I saw our fact sheet on the counter. It is a very beautiful clinic in a colonial building. All of the showcases are of a beautiful wood with glass. Very very beautiful. The clinic had only been opened 2 weeks previously. It was beautifully equiped with slit lamp, what else? a beautiful macintosh computer. We asked the receptionist to knock on the door to tell Dr. Torres that we had wanted to meet with him. She did in fact open the door, and told him that we were there. He came out and we simply said that we had not understood that they had already established the clinic in Cuenca. (We had asked them at least 4 times if they had or had not.) Dr. Torres responded that the equipment was not theirs. As we were now late for our airplane, he said that he would contact us in the hotel American Suites.

ORLANDO OLIVA

Tuesday, June 4th

Blind School Survey-
Maria Eugenia Sanchez de Oliva said that she would complete the follow-up on the Blind School Survey for Guatemala. We need to

discuss a scope of work as well as fee for this task.

Orlando said that he doubts the validity of the findings of the survey because many were incomplete. Orlando had to fill in missing parts. Part of this was just surmizing. There were errors in the reporting. There was a resident's name on the surveys indicating that it was this doctor that had filled them out as opposed to Dr. Hermes who was sent to Colombia for training on how to conduct the survey. It needs to be decided exactly what we want to do with this.

LIONS CLUB- What other conditions would he like to see put to the lions club cataract survey protocols?

INCLUSION OF NEW COUNTRIES INTO RESPACK:
Received a letter from Dr. Calderon in Nicaragua
Orlando reports that many doctors in Venezuela have interest in entering the program.

Things to find out:

If SALUD covers ophthalmology
Ciba Vision

Participants in the Equipment Maintenance and Repair Workshop, June 1, 1996 ECUADOR

L to R: Dr. Victor Carrion, Dr. Orlando Oliva, Dra. Rosemary Guaman, Dr. Manuel Alvarez, Dr. Roberto Proano (IEF contact in Ecuador) Javier Prada, Instructor, and Dr. Jorge Rivera

ATTACHMENT G

REPORTE DEL VIAJE A ECUADOR, ORLANDO OLIVA, 29 MAYO - 7 JUNIO, 1996

REPORTE DE VIAJE A ECUADOR
MAYO 29 A JUNIO 7 DE 1996
DR. ORLANDO OLIVA

Mayo

Miércoles 29:

Día de viaje Guatemala - Ecuador. El Dr. Proaño nos informó acerca de las actividades programadas para nuestra visita.

Jueves 30:

Visita a Hospital Vozandes en Quito, conversamos con el Dr. Jorge Rivera acerca de la posibilidad de contactar a nuevos participantes y a representantes de la Sociedad Oftalmológica Ecuatoriana.

Conversamos con la Dra. Ximena Velasteguí quien ofreció hacer contacto con residentes y otros candidatos potenciales para el programa Respack.

Viernes 31:

Por la mañana visitamos a la Dra. Delia de Guerra, Presidenta de la Asociación Oftalmológica de Quito, le explicamos lo que es el programa Sightreach y lo que estamos haciendo actualmente en Ecuador, ella se mostró sumamente interesada y nos ofreció todo su apoyo como presidenta de la Sociedad de Oftalmología de Quito (hay división entre los oftalmólogos de Quito, Cuenca y Guayaquil); nos comentó además que ella trabaja haciendo labor social en la Fundación Vista para Ciegos en Quito junto con otros 5 oftalmólogos y que en este lugar se atienden exclusivamente a pacientes de escasos recursos, pidió ayuda si hay disponible para esta fundación.

Posteriormente visitamos la Fundación Vista para Ciegos en Quito donde el Dr. Javier Cabezas nos indicó la forma en que trabajan, tienen consultorio completo, cuentan con Biómetro y además tienen una sala de operaciones completa con microscopio, vitreófago y Facoemulsificador. Acá la cirugía de catarata le cuesta al paciente aproximadamente $30.00, están trabajando actualmente con Lentes Intraoculares Aurolab.

A las 18:30 Horas nos reunimos con residentes del postgrado de Oftalmología y algunos residentes de otros hospitales:

NOMBRE	PROGRAMA DE RESIDENCIA	AÑO
Jorge Zurita	Universidad Central	1
Teófilo González	"	1
José Barahona	"	1
Lorena Orquera	"	1
Gustavo Mejía	"	1
Juan Carlos Bastidas	"	1

Juan Villavicencio	"	1
Tania Guzmán de I.	Patronato San José del Norte	5
Orlando Canseco	Hosp. Carlos Andrade Marín	1
Janeth Arellolo	"	1
Amparo Salinas	"	1
Dra. Ximena Velasteguí		Graduada

La reunión se llevó a cabo en el auditorium de la Clínica Oftálmica propiedad de los Drs. Velasteguí, hicimos una exposición de lo que es el programa Sightreach y lo que estamos haciendo actualmente en Ecuador con el componente Respack, los residentes se mostraron interesados pero desafortunadamente la mayoría son del primer año, por problemas en el postgrado han dejado de preparar residentes en algunos años en este país.

La Dra. Ximena Velasteguí comentó durante la reunión que durante su residencia en el Hospital Rodolfo Robles de Guatemala, tuvo la oportunidad de comprar un set de Oftalmoscopio-Retinoscopio con la ayuda del Sr. Jack Blanks, de IEF, nos preguntó si sería posible hacer lo mismo con las personas que llegaron a la reunión ya que Welch Allyn tiene este tipo de ayuda para residentes.

A las 21:00 Horas nos reunimos con el Dr. Hugo Fabián Almeida quien es un Oftalmólogo de 45 años aproximadamente que ha trabajado para el ejército ecuatoriano, aparentemente muchos años se ha dedicado a ejercer medicina general en hospitales militares de diferentes regiones del país, él nos dijo que está interesado en iniciar su clínica en la provincia de Imbabura, en la ciudad de Otavalo, quiere hacer un proyecto grande, inclusive habló de un microscopio de buena calidad, ultrasonido, láser y cámara de angiofluoresceina, nos comentó que ya tiene el local y que mientras se retira del hospital militar puede empezar a ir durante los fines de semana pero que su idea es irse a radicar allá pues su familia paterna es de esta región, acordamos que de ser posible iríamos a conocer este lugar.

Junio

Sábado 1

Se llevó a cabo el taller de mantenimiento y reparación de equipo oftalmológico con la ayuda de Javier Prada, de 9:30 a 17:00 horas en la clínica del Dr. Jorge Rivera ubicada en Sangolquí, área periférica de Quito, esta clínica se encuentra en un centro médico, hay varios médicos con diferentes especialidades y actualmente han iniciado servicio de hospitalización y sala de operaciones, el Dr. Rivera está realizando una buena práctica de acuerdo a los fines de la fundación, el precio de su consulta es de aproximadamente $7.00, en la región existen algunas fábricas que trabajan con seguros de gastos médicos le ha beneficiado un poco. El Dr. Rivera en estos momentos no está haciendo procedimientos quirúrgicos en esta clínica.

Con respecto al equipo el Dr. Rivera ha tenido problemas con el Lensómetro marca Khosla. En el taller la Dra. Rosemary Guamán

hizo entrega del oftalmoscopio indirecto Welch Allyn que no ha funcionado desde que lo recibió, Javier Prada lo revisó pero no pudo repararlo por falta de instrumentos adecuados y sugirió que por ser un aparato nuevo se llevara al distribuidor que lo vendió.

Los participantes se mostraron muy interesados en el taller y pienso que sí captaron mucho de lo explicado por Javier, el lugar donde se efectuó este taller no fué muy adecuado ya que se hizo en una de las clínicas con poco espacio y un poco incómoda para este efecto.

Después del taller fuimos a visitar la clínica del Dr. Manuel Alvarez en Machachi, lugar localizado aproximadamente a 1 hora de Quito; su clínica está ubicada en el centro de la población en un centro médico donde hay atención de otras especialidades, cuentan con hospitalización y sala de operaciones. Su clínica está funcionando adecuadamente, el precio de la consulta es de $7 dólares o menos, ha hecho algunas cirugías y viendo sus estadísticas de consultas es evidente que tiene buena afluencia de pacientes.

En cuanto al equipo, el Dr. Alvarez ha tenido problemas con la lámpara de hendidura, la cual fué reparada por Javier Prada y además el Microscopio Scan Optics le salió defectuoso desde el principio, Javier reparó el microscopio casi totalmente (no tenía suficientes herramientas ni el catálogo) y le indicó al Dr. Alvarez como ajustarlo por completo.

El Dr. Alvarez nos comentó que va a capacitar maestros para medir agudeza visual. Además, como parte de su estrategia para captar más pacientes quirúrgicos, disminuye el costo de la cirugía a un paciente si él mismo le remite un paciente con un problema quirúrgico también.

Lunes 3

Volamos con la Dra. Rosemary Guamán a la ciudad de Loja, localizada aproximadamente a 300 kilómetros de Quito. La Dra. Guamán fue aceptada en el programa en junio de 1995, pero aún no ha iniciado su práctica ya que regresó recientemente del curso oftalmológico de Puerto Rico. Loja tiene aproximadamente 100,000 habitantes y cuenta con cantones aledaños con unos 50,000 habitantes, en esta localidad actualmente hay 3 oftalmólogos, pero conversando con varias personas pude determinar que si existe necesidad de más oftalmólogos en esta región.

Fuimos a visitar la clínica de la Dra. Guamán que está ubicada en un centro clínico donde existen otros especialistas, es un lugar bastante adecuado y la clínica está bien organizada; le cambiamos el fusible a la lámpara de hendidura de 220 a 110, sin embargo no funcionó por lo que con la ayuda de un electricista se determinó que la fuente de poder y el transformador no están funcionando adecuandamente, por lo que esta pieza se llevaría a Miami para entregarla a Intermed. Además le colocamos el tonómetro de aplanación a dicha lámpara.

La Dra. Guamán está bien motivada para efectuar jornadas fuera de Loja y actualmente tienen programada con sus 3 colegas del centro clínico (odontólogo, pediátra, inmunólogo) una jornada en Cariamanga, población localizada aproximadamente a 4 horas de Loja; el valor de la consulta será de $2 dólares, además en este momento se disponía a hacer evaluación de 50 aspirantes en la Escuela de Policías; por último nos comentó que aplicará en el hospital Isidro para trabajar como Oftalmóloga durante media jornada en dicho hospital.

Por la noche nos dirigimos a la ciudad de Cuenca, a 4 horas de Loja.

Martes 4

Contactamos al Dr. Pablo Zeass, quien fue el primer participante en ser aceptado en el programa para Ecuador, no compró el equipo debido a que no tenía dinero pero también comentó que le habían informado algunas personas que el equipo se demoraba mucho en llegar, nos invitó a conocer su clínica en Azogues, ciudad con aproximadamente 100,000 habitantes, localizada a 45 minutos de Cuenca, Azogues es la capital de la provincia de el Cañar, que cuenta con aproximadamente 207,000 habitantes. Esta clínica según nos informó, ha estado funcionando desde hace un año pero sin equipo oftalmológico completo, al llegar al lugar vimos en el exterior un rótulo dorado que dice Optica Metropolitana, cuando entramos vimos que es una Optica muy lujosa con armazones sumamente caras; el Dr. Zeass nos presentó a su socio, el Dr. Torres, y al ingresar a la clínica vimos que únicamente contaban con una caja de pruebas, una unidad sin foróptero, juego de oftalmoscopio-retinoscopio y queratómetro, nos comentaron que además tienen un poco de equipo quirúrgico, pero que a sus pacientes privados los operan en Cuenca, el valor de la consulta en esta clínica es de aproximadamente $7 dólares.

Ambos médicos nos dijeron que desean abrir una clínica posteriormente en Cuenca, pero que definitivamente tienen más interés en conseguir el equipo para la clínica de Azogues, ya que han estado funcionando únicamente como optómetras con caja de pruebas y por lo tanto tienen interés en ser parte del programa Respack. Esto lo recalcaron en aproximadamente 4 veces, comentando inclusive, que la clínica de Cuenca si la abren tal vez dentro de unos 6 meses, será con algún tipo de apoyo por parte de una ONG que apoya con financiamiento.

El Dr. Zeass nos comentó que atienden todos los días a pacientes de escasos recursos en el hospital de la localidad, sin embargo el Dr. Torres dijo que únicamente lo hacen una semana al mes. Fuimos a conocer este hospital donde existe equipo básico para una consulta.

Miércoles 5

Durante el recorrido hacia el aeropuerto, en Cuenca observamos muy cerca del centro de la ciudad un rótulo que dice Optica Metropolitana exactamente igual al de la óptica de

Azogues. Continuamos el recorrido pero decidimos regresar y al entrar vimos que es una óptica muy lujosa, más que la de Azogues y observamos nuestra hoja informativa en el escritorio de la secretaria, le preguntamos que quiénes son los médicos de esa clínica, ella nos informó que el Dr. Zeass y el Dr. Torres. Pedimos hablar con el Dr. Torres que era quien se encontraba en ese momento y al atendernos nos dijo que esa clínica no es de ellos ya que nosotros le dijimos que entendimos que aún no la habían iniciado; pedimos conocerla y esta es una clínica sumamente lujosa que cuenta con lámpara de hendidura, unidad con foróptero, queratómetro, proyector con control remoto, cámara de angiofluoresceina, una computadora y otros instrumentos básicos.

Observando esta clínica todos los diplomas que se encuentran en ella son de los doctores mencionados.

Llegamos a Quito a las 11:00 horas y nos encontramos con el Dr. Hugo Almeida, quien nos llevaría a conocer el lugar seleccionado para su clínica en la ciudad de Otavalo, provincia de Imbabura, ciudad localizada a 110 kilómetros de Quito, con un área de influencia bastante grande entre las cuales se encuentra San Pablo del Lago, situada a 8 kilómetros de la misma, con una población de 10,000 habitantes. Al llegar a Otavalo, entramos en un pequeño centro comercial donde ya se encuentra anunciado el nombre del Dr. Almeida y al conocer su local vimos que ya cuenta con una unidad, oftalmoscopio-retinoscopio, lente de 3 espejos y lámpara de hendidura, él dijo que quisiera poder dividir el paquete básico ya que no le interesa tener el oftalmoscopio indirecto y además tiene lámpara y lente de 3 espejos.

El lugar más cercano donde hay oftalmólogo es en San Antonio de Ibarra a 30 minutos de Otavalo, donde existen 3 de ellos y uno de los cuales trabaja en esa región en un hospital oftalmológico de ayuda financiado por italianos.

Al regreso de Otavalo pasamos a visitar la ciudad de Calderón, que queda a unos 15 minutos de las afueras de Quito y en la cual el Dr. Carrión quiere poner su clínica, él estaba aceptado para irse a Loja, pero debido a que le trasladaron su plaza en el Hospital Nacional, tiene que permanecer cerca de Quito. Al llegar no encontramos al Dr. Carrión ya que nos retrasamos y no pudo esperarnos más tiempo, pero tuvimos oportunidad de conocer el lugar y a mi parecer no es muy adecuado en este momento ya que hay que hacer varios arreglos para poder ser utilizado como clínica, sin embargo, el dueño de dicho local dijo que puede tenerlo listo en muy poco tiempo, tiene la ventaja de que hay un centro clínico y un centro de salud en frente de él.

Personalmente creo que el Dr. Carrión ha estado dando uso al equipo de Respack probablemente en una clínica de Quito.

Jueves 6

Fuimos con el Dr. Viteri a conocer el lugar donde supuestamente va a iniciar su clínica de Respack, se llama

Chillogallo, está localizado en las afueras de Quito, según refiere tiene área de influencia del sur de Quito, de aproximadamente 100,000 habitantes, nos mostraron el centro médico donde existen más especialistas, hay hospitalización y sala de operaciones, en este momento no está construído el local para su clínica que supuestamente estará en el tercer nivel, sin embargo, nos mostraron un local al lado ubicado en la casa de el médico dueño de este centro; dicho local me parece totalmente inadecuado es un área de 2.5 X 2.5 metros, localizado en la parte baja de la casa.

El Dr. Viteri dice que no ha iniciado su clínica debido a que no sabía como cambiar el fusible de 220 a 110 (tiene casi un año de tener su equipo) y que por lo tanto estaba esperando a que alguien de IEF llegara para resolver este problema, además él no asistió al taller de mantenimiento y reparación de equipo supuestamente por problemas de salud. Este doctor estuvo comentando que vió un poco mal el lensómetro Khosla y que le gustaría comprar otro y además quiere obtener un tonómetro de aplanación; le respondí que es necesario ver sus actividades en la clínica de Respack antes de que él pueda comprar más equipo a través de IEF.

Me atrevería a asegurar que el Dr. Viteri tiene clínica en Quito y que está utilizando para ello el equipo de Respack.

Más tarde nos reunimos en el hotel con Ellen y le entregué la traducción de la guía para compra de equipo oftalmológico y los boletines informativos que distribuye la Asociación Panamericana de Oftalmología. Además discutimos nuestras experiencias con respecto a las visitas efectuadas. Ellen me entregó información obtenida sobre el proyecto SightFirst y los resultados de la encuesta de la escuela de ciegos efectuada en Guatemala.

A las 18:00 horas nos reunimos con el Dr. Roberto Proaño y le informamos acerca de todas nuestras apreciaciones durante el viaje, él dijo que ve un poco problemática la situación de los doctores Carrión y Viteri y que tratará de presionarlos para que cumplan con lo establecido por el programa. Además, acordamos que conversará con su abogado para ver en que forma se puede hacer un compromiso legal entre la Fundación y los participantes. Le solicité al Dr. Proaño (como a los participantes) que nos envíe información estadística de los pacientes atendidos en las diferentes clínicas cada 2 meses. El Dr. Proaño nos comentó que el Dr. Almeida no ha tenido experiencia quirúrgica oftalmológica desde hace varios años (el mismo comentario había escuchado anteriormente), si entra el Dr. Almeida al programa no puede vendérsele el paquete básico dividido.

Por otro lado el Dr. Proaño no puede hacerse cargo del programa a nivel de Guayaquil ya que no dispone de tiempo. Por último, discutimos aspectos acerca del próximo curso de manejo gerencial de la práctica oftalmológica, el Dr. Proaño tiene acceso a un lugar adecuado para llevarlo a cabo y dejamos como fecha tentativa el sábado 31 de agosto y domingo 1 de septiembre.

Me reuní por la noche con la Dra. Ximena Velasteguí quien me informó que quiere iniciar una clínica en un área periférica de Quito y que le gustaría participar en respack, la cual previamente había conocido y realmente el lugar no me parece adecuado, sin embargo ella tiene un proyecto de ayuda en un lugar localizado en la Sierra para atender en forma gratuita a pacientes y el cual lo atiende con un compañero un fin de semana al mes y me dijo que también usaría este equipo para llevarlo allá, en este lugar captan pacientes para cirugía y los traen a Quito para operarlos con la ayuda monetaria de una ONG.

Viernes 7

A mi regreso a Miami llamé a Optimetrics quienes enviaron a recoger el cheque para la compra del lensómetro para el Dr. Jorge Rivera. Posteriormente, entregué la fuente de poder de la lámpara de hendidura de la Dra. Guamán en las oficinas de Intermed.

CONCLUSIONES

1. De los 5 participantes que han comprado el equipo en Ecuador actualmente 2 han iniciado su práctica que parece una práctica adecuada para los objetivos de Respack.

2. La Dra. Rosemary Guamán está a punto de iniciar su práctica en Loja y parece que lo hará en forma adecuada.

3. Dudo de la honestidad de los Drs. Carrión y Viteri para el desarrollo de sus clínicas de Respack en áreas necesitadas.

4. Ha habido problemas en Ecuador en cuanto al funcionamiento de algunos instrumentos, todos los participantes se quejan de la calidad de Khosla.

5. No hay cobertura del programa en las áreas de la costa y oriente.

6. El taller de mantenimiento y reparación de equipo tuvo éxito.

7. No considero a los Drs. Zeass y Torres personas aptas para participar en el programa Respack.

RECOMENDACIONES

1. Tratar de concientizar de alguna manera a los Drs. Carrión y Viteri para que cumplan con el compromiso adquirido con IEF.

2. Explorar otras marcas de equipo que puedan ser utilizados en lugar de Khosla, tal vez comprar unicamente la caja de pruebas y el instrumental quirúrgico con esta marca.

3. Tratar de extender el programa contactando a otros representantes para el programa en las áreas oriental y en la costa.

4. Buscar una forma legal que obligue a los participantes de Respack a cumplir con el compromiso adquirido con IEF.

5. No aceptar a los Drs. Zeass y Torres en el Programa de Respack.

6. Hablar con Welch Allyn para explorar la posibilidad de ayudar a los residentes con la compra de Oftalmoscopio-Retinoscopio a bajo costo.

7. Evaluar detenidamente la participación del Dr. Almeida en el programa y determinar si es conveniente tanto para IEF como para él.

8. Hacer una visita de Supervisión por parte de IEF cada 6 meses.

cc. Ellen Parietti
John Barrows
Martha de Piedrasanta

ATTACHMENT H

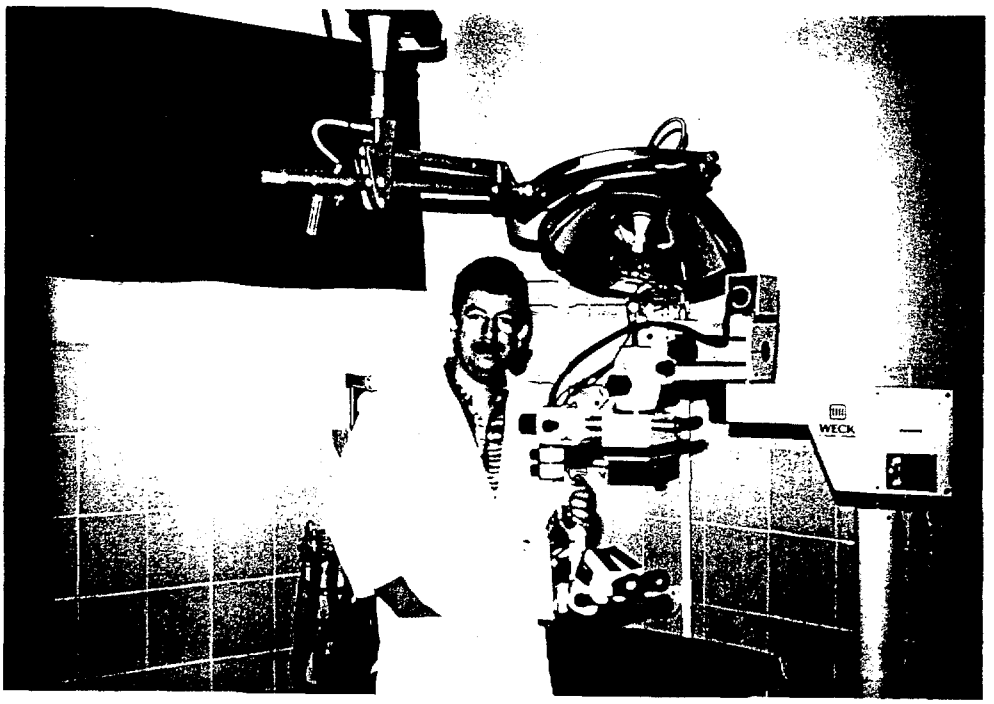
JORGE CISNEROS, OUTREACH ACTIVITIES

Lista de Candidatos a Cirugia de Catarata Binocular

1. Lauraneo Galeas Rodas	*74 años*	*Cerro Trapiche, Radio Valle*
2. Nicolas Lopez Miranda	*66 años*	*Concepcion de Ma. (Valle del palito)*
3. Amalia Mondragon	*55 años*	*Yusguare (San Luis Plan Jocote)*
4. José V. Oviedo	*80 años*	*B. La Libertad, Chol.*
5. Sabas Vasquez	*64 años*	*Yusguare (aldea La Permuta)*
6. Simon Salazar	*74 años*	*Orocuina, Chol.*
7. Eucebia Nuñez	*60 años*	*Fte. a INCATEC, chol.*
8. Vicenta Hernández	*51 años*	*Choluteca*
9. Anastacio Zuniga	*77años*	*Triunfo, Chol.*
10. Reyna Montecino	*27 años*	*B° La Libertad Chol.*
11. Juana Peralta	*60 años*	*Marcovia Chol.*
12. Enemecio Rodriguez	*65 años*	*Choluteca*
13. Pilar Padilla	*78 años*	*Orocuina, Chol*
14. Eduviges Betanco V.	*63 años*	*Choluteca*
15. Maria Catalina Pineda	*64 años*	*Choluteca*
16. Laureano Galeas Rodas	*76 años*	*Choluteca*
17. Fausto Espinal	*73 años*	*B. Istoca Chol.*
18. Juan Francisco Zerón	*66 años*	*Choluteca*
19. Maraia Bernardina Suarez	*90 años*	*Choluteca*
20. Silvia Barahona	*60 años*	*Choluteca*
21. Nicolas Lopez	*65 años*	*Choluteca*
22. Cristino Rodas	*80 años*	*Pavana, Chol.*
23. Josefina Villatoro	*78 años*	*Choluteca*
24. Evarista Garcia	*64 años*	*Marcovia, Chol*
25. Romilio Sanchez	*74 años*	*Namacigue, Chol.*
26. Ernesto Nuñez Garcia	*78 años*	*Col. Las Acacia. Chol.*
27. Guillermina Espinal	*85 años*	*B. La Libertad Chol.*
28. Emilio Herrera	*78 años*	*B. Campo Sol Chol.*
29. Soila Peña	*59 añso*	*B. Aceituno, Chol.*
30. Aquilino Rios Alvarez	*75 años*	*San Lorenzo, Valle*
31. Romilio Sanchez Lagos	*74 años*	*Namasigue Chol.*
32. Juan Gomez	*78 años*	*Namasigue Chol.*
33. Jose T. Cañada	*67 años*	*Choluteca*
34. Pastora Diaz	*75 años*	*Goascoran, Valle*
35. Evaisto Nuñez	*40 años*	*San Lorenzo, Valle*
36. Jauna Barahona	*74 años*	*Nacaome, Valle*
37. Lucia Cruz	*83 años*	*San Fco. San Marcos de Colon*
38. Rosa Espinal	*34 años*	*Choluteca*
39. Fanor Vallejo	*84 años*	*Triunfo, Chol.*
40. Sebastian Benitez	*85 años*	*Choluteca*
41. Luisa Aguilera	*74 años*	*Choluteca*
42. Jose V. Oviedo	*80 años*	*Choluteca*
43. Indalecio Flores	*64 años*	*San Lorenzo, Valle*
44. Albino Flores	*91 años*	*Choluteca*
45. Jose Flores Nuñez	*76 años*	*Concepción de Maria, Chol.*
46. Guillermina Servellon	*60 años*	*Alicianza, Valle*
47. Jose Sierra	*82 años*	*Choluteca*

48.Felix Espinal	*94 años*	*Alianza, Valle*
49.Francisco Uriarte	*39 años*	*El Triunfo, Choluteca*
50.Juan Ramon Martinez	*49 años*	*Choluteca*
51.Felix Alvarez	*55 años*	*Choluteca*
52.Santos Carranza	*75 años*	*Liure*
53.Felipe Sierre	*62 años*	*Choluteca*
54.Jose Sierra	*90 años*	*Aliaza, Valle*
55.Salomon Lanza	*80 años*	*Choluteca*
56.Fidelia Bonilla	*81 años*	*Choluteca*
57.Ernesto Guitierrez	*70 años*	*Goascoran Valle*
58.Maria Estrada	*59 años*	*El Corpus, Chol.*
59.Alejandra Garcia	*76 años*	*Nacaome, Valle*
60.Rosalia Flores	*72 años*	*Choluteca*
61.Rosa Digna Maradiaga	*55 años*	*Choluteca*
62.Simón Medina	*85 años*	*Choluteca*
63.Argentina Rodriguez	*74 años*	*Choluteca*
64.Cecilia Amador	*76 años*	*Choluteca*
65.Maria Hernandez	*52 años*	*Marcovia, Chol.*
66.Sabaz Velasquez	*75 años*	*San Lorenzo, Valle*
67.Felipe Motiño	*69 años*	*Choluteca*
68.Ofelia Martinez	*77 Años*	*Choluteca*
69.Guillermina Velasquez	*80 años*	*El Triunfo, Choluteca*
70.Pedro Maradiaga	*72 años*	*Choluteca*
71.Valentin Garcia	*67 años*	*Alianza, Valle*
72.Rogelio Mendoza	*69 años*	*Morolica, Choluteca*
73.Sixta Reyes	*72 años*	*Marcovia, Choluteca*
74.Digna Vasquez	*41 años*	*Choluteca*
75.Mercedes Tercero	*86 años*	*San Marcos de Colon*
76.Cornelio Aguirre	*70 años*	*Choluteca*
77.Jose Santos Reyes	*32 años*	*Valle*
78.Carlos Molina	*54 años*	*Choluteca*
79.Elena Ramirez	*66 años*	*Choluteca*
80.Jose Molina	*60 años*	*Choluteca*
81.Jose de la Paz Aguilar	*96 años*	*San Marcos de Colon*
82.Reina Laura Aguilera	*29 años*	*San Marcos de Colon*
83.Pedro Joaquin Garcia	*74 años*	*San Marcos de Colon*
84.Maria Florencia Herrera	*71años*	*San Marcos de Colon*
85.Maria Indalecia Hernandez	*79 años*	*San Marcos de Colon*
86.Jose Angel Hernandez Chavez	*83 años*	*San Marcos de Colon*
87.Jose tomas Montalvan Calderon	*67 años*	*San Marcos de Colon*
88.Santos Mondragon Rios	*71 años*	*Danli, El Paraiso*
89.Demetrio Lopez Lainez	*56 años*	*Choluteca*
90.Emerita Ponce	*85 años*	*San Marcos de Colon*
91.Yadira Quiroz	*30 años*	*San Lorenzo Valle*
92.Santiago Sandobal Izaguirre	*73 años*	*San Marcos de Colon*
93.Juana Tercero De Rivera	*65 años*	*San Lorenzo Valle*
94.Josefa Velasquez Gonzales	*79 años*	*San Marcos de Colon*
95.Jose Irene Villanueva	*65 años*	*San Antonio Flores, Chol.*
96.Consuelo Zepeda Flores	*61años*	*Choluteca*
97.Cosntantino Moncada	*82 años*	*Morolica, Chol.*
98.Anselmo Reyes	*65 años*	*Orocuina, Chol.*

99.Constantino Mondragon	*74 años*	*Marcovia, Chol.*
100.Emi Sori	*47 años*	*Choluteca*
101.Aquilino Rios	*75 años*	*San Lorenzo, Valle*



top: Dr. Jorge Cisneros with donated microscope, first cataract patient, and Dr. Raul Gomez, IEF Honduras Director

bottom: Dr. Jorge Cisneros with microscope in his clinic in the San Francisco de Asis hospital, Choluteca, Honduras

ATTACHMENT I

MONTHLY REPORT FOR ROSEMARY GUAMAN

Loja, 17 de Julio de 1996

INTERNATIONAL EYE FOUNDATION

Ellen Paretti. MPH.

Program Officer

Me es grato dirigirme a Uds. para informarles que el consultorio de OFTALMOLOGIA está funcionando aproximadamente dos meses , estamos realizando visitas los fines de semana a los diferentes cantones se esta aciendo labor social , el día 14 de Julio estuvimos en el canton Catamayo (LA TOMA) se atendio a 40 pacientes ;
Además me permito informarles que el lugar de atención OFTALMOLOGICA que estaba planificado en la Toma lo cambie por las siguientes razones

1.- La poblacion de Loja tiene aproximadamente 110.000habitantes la Provincia 190.000 habitantes a la fecha actual contamos con4 OFTALMOLOGOS EN LA CIUDAD DE LOJA ; al estar con mi consultorio en La Ciudad De Loja puedo cubrir los barios URBANO MARGINALES como el Valle, Pradera, Plateado , incluso megustaria hacer atención en una UNIDAD MOVIL ; por mis limitaciones economicas me es imposible que se realize este proyecto tempranamente ya que estoy iniciandome recien la especialidad ; si ustedes me ayudarián hacer este objetivo realidad la poblacion de Loja se lo agradeceria.

2.- Considero Loja un sitio ideal para hacer el desplasamiento a las diferentes cantones de La Provincia De Loja ya que en La Ciudad contamos con todos los servicios basicos de comunicación .

3.- Al dejar mi consultorio en el Canton Catamayo (LA TOMA) que se encuentra a 90 km de Loja me tocaria dejarlo al consultorio sin la proteccion necesaria .

4.- El Canton Catamayo (LA TOMA) se considera zona conflictiva y al producirse un asalto me quedaria sin los instrumentos de trabajo que me atocado mucho tratar de reunir para comprar el 1º paquete.

5.- Soy una profesional de pocos recursos economicos ya que estamos partiendo nuevamente con mi familia en el trabajo en la Ciudad de Loja pero iguaslmente me interesa trabajos y sacar el programa y los proyectos adelante .

12

6.- Esperando se tome encuenta mis razones del cambio de lugar me suscribo de ustedes atentamente .

Dra Rosemary Guamán

Dra. Rosemary Guamán
POSTG. OFTALMOLOGIA
CODIGO C.M.L. 1[illegible]

ATTACHMENT J

RESULTS OF BLIND SCHOOL SURVEY, GUATEMALA

RESULTS OF BLIND SCHOOL STUDY GUATEMALA 1994.

REPORT TO INTERNATIONAL EYE FOUNDATION

Analysis performed by Clare Gilbert

May 1996

Miss Clare Gilbert FRCOphth., MD., MSc.,
Department of Preventive Ophthalmology,
Institute of Ophthalmology,
Bath Street,
LONDON EC1V 9EL

Tel: **0171 608 6900**
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E-mail: **smheceg@ucl.ac.uk**

DEMOGRAPHIC DETAILS:

The study included 77 children, 73 of whom were severely visually impaired (SVI) or blind. In children with SVI and blindness 39 (53%) were male, and thier ages ranged from 4 - 15 years (mean 10 years).

2. WHO CATEGORIES OF VISUAL LOSS:

See Table 1A and 1B.

Table 1A. WHO categories of visual loss

WHO Category	Level of vision	N	%
No impairment	≥6/18	0	*0*
Visual impairment	<6/18 - 6/60	4	*5.2*
Severe visual impairment	<6/60 - 3/60	7	*9.1*
Blind	<3/60 - NLP	66	*85.7*
Cannot test		0	*0*
Total:		***77***	***100***

Table 1B WHO categories of visual loss - low vision

WHO Category	Level of vision	N	%
No impairment	≥6/18	0	0
Low vision	<6/18 - light perception	49	63.6
Totally blind	No light perception in both eyes	28	36.4
Cannot test		0	0
Total:		**77**	**100**

3. CAUSES OF VISUAL LOSS IN CHILDREN WITH SVI AND BLINDNESS.

The anatomical causes are shown in Table 2, and the underlying causes in Table 3. A detailed breakdown in shown in Appendix 1.

Table 3. Anatomical site of abnormality in children with SVI and blindness

Site of	abnormality	*Subtotal*	N	%
Whole globe:	Microphthalmos	*9*	10	*13.7*
	Removed	*1*		
Cornea/phthisis:	Corneal scar	*5*	7	*9.6*
	Phthisis bulbi	*1*		
	Sclerocornea	*1*		
Lens:	Cataract	*3*	9	*12.3*
	Aphakia	*6*		
Uvea:	Uveitis	*3*	3	*4.1*
Retina:	Toxoplasmosis retinitis	*8*	24	*33.0*
	Retinoblastoma	*8*		
	Retinal dystrophy	*4*		
	ROP	*3*		
	Albinism	*1*		
Optic nerve:	Optic atrophy	*10*	12	*16.4*
	Optic nerve hypoplasia	*1*		
	Coloboma	*1*		
Glaucoma:	Glaucoma/buphthalmos	*6*	6	*8.2*
Other:	Cortical blindness	*2*	2	*2.7*
Total:		*73*	**73**	***100***

Table 4. Aetiological categories of visual loss in children with SVI/blindness

Aetiological	category	*Subtotal*	N	%
Hereditary disease:	Autosomal Dominant	*4*	12	16.4
	Autosomal recessive	*2*		
	Cannot specify	*6*		
Intrauterine factor:	Toxoplasmosis	*13*	13	17.8
Perinatal factor:	Retin of prematurity	*3*	3	4.1
Childhood factor:	Measles	*3*	10	13.7
	TB meningitis	*2*		
	Trauma	*1*		
	Other	*4*		
Unknown:	Cataract	*9*	35	48.0
	Glaucoma	*5*		
	Retinoblastoma	*5*		
	Cong. abnormalities	*9*		

4 AVOIDABLE CAUSES OF SVI AND BLINDNESS

Causes amenable to primary prevention have been analysed as well as those that are amenable to secondary and tertiary prevention. The total number of children with avoidable causes is 41 (56%).

Table 4. Avoidable causes of blindness

Preventable causes	N	%	Treatable causes	N	%
Toxoplasmosis	13	17.8	Cataract	9	12.3
Autosomal Dominant disease	4	5.5	Glaucoma	6	8.2
Measles	3	4.1	ROP	3	4.1
TB meningitis	2	2.7			
Trauma	1	1.4			
Total:	**23**	**31.5**	**Total:**	**18**	**24.6**

5 ACTION NEEDED:

The proportion of children needing optical services, and medical or surgical treatment has been determined (Table 5).

Table 5. Action needed

Optical services	N	Treatable causes	N
None	56	None	71
Refraction	8	Medical treatment	2
Spectacles	6	Surgery	0
Low vision devices	10		
Total:	**80***	**Total:**	**73**

* some needed more than one intervention

Optical services were needed by 17 children, and medical treatment in 2 children.

6 PREVENTION CHILDHOOD BLINDNESS IN GUATEMALA

6.1 Toxoplasmosis (13 children):

Congenital toxoplasmosis was the single commonest cause of SVI and blindness in this study. Toxoplasmosis can cause visual impairment as a result of chorioretinitis, optic atrophy, cortical damage (often associated with mental retardation), anterior uveitis, posterior uveitis and secondary cataract. The infection is caused by the organism *Toxoplamsa gondii,* the host animal being the cat. Infection during pregnancy can result in congenital infection in the infant, and the congenital disease is more serious if infection occurs early in pregnancy. There are two approaches to prevention:

Primary prevention: health education regarding risks - i.e. not handling cat litter during pregnancy, washing fruit and vegetables, cooking meat well etc.. As yet there is no effective vaccine.

Secondary prevention: This entails detecting women who *develop* antibodies to toxoplasmosis during pregnancy i.e. they go from being seronegative to seropositive (which signifies recent infection). The therapeutic options then include termination of the pregnancy, or treatment with appropriate medication during pregnancy. Secondary prevention requires facilities for detecting antibodies, for treating infected women, and for monitoring the response to treatment.

6.2 Cataract and glaucoma (15 children):

In most of the children in this study the underlying cause was not known. Secondary and tertiary prevention require early identification of affected infants and children, followed by surgery, correction of aphakia (for children with cataract), and good follow up.

6.3 Autosomal Dominant disease (4 children):

Primary prevention entails genetic counselling, and informing parents of the risk of disease in their offspring (50%), with the option of limiting their family size.

6.4 Retinopathy of prematurity (ROP, 3 children):

Although retinopathy of prematurity only caused blindness in 3 children in this study there is evidence that ROP is becoming a major cause of blindness in South American countries. This is presumably because intensive neonatology units are being established which means that premature infants are now surviving whereas before they would have died. Risk factors for ROP include premature birth, low birth weight, and high levels of oxygen in the blood. The latter occur if supplemental oxygen is used without adequate monitoring of blood oxygen levels. As the condition is potentially preventable, and the early stages of ROP can be effectively treated to prevent blindness there is a need to improve awareness amongst health professionals (paediatricians, neonatologists as well as ophthalmologists) so that control measures can be introduced.

Primary prevention:

Secondary prevention:
Screening by ophthalmologists of premature babies at risk (i.e. those weighing less than 1,500 gms at birth and/or born before 32 weeks gestation) in order to detect treatable disease i.e. "threshold disease" (Stage III "plus" disease affecting 5 or more continuous clock hours or 8 or more non-contiguous clock hours) followed by laser of cryotherapy to the avascular retinal periphery. Screening should start 6-7 weeks after birth. Secondary prevention requires a motivated and skilled ophthalmologist as well as equipment for treating threshold disease.

Tertiary prevention:
Complex vitreoretinal surgery, while it can reattach retinal detachments (Stage IV and V) has essentially been shown to be ineffective at restoring function.

APPENDIX 1

All CAUSES OF SEVERE VISUAL IMPAIRMENT AND BLINDNESS BY ANATOMICAL SITE OF ABNORMALITY

	Heredit	Intraut	Perinat	Childhd	Unknown	Subtotal	Total
Anophthalmos							
Microphthalmos	3				6	9	
Removed				1		1	
Disorganised							
Other							
							Globe: 10
Buphthalmos					2	2	
Glaucoma	1				3	4	
							Glaucoma: 6
Phthisis				1		1	
Staphyloma							
Scar				4	1	5	
Keratoconus							
Dystrophy							
Other					1	1	
							Cornea/phth 7
Cataract					3	3	
Aphakia					6	6	
Other							
							Lens: 9
Aniridia							
Coloboma							
Uveitis		3					
Other							
							Uvea: 3
Dystrophy	3				1	4	
Albinism	1					1	
ROP			3			3	
Retinoblastoma	3				5	8	
Other		8				8	
							Retina: 24
Atrophy	1	2		4	3	10	
Hypoplasia					1	1	
Other					1	1	
							Optic nerve: 12
Refractive							
Amblyopia							
Cortical						2	
Nystagmus							
Normal vision							
							Other: 2
Not examined							
Other, not listed							
TOTAL:	**12**	**13**	**3**	**10**	**35**	**73**	**73**

INTERNATIONAL CENTRE FOR EYE HEALTH

INTERNATIONAL CENTRE FOR EYE HEALTH

(Department of Preventive Ophthalmology)

INSTITUTE OF OPHTHALMOLOGY
UNIVERSITY COLLEGE LONDON
Associated with Moorfields Eye Hospital NHS Trust

UCL

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FAX TO: **Ellen Parietti,**
Program Officer, IEF
001 301 986 1876

FROM: **Clare Gilbert**
0171 250 3207
E-mail: smheceg@ucl.ac.uk

DATE: **23.5.96**
PAGES: 9

Dear Ellen,

Here is the Guatemala data and report. I am sorry it has taken so long to get it to you - the member of staff who said that she would help with data entry went away for a month before tackling it. I therefore set too and did it all myself.

Please let me know if you require any further analyses.

Kind regards,

Clare

Clare Gilbert

ATTACHMENT K

ASSESSMENT OF GUATEMALA BLIND SCHOOL SURVEY DATA

FUNDACION INTERNACIONAL DEL OJO
17 Avenida 5-39, Zona 14
Tel/Fax: (502-2) 637422

T E L E F A X

páginas: 1

A: ELLEN PARIETTI

DE: ORLANDO OLIVA

ASUNTO: ENCUENSTA EN ESCUELA DE CIEGOS

FECHA: 25/JUNIO/96

Ellen, con respecto a los resultados de la encuesta de ciegos, mi opinión personal es que algunos de los datos no son del todo confiables debido a que cuando yo revisé todos los formularios de los niños evaluados, detecté que faltaban algunos datos en varias encuestas y los llené debido a que tengo conocimientos en oftalmología y otros sinceramente por lógica.

Con respecto a Khosla, te cuento que hablé con el representante de ella acá y me dijo que va a ver que puede hacer, está un poco molesto con ella porque ha estado vendiendo equipo a otras personas de Guatemala y no lo ha tomado en cuenta para ello.

Atentamente.

ATTACHMENT L

"INFORME DE RESULTADOS DE EVALUACION DE AGUDEZA VISUAL DE LOS NINOS DE PRIMER GRADO DE LAS ESCUELAS CON AULA RECURSO EDUCACION ESPECIAL."

INFORME DE RESULTADOS DE EVALUACION DE AGUDEZA VISUAL DE LOS NIÑOS DE PRIMER GRADO DE LAS ESCUELAS CON AULA RECURSO EDUCACION ESPECIAL

Para: Dr. Raúl Gómez
Srita. Ellen Parietti

De: Dra. Marylena Arita

Fecha y Lugar: Tegucigalpa, 30 de abril de 1996.

I. ANTECEDENTES

En el año de 1995, la Sección de Educación Especial del Ministerio de Educación, solicita a Fundación Internacional de Ojos apoyo técnico y financiero para llevar a cabo la formación técnica de 166 Maestros de Educación Especial que laboran en las Aulas Recurso del Ministerio de Salud de todo el país.

Es así como el 25 de marzo de ese año se inicia la capacitacion de estos maestros, seleccionando como lugares sede para efectuar esta actividad las ciudades de : Comayagua, Depto de Comayagua; Catacamas, Depto de Olancho y San Pedro Sula, Depto de Cortés.

Posteriormente, estos maestros de aula recurso, realizaron un efecto multiplicador capacitando maestros de primer grado de todos los departamentos del país, exceptuando Islas de la Bahía y Gracias a Dios.

El total de maestros despues de recibir la capacitación en cada una de las sedes procedió a realizar la evaluación de agudeza visual a los niños de primer grado de sus escuelas.

II. Meta:

Llegar a 15,840 niños de primer grado de todo el país.

III. Instituciones participantes:

a. Fundación Internacional de Ojos
b. Sección de Educación Especial del Ministerio de Educación
c. Comité Nacional de Prevención de la Ceguera

IV. Estrategia de trabajo:

Cada maestro debería de entregar su hoja de reporte de niños evaluados al Supervisor de su Area y este a la División de Educación Especial del Ministerio de Educación.

Cada maestro debería de buscar primero las alternativas de atención dentro de su aula; comunicar a los padres de familia del problema, darle una referencia apropiada en cada caso a una institución de salud.

V: Compromiso de FIO y Ministerio de Educación:

1. En coordinación con la Sección de Educación Especial dar seguimiento al proceso de capacitación.

2. Buscar alternativas para capacitar al mayor número de docentes a través de una tecnología apropiada

3. Gestionar brigadas oftalmológicas de apoyo a la problemática detectada en los diferentes departamentos, a través del Comité de Prevención de la Ceguera.

4. Editar y divulgar la memoria del proceso de capacitación ante las autoridades y organismos correspondientes.

Vl. Logros

a. Capacitación:

Se capacitó en toma de agudeza visual un total de 185 maestros de Primer Grado que representa mas de la meta propuesta (169 maestros)

Los maestros capacitados realizaron un efecto multiplicador, capacitando 664 maestros de primer grado de todo el país.

b. Toma de Agudeza Visual:

Hasta el momento de este informe se reportó un total de 6291 niños evaluados de 106 escuelas (Ver anexo 1 al 5)del país distribuidos en así:

b.1 1041 en el Departamento de Francisco Morazán
b.2 3570 en el Departamento de Ocotepeque
b.3 675 en el Departamento de Cortés
b.4 99 en el Departamento de Santa Bárbara
b.5 906 en el Departamento de Olancho.

De este total de niño se encontró el siguiente resultado de la toma de agudeza visual (se tomó como parámetro la selección del ojo con agudeza visual mas pobre.

Se obtuvieron los siguientes resultados:

Visión 20/20	=	4849
Visión 20/30	=	862
Visión 20/40	=	380
Visión 20/50	=	102
Visión 20/60	=	19
visión 20/70	=	67
Visión 20/80	=	12
Total de AV tomadas	=	6291

Los departamentos que presentan mayores problemas de agudeza visual de acuerdo a número de casos son:

1. Ocotepeque tiene 518 niños con visión > 20/30
2. Olancho tiene 337 niños con visión > 20/30
3. Cortés tiene 327 niños con visión > 20/30
4. Francico Morazán tiene 260 niños con visión >20/30

Al analizar estos datos es necesario tomar en cuenta los siguientes aspectos:

1. Cada uno de los Departamentos analizados no realizó un número similar de niños Ejm.

El Departamento de Ocotepeque fué el que mas escuelas evaluó (3570 niños de 81 escuelas)por lo tanto tenía mas posibilidades de encontrar mas casos anormales.

El Departamento de Santa Barbara solo presentó datos de una sola escuela (99 niños) y todos tuvieron agudeza visual 20/20. Aunque solo se evaluaron noventa y nueve niños se esperaba encontrar alguna alteración. Quizás se deba a fallas en la toma de agudeza visual.

V. Limitantes:

1. El Ministerio de Educación no realizó monitoreo ni supervisión durante las evaluaciones de agudeza visual por razones de presupuesto.

2. Tiempo muy limitado de capacitación.

3. Escaso recurso humano para codificar toda la información por parte del Departamento de Informática del Ministerio de Educación.

4. Limitada capacidad del Ministerio de Salud para dar respuesta a las referencias. Honduras cuenta con número insuficiente de oftalmólogos para atender todo el país.

5. La mayoría de padres de familia son de recursos muy limitados. Esto en la mayoría de los casos impide que puedan viajar hasta un sitio donde se encuentre personal especializado.

VI. Conclusiones

1. Aún cuando la Sección de Educación Especial del Ministerio de Salud refiere que se recibieron informes de todo el país; solo llegó a nuestras manos un 25% para ser codificado.

2. No podemos asegurar la calidad de los datos expuestos en este informe porque ninguna de las tomas de agudeza visual fué supervisada.

3. Muchas de las escuelas enviaron la información, sin embargo, no todas hicieron uso del formato sugerido, a pesar de que se les enseño la forma de llenado.

4. Hubo una excelente coordinación con oftalmólogos del Comité y otros oftalmólogos tanto del Hospital San Felipe como privados así como también cona las maestras de la Sección de Educación Especial del Ministerio de Educación.

5. Esta es una buena experiencia piloto que nos dejará muchas enseñanzas para el desarrollo de futuras actividades de salud ocular.

6. Hay bastante interés por parte del Comité Nacional de Prevención de la Ceguera para realizar todas las gestiones que sean necesarias para organizar algunas brigadas de atención oftalmológica a los sitios sede.

6. Revisión del sistema de capacitación a través de "EFecto Multiplicador" , ya que este tipo de metodología exige no solo una normatización de procedimientos y contenidos sino también la capacitación del recurso humano en la transmision de dichos contenidos así como también una supervisión y monitoreo cuidadoso durante la marcha.

Anexo # 1

NUMERO DE NIÑOS EVALUADOS POR ESCUELA EN CADA DEPARTAMENTO

Departamento de Cortes	Número de Niñosevaluados	Porcentaje
1. Escuela 15 de Septiembre	34	5%
2. Escuela 15 de Septiembre 1821	103	15%
3. Escuela Gabriela Mistral	35	5%
4. Guía Técnica #3 Fco. Morazán	85	12.6%
5. Escuela Leopoldo Aguilar	140	21%
6. Esc. Lila Luz de Maradiaga	278	41.2
	675	100%
Departamento de Olancho		
1. Escuela Felícita Navarro	183	20%
2. Escuela Juan J. Castro	100	11
3. Escuela Manuel Garay Cortés	53	6%
4. Escuela Miguel Morazán	215	23.7
5. Escuela Policarpo Melara	35	3.9
6. Escuela Ramón Villeda Morales	177	19.5
7. Escuela Ramona Tejeda	48	5.3
8. Esc. Rosa Luisa de Ochoa	95	10.5
Total	906	100%

Anexo # 2

Nombre de la Escuela Departamento de Fco. Morazán	Número de niños evaluados	%
1. Escuela Centroamericana	181	17.4
2. Esc.Ensayo Dionisio Herrera	1	0.1
3. Escuela Dr. Esteban Mendoza	56	5.4
4. Jardín de Niños Chema	59	5.7
5. Esc. José Cecilio del Valle	83	8.0
6. Escuela Las Américas	202	19.4
7. Escuela Las Cañadas	41	3.9
8. Escuela Los Angeles	12	1.2
9. Es. Oswaldo López Arellano	57	5.5
10.Escuela República de Paraguay	349	33.5
Escuelas del Departamento Santa Barbara		
1. Escuela Francisco Morazán	99	100%
Escuelas del Departamento de Ocotepeque		
1. Escuela 3 de Octubre	36	1.0
2. Escuela Alberto Flores	18	0.5
3. Alvaro Contreras	100	2.8
4. Escuela Candido Mejía	94	2.6
5. Escuela Carlos Hartling	31	0.9
6. Escuela Carlos Hartling2	40	1.1.
7. Esc. Carlos Manuel Arita	27	0.8

Anexo # 3

Continuacion del cuadro de Escuelas de Departamento de Ocotepeque.....

Nombre de la Escuela	N de niños evaluados	%
8. Escuela Cristobal Colón	3	0.1
9. Escuela Cristobal de Olid	12	0.3
10. Escuela Danilo Carbajal Molina	13	0.4
11. Escuela Dionisio de Herrera	37	1.0
12. Escuela Francisco Valle Mayorga	20	0.6
13. Escuela Guillermo López Rodezno	8	0.2
14. Escuela Dr. Juan Lindo	86	2.4
15. Escuela Dr. Juan Manuel Gálvez	19	0.5
16. Escuela Juan Manuel Lindo	1	0
17. Escuela Dr. Miguel Paz Barahona	18	0.5
18. Escuela Dr. Prudencio Arita	46	1.3
19. Escuela Ramón Rosa	38	1.1
20. Escuela Salvador Corleto	27	0.8
21. Escuela Virgili Rodezno	90	2.5
22. Escuela El Adelanto	74	2.1
23. Escuela Enrique Villeda	8	0.2
24. Escuela Ernesto Mejía Fuentes	32	0.9
25. Escuela Francisco Morazán	3	0.1
26. Escuela Eugenio Matute	22	0.6
27. Escuela Eusebio Ventura Quezada	130	3.6
28. Escuela Evangelica Amigos	21	0.6
29. Escuela Francisco Morazán	607	17
30. Escuela Froilán Turcios	29	0.8
31. Escuela Humberto Regalado Hernandez	41	1.1

Anexo 4

Cont... Escuela Departamento Ocotepeque

Nombre de la Escuela	N de niños evaluados	%
32. Escuela Policarpo Paz G	20	0.6
33. Escuela Guillermo Ayes	4	0.1
34. Gustavo Zúniga Andrades	13	0.4
35. Esc. Herlinda Cardona	16	0.4
36. Esc. Humberto Regalado H.2	56	1.6
37. Esc. Jorge Humberto Arita	32	0.9
38. Escuela José Arturo Duarte	52	1.5
39. Esc. José Cecilio del Valle	295	8.3
40. Escuela José Rubén Sosa	33	0.9
41. Escuela José Trinidad Caba-ñas	229	6.4
42. Escuela José Trinidad Reyes	192	1.4
43. Esc. Juan Alberto Melgar	47	1.3
44. Juan José Flores	12	0.3
45. Escuela Juan Lindo	18	0.5
46. Escuela Juan Manuel España	30	0.8
47. Escuela Juan Manuel Mejía	17	0.5
48. Escuela Lauro Carranza P.	54	1.5
49. Escuela Lempira	42	1.2
50. Escuela Josefina Gamero	12	0.3
51. Escuela Luis Landa	6	0.2
52. Esc. Manuel Antonio Mejía	12	0.3
53. Escuela Manuel Bonilla	57	1.6
54. Escuela Manuel Fernández	4	0.1
55. Esc. Manuel Gonzales Pinto	20	0.6
56. Escuela Miguel A. Cruz	5	0.1
57. Esc. Miguel Paz Barahona	29	0.8

RESULTADOS DE AGUDEZA VISUAL DE LOS NIÑOS DE PRIMER GRADO

ESCUELAS DEL DEPARTAMENTO DE CORTES

AGUDEZA VISUAL	N	%
20/30	230	70.3
20/40	50	85.6
20/50	33	95.7
20/60	1	96.
20/70	13	4
	327	100

Resultados de Agudeza Visual de los Niños
de las Escuelas del Departamento de Olancho

Agudeza Visual	N	%
20/30	141	41.8
20/40	168	49.9
20/50	15	4.5
20/60	2	0.6
20/70	11	3.3
Total de niños evaluados	337	100

Resultados de Agudeza Visual de los Niños
de las Escuelas del Departamento de Ocotepeque

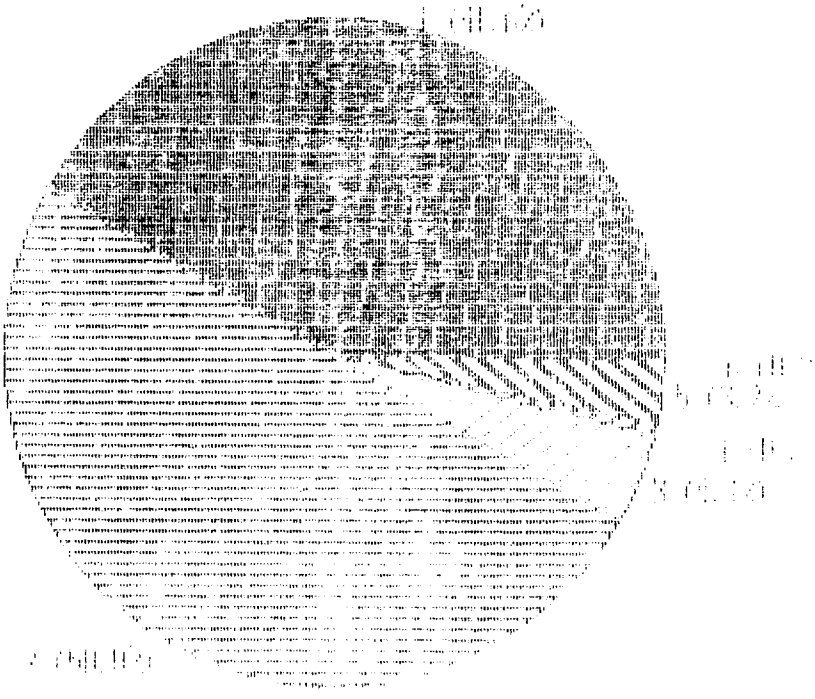
Agudeza Visual	N	%
20/30	363	70
20/40	96	18.5
20/50	22	4.2
20/60	15	2.9
20/70	12	2.3
20/80	10	1.9
Total de niños evaluados	518	100

Resultados de Agudeza Visual de los Niños
de las Escuelas del Departamento de Francisco Morazán

Agudeza Visual	N	%
20/30	128	49.2
20/40	66	25.4
20/50	32	12.3
20/60	1	0.4
20/70	31	11.9
20/80	2	0.8
Total de niños evaluados	260	100

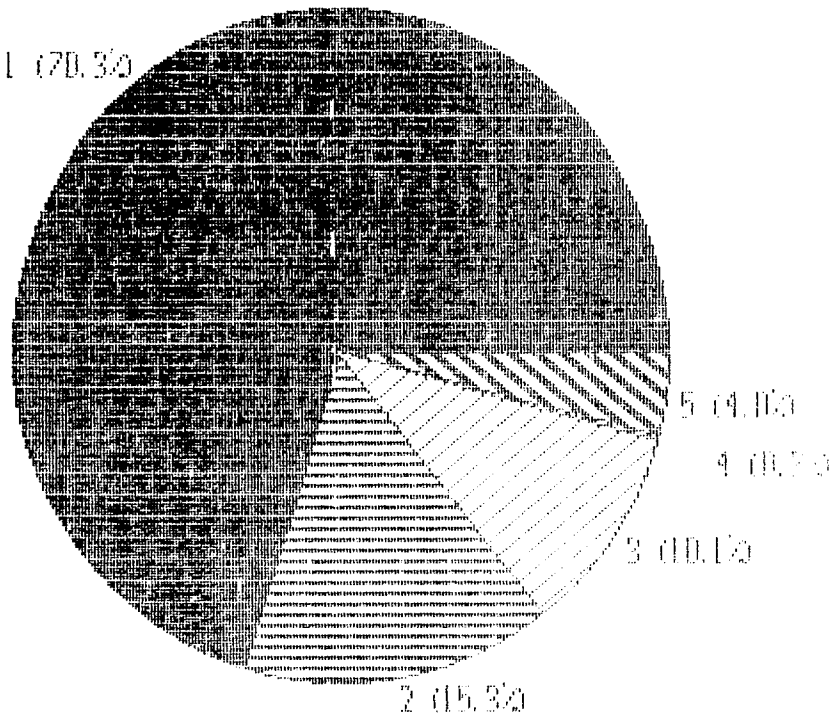
Nota: Los niños evaluados en la escuela del Departamento de Santa Bárbara todos fueron reportados con visión 20/20 (99 niños).

Grafico de Resultados de Evaluacion de
Agudeza Visual de Escuelas del
Olancho



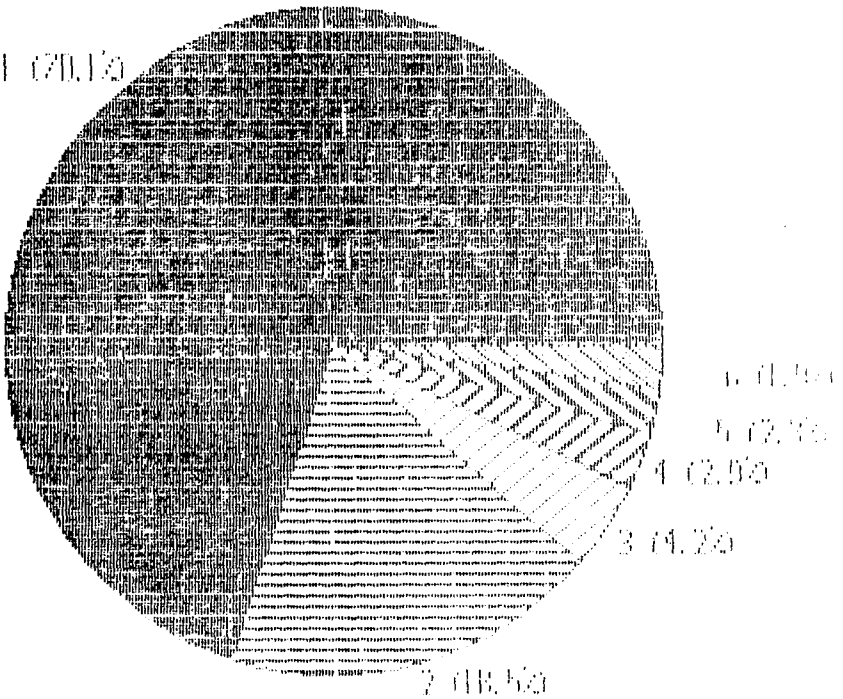
uno=30/20
dos=40/20
tres=60/20
cuatro=60/20
cinco=70/20
seis=80/20

Grafico de Evaluacion de Agudeza Visual
Escuelas del Depto de Cortes



uno =30/20
dos =40/20
tres=50/20
Cuatro=70/20
Cuatro=60/20
cinco=70/20
seis=80/20

Resultados de Evaluacion de [illegible]
Departamento Ocotepeque



ATTACHMENT M

INFORME SOBRE LOS ADVANCES DE ACTIVIDADES DEL COMITE NACIONAL DE LA PREVENCION DE CEGUERA

PARA: Dr. Raúl Gómez
Ellen Parietti

DE: Marylena Arita

Fecha: 25 de junio de 1996.

Asunto: Avances de actividades del Comité Nacional de Prevención de la Ceguera.

A. Avances de la brigada canadiense que esta trabajando en Honduras a solicitud del Comité de Prevención de Ceguera.

Adjunto encontrará la planificación de la visita al país de la brigada canadiense que esta integrada por los siguientes estudiantes de optometría y su profesor, provenientes de la Universidad de Montreal :

1. Pascal Michaud
2. Pascal Lebrun
3. Marie Claude Barrette
4. Manon Thibaooeau
5. Erick Jalbert
6. Dr. Daniels

Trabajo realizado (de acuerdo a agenda)

Lunes 17 de junio

1. Comunidad: Col. San Francisco

Total de personas refractadas: 71

Martes 18 de julio

2. Comunidad: Escuela Oswaldo López Arellano

Total de niños refractados 29
Total de adultos refractados de diferentes zonas marginadas. 6

Miercoles 19 de junio

3. Comunidad: Tres de Mayo

Total de adultos refractados 97

lentes entregados 55

jueves 20 de junio

4. Comunidad: Villa Cristina

Total de adultos refractados 35

lentes entregados 25

Viernes 21 de junio

5. Comunidad: Escuela Paraguay

Total de niños refractados 55
Lentes entregaados : 8

Total de adultos refractados: 18
Lentes entregados:

6. **Lunes 24 de junio**

Comunidad: Las Crucitas

Total de adultos atendidos: 67
Lentes entregados : 19

Patologías referidas al Hospital San Felípe para ser atendidas por Dra. Doris Alvarado en el Hospital San Felípe y otros oftalmólogos de RESPACK.

1.	Catarátas	38
2.	Pterigión	20
3.	Pinguécula	1
4.	Esotropía OD	2
5.	Degeneración macular	1
6.	Atrofia macular	1
7.	Estrabismo mas ambliopía	1
8.	Estrabismo	1

La brigada el día de hoy esta trabajando en la Escuela Alvaro Contreras donde estará atendiendo niños y adultos.

Los días restantes estaran atendiendo personas de las Colonías marginadas de Los Pinos, otras áreas de la Col. San Francisco y Col. Alemania.

El último día se hará un coctel de despedida donde se invitarán a representantes de Banca, empresa privada , CLub y otras organizaciones donantes como UNICEF.

Los niños estan siendo atendidos en forma gratuita.

Los adultos se les practica su exámen sin costo alguno y si necesita lentes se les pide una contribución simbólica que no pase de L 10. 00 (1/4 de dolar) para cubrir las personas que no pueden pagar esta contribución y como parte de la contribución comunitaria para esta brigada. También cada una de las comunidades esta brindando el local, mobiliario y luz eléctrica en forma gratuita. El Ministerio de Educación esta colaborando con un motorista y un busito para uso de la brigada las 24 horas del día durante estos quince días.

Al finalizar esta actividad se dará un informe financiero y de logros a cada una de las instituciones donantes y se hará un agradecimiento público por el periódico.

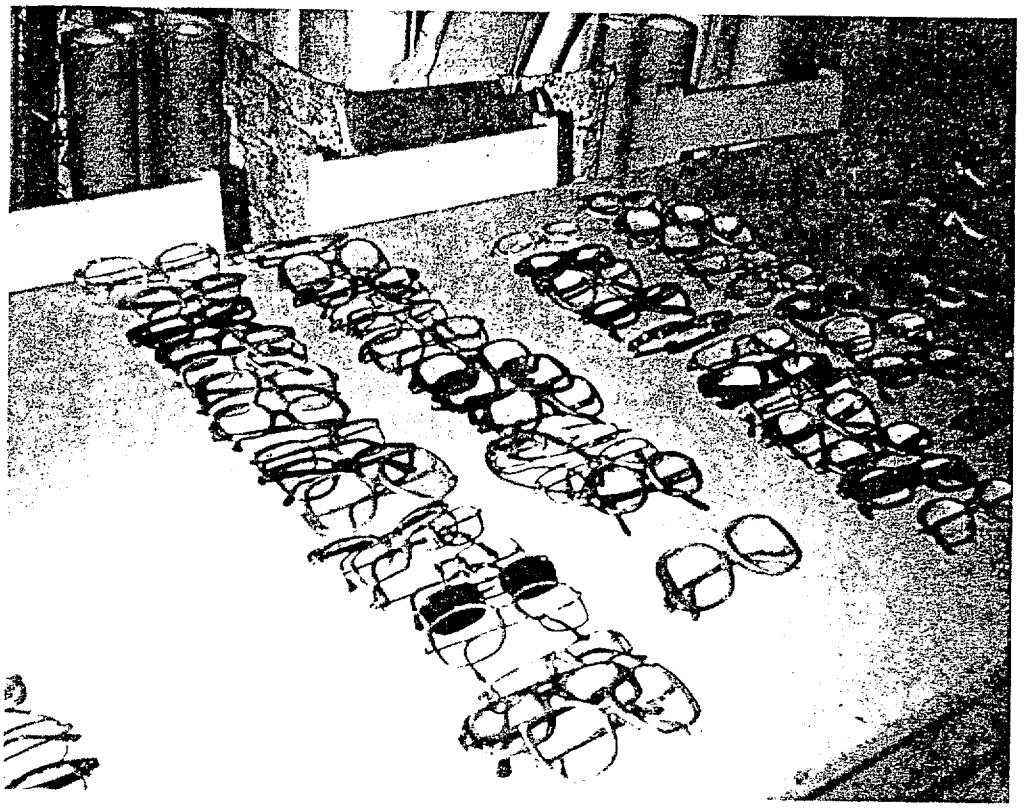
En el coctel de despedida se entregarán pergaminos a cada una de las instituciones y donantes particulares.

CRONOGRAMA DE TRABAJO BRIGADA DE OPTOMETRISTAS DE LA UNIVERSIDAD DE MONTREAL CANADA.

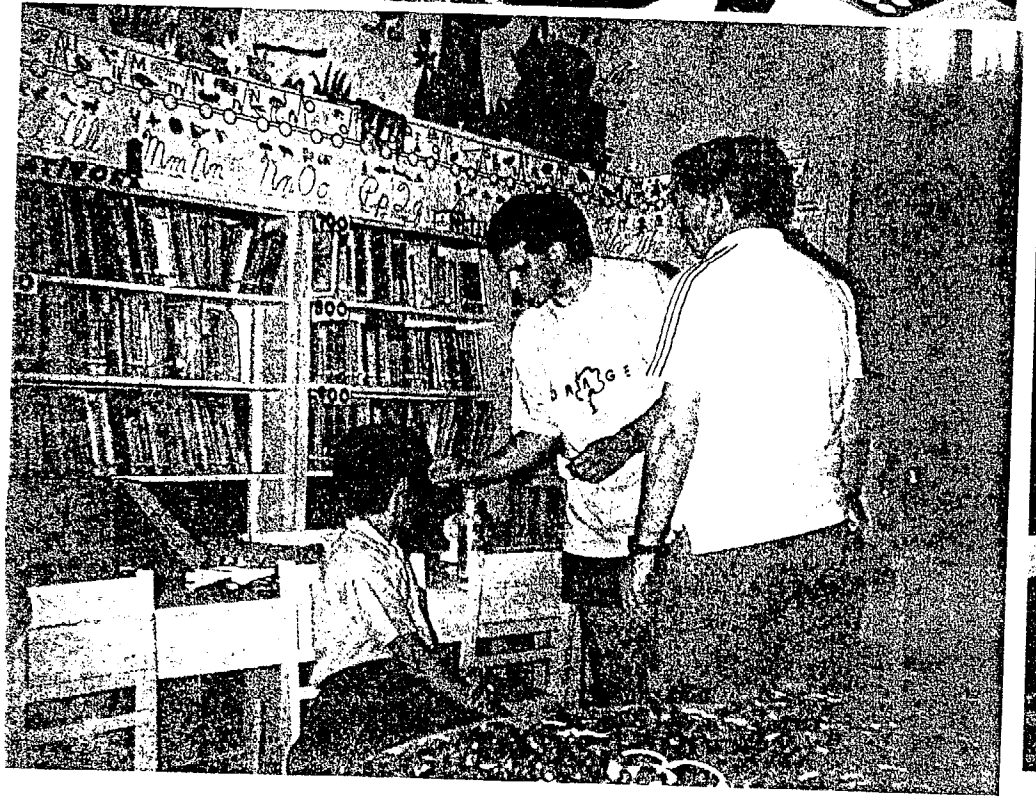
17-30 de Junio de 1996

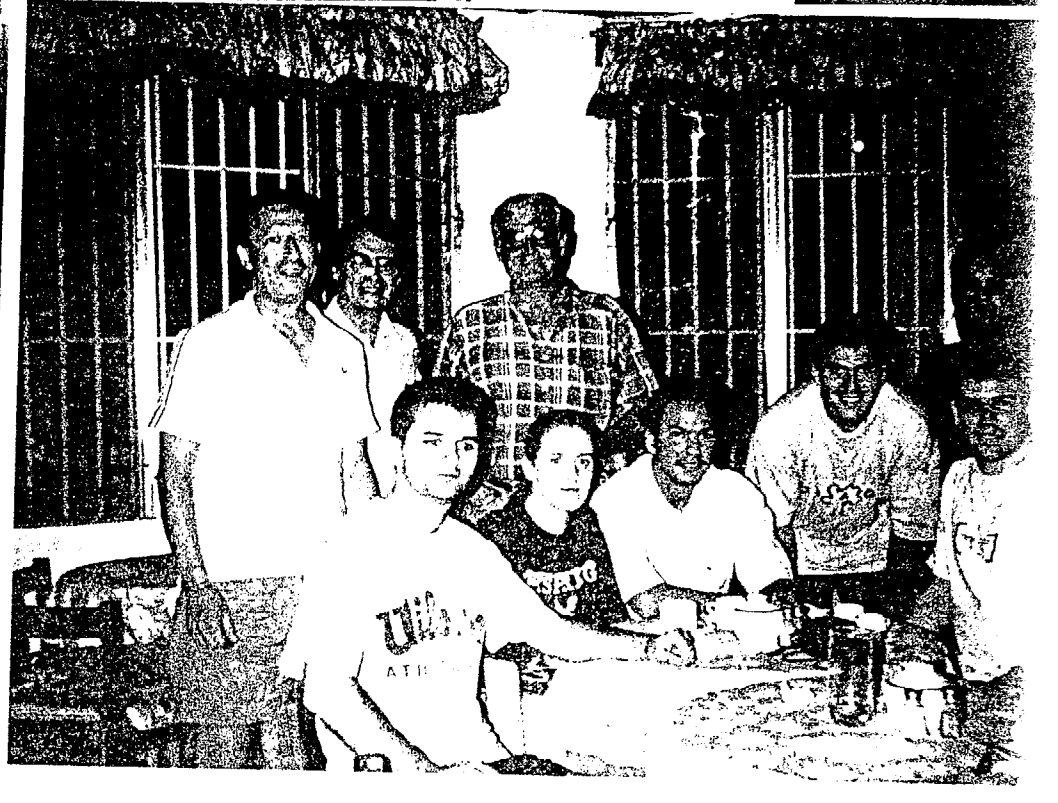
Número	Fecha	Comunidad	Local	Número de personas
1	17/06/06	San Francisco	Guarderia Ministerio Trabajo	60 personas preferible mente adultas
2	18/06/96	Varías Escuelas	Francisca Reyes	80 niños
3	19/06/96	3 de Mayo	Módulo de la Junta Nacional de Bienestar Social	60 adultos y niños
4	20/06/96	Col. Villa Cristina	Escuela	60 niños y adultos
5	21/06/96	Varías Escuelas	Escuela Estados Unidos	80 niños
6	22/06/96	La Tigra	Finca en Transforma-ción	8-10am. adultos y niños sin filtrar
7	24/06/96	~~Virila Adela~~ CUETAC	Centro de Salud	Adultos
8	25/06/96	varías Esuelas	Escuela Alvaro Contreras	80 niños
9	26/06/96	Flor del Campo ylas Torres	Centro Comunal	60 adultos y niños
10	27/06/96s	Los Pinos	Escuela Herman Herrera	Adultos y más niños
11	28/06/96	Col. Alemán	La UNCIH	Adultos y niños

Obs. Cada institución participante del Comité de Prevención de la Ceguera se hará responsable del éxito y coordinación de las pre-brigadas y brigadasde acuerdo a lazona de influenciaseleccionada.




ECHEVERRI





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AGENDA DE ACTIVIDADES

BRIGADA DE LA UNIVERSIDAD DE MONTREAL

DIA DOMINGO 16 DE JUNIO

RESPONSABLE : TODO EL COMITE

Recibimiento en el Aeropuerto de Toncontín Traductores : Licda María Luisa Zaldivar Dr. Gustavo Avila Srita. Gracia Risso	11:50 a.m.
Alojamiento de la brigada	1:00 p.m.
Almuerzo	1:30 p.m.
Sesión de coordinación (Oficinas de FIO) Traductores : Srita Magda Risso	3:00 p.m.
Libre	4:00 p.m.
Cena (Todo el Comité) Traductores: Srita Risso	8:00 p.m.

LUNES 17 DE JUNIO DE 1996.

Responsable : Dra. Marylena Arita

TRADUCTORES Recoger Srita Georgina Risso Srita Gracia Risso	6:30 a.m.
Desayuno en **SUPER DONAS** Responsable: Dra. Arita.	7:00 a.m.
Recoger Equipo en FIO	
Traslado a la Guardería del Ministerio del Trabajo. Col San Francisco (Responsable : FIO/ INFRACNOVI	8:00 a.m.
Inicio de trabajo	8:30 a.m.
Llevar meriendas Dra. Arita	10:00 a.m.
Oficinas de FIO (Dejar equipo)	1:00 p.m.
Traslado al Hotel	1:00 p.m.
Almuerzo Chomi's (CORTESIA)1	2:00p.m.
Paseo por la ciudad Resposable: Licda. Betulia Cárcamo Ministerio de Educación	3:00 p.m.
- Parque Central - Catedral - Museo - iglesias	
Merienda café PARADIZO	
- Parque la Leona	
Traslado al hotel	6:00 p.m.
CENA Restaurante Chino	7:00 p.m.

(Dra. Alvarado)
(Dra. Arita)

MARTES 18 DE JUNIO

RESPONSABLE DE BRIGADA: LICDA. BETULIA CARCAMO

Traductores:

Recoger Licda Zaldivar Traductora 6:30 a.m.
Srita Gracia Risso

Desayuno en SUPER DONAS 7:00 a.m.
Responsable: Dra. Arita.

Recoger Equipo en FIO

Traslado a Escuela Francisca Reyes 8:30 a.m.

Meriendas 10:00 a.m.
Dra. Arita

Dejar equipo en FIO 1:00 p.m.

Traslado al sitio de alojamiento

Almuerzo :Restaurante Jack's (CORTESIA)1 2:00 p.m.

Traductores: Srita Risso
Licda. Zaldivar

Visita a la Basilica de Suyapa y Aldea 3:00 p.m.

libre

CENA: Restaurante D,BARROS (Cortesía) 7:00

Responsable: Sr. Alejandro Contreras
(UNCIH)

MIERCOLES 19

Responsable: Dra. Hadizabel Burgos
Dra. Doris Alvarado
Traductores:

Recoger Licda Zaldivar Traductora 6:30 a.m.
Srita Magda Risso

Desayuno en **SUPER DONAS** 7:00 a.m.

Recoger Equipo en FIO

Traslado al CESAMO 3 de Mayo 8:00 p.m.

Merienda

Dejar equipo FIO 1:00 p.m.

traslado al Hotel

Almuerzo en TACO BELL (Cortesía)1 2:00 p.m.

Uso del Club

CENA en el club.

JUEVES 20 de junio

RESPONSABLE: Dra. HADIZABEL Burgos
Union Nacional de Ciegos

Recoger Dr. AVILA 6:30 a.m.
Srita Magda Risso

Desayuno en **SUPER DONAS** 7:00 a.m.

Recoger Equipo en FIO

[illegible] 8:00 a.m.

merienda 10:00 a.m.

Dejar equipo y traslado al hotel 1:00 p.m.

Almuerzo: CHOMI's (cortesía)2 2:00 p.m.

Visita a Centros Comerciales 3:00 p.m.

CENA Pizza Hot 7:00 p.m.

VIERNES 21 DE JUNIO

RESPONSABLE **Licda Betulia Carcamo**

Recoger Licda Zaldivar Traductora 6:30 a.m.
Srita Gracia Risso

Desayuno en **SUPER DONAS** 7:00 a.m.

Recoger Equipo en FIO

Traslado a Escuela Estados Unidos 8:00 a.m.

merienda 10:00 a.m.

Dejar equipo y traslado al hotel 1:00 p.m.

Almuerzo: Taco Bell (Cortesía) 200
p.m.

libre

Cena Restaaurante TACO TACO 7:00 p.m

SABADO 22 DE JUNIO

RESPONSABLE **Licda Hadizabel Burgos**
Dr. Mario León Gómez

Recoger Licda Zaldivar Traductora 6:30 a.m.
Srita Gracia Risso
Srita Magda Risso

Desayuno en SUPER DONAS 7:00 a.m.

Traslado a la Tigra 8:00 p.m.

Dejar equipo en INFRACNOVI 4:00 p.m.

Recoger Traductores

Salida a "PLAYA LAS GAVIOTAS" 4:30 p.m.
Traductores: Srita. Tania Pineda
Licda Zaldivar

DOMINGO 23 DE JUNIO

Responsable: Dra. Hadizabel Burgo
Dr. Mario León Gomez

PLAYA Las Gaviotas

(libre)

LUNES 24 DE JUNIO

Responsable : Dra. Doris Alvarado

Recoger Licda Zaldivar Traductora 6:30 a.m.
Srita Gracia Risso
Desayuno en SUPER DONAS 7:00 a.m.
Responsable: Dra. Arita.

Recoger Equipo en FIO

Traslado a Las Crucitas 8:30 a.m.

Responsable de la Brigada: Dra. Marylena Arita
Dr. Edmundo Osorno

Meriendas 10:00 a.m.
Dra. Arita

Dejar equipo en FIO 1:00 p.m.

Traslado al sitio de alojamiento

Almuerzo: (Valle de Angeles) 2:00 p.m.

3:00 p.m.

CENA Burger King 7:00 p.m.

MARTES 25 DE JUNIO

Recoger Licda Zaldivar Traductora 6:30 a.m.
Srita Gracia Risso
Desayuno en **SUPER DONAS** 7:00 a.m.

Responsable: Licda. Betulia Cárcamo

Recoger Equipo en FIO

Traslado a La Escuela Alvaro Contreras 8;00 p.m.

Meriendas 10:00 a.m.

Dejar equipo en FIO 1:00 p.m.

Traslado al sitio de alojamiento

Almuerzo: Club del Banco Centroamericano 2:00pm

Libre, club

Cena: Club 8:00 p.m.

MIERCOLES 26 DE JUNIO

Recoger Licda Zaldivar Traductora 6:30 a.m.
Srita Gracia Risso
Desayuno en **SUPER DONAS** 7:00 a.m.

Responsable: Dra. Arita

Recoger Equipo en FIO

Traslado a CESAMO San Francisco 8;00 p.m.

Meriendas 10:00 a.m.

Dejar equipo en FIO 1:00 p.m.

Traslado al sitio de alojamiento

Almuerzo : Wendy's

Resto del día libre

JUEVES 27 DE JUNIO

Recoger Srita Magda Risso 6:30 a.m.
Srita Gracia Risso
Desayuno en **SUPER DONAS** 7:00 a.m.

Responsable: Dra. Hadizabel Burgos
Dr. Edmundo Osorno

Recoger Equipo en FIO

Traslado a Los Pinos 8;00

Meriendas 10:00 a.m.

Dejar equipo en FIO 1:00 p.m.

Traslado al sitio de alojamiento

Almuerzo: 2:00pm

CENA: JAck's (Cortesía)

VIERNES 28 DE JUNIO

Recoger Licda Zaldivar Traductora 6:30 a.m.
Srita Gracia Risso

Desayuno en SUPER [illegible]

Responsable: UNCIH
Ing. Jimmy Daccaret
Dr. Gustavo Avila
Dra. Doris Alvarado

Recoger Equipo en FIO ____

Traslado a Colonia Alemania
8;00

Meriendas 10:00 a.m.

Traslado al sitio de alojamiento

Almuerzo: Burger King

CENA: DESPEDIDA

Responsable: TODO EL COMITE

*****

LA PRIMERA SEMANA DE MERIENDAS ESTARA CUBIERTA POR REPOSTERIA EL HOGAR

draft

AYUDA MEMORIA

11 de junio 1996
Inicio 7:p.m.
Cierre: 10:00 p.m.

AGENDA

1. Visita del Sr. Wayne Cannon (Help The World See)
   Consultor para OPS.

Asistencia:

1. Dr. Edgardo Navarrete (Hospital San Felipe)
2. Dr. Gustavo Avila. (Ministerio de Salud)
3. Dra. Marylena Arita (Fundación Internacional de Ojos)
4. Dra. Doris Alvarado (Hospital San Felipe)
5. Ing. Jimmy Dacarett (Club Rotario de Tegucigalpa)
6. Dr. Mario León Gómez (Médico Oftalmólogo Privado)
7. Dra. Hadizabel Burgos (Instituto Franciscano del No Vidente)
8. Dr. Raúl Gómez (Fundación Internacional de Ojos)
9. Sr. Alejandro Contreras (Unión Nacional de Ciegos)
10. Dr. Edmundo Osorno (Vision Mundial, Honduras)

Desarrollo

El día 10 de junio de 1996 , en las instalaciones de Fundación Internacional de Ojos tuvo lugar una sesión extraordinaria del Comité Nacional de Prevención de la Ceguera , durante la cual se contó con la visita del Sr.Wayne Cannon,de la ONG,Help The World See.

El Dr. Wayne, hizo su práctic privada en Zonoma, California y desde hace diez añós se interesó en trabajos relacionados con la prevención. Hay una gran variedad de servicios de oftalmología que abarcan adultos y niños. La mayor necesidad es la atención primaria de salud ocular. Toda persona necesitará lentes en algun momento de su vida. Por todo esto el decidió trabajr con prevención de la ceguera en países en desarrollo

En estos países encontramos dos problemas:

1. No hay suficientes médicos oftalmólogos para el área rural

2. El mayor problema es el costo de los servicios.

Hay una piramide economica: la base es lo que no tiene nada los que tiene my poco y los que tienen mucho y buscan atención privada.

Dentro de esta piramide hay un grupo intermedio que puede pagar algo. Este grupo intermedio y el de base no tienen dinero para pagar un servicio privado, excepto por la ayuda que viene del gobierno , o de los rotario , o de los leones.Para ayudar a esta gente se necesita dinero y el gobierno tiene algo pero no es suficiente.

En nuestro concepto, para encontrar este dinero se han creado las clínicas que provean servcicios de atención a un costo muy bajo que proporcione servicios a la población intermedia de la piramide a un bajo costo y de esa manera , si hacemos un buen trabajo y tenemos una buena administración, tendremos autosostenibilidad y dinero extra. El Dr. Wayne trabaja para establecer estas clinicas . El tiene un pequeña fundación que ayhuda a realizar esto en paises como La Paz, bolivia, Belice , Bogotá. Estas clínicas son todas autosostenibles y generan dinero para poder pagar a los que no tienen. trabajanodp con OPS para crear mas clínics tengo muchas propuestas de otros países . La OPS recomienda que la próxima clinica sea en Honduras. Hay muchos problemas que podemos solucionar; para esto necesitamos tener lo siguiente;

1. Aprobación del gobierno.
   hay muchas personas a las que no les gustaríá éste proyecto como por ejemplo a algunas opticas privadas y otros que lo pueden considerar una competencia.

Cuando yo estableci la primera clinica en Belice ya estaba trabajando con OPS y despues Juan Carlos Silva visitó la clinica.

La razón es que hay un acuerdo. El dinero que se obtiene es solo para Eye Care y el gobierno no lo debe de utilizar para otra cosa, no lo debe derivar para otras necesidades del . Ellos prefieren firmar un acuerdo con una ONG y asegurarnos que vamos a trabajar sin problemas del gobierno. En Bolivia o Belice trabajamos con una ONG. En Colombia tenemos una ONG para que administre eso. Debemos trabajar con un concepto claro y definido del MSP y el dinero debe pertenecer al proyecto y no al gobierno. Esto es por razones de sostenibilidad, para abrir mas clinicas y ayudar a los mas pobres.

Tradicionalmente esto solo lo hemos logrado trabajando con ONG, esto no quiere decir que con el gobierno sea imposible hacerlo.

Con el dinero de la clínica se puede proveer servicios para un nivel secundario y terciario, en la medida que hagamos un buen trabajo con las clínicas. LA manera como ellos mantienen los bajos costos es que la clínica no es para hacer negocio. El costo inicial aproximado del proyecto es de 50 a 70mil dolares e incluye todo el equipo mas el entrenamiento de los tecnicos y el administrador. Su trabajo consiste en conseguir el dinero para establecer clínicas y despues ellos proveen el material por tres meses. Despues de este tiempo la clínica es capaz de generar sus propios materiales. El tiene contacto para comprar esto materiales a bajo costo. El costo para lentes es de Dos dolares, son de plastico y son tamaño standar de USA, de primera calidad. La ONG que fabrica esos lentes los da a ese precio para ayudar. Se usan de dos a cinco dolares para marcos y molduras.

El costo adicional se reduce en la medida que producimos mas. Los lente redondos (blancos) . Cuando el paciente escoje la moldura se le da la forma y eso se llama Edging, ellos proporcionan las maquinas, lo unico que se necesita es entrenar la persona. Siempre se establece un comite que este controlando al gerente.

Para comenzar se necesitan un administrador y dos técnicos, una maquina para cada tecnico. Si el negocio crece se agrega otro tecnico y otra maquina. Cada clinica produce mas de 100 lentes (50 a 75 por tecnico). Son aproximadamente 20,000 al año. los mismos técnicos dan atención tambien al publico.

Perfil para los tecnicos: Estos deben tener buenas notas en algebra y matematicas. (bachilleres) lo mismo para el administrador. Este ultimo debe saber como fabricarlos para hacer un trabajo de calidad.

El en este viaje se puso en contacto con el Dr. Granados, consultor de OPS en Honduras y el Dr. Silva.

Pasos:

1. Carta del gobierno (presidente o primera dama)
2. Carta del MSP
3. Carta del Hospital San Felipe

Despues es importante que el Comite defina la manera como se va a administrar el proyecto.

En Bolivia, por ejemplo este comite esta formado por OPS, Junta Nacional de Bienestar Social, Instituto de oftalmologia , Asociacion oftalmologica, club de leones o rotario.

La naturaleza de la clinica es una ONG, necesitamos un documento legal, un acuerdo , un documento legal.

Actualmente la optica ya tiene un comite formado por damas voluntarias.

Ellos necesitan un acuerdo entre el comite y la organizacion , en el cual se diga de que si por alguna razon la clinica no llegara a funcionar, todo el equipo regresaría a ellos.

1. Documentos 2. Organizacion 3 Entrenamiento 3. entrenamiento 4 funcionamiento.

ATTACHMENT N

SCREENING ACTIVITIES BY CHILD SIGHT WORKSHOP PARTICIPANTS

TALLERES DE CHILDSIGHT

En Guatemala se dieron 4 talleres por parte del programa childsight, éstos fueron impartidos por personal del comité pro-ciegos y sordos de Guatemala (técnicos y residentes de oftalmología) y por el Dr. Orlando Oliva (Oftalmólogo de IEF), los talleres se desarrollaron con una duración de 2-3 días y al final de cada uno se hizo una práctica para determinar si las personas participantes adquirieron conocimientos.

El contenido de los talleres fué sumamente extenso y se incluyeron varios temas: agudeza visual, enfermedades infecciosas, cataratas, glaucoma y otros.

Los primeros dos talleres fueron impartidos en Cobán alta Verapaz:

El **primero** a médicos, enfermeras y técnicos en salud rural de los distritos de salud de chamelco, carchá y cobán, además de 4 supervisores del proyecto ampros de IEF, del 3-5 de Octubre de 1995, asistieron en total 30 participantes, al entrevistar al personal del ministerio de salud refirieron que han tenido oportunidad de evaluar pacientes y referirlos a la clínica del comité pro-ciegos en carchá, sin embargo se quejaron de que las personas referidas no han obtenido tratamiento en dicho lugar, no poseen ningún tipo de estadística en la que conste la cantidad de pacientes que han sido evaluados por ellos.

Por otra parte los supervisores de IEF, compartieron lo aprendido con sus compañeros de trabajo y se han efectuado evaluaciones de pacientes por parte de ellos, inclusive se efectuó ya una jornada en colaboración con el comité pro-ciegos, se atendió a 129 pacientes.

El **segundo** taller del 5-7 de Octubre de 1995, fué dirigido a 17 promotores de salud de los mismos distritos de salud mencionados anteriormente, al entrevistar a estos promotores, todos compartieron la opinión de que el taller fué muy útil y que han evaluado algunos pacientes, ignoran si tuvieron tratamiento para su problema ocular y no tienen datos de la cantidad de personas evaluadas. Ellos fueron instruidos para referir a estos pacientes a la clínica satélite del comité en Carchá.

El **tercero** se impartió a 16 promotores de ASECSA del 13-16 de Febrero de 1995 en Chimaltenango, ellos estuvieron muy motivados y se hizo una práctica en San Juan Comalapa evaluando aproximadamente a 200 pacientes de los cuales se

refirieron probablemente 15 a la clínica del comité pro-ciegos en Zaragoza, al entrevistar al personal de ASECSA, dieron buenas referencias del taller pero no disponen de datos estadísticos acerca de la cantidad de personas evaluadas y referidas.

Una promotora de ASECSA nos contactó a finales de 1995 para solicitarnos que hiciéramos una jornada en Colomba Costa Cuca, Quetzaltenango, nos indicó que ella evaluó a varios pacientes y que tenía aproximadamente 150 para evaluar, ésto no pudo llevarse a cabo debido a que en esos momentos no teníamos disponibilidad para hacer una jornada, se hizo contacto con el comité pro-ciegos para que ellos hicieran dicha jornada pero no pudo ser así, hemos tratado de localizar a María Eulalia Ramírez, quien fué la promotora mencionada pero ha sido imposible poder ofrecerle la ayuda ya que ahora podemos hacerlo. En comunicación telefónica con la Sra. Rosa Amalia de Vásquez, directora de prevención de ceguera del comité pro-ciegos, me comunicó que recientemente participó en una jornada organizada por el club rotario en Tecpán, Chimaltenango y que allí encontró a algunos de los promotores de ASECSA que participaron en el taller que les ofrecimos y que expresaron que ellos han estado evaluando pacientes y ellos fueron parte muy importante para la organización de dicha jornada, se atendieron en total 176 pacientes.

El cuarto y último taller se dió en San Cristobal, Totonicapán a 4 capacitadores del proyecto Hope de Quetzaltenango, 16 promotores del proyecto Hope en Totonicapán y 2 promotores de ARIDEN, a principios de Septiembre de 1995, hablé por teléfono con el Dr. Pineda (Director de la Institución) quien me dijo que ignora si existen archivos estadísticos de las personas evaluadas por los promotores, de todos modos indicó que me contactarían para corroborar este dato y si es posible hacer jornadas en conjunto.

ATTACHMENT O

FIRST NATIONAL CONFERENCE ON THE PREVENTION OF BLINDNESS, FEBRUARY 13-14, 1996, TIRANA, ALBANIA

THE STATE OF OPHTHALMOLOGY IN ALBANIA IN 1995

Let us see how some elements of Eye Care Services actually are in Albania.

The Ophthalmologic Community

Albania, a small country with a population of 3.245.000 habitants, has 78 ophthalmologists, or one ophthalmologist per 42.142 habitants, except six doctors that are in retirement. Three of them are still working in private practices. In Tirana, 26 ophthalmologists work including five residents and the six people in retirement: in the Eye Department of the University Clinic, in the three polyclinics of it, and the Military Hospital. Thirty-seven doctors are spread in the rest of the country: five in Shkoder, four in Vlore, three in Fier and Berat, two ophthalmologists are working in each of the districts of Durres, Gjirokaster, Korce; while there is only one ophthalmologist in each of the following districts of Kukes, Lezhë, Elbasan , Krujë, Kavajë, Lushnjë, Tepelenë, Përmet, Librazhd, Pogradec, Kolonjë, Sarandë. There is no ophthalmologist working in the districts of Devoll, Pukë, Peqin, Malësi e Madhe, Mirditë, Diber, Bulqize. At this time, 15 residents are getting ready to work in the Districts outside of Tirana.

In the community 44 men and 36 ladies participate. In the next five years, eight persons will arrive at the age of retirement. Actually, in the community of the residents, the ladies are predominating. (12/8). The Albanian Ophthalmic Community has been organized for the first time in its Society. This was the first professional society in Albania, April 9, 1992. In 1995, for the first time in Albania, the National Blindness Prevention Committee was nominated.

The year 1992 was a new step for the preparation of the new Albanian ophthalmologists because:

- For the first time we had the 4-year programme of specialization, which creates the promises for the creation of a generation of better quality.
- The deep social-economic changes with democratic developments, created opportunities of contacting the communities abroad.
- The preparation process is positively modified because of the updated information that foreign ophthalmologists brought.

Short History

The ophthalmic community was created in the 1930's, when for the first time this service was opened by Prof. Kristo Kristidhi. Until 1950, only two ophthalmologists were working in Albania; one in Tirana and an other one in Korca. In the years 1950-60 six new ophthalmologists entered in service, specialized mostly in the eastern countries. From the years 1960 to the 1980s our community grew six times with the entering in service of 36 ophthalmologist specialized totally in Albania. From 1981 through 1990, 23 other ophthalmologists started their work. In this time 20 ophthalmologists are getting specialized. As known, Prof. Kristo Kristidhi made the foundations of the Albanian Ophthalmic School, and it got the modern characteristics from the patience and dedication of Dr. Andea Aronit. In the consolidation of it have merits also many honored colleagues that are today in this hall.

The equipment

This component has been the worst part of the eye care services in the whole country especially before 1990-91. Most of the districts where ophthalmologists were working, there were no biomicroscopes. The pressure was measured with very old tonometres (type Macllacov). The most important medicines were missing, such as thimopthol, kortisonics, antibiotics etc.

After 1991 because of the cooperation with NGOs such as:
- The International Eye Foundation
- Health for Humanity
- ORBIS International
-SOROS Foundation
- Task Force Albania
- CEMPEA
-Light to Albania
the situation of equipment is totally different.

This is most apparent in the tertiary center (Eye Department of the University Medical Center of Tirana) that during this time was with:

1.	Biomicroscope	5
2.	Scanner type A	2
3.	operator microscope (one of them with video-camera and monitor)	3
4.	indirect ophthalmoscope	4
5.	computerized perimeter	2
6.	keratometer	1
7.	aplanation tonometer	2
8.	examination lenses 90D, 60D, 20D	3 complete
9.	lenses set	4 complete
10.	retinoscope	3
11.	computer, printer	1
12.	photocopy machine	1
13.	lensometer	2
14.	three mirrors lens Goldmann	3
15.	prism lens	4
16.	equipment for measuring vision	6

This equipment assures a complete ophthalmic examination.

During all these years, apart from the state budget that was minimal, the tertiary clinic could realize the lens implantation in the posterior chamber, in almost one of third of the cases with cataract extraction: from 741 cases in total, 250 are with implantation of lenses in the posterior chamber. Most of the operations are made with the use of visco-elastics and nylon sutures 10.0; and 9.0.

Improvements are done in the other districts also, specially in the secondary centers in: Shkoder, Vlore, that are equipped with:

1.	operator microscope	2
2.	indirect ophthalmoscope	2
3.	keratometer	1
4.	aplanation tonometer	1
5.	examination lenses 90D, 60D, 20D	2 set
6.	lenses	1 set
7.	retinoscope	2
8.	lensometer	1
9.	3 mirrors Goldmann lens	1
10.	other surgical supply	2 complete

Also, the District of Elbasan is equipped with an operating microscope. While before some centers of eye care services as Kruje, Kukes, Kavaje didn't have bio-microscopes, now they have got one.

Nevertheless, we should be aware that the improvement of the equipment in the three levels of eye care services has not led to a better level of training. The training of the ophthalmologists with the three months rotation in the central clinic and by the help of the seminars and scientific conferences that our society organizes and by sending the foreign doctors in the secondary centers. About the equipment still is necessary standardization of it in all three levels (primary, secondary and the tertiary) and the standardization of the surgery. I think this will lead to the lowering of the percentage of blindness with yatrogen etiology that we should be aware that in Albania it exists. It exists because: is it possible to have a good quality in a surgery without an operating microscope, with very old operating techniques. How can we think that 5% of the congenital glaucoma and 29% of the congenital cataracts that are operated in the district out of Tirana, to have optimal results? Or when 81% of perforate traumas are operated with naked eye, without visco-elastics, and with inadequate sutures. I think that the standardization of the equipment, of the operating techniques, curative protocols, screenings, will be themes that our society will be dedicated to in the future.

Training

The training for our community during 1995 has been very intensive. It has been done by:

- The Albanian Ophthalmic Society (AOS).
- Foreign ophthalmologists that have done training activities of two weeks in Tirana, in Vlore, Shkoder. During this year, eight doctors have come, mostly from the USA. They have worked a total of two months.
- The continuous training of the staff of the clinic and of the residents, from the literature every day and once a week by the discussion of the most serious cases.
- By sending doctors to international activities as the one in Milano, the European Ophthalmic Society, and the international conference of the Ocular Infections in Jerusalem.

- By providing updated literature in 4 Western journals, by providing books and tracts of years '90-'94, of the types, and video-types.
- The training of the doctors in Vlore and Elbasan by the Italian ophthalmologists.

These forms of training undoubtedly make grow the quality of the specialization of the ophthalmologists in Albania because:

- They learn very early the modern methods of the examination.
- They learn updated surgical techniques without practicing the old ones.
- They are able to use the microscope from the beginning of their work.
- The criterion established for getting specialized in ophthalmology is:
  - Age under 28 years old.
  - The general test.
  - Average marks over 8.5 (of a maximum 10 points)
  - Knowledge of one foreign language

These are the factors that create optimism for the future of the ophthalmic community in Albania. This optimism comes from the fact that from 20 residents, 12 know two foreign languages.

From the very precious experience of 19 95 we have learned a lot about the training.

- The two-week training programme from the foreign doctors can be done within one week increasing the intensive work time from 7:30 a.m. to 6:00 p.m., a decision approved by the staff and the residents of the clinic.
- The trips of the foreign doctors should be better prepared by us. It is better to choose the patients before and to precise the themes of the lessons and the surgeries that are going to be done.
- All the organizational part should be improved so that we could avoid the confusion and the inefficiency of the work that we had several times this year.
- The programme also should be adopted after the request of the residents of the different years of study
- We should make better use of the library so that it can serve the doctors of our clinic and all the other ophthalmologists also.
- Doctors from the other districts should be invited to be trained in Tirana when the foreign doctors are here, to follow the one week course of training. And we should look for a way of financing this idea.
- We should accelerate the purchase of the TV and TV-Video part of the project of $15.000 that SOROS Foundation financed for the Albanian Ophthalmic Society. This will improve the learning of the different surgical techniques.
- We should try to apply the ..... system for the evaluation of the searching work of the members of our community.

<u>How survived and improved the eye care services in Albania after 1991</u>

As in all other fields of life, health and in concretely in the eye care services, the period after 1991 is associated with a total shock.

a. The total stop of the investments from the state.

b. The total change of the mentality of the doctors and the patients.
c. The deterioration of all the links of the prevention of blindness.
d. The putting out work of most of the very old equipment.

In this situation the only solution was the opening and the cooperation with the foreign NGOs. I cannot leave without mentioning their help in this difficult time:

- The International Eye Foundation, especially Mrs. V. Sheffield
- The corporation Health for Humanity, especially Dr. May Khadem
- The Society Task Force Albania, especially Mr. John Van Veenen
- And the organizations of: ORBIS International, SOROS Foundation, CEMPEA, Light to Albania, and other societies that I do not know which helped with donations and eye care services in the districts of: Vlore, Shkoder, Kavaje, Kruje, Kukes.

We would like the Albanian Ophthalmic Society to have a complete inventory of all these donations so we would not have duplication of the equipment. Anyway, the value of this help cannot be limited only in the material donations. But what is more important are the training and experience that we get from the cooperation with these organizations, such as:

a. they brought the changing of our professional concepts.
b. our organizational concepts.
c. and experience in the elaboration of the strategies short run and long run for the service in the University Eye Clinic and for the perspective of this service in all Albania.

With the help of these organizations, three projects are actually going on in Albania:

a. The project sponsored by SOROS Foundation in cooperation with Health for Humanity, IEF and the Albanian Ophthalmic Society.
b. The screening project sponsored by SOROS, given to the AOS to buy the equipment necessary for the screening of the children of ages preschool and school.
c. The project for the prevention of blindness in children, initiated by IEF and financed by USAID.

We have prepared and submitted to the SOROS Foundation a project that is a product of the cooperation between HH, Eye Clinic and AOS. This 4-year project, that we hope to get approved soon, will bring deep changes in five secondary centers (Shkoder, Vlore, Gjirokaster, Diber) and in the tertiary center in Tirana.

In this project, it is previewed that the microsurgery could be applied in the five secondary centers. In this time the tertiary level is going to be supplied with Diode or Argon Laser and with Scanner type B. Every one of you can think what changes the equipment mentioned above can bring for the treatment of our patients.

For all this I would like to thank the Bahái community, especially Health for Humanity and its secretary Dr. May Khadem, my friend and the friend of every ophthalmologist that met her. Naturally a special thanks is for SOROS Foundation and Mrs. Valdete Sala.

Thank you for the attention!

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ATTACHMENT P

SUMMARY OF THE FIRST COURSE FOR NON-OPHTHALMOLOGIST IN BULGARIA, STARA ZAGORA, DECEMBER 1995 AND DESCRIPTION OF THE VIDEO OF THIS EVENT

Videotape
of the First Course for Non-ophthalmologists
from the IEF's ChildSight Project in Bulgaria
Stara Zagora, December 1995

The President of the Medical University of Stara Zagora, Prof. Hristo Chouchkov will welcome the participants in the First Course for Non-ophthalmologists from the IEF's ChildSight Project in Bulgaria.

Although he is not an ophthalmologist, he is well acquainted with the problems of blindness, especially child blindness in Bulgaria. He is proud that this program starts in his University. He is positive that this course will bring much knowledge to all participants, and generate new ideas about prevention of blindness in Southern and East Southern Bulgaria. Good luck to all participants!

Prof. Chouchkov emphasized on the international significance of this course. He is sure that by the means of these international projects, the worldwide experience will be brought to Bulgarian ophthalmology.

Dr. Filipov who is responsible for the ChildSight Project in Bulgaria, will introduce the chief lecturers: Dr. Dima Petkova from Medical University of Plovdiv - Assistant Professor of Ophthalmology and Prof. Petrova who is neonatologist at the Clinic of Pediatrics in Medical University of Stara Zagora.

This is the beginning of the program. Good luck to all participants! Welcome!

Dr. Filipov is introducing Prof. Vassileva to the course. She is very glad that their common dream with Prof. Filipov to start this program has become true. Lets's say some words about the program:

Maybe you, neonatologists are already aware of the efforts of ophthalmologists to design a strategy for prevention of child blindness in Bulgaria. We have to do everything possible and mobilize our efforts to be sure that we are trying to do our best. We have many things to do, as a large amount of the blindness is preventable. We have started some programs in 1990. One of the components of this programs is epidemiology research.

Prof. Vassileva underlines the significance of the program and its organization. She is giving an example - American Academy of Science and American Academy of Ophthalmology. A significant part of our job is organization, we could be perfect doctors but if do not have the structures and the organization that could bring the patient to the doctor, we will not be successful. As you know, we have now some financial problems, all countries in our part of the world have currently financial problems, so we need support to prevent blindness.

Prof. Vassileva suggests that participants introduce themselves and the hospitals they are coming from. She wishes good luck to all participants and all the course.

Prof. Filipov is welcoming the participants.

Dr. Dimova - Pediatric Clinic, Stara Zagora
Dr. Shumelieva - Neonatologist from Haskovo Region Hospital
Dr. Nikolov - Pediatrician from Haskovo
Dr. Boycheva, Neonatologist
Dr. Valcheva, Head of the Pediatric Clinic, City of Yambol
Dr. Ilchevska, Micropediatrician, Kardjali
Dr. Topalova, Neonatologist, Sliven
Dr. Andonov from Smolyan
Dr. Hristov, University Pediatric Clinic, Plovdiv
Dr. Ganeva, Neonatologist from Stara Zagora
Dr. Todorova, Neonatologist, Stara Zagora
Dr. Gospodinov, Resident of Ophthalmology, Stara Zagora
Dr. Georgieva, Resident in the Eye Clinic, Stara Zagora
Dr. Rousskova
Dr. Djelebova, Resident in Eye Clinic, Stara Zagora
Ms. Koleva - International Eye Foundation. She is the engine of everything. One of the best specialists in organization.
Dr. Djelebov, Assistant Professor in Eye Diseases, University Eye Clinic in Stara Zagora
Assoc. Prof. Emil Filipov - working for long years on prevention of blindness problems, 30 years working in Sofia, has been working as Head of the University Eye Clinic in Stara Zagora for six years.

As you know we have to begin from somewhere. Let us start from somewhere, and this would be those meetings. Let us share our experience. Let us try to prevent the preventable blindness. Let us establish a system for prevention of preventable blindness in children.

Summary
of the First Course for Non-ophthalmologists
from the IEF's ChildSight Project in Bulgaria
Stara Zagora, December 1995

The first lecture is: Reasons and Development of the Child Blindness. Anatomy of the Peripheral Part of the Visual Apparatus. Methods of Examining the Eye, Performed by Non-ophthalmologists.
Lecturer: Dr. Petkova, Ophthalmopediatrician, University Eye Clinic, Plovdiv.

The lecture was on retinoblastoma, Vitamin A deficiency, congenital cataract and strabismus. A discussion followed the lecture. Main topics: What is a white pupil and how to find it; What to do after finding a white pupil; What is the early strabismus and what is behind it.

Prof. Vassileva and Assoc. Prof. Filipov shared their experience with the non-ophthalmologists.

Second lecture: Anatomy of the Eye. Anterior and Posterior Segments.
A lot of questions followed, like: Why does the eye enlarge in congenital glaucoma, and why it does not in other kinds of glaucoma; How to make examination on the anterior segment; How to use the ophthalmoscope; What is the organization of eye care in the USA. Prof. Vassileva and Dr. Filipov showed to participants how to use eye De Mar? eyelid fixation and how to use the ophthalmoscope.

Lecturer: Dr. Petkova

Third lecture: Pathology of the lens. Retinoblastoma and Strabismus.

Fourth lecture: Pathology of the Eye Lid and Anterior Segment.

Lecturer: Dr. Petkova

The diseases were introduced to the participants. After the lecture, a discussion on several issues took place, guided by Dr. Petkova and Dr. Filipov: The role of non-ophthalmologists strabismus treatment, How to treat monocular blindness; How and when to operate congenital cataract; What to do in retinal blastoma patients; How to follow retinoblastoma patients.

The participants wanted to know how to find conjunctivitis and how to treat it; bacterial, allergic, vernal and others; How to treat foreign body on the conjunctiva; How to find herpes simplex infection; What is the prognosis of corneal scars.

The discussion lasted more than two hours.

Fifth and sixth lectures: Retinopathy and problems of the prematurity.

Assoc. Filipov and Assoc. Prof. Petrova talked about ocular and non-ocular problems of prematurity. Dr. Filipov talked about ROP and differential diagnosis; When to make the first ophthalmic exam; How to use the indirect ophthalmoscope; What is the treatment; What are the stages.

Dr. Petrova talked about the problems of prematurity as a whole condition.

Seventh lecture: Monogenous diseases and ocular pathology. Performed by Prof. Petkov - Head of Department of Pediatrics in Medical University of Stara Zagora and Dr. Petrov - Clinical Assistant at the University Eye Clinic. Special attention was given to betathalasimia? and ocular findings in betathalasimia. A discussion on hemoglobinopathies and their role for ocular findings, leukemia and other blood diseases; Etiology of Lens Opacities; What is Siderosis?; What is Halcosis?; How to treat them and How to make an efficient therapy.

The following discussion was again on ROP as all participants wanted Prof. Filipov to repeat everything about the etiology and clinic in ROP. Special attention was given to the stages and treatment.

Eighth lecture: Registration and documentation of the patients with ocular pathology. The role of non-ophthalmologists in prevention of preventable child blindness. Dr. Filipov and Dr. Petkova introduced in details the ocular documentation to participants. There was a discussion: When to perform the first exam; How to perform control exams; How to organize such system that would permit for each child in Bulgaria to receive a competent ophthalmic care.

ATTACHMENT Q

MANUAL VISIONS SCREENING AND PRIMARY EYE CARE, KAREN VAN DIJK

CURRICULUM

VISION SCREENING AND PRIMARY EYE CARE

FOR TRAINING

* HEALTH SURVEILLANCE ASSISTANTS
* PRIMARY SCHOOL TEACHERS
* COMMUNITY BASED WORKERS

INTERNATIONAL EYE FOUNDATION
and
MALAWI LOW VISION PROGRAMME

DEVELOPED FOR USE IN MALAWI
BY KARIN VAN DIJK

JANUARY 1996

CURRICULUM

VISION SCREENING AND

PRIMARY EYE CARE

FOR TRAINING

* HEALTH SURVEILLANCE ASSISTANTS
* PRIMARY SCHOOL TEACHERS
* COMMUNITY BASED WORKERS

INTERNATIONAL EYE FOUNDATION
and
MALAWI LOW VISION PROGRAMME

DEVELOPED FOR USE IN MALAWI
BY KARIN VAN DIJK

JANUARY 1996

Preface

This curriculum was developed as a result of cooperation between the International Eye Foundation under their Child sight grant and the Malawi Low vision programme, attached to Education of the Blind.
Both parties were concerned by the possibly high number of people with visual problems in Chikwawa district.
The aim of the pilot programme set up in Primary Eye Care and vision screening is to identify visual problems early and refer, to identify curable low vision and blind people and to refer those who are incurably blind or low vision to other services, like for example Education of the Blind - specialist teachers.
The Low vision programme is particularly interested in finding low vision and blind children at the earliest age possible.
The programme started with training 3 Health Surveillance Assistants (HSAs) Supervisors into trainers. After practising their skills in vision screening, they trained the first group of 13 HSA's in Chikwawa in November 1995. A second group of primary school teachers has been trained as well.
Further training is planned.

The following people have contributed to a great extent to this curriculum and to the pilot programme:

- Mr Steve Kanjoloti, Ophthalmic Medical Assistant at Chikwawa District Hospital and in charge of the mobile eye unit in the Lower Shire
- The 3 HSA -supervisors, Ms. A.R. Chabwera, Mr. M.D. Alifinali, and Mr. H. Kalavina. who are training the different HSA's and school teachers

And last but not least to

- Mr. Joe Canner and staff of the International Eye Foundation for all the support in resources and logistics.
- IEF for funding the programme
- Education of the Blind for giving me time to develop this programme
- Christoffel Blindenmission for their support to the low vision programme in Malawi.

Some text and illustrations come from: "Assessment of low vision in developing countries" by Jill Keeffe, including the E-chart used for screening.

Karin van Dijk, January 1996

CONTENT

INTRODUCTION

This curriculum can be adapted to different target groups.
Each lesson plan contains materials relating to a specific topic. The material covered in each lesson plan can be shortened to need.

Examples of use:

For health surveillance assistants:
- All lesson plans can be used in a 2 day workshop
- If less time is available, lesson plan 9 and 10 can be left out (which of course changes the objectives of the training)

For primary school teachers:
Screening of large groups of children will be done by teachers, so a short procedure for screening is needed.
Suggested lesson plans for 1 day training

1 Primary eye care - the basics
4 + 5 Distance and near vision screening
6 Forms and referral
7 Myths and facts
8 Detecting visual problems in a school child (pre-school can be left out)
Summary and evaluation

If more time is available, other sessions can be included:
For example the one on tips for use of low vision, looking at school children.

* *Example time tables and objectives can be found on the next pages*

Assuming there are few resources, the training uses a lot of flipcharts that have been prepared before hand. This makes good feedback easy and gives participants a chance to compare their own findings with those of the trainer.
In the lesson plan the flipcharts needed are underlined.

Handouts are kept to a minimum, the essential ones (recommendation list, prevention of eye problems, use of E-chart can also be made available in Chichewa).

If vision screening is taught, with the use of a pinhole, the handouts marked '*Alternative* handout (when pinhole is used)' need to be given to the participants instead of the preceding handout.

At the end of this curriculum the screening forms (one for use without pinhole, one for use with pinhole) and the referral form can be found, for photocopying.

OBJECTIVES
FOR THE PEC/VISION SCREENING/LOW VISION TRAINING

For Health Surveillance assistants

Objectives:

Review of Primary Eye Care

- Name major parts (5) of the eye, with emphasis on anterior segment.
- Describe role each part plays and practical consequences of disease/disorder in each part
- Recognise the 6 signs of a healthy eye
- State the procedure for an external examination of the eye
(- Recognise and treat conjunctivitis
- Identify one ocular emergency: corneal ulceration
- Manage this emergency, before referral)
- Illustrate 5 measures to prevent visual impairment/blindness

* ( ) - if tetracycline eye ointmentand patching materials are available

Vision screening

- Illustrate in practical terms what visual acuity means
- Accurately measure distance and near visual acuity of another participant/ a child, using Keeffe E-chart
- Interpret results of visual acuity testing in terms of sighted, low vision, blind
- Discriminate between 3 myths and facts concerning use of vision
- Ask relevant questions to carers/teachers regarding a child's visual behaviour.
- List 8 signs that may indicate a vision problem in a pre-school child, school child and adult

General

- State in which cases referral is needed and to whom (medical/pre-school/education)
- Record the results

PROGRAMME

Training of Health Surveillance Supervisors in Vision screening/primary eye care

Day 1

Morning — Opening

Introduction to the pilot programme
Personal introductions
Objectives of training, and expectations

Review Primary Eye Care:
- Structure of eye
- Common eye problems
- 6 healthy signs of an eye; eye examination
- Prevention
- Referral
- Treatment of conjunctivitis

Afternoon — Primary Eye Care continued, if needed

Vision screening:
- Importance
- Simulating low vision
- Explaining use of E-chart: distance visual acuity
  near visual acuity
- What is normal vision, low vision and blindness
- Practice testing distance vision + recording results

Day 2

Morning — Vision screening continued
- Practice near vision + recording of results
- Referral
- Summary of screening procedure
- Myths and facts concerning use of vision
- Detecting visual problems in a (pre-) school child
- Recording + referral

Afternoon
- Practical tips for stimulating use of limited vision
- Case studies: reviewing the whole screening procedure
- What to do back at work

- Evaluation
- Closing

Teaching hours and breaks

8.00 - 10.00	Training	1.00 - 3.00	Training
10.00 - 10.30	Tea break	3.00 - 3.30	Tea break
10.30 - 12.00	Training	3.30 - 5.30	Training
12.00 - 1.00	Lunch		

OBJECTIVES
FOR THE PEC/VISION SCREENING/LOW VISION TRAINING

For Primary school teachers

Objectives:

Primary Eye Care

- Recognise the 6 signs of a healthy eye
- Illustrate 5 measures to prevent visual impairment/blindness

Vision screening

- Illustrate in practical terms what visual acuity means
- Accurately measure distance and near visual acuity of another participant/ a child, using Keeffe E-chart
- Interpret results of visual acuity testing in terms of sighted, low vision, blind
- Discriminate between 3 myths and facts concerning use of vision
- Ask relevant questions to carers/teachers regarding a child's visual behaviour.
- List 10 signs that may indicate a vision problem in a pre-school child, school child and adult

Low vision

- List practical accommodations a teacher can make to assist a child having vision problems

General

- State in which cases referral is needed and to whom (medical/pre-school/education)
- Record the results

PROGRAMME

1 day Training of Primary school teachers in Vision screening

Morning: 8.00 -8. 45	Introduction to the pilot programme Personal introductions Objectives of training, and expectations	
8.45 -10.00	Looking for eye problems - 6 healthy signs of an eye; eye examination - Detecting visual problems in a (pre-) school child - Prevention - Referral	
10.00	Opening	
10.45- 12.00	Vision screening: - Importance - Simulating low vision - Use of E-chart: distance visual acuity pinhole near visual acuity - What is normal vision, low vision and blindness - Practice testing distance vision + recording results	
Afternoon: 1.00 - 3.00	- Continued practice distance vision - Practice near vision + recording of results - Referral - Summary of screening procedure - Recording + referral	
3.30 - 4.30	- Myths and facts concerning use of vision - Practical tips for stimulating use of limited vision - What to do back at work	
4.30	- Evaluation - Closing	

This programme can be extended to a training of 1 1/2 day to allow for more practice

INTRODUCTION SESSION

What to cover at the start of a workshop

* Give out files, pens, etc.
  Circulate list for participants to fill in their names, work areas and addresses

* Welcome and personal introduction by trainer(s)
  Describing the role of the trainer = facilitator, not lecturer!

* Introduction by participants: name, area, number of years experience, (favourite food)

* Explaining how the event came about: Work of IEF, low vision programme in Malawi, what will happen in Chikwawa district

* Introducing aims and objectives, and the workshop (short)
  Give out objectives and programme (or if possible give out evening before or send before workshop)

* Asking for expectations of participants: e.g., through:
  - each individual writes down 3 things she expects (to learn)
  - then sharing in a small group of 3 or 4: agree on 3 expectations
    Write these down on a flipchart
  - Flipchart are put up in front: trainer goes through + compares to programme

* Agreeing ground rules: no smoking, ask many questions, time keeping!

* Dealing with practical matters: teaching times, breaks
  financial issues
  food, accommodation, etc.

* Answering participants questions

LESSONPLAN 1

Aim/Title: **Time: 50- 60 min**

Primary Eye care: external parts of eye, 6 healthy signs of an eye, eye examination (Review)

Objectives:

By the end of the session the student will be able to:

* Identify the external parts of the eye
* Examine the external parts of the eye
* Recognise 6 healthy signs of an eye

Method/Plan of lesson:		**Time + materials**
* *Introduction*:	What is session about (objectives)	5
* *Exercise in pairs*:	Draw picture of eye by looking at each others eyes + list parts of eye you can see	10
* *Feedback*:	Ask participants to name parts, using Big picture of eye on flipchart Part, fill in names of parts on handout - diagram Eye diagram to fill in	15
**Brainstorm*	What a healthy eye should look like: 6 signs" Flipch. with 6 signs Discuss referral of those who do not have 1 or more of 6 healthy signs	20

Handouts

- Drawing of eye
- 6 healthy signs of an eye

Comments:

LESSON NOTES 1 **Primary Eye Care**

* **Introduction** What is PEC/ importance of healthy eyes

* **Structure of eye:** let participants look into each others eye and note down the parts they see on the diagram/picture provided.
  Ask (or explain): - what these parts are used for
  - 6 signs of a healthy eye

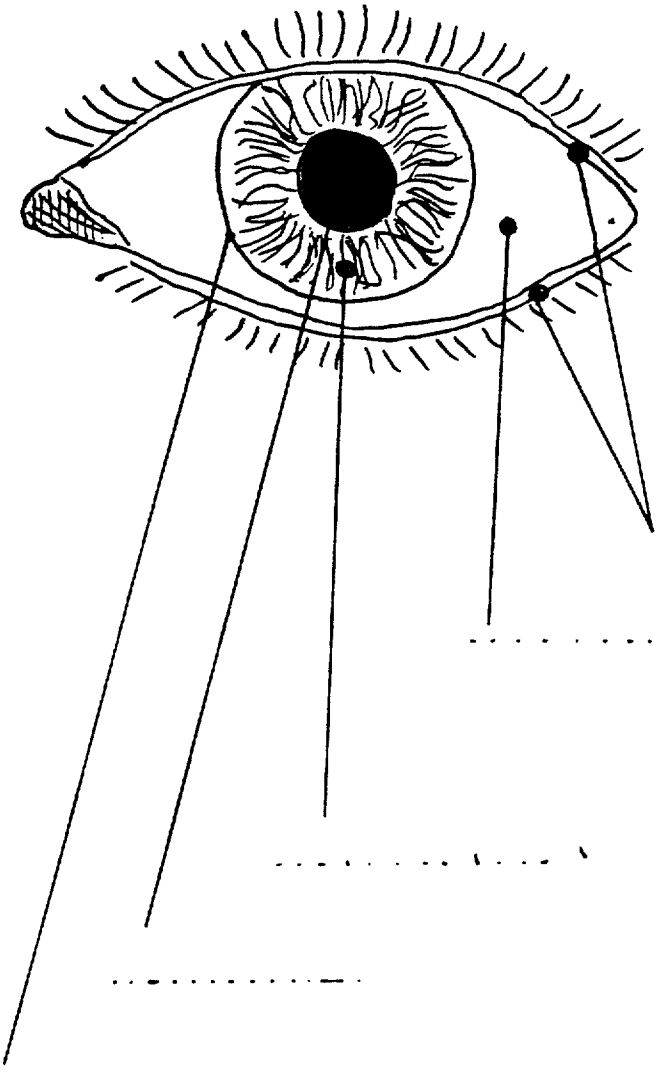
- Only explain eye parts from what people can see in each other eyes
  - white part (Conjunctiva)
  - pupil
  - iris
  - cornea (black part; clear covering)
  - add: lens
  - eye lids

* **Discuss what these parts should look like when healthy**
  6 RULES FOR A NORMAL, HEALTHY EYE
  1. The eyelids should open and close properly.
  2. The conjunctiva should be clear.
  3. The cornea should be clear.
  4. The pupils should be black, round and the same size.
  5. The eye movements should be normal. (Show picture of crossed eye)
  6. The vision should be good.

* How to examine the eye: to find out if it is healthy or not
  What is first thing you do?
  1. Ask: what is the problem (history)
  2. Check vision (show chart and explain they will learn this in this seminar later)
  3. Examine signs of (un) healthy eye (you know what normal eye looks like)

  Refer those with 1 or more of the 6 healthy signs not present.

HANDOUT



HANDOUT

6 RULES FOR A NORMAL, HEALTHY EYE

1. The **eyelids** should open and close properly.

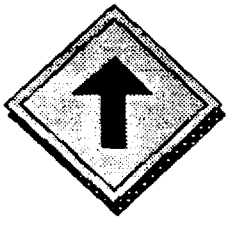
2. The **conjunctiva** should be clear.

3. The **cornea** should be clear.

4. The **pupils** should be black, round and the same size.

5. The **eye movements** should be normal.

6. The **vision** should be good.



LESSONPLAN 2

Aim/Title: **Time: 1 hr 40 - 2hr 20 min**

Primary Eye Care: Prevention and referral

Objectives:

By the end of the session the student will be able to:

* Mention 6 common eye problems, relating to the parts affected
* Illustrate 5 measures to prevent visual impairment
* State in which cases referral is needed and to whom

Method/Plan of lesson:		**Time + materials**
* *Introduction What* is session about (objectives)		3
* *Small group exercise:* 3 groups		
	Each group writes on flipchart:	20 - 30
	" For each part of the eye write 1 or 2 problems you have seen/heard about"	
* *Feedback:*	Put all 3 flipcharts on wall in front + ask for comments	
	Discuss common eye problems	
	Repeat 6 healthy signs of an eye	25
* *Question/answer*	Ask: 'How can people get eye problems"	15 min
	List them on flipchart Flip. with how you get eye problems	
* *Brainstorm:*	Ways of prevention	10
(Or alternatively:		
* *Drawing exercise* :	Ask participants to draw how an eye problem can be prevented	
	Participants show 1 by 1 their drawing, others guess what it is	
	Trainer writes list on flipchart	25
	(Hang all drawings on wall afterwards as reminders)	)
* *Question exercise:*	List of examples of eye problems on flipchart (ready):	
	e.g.: Red eye and no other problems Ask: Do you refer or not? Flip. with eye problems	
	Write correct answer after each example	
	Trainer gives explanation (per example)	10 -15
Optional:		
* *Demonstration + discussion*	Treatment of conjunctivitis	20

Handouts	**Materials**
How you can get eye problems	Tetracycline eye ointment
Conjunctivitis	

Comments:

LESSON NOTES 2

What can be wrong with eyes + how does it happen + prevention

- **List of eye problems**

Ask the participants to list, either through brainstorm or in small groups what can go wrong with each part of the eye just discussed

Examples

General	Eye is painful and red	
	Cannot see at night	*Complaints by patient*
	Cannot read/see properly	
Lids	Sores on lids	
	Lids swollen	
	Eye lashes turning in	(trachoma)
	Not open/or not close	
Conjunctiva	Red	
	Foreign bodies	
	Foamy spots	(=Bitots spots; vit A deficiency)
Cornea	Scar - whitish part	
	Conjunctiva grows in to black part	(pterygium)
	Corneal ulcer Eye red, tearing, fearing of light	
Pupil	White	(cataract)
	Does not respond not to light	(size does not change)

- **Causes of eye problems** (group discussion)

- Through the environment:
  - Dry (lack of water)
  - Dusty (lack of water)
  - Dirty (animal/human faeces)
  - Discharge (on children's faces)
- Diet
- Injury

- Eye diseases can be passed from one person to another through:

Fingers	eye-finger-eye
Flies	eye-fly-eye
Sharing towels, chitenje	eye-cloth/sheet/chitenje-eye
Family	between mother, brothers, sisters,.....

* **Prevention**
  * Wash your face and hands a few times every day.
  * Do not dry your face with a dirty cloth or towel.
  * Eat food like dark green leafy vegetables, pawpaw, carrots, tomatoes, peppers for vit A.
  * Keep your home and latrine clean, so flies cannot breed.
  * If any of the signs for a healthy eye are not there, go to an O.M.A.
  * Do not put any local mankhwala in the eye.

* **Treatment of conjunctivitis** Tetracycline eye ointment - 3 days 3 x a day
  See handout

* **Referral**
  Refer when any of the 6 signs of a healthy eye are missing!

- Use following examples + ask participants for referral yes/no (prepare on flipchart)

	Complaint	*Referral yes/no*
1.	Eye healthy; complaint: eyes water sometimes	NO
2.	Red eye + nothing else wrong	NO
3.	White thing on black part of eye	YES
4.	Patient says eye painful No other problems seen	NO
5.	Eye lashes turning in	YES
6.	Night blindness	YES NO, if HSA has vit A.

HANDOUT

HOW YOU CAN GET EYE PROBLEMS

- **Through the environment:**

Dry	(lack of water)
Dusty	(lack of water)
Dirty	(animal/human faeces)
Discharge	(on children's faces)

- Diet — Not enouhg vitamine A/ genarl malnutrition
- Injury

- **Eye diseases can be passed from one person to another through:**

Fingers	eye-finger-eye
Flies	eye-fly-eye
Sharing towels, chitenje	eye-cloth/sheet/chitenje-eye
Family	between mother, brothers, sisters,.....

PREVENTION OF EYE PROBLEMS

* Wash your face and hands a few times every day.
* Do not dry your face with a dirty cloth or towel.
* Eat food like dark green leafy vegetables, pawpaw, carrots, tomatoes, peppers for vit A.
* Keep your home and latrine clean, so flies cannot breed.
* If any of the signs for a healthy eye are not there, go to an O.M.A.
* Do not put any local mankhwala in the eye.

CONJUNCTIVITIS

HANDOUT

* ***All*** **these signs need to be present:**
  - RED EYES
  - PUS DISCHARGE
  - TEARING
  - GRITTY SENSATION

* If these 4 signs are present: **treat for conjunctivitis**
* **Treatment:**
  - Tetra cycline eye ointment 3 times a day for 3 days

  Or:
  - Chloramphenicol eye ointment 3 times a day for 3 days

✂ ----------

CONJUNCTIVITIS

HANDOUT

* ***All*** **these signs need to be present:**
  - RED EYES
  - PUS DISCHARGE
  - TEARING
  - GRITTY SENSATION

* If these 4 signs are present: **treat for conjunctivitis**
* **Treatment:**
  - Tetra cycline eye ointment 3 times a day for 3 days

  Or:
  - Chloramphenicol eye ointment 3 times a day for 3 days

LESSONPLAN 3

Aim/Title:	**Time:** 40 - 50 min
Importance of vision screening	
Simulation of low vision	
Objectives:	
By the end of the session the student will be able to:	
* List 3 reasons why vision screening is important	
* Illustrate 2 problems of seeing very little	

Method/Plan of lesson:		**Time + materials**
* *Introduction:*	what is session about (Objectives) what is vision screening	7
* *Short talk/asking questions*:	Importance of screening: 3 reasons (Note down on flipchart)	5 - 10
* *Simulation exercise*	Individuals try 2 different simulation spectacles, doing tasks like reading, threading a needle, walking in shade and sun	15 - 20 Simulation spectacles Old newspapers Needles + thread
Feedback: "What was difficult; How did you feel?"		10

Handouts
None

Comments:

LESSON NOTES 3 Vision screening

* **Introduction:**

* What is vision screening + Why is it important *Short talk*
- Looking for eye problems.
- Trying to find them at early stage...

- Early referral of those with visual problems
  - many can have better vision after treatment/with glasses
  - small children with little vision need to be found, so we can
    + try to improve vision early
    + tell parents to encourage child to use vision

* **What is low vision: introduction**

- Do simulation exercise.
  Let participants walk, in and outside, in shade and in sun. Let them do a near task, like reading, threading a needle
  Feedback
  Ask experiences: blurred vision/ difficult to read
  scary, insecure
  walking slowly
  Explain:
  'This is some of the people we are looking to find in screening'
  All people see different.
  These people need medical referral and education/rehabilitation help.
  Through training HSA's in screening, we hope to find people with visual problems at the earliest age possible. The sooner they get help the better."

LESSONPLAN 4

Aim/Title: **Time:** 1 1/2 - 13/4 hrs

General instructions on use of E-chart
Distance vision screening

Objectives:

By the end of the session the student will be able to:

* Illustrate in practical terms what visual acuity means
* Accurately measure distance visual acuity of another participant. using Keeffe E-chart
* Use correct testing principles, like the correct sequence, good light, right distance, chart at eye level.
* Interpret results of distance visual acuity testing, in terms of normal vision, low vision and blindness

Method/Plan of lesson:		**Time + materials**
* *Introduction*	What is session about (objectives)	3
* *Short talk:*	What is visual acuity + show E-chart What is 6/6, 6/18, 6/60, 3/60: what do these figures mean.	10
* *Demonstration:*	Use of E-chart (using co-trainer); Step-by- step Flipch. 4 steps of testing	15
* *Practice*	In pairs - testing each others (normal) distance vision - note down results E-charts Rope of 6m	15
* *Talk:*	Meaning of normal vision, low vision, blindness, using VA measures Ask for general principles when testing (light, distance, etc) Flipch. with general testing instructions	10
* *Demonstration*	Filling in form: name.... distance VA	5
(Optional:	Use of pinhole + its meaning) Screening forms (Pinholes)	(10)
* *Practice 2*	In pairs: Testing each other using simulation spectacles Filling in results every time on form	20
* *Feedback*	Common mistakes (not using general principles, showing small E's at a distance of 3 m, ...) + Invite questions!	10
* *Short talk*	1. Referral: only when VA below 6/18 2. If patient has great problems with 1 eye, test Right and left eye separately + *Demonstrate* how to cover eye	10

Handouts

- Vision screening
- Testing distance screening
- Using the E-chart
- Screening form

Comments: Use of pinhole is particularly useful when screening schoolchildren.

LESSON NOTES 4 Use of E-chart + Distance vision

* **What do you do in screening?**

- Find out visual acuity (= how clear we see).
  Both distance (walking, blackboard) and near (for reading, sewing...)
- What is visual acuity:
  Demonstrate chart: explain visual acuity practical
  Big E can be seen by people with normal vision at distance of 60 m
  If some one can see this E only at 6 m we say VA = 6/60

* **What is normal vision, low vision. blindness, using chart**

VISUAL ACUITY	6/6 to 6/18	=	"normal" vision
	< 6/18 to seeing light	=	low vision
	no light seen	=	blindness

* **Important factors in screening**

- good lighting shady area/room with electric light
- distance 6 m start or closer check your steps
- eye level of child/adult
- teach the test! (explain near a person how to respond to E's)

* **General testing instructions + 4 steps**

- explain E's = its use
- use it any direction: change Big E behind back
- Usually a person is tested with both eyes open.

1. **Always start with 4 medium-large E's at 6m**: you find out straight away:
   Sighted = 6/18. 3 out of 4 correct. Testing finished
   Low vision = < 6/18 Not 3 out of 4 correct, now try:

2. **Largest E =** 6 /60 (if 3 out of 4 are seen) **at 6 m**
   If not seen:

3. **Largest E at 3 metres =** 3/ 60 If not 3 out of 4 seen:

4. < 3/60.

* **Filling in of form** Recording of results

- Demonstrate on flipchart
- Check while participants are practising
- Add: with glasses, if those are used.

* **Feedback: common mistakes** See handout on using E-chart

- not at eye level
- not correct testing distance : 6 m / 3 m
- not enough light/ too much (sun) light!
- covered the E partly with finger or pointer.

* **Testing each eye separately**: See handout: 'Using the E-chart'

Optional

* **practice with pinhole + explanation**

* Why use pinhole
- Pinhole is used when VA < 6/18 to see if glasses might improve vision.
  Pairs do it once, using their own vision.

* How to use it
- Use it for anyone with visual acuity < 6/18
- Make sure it is put right on the nose, against the face. the person looks through the small holes.
  Again test distance visual acuity at 6 metres.
- Record findings. If vision is improved with the pinhole, refer the person to be checked for glasses.

* Feedback
- Correct any mistakes
- Improvement can be seen for example in:
  + Visual acuity improves: Without pinhole 3/60 - with 6/60 or 6/18
  + or in telling E's with more confidence/speed
- Remember pinhole restricts field and limits light: it cannot be used as a substitute for glasses!
- *You cannot use pinhole with near vision, only when testing distance vision*

* Explain what to fill in on screening form

VISION SCREENING

HANDOUT

- **It will help to:**
  - identify people who need to be examined or treated by an eye specialist or who might need spectacles.
  - identify people with low vision, as distinct from those with normal vision and those that are blind

- **Definitions**

"Normal" vision
A person is able to perform all close and distant tasks that are normally expected in his/her community. Some people may need spectacles to get "normal" vision.

Low vision
There is significantly reduced vision, that is:
Visual acuity is less (worse) than 6/18 in the better eye or visual fields are very narrow (less than 20 degrees in diameter).
After treatment or by using spectacles vision cannot be corrected to "normal".
But he/she can still use vision to do some tasks.

- Total blindness
A person is unable to see light

- Visual acuity
It is a measure of the ability of the eye to see detail.

VISUAL ACUITY	6/6 to 6/18	=	"normal" vision
	< 6/18 to seeing light	=	low vision
	no light seen	=	blindness

* Note:
The measure of visual acuity does not tell *how well vision is used.*
For example: One person with 6/60 might be able to walk around easily, another with the same visual acuity of 6/60 might have problems.

* Adapted from: Assessment of low vision in developing countries, by Jill Keeffe

HANDOUT

USING THE E-CHART

General testing instructions and sequence of working

- Usually a person is tested with both eyes open.

1. First test distance visual acuity

* If you think there is little or no vision in 1 eye, it may be useful to test each eye separately.
Test the right eye first. Ask the person to cover the left eye with the palm of the left hand, keeping both eyes open. Make sure the eye is properly covered.
Record the visual acuity

Now cover right eye with right hand and test the left eye. Record the visual acuity for the left eye.

2. If VA (visual acuity) is below 6/18, use a pinhole, to see if vision can be improved by spectacles.

3. Test near vision
This is done to see if people can cope with near tasks, like reading sewing, eating, crafts and the like.
The smallest E's (N8) are similar to the size of print in books for older children and adults or to tasks like threading a needle or weaving.
The middle sized E's are like the print in standard 1 or 2 books. People who can just see these symbols might have difficulty seeing fine detail or small patterns.
The largest size (N48) is found in heading in newspapers, on labels.

4. Check the eyes for the 6 healthy signs

5. Complete your screening form and when needed the referral form: 'Form for patient'

☒ Testing a child too young to understand the use of the E-chart

1. Ask questions, as outlined on the observation list.
You can do some simple tests, like slowly moving a coloured/shiny object or light in front of the child's face and see if the eyes can follow it.

2. Check the eyes for the 6 healthy signs

* Adapted from: Assessment of low vision in developing countries, by Jill Keeffe

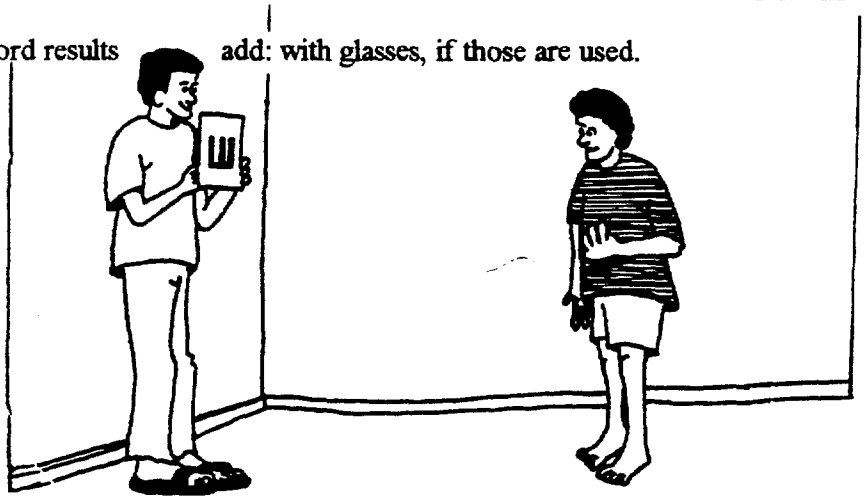
HANDOUT

* **Testing distance vision**

* Use correct testing distance : 6 m / 3 m
  Make sure you know how long your own steps are! You might need 7 steps to reach 6m!
* Teach the test!
* Make sure there is enough light, but do not work in full sunlight!
* Use chart at eye level of child/adult
* Use chart against good background; move it to check if it is seen.
* Avoid covering the E partly with finger or pointer.

1.	**Always start with 4 medium-large E's at 6m**: you find out straight away:			
	Sighted	=	6/18.	3 out of 4 correct. Testing finished
	Low vision	=	< 6/18	Not 3 out of 4 correct, now try:
2.	**Largest E =**		6 /60 (if 3 out of 4 are seen)	**at 6 m**
				If not seen:
3.	**Largest E at 3 metres =** 3/ 60			If not 3 out of 4 seen:
4.			< 3/60.	

* Record results add: with glasses, if those are used.

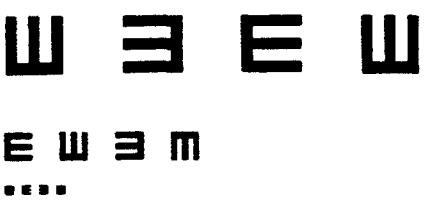


Testing near vision (Near acuity)

- There is no standard distance: just a best distance:
  Children can hold it as close as they like.
  Adults might need to hold it further away, especially when getting older
- Make sure the head does not give shadows on the chart.

- Start with the largest E. If a person cannot see these, tell him to hold the card closer to the eyes.
- Record the smallest size able to be read correctly.
- Also measure and record the distance the card is held from the eyes.

- With children near visual acuity can be considerable better than distance visual acuity!



Alternative HANDOUT (when pinhole is used)

* **Testing distance vision**

* Use correct testing distance : 6 m / 3 m
  Make sure you know how long your own steps are! You might need 7 steps to reach 6m!
* Teach the test!
* Make sure there is enough light, but do not work in full sunlight!
* Use chart at eye level of child/adult
* Use chart against good background; move it to check if it is seen.
* Avoid covering the E partly with finger or pointer.

1.	**Always start with 4 medium-large E's at 6m**: you find out straight away:			
	Sighted	=	6/18.	3 out of 4 correct. Testing finished
	Low vision	=	< 6/18	Not 3 out of 4 correct, now try:
2.	**Largest E =**		6 /60 (if 3 out of 4 are seen) **at 6 m**	
				If not seen:
3.	**Largest E at 3 metres = 3/ 60**			If not 3 out of 4 seen:
4.			< 3/60.	

* Record results add: with glasses, if those are used.

Pinhole

- Use it for anyone with visual acuity < 6/18
- Make sure it is put right on the nose, against the face. the person looks through the small holes.
  Again test distance visual acuity at 6 metres.
- Record findings. If vision is improved with the pinhole, refer the person to be checked for glasses.
- Improvement can be seen for example in:
  + Visual acuity improves: Without pinhole 3/60 - with 6/60 or 6/18
  + or in telling E's with more confidence/speed
- Remember pinhole restricts field and limits light: it cannot be used as a substitute for glasses!
- *You cannot use pinhole with near vision, only when testing dist. nce vision*

Testing near vision (Near acuity)

- There is no standard distance: just a best distance:
  Children can hold it as close as they like.
  Adults might need to hold it further away, especially when getting older
- Make sure the head does not give shadows on the chart.

- Start with the largest E. If a person cannot see these, tell him to hold the card closer to the eyes.
- Record the smallest size able to be read correctly.
- Also measure and record the distance the card is held from the eyes.

- With children near visual acuity can be considerable better than distance visual acuity!

HANDOUT

SCREENING FORM

Name **Age**

Address/area

Tested by **Date**

DISTANCE VISUAL ACUITY

Both eyes 6/18 ☐ 3/60 ☐

6/60 ☐ < 3/60 ☐

Cannot be tested: believed sighted ☐

believed blind ☐

NEAR VISION

None ☐ Medium (N20) ☐

Large (N48) ☐ Small (N8) ☐

Distance from test card to eyes _____ centimetres

COMMENTS ON EYES _____

_____

_____ ***Referred:*** Yes ☐ No ☐

SCREENING FORM

Name **Age**

Address/area

Tested by **Date**

DISTANCE VISUAL ACUITY

Both eyes 6/18 ☐ 3/60 ☐

6/60 ☐ < 3/60 ☐

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Distance from test card to eyes _____ centimetres

COMMENTS ON EYES _____

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SCREENING FORM

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Cannot be tested: believed sighted ☐

believed blind ☐

NEAR VISION

None ☐ Medium (N20) ☐

Large (N48) ☐ Small (N8) ☐

Distance from test card to eyes _____ centimetres

COMMENTS ON EYES _____

_____

_____ ***Referred:*** Yes ☐ No ☐

Alternative HANDOUT (when pinhole is used)

SCREENING FORM

Name **Age**

Address/area

Tested by **Date**

DISTANCE VISUAL ACUITY

Both eyes	6/18	☐	Pinhole: Not improved	☐
	6/60	☐	6/18	☐
	3/60	☐	6/60	☐
	< 3/60	☐	3/60	☐
Cannot be tested: believed sighted		☐	< 3/60	☐
believed blind		☐		

NEAR VISION

None	☐	Medium (N20)	☐
Large (N48)	☐	Small (N8)	☐

Distance from test card to eyes _____ centimetres

COMMENTS ON EYES _____

_____ ***Referred:*** Yes ☐ No ☐

_____

SCREENING FORM

Name **Age**

Address/area

Tested by **Date**

DISTANCE VISUAL ACUITY

Both eyes	6/18	☐	Pinhole: Not improved	☐
	6/60	☐	6/18	☐
	3/60	☐	6/60	☐
	< 3/60	☐	3/60	☐
Cannot be tested: believed sighted		☐	< 3/60	☐
believed blind		☐		

NEAR VISION

None	☐	Medium (N20)	☐
Large (N48)	☐	Small (N8)	☐

Distance from test card to eyes _____ centimetres

COMMENTS ON EYES _____

_____ ***Referred:*** Yes ☐ No ☐

_____

SCREENING FORM

Name **Age**

Address/area

Tested by **Date**

DISTANCE VISUAL ACUITY

Both eyes	6/18	☐	Pinhole: Not improved	☐
	6/60	☐	6/18	☐
	3/60	☐	6/60	☐
	< 3/60	☐	3/60	☐
Cannot be tested: believed sighted		☐	< 3/60	☐
believed blind		☐		

NEAR VISION

None	☐	Medium (N20)	☐
Large (N48)	☐	Small (N8)	☐

Distance from test card to eyes _____ centimetres

COMMENTS ON EYES _____

_____ ***Referred:*** Yes ☐ No ☐

LESSONPLAN 5

Aim/Title: **Time:** 75 min

Near vision screening

Objectives:

By the end of the session the student will be able to:

* List 3 activities for which we need near vision
* Explain the meaning of N8, N20, N 48
* Accurately measure near vision of another participant
* Record the results on the screening form

Method/Plan of lesson:		**Time + materials**
* *Introduction*	What is the session about (objectives)	3
* *Short talk/ asking questions*	What is near vision used for, why test it	10
* *Demonstration*:	How to test near vision; Explanation of 3 sizes N's; how to record results (using co-trainer: a. once with normal vision b. once under simulation spectacles) E-chart Simulation spectacles Ruler Screening forms	20
* *Practice in pairs*	1. normal vision + record results 2. with simulation spectacles + record results same as above	30
* *Feedback*:	Common mistakes	10

Handouts

- Screening forms

Comments:

LESSON NOTES 5 Near vision see handout on screening

* **What it is and what you use it for**
- = Vision you use for near tasks
- For e.g. reading, sewing, peeling, crafts

- Show the side of the chart with the small E's: This test is done to see if people can cope with near tasks.

- The smallest E's (N8) are similar to the size of print in books for older children and adults or to tasks like threading a needle or weaving.
  If these small E's can be seen there is no problem.
- The middle sized E's are like the print in standard 1 or 2 books. People who can just see these symbols might have difficulty seeing fine detail or small patterns.
- The largest size (N48) is found in heading in newspapers, on labels.

* **How to test**
* General instructions
- Client chooses distance, holds card
- There is no standard distance: just a best distance:
  Children can hold it as close as they like.
  Adults might need to hold it further away, especially when getting older
- Do the test in good light
- Make sure the head does not give shadows on the chart.

* Sequence
- *Start with the largest E.* If a person cannot see these, tell him to hold the card closer to the eyes.
- *Record the smallest size* able to be *read correctly.*
- Also *measure and record the distance* the card is held from the eyes, when the client is reading the smallest row he/she can see.

- With children near visual acuity can be considerable better than distance visual acuity!

* **Feedback**
- Common mistakes: - Tester holds card in stead of client
  - Forgotten to tell client to hold card as close as they
  - Tested in dark room

  General instructions, sequence and recording can be emphasized again.

LESSONPLAN 6

Aim/Title:	**Time:** 60 min.
Screening procedure: eyes and acuity combined	
Forms and referral (+ forms)	
Objectives:	
By the end of the session the student will be able to:	
* List sequence of testing, using 3 headings	
* Fill in referral slips, based on screening forms used	
* Explain who to refer, based on visual acuity figures and comments on eyes	

Method/Plan of lesson:		**Time + materials**
* *Introduction*	What is session about (objectives)	3
* *Short talk/asking questions*		
	Sequence of testing	10
	(1. history, 2. visual acuity, 3. eye check: list on flipchart)	
* *Case study*	Individual exercise:	10
	'Who to refer from the 3 case studies' Tick the yes or no box	
* *Feedback*:	Check in front of group if they referred the right people + discuss who (not) to refer for each case study	10
* *Individual exercise*	Fill in referral slips based on 3 case studies	10
* *Feedback*	Check slips + participants can check each others slips	15
	Demonstrate on flipchart	Flipch. with referral form

Handouts
- Screening forms
- Referral slips
- 3 Case studies on screening form

Comments:

LESSON NOTES 6 **Screening procedure + referral + forms**

* **Sequence of screening**

1. HISTORY
2. VISUAL ACUITY distance
   (pinhole)
   near
3. EYE CHECK

* **Who to refer**

- VA < 6/18
- Near vision N20 or N48
- vision improves with pinhole
- Any of the 6 healthy signs of an eye is not healthy

* **Filling in of referral slips**

- Example of a correctly filled in referral slip on flipchart
- Name, age, ... all information is important

HANDOUT

FORM FOR PATIENT **to take to nearest health centre or hospital**

Name **Age**
Tested by ____________________ Area _____________ Date ___________

Distance visual acuity _____________
Near vision _____________
Comment on eyes and/or on problem signs _____________________________
____
____

FORM FOR PATIENT **to take to nearest health centre or hospital**

Name **Age**
Tested by ____________________ Area _____________ Date ___________

Distance visual acuity _____________
Near vision _____________
Comment on eyes and/or on problem signs _____________________________
____
____

FORM FOR PATIENT **to take to nearest health centre or hospital**

Name **Age**
Tested by ____________________ Area _____________ Date ___________

Distance visual acuity _____________
Near vision _____________
Comment on eyes and/or on problem signs _____________________________
____
____

FORM FOR PATIENT **to take to nearest health centre or hospital**

Name **Age**
Tested by ____________________ Area _____________ Date ___________

Distance visual acuity _____________
Near vision _____________
Comment on eyes and/or on problem signs _____________________________
____
____

CASESTUDY

HANDOUT

SCREENING FORM

Name Simplex Khembo Age 6
Address/area ~~~
Tested by ~~~ Date ~~~
DISTANCE VISUAL ACUITY

Both eyes	6/18	☑	3/60	☐
	6/60	☐	< 3/60	☐
Cannot be tested: believed sighted		☐		
believed blind		☐		

NEAR VISION

None	☐	Medium (N20)	☐
Large (N48)	☐	Small (N8)	☑

Distance from test card to eyes 15 centimetres
COMMENTS ON EYES Look healthy

Referred: Yes ☐ No ☐

SCREENING FORM

Name Christina Ngalu Age 16
Address/area ~~~
Tested by ~~~ Date ~~~
DISTANCE VISUAL ACUITY

Both eyes	6/18	☐	3/60	☐
	6/60	☑	< 3/60	☐
Cannot be tested: believed sighted		☐		
believed blind		☐		

NEAR VISION

None	☐	Medium (N20)	☐
Large (N48)	☐	Small (N8)	☑

Distance from test card to eyes 5 centimetres
COMMENTS ON EYES Look healthy

Referred: Yes ☐ No ☐

SCREENING FORM

Name Peter Lova Age 40
Address/area ~~~
Tested by ~~~ Date ~~~
DISTANCE VISUAL ACUITY

Both eyes	6/18	☑	3/60	☐
	6/60	☐	< 3/60	☐
Cannot be tested: believed sighted		☐		
believed blind		☐		

NEAR VISION

None	☐	Medium (N20)	☐
Large (N48)	☐	Small (N8)	☑

Distance from test card to eyes 30 cm centimetres
COMMENTS ON EYES: Inside of eyelids very Red, teasing, discharge of pus. Complains of pain

Referred: Yes ☐ No ☐

LESSONPLAN 7

Aim/Title: **Time:** 35 min

Myths and facts concerning use of vision

Objectives:

By the end of the session the student will be able to:

* Discriminate between 3 myths and 3 facts regarding use of vision
* Illustrate importance of using vision where possible, from an early age

Method/Plan of lesson:		**Time + materials**
* *Statement game*	'Myths and facts'	Paper with statements for trainer
* *Feedback and discussion*	on most common myths in Malawi	25
* *Discussion:*	'Vision is learned': importance of early use	10

Handouts

- Myths and facts

Comments:

LESSON NOTES 7 **Myths and facts concerning use of vision**
See handout myths and facts

* **Statement game:**
Write true, untrue and silly statements regarding use of vision
Procedure:
Draw (imaginary) line through the room. One end is 100 % = total agreement, other end 0% (total disagreement), middle = 50 % (true and untrue).
Read a statement and ask participants to go and stand at the place that reflects their agreement/disagreement.
Ask 1 or 2 people why they are standing at a certain place. Give short feedback.
Read next statement, etc
Game should go fairly fast.

* **Suggested statements on use of vision**

- Children who still have a little sight should not use it too much, so the vision does not get worse.

- Most children with Low vision are mentally handicapped as well.

- Reading by holding a book very close to the eyes will harm the eyes.

- If a hospital prescribes glasses, this means that you are losing your sight slowly, but surely. You will go blind in the long run.

- Blind men should not marry blind women, just sighted ones or Low vision ones.

- Reading or sewing in a dim light will damage sight.

- Electric lighting is bad for the eyes.

- Low vision or Blind people can hear better than sighted people

- Looking into the lights of cars at night will make your vision worse, over the years.

* **Feedback:** Summarise after game:
- Vision is learned. If a small child with very little vision stays at home and is not stimulated to use her vision, she will not be able to use the little vision she has well by the age of 6 or 7. It cannot be improved later. The early years are important to develop use of vision, to see and to understand what it is you see.

* Make sure everyone goes home with the FACTS!!!

HANDOUT

MYTH AND FACT
Concerning use of vision

Myth	Fact
My sight will wear out if I use it too much.	Eyesight cannot be worn out by use. Use it as much as you want to.
Keeping a book very close when reading, will reduce my vision in the long term.	Vision will not reduce, although the muscles that move the eyes may tire. If this happens, rest for a few minutes.
If a hospital prescribes glasses, this means that you are losing your sight slowly, but surely. You will go blind in the long run.	Most people over 40, need glasses for reading. That is normal. *Glasses improve vision for those who need them.*
Reading or sewing in a dim light will damage my sight.	It is not helpful to read in a dim light, but it cannot harm the eyes.
Looking into the lights of cars at night will make your vision worse, over the years.	No, but it might be difficult to see for a few seconds.
Electric lighting is bad for the eyes.	Good lighting of any sort is a valuable aid to vision.
If a child has already poor vision, she should not use it too much. Else she might lose all her sight.	It is very important to stimulate a child with poor vision to use sight as much as possible. Show her things close-by, take her around outside, use bright colours to encourage her to look.

LESSONPLAN 8

Aim/Title: **Time:** 60 min

Detecting visual problems in a pre-school and a school age child

Objectives:

By the end of the session the student will be able to:

* List 8 signs that may indicate a vision problem in a school age child(class room)and in a pre-school child
* State in which cases referral is needed and to whom (medical/pre-school/education)
* Record the findings

Method/Plan of lesson:		**Time + materials**
* *Introduction*:	objectives of session	5
* *Small group exercise*:	Make 2 groups, each gets different age group 1. 0 - 5 yr old 2. primary school age 1. List of possible things/behaviour that indicate visual problems 2. How to find out these problems, e.g. simple test, asking parents. Write keywords, such as colour, light, on blackboard: these can be used in exercise	30
* *Feedback + discussion*	Use recommendations list	20 Flipchart with list visual problems
	What to fill in on screening form + referral slip Location of specialist teachers	10

Handouts

- Recommendations list

Comments

LESSON NOTES 8 **Detecting visual problems in (pre) school child**

* **Introduction:**
We cannot test everyone with the E-chart. Younger children will not understand.
But we want to identify visual problems at an early age, to save as much sight as possible. This session is about how to find out, without using E-chart

* **Finding out visual problems: looking at behaviour and eyes**
* *Small group exercise*:2 groups, each gets different age group
1. 0 - 5 yr old 2.primary school age
* *Give each group a flipchart* to write on
- 1. List of possible things/behaviour that indicate visual problems
2. How to find out these problems, e.g. simple test, asking parents.

- Give this guidance:
'Please think of what children in the particular age group normally do, e.g.
- school child reads:
- 0 - 2: reaching for things
- 2 - 5: playing, running around } Can you think of any problems that indicate something wrong with vision

- 'Think of: a. What can you ask parents?
b. behaviour, e.g. falling over things
c. simple tests, e.g. can child see light
- Keep in mind these key words (important for seeing things):

Light	Size	Distance
Colour	Contrast	Movement (it is easier to see moving things)

* **Feedback + discussion** (how do you find out visual problems)
- Put flipcharts in front; Go through lists, ask clarification
- Compare with recommendations list (give out to participants) on + talk through

* **Referral + recording**
Explain who to refer Ask questions to make sure they have understood,
Like: If a child's eyes are crossed, but she sees well, do you refer or not
Answer: yes!!!

* **Specialist teacher**
- Always refer to OMA first; after check-up/treatment (if there are still severe visual problems) to specialist teacher or pre-school group

* **Summarise:**
☒ Testing a child too young/not able to understand the use of the E-chart
1. Ask questions, as outlined on the observation list.
You can do some simple tests, like slowly moving a coloured/shiny object or light in front of the child's face and see if the eyes can follow it.
2. Check the eyes for the 6 healthy signs

HANDOUT

OBSERVATION LIST AND LIST OF RECOMMENDATIONS

DISTANCE VISUAL ACUITY

Vision is 6/18 or better - no further action	☐	
Vision is worse than 6/18	☐	Refer to O.M.A.

NEAR VISION

Can see small (N8) Es - no further action	☐	
Cannot see small (N8) Es, only medium or large Es	☐	Refer to O.M.A.

EYES

Red eyes/ cornea not clear/ pupil not black/ lids do not close or open properly/lens white	☐	Refer to O.M.A.
Eye painful, waters + cornea hazy + light pains the eye	☐	Patch and then refer to O.M.A.

OTHER SIGNS TO LOOK/ASK FOR:

Small children/babies

* Not aware of light
* Not smiling at the parents/sisters/brothers
* Seems not to follows a moving object with eyes
* Is not reaching for things near, small objects
* Both eyes not moving together/ Eyes do not appear straight
* Eyes flicker constantly
* Dislikes sunlight intensely/ shuts or squints eyes

Older/school age children/adults *in addition to signs outlined above, look for:*

* Complains of not seeing clearly at night
* Rubs eye frequently
* Screws up face/eyes and frowns when trying to see something
* Shuts or covers one eye
* Pushing eyeballs with fingers and knuckles
* Complain of headaches/ nausea/ dizziness following close work
* Clumsines. and trouble walking in a new environment/ Stumbling over objects
* Excessive blinking
* Holding one's head in a awkward position/tilting to one side
* Holds book too far from/too close to face
* Seems not able to recognise people's faces/read blackboard from a distance

☐ **REFER to OMA, if any of these signs are observed by you and/or mentioned by family member/guardian ...**

List on the 'form for patient' (which will be taken to the OMA)

- ***distance and near visual acuity***
- ***the signs observed or mentioned***

Alternative HANDOUT (when pinhole is used)

OBSERVATION LIST AND LIST OF RECOMMENDATIONS

DISTANCE VISUAL ACUITY

Vision is 6/18 or better - no further action	☐	
Vision is worse than 6/18 but improves with pinhole	☐	Refer to O.M.A.
Vision is worse than 6/18 but does not improve with pinhole	☐	Refer to O.M.A.

NEAR VISION

Can see small (N8) Es - no further action	☐	
Cannot see small (N8) Es, only medium or large Es	☐	Refer to O.M.A.

EYES

Red eyes/ cornea not clear/ pupil not black/ lids do not close or open properly/lens white	☐	Refer to O.M.A.
Eye painful, waters + cornea hazy + light pains the eye	☐	Patch and then refer to O.M.A.

OTHER SIGNS TO LOOK/ASK FOR:

Small children/babies

* Not aware of light
* Not smiling at the parents/sisters/brothers
* Seems not to follows a moving object with eyes
* Is not reaching for things near, small objects
* Both eyes not moving together/ Eyes do not appear straight
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* Rubs eye frequently
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* Shuts or covers one eye
* Pushing eyeballs with fingers and knuckles
* Complain of headaches/ nausea/ dizziness following close work
* Clumsiness and trouble walking in a new environment/ Stumbling over objects
* Excessive blinking
* Holding one's head in a awkward position/tilting to one side
* Holds book too far from/too close to face
* Seems not able to recognise people's faces/read blackboard from a distance

☐ **REFER to OMA, if any of these signs are observed by you and/or mentioned by family member/guardian ...**

List on the 'form for patient' (which will be taken to the OMA)
- ***distance and near visual acuity***
- ***the signs observed or mentioned***

LESSONPLAN 9

Aim/Title: **Time:** 50 min

Practical tips for use of low vision

Objectives:

By the end of the session the student will be able to:

* Illustrate 4 basic ideas for stimulating low vision children to use their vision

Method/Plan of lesson:		**Time + materials**
* *Introduction*:	objectives of session	5
* *2 groups exercise:*	Letter competition: Give each group certain letters: list ideas/objects/toys/activities that can be used to stimulate a child with little vision to use the vision. Each group makes list on flipchart. Each letter is used once. One with the most signs... wins! Flipchart with a, c, d, h, l, r, s, Flipchart with b, h, k, p, r, s, t	15
* *Feedback*	Flipch with ideas	15
* *Discussion*	Advice to give to parents Combine with facts learned about use of vision	15 min

Handouts

- Ideas for a assisting a child with vision problems

Comments

LESSON NOTES 9 **Stimulating use of vision**

* **Introduction**

- Repeat: vision is learned, let's look how we can give simple advice that might help a child that sees little, to use vision as best as possible.

* **Letter exercise**

- Competition in 2 groups: split the large group through the middle.
  Give each group certain letters:
  (using each letter once) One with the most signs... wins!
  (a, c, d, h, l, r, s,) and (b, h, k, p, r, s, t)
  Each group chooses a writer: this person sits on floor with flipchart in front that has the 8 letters on it. When ever one of his group member shouts out an idea he writes it.

- This is what they have to do:
  "List ideas/objects/toys/activities that can be used to stimulate a child with little vision to use the vision. Each idea has start with one of the 8 letters. You can only use each letter once."

- Write again on board the key words they need to remember:
  Colour, contrast, size, distance, light
- Encourage and help each group!!
- Who is ready first, 'wins'.

* **Discussion/feedback**

- Put flipcharts in front. Discuss ideas
  Add as key word: 'Variety' (see handout)
  Each low vision child needs to go to many different places, see different things, so do not put small child always in same place.
- Show ready flipchart with ideas (see handout ' Ideas for assisting a child with vision problems'

- Emphasize basic advice to give to parents

- Repeat some of the facts':
  - it is good to use vision as much as possible
  - it does not harm the eyes to hold things very close

HANDOUT

IDEAS FOR ASSISTING CHILDREN WITH VISION PROBLEMS

- **Distance**

  Make sure there are shiny, colourful objects near a child, so she can see and explore.

  Let child come as close as he/she likes:
  - to look at food
  - to read from the blackboard
  - to read

- **Colour**

  Use bright colours

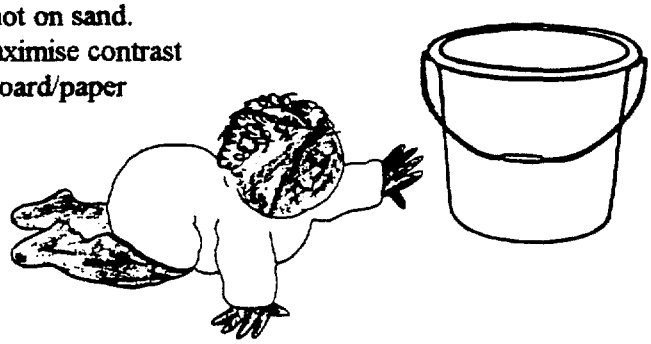
  Colour contrast

- **Contrast**

  Good contrast with the background

  Suggestions to improve contrast

  * Put red or blue cup on light plate
  * Put broom next to dark bucket, not on sand.
  * Clean the blackboard often to maximise contrast
  * Use a black felt pen on a white board/paper



- **Size**

  Play with a larger ball

  Write bigger

  Make teaching materials larger

- **Lighting and sitting position**
  * Good natural light (but no bright sunlight) is best.
  * No direct light, shining into face and eyes: light should come 'over the shoulder'.
  * Let child sit near a window or door, or under a tree

- **Variety**
  * Give a small child different experiences, Vary the place where she plays, take her out: to the well, to the market. Show her new things at close distance.

Let a child use his or her sight as much as possible.
Encourage him/her to look at things.

LESSONPLAN 10: Optional

Aim/Title:
Practice on real patients
Review of whole screening procedure; What to do back at work
Objectives:
By the end of the session the student will be able to:

* Implement the whole screening procedure, including taking history, using the E-chart/asking relevant questions/testing vision in pre-school children, looking for the 6 healthy signs of an eye, referring and recording.

Method/Plan of lesson:		**Time + materials**
* *Practice*	Screen e.g. mothers and their small child	1 - 1 1/2hour
		E-chart,
		Screening + referral forms,
		Recommendations list
		(Pinhole)
**Feedback and discussion*		
	- What did you find, who was referred, any problems	
	- What to do back at work:	Screening 1 x a week
		Filling in forms
		Referral + list of referrals for:
		Follow -ups
		Treatment conjunctivitis
		Supervision by HSA supervisor
		+ 3-monthly collection of forms

Handouts

- Enough screening and referral forms

Comments:

EVALUATION

Objectives:

By the end of the session the student will be able to:

* Evaluate content, timing, style and practical arrangements of this workshop

Method/Plan of lesson:		**Time**
* *Individual exercise*	Filling in of evaluation from Name not needed	20
	Evaluation form	

OFFICAL CLOSING + CERTIFICATES

EVALUATION

We would appreciate your comments on this workshop so we can improve on it, and find out what else you need to learn. You do not need to write your name on it. Please finish the following sentences:

* The topic I found most useful was .....

  .....

* I had difficulty with .....(For example: a certain topic/an exercise/ trainer/ Include anything you would like to comment on.)

  .....

* Please include next time .....

  .....

* Any other comments? .....

SUPERVISION CHECKLIST
For supervising HSA's in Vision screening and Primary Eye Care

❑	Frequency of screening:	E.g. is it done regularly, once a week
❑	Location of screening:	Both health centre and village
❑	Taking history:	Is patient or parent asked questions about what is seen and what not/ any problems
❑	Distance Acuity (Use of E-chart)	Done in good light? Correct sequence? Correct distance (6 m/3m)? Form filled in correctly?
❑	Near Acuity	Does patient hold card? Form filled in correctly?
❑	Checking eyes	Done correctly (looked for 6 signs) Form filled in correctly?
❑	Referral	Is observation list used? Is patient referred for the reasons as indicated on observation list? Referral form filled in correctly?
❑	Explanations to patient/ parents/caretakers	Is the eye problem explained? Was it the correct explanation? Is the reason for referral explained? Are appropriate preventive measures discussed?
	If patient is low vision:	Is advice on use of vision given: for example: - to use it as much as possible - to use bright colours - to use good lighting conditions - to place objects near
❑	Giving eye ointment	Is it only given for conjunctivitis? Explanation of - how to use it - how often

SCREENING FORM

Name **Age**

Address/area

Tested by **Date**

DISTANCE VISUAL ACUITY

Both eyes	6/18	☐	3/60	☐
	6/60	☐	< 3/60	☐
Cannot be tested: believed sighted		☐		
believed blind		☐		

NEAR VISION

	None	☐	Medium (N20)	☐
	Large (N48)	☐	Small (N8)	☐

Distance from test card to eyes _____ centimetres

COMMENTS ON EYES _____

_____

_____ ***Referred:*** Yes ☐ No ☐

SCREENING FORM

Name **Age**

Address/area

Tested by **Date**

DISTANCE VISUAL ACUITY

Both eyes	6/18	☐	3/60	☐
	6/60	☐	< 3/60	☐
Cannot be tested: believed sighted		☐		
believed blind		☐		

NEAR VISION

	None	☐	Medium (N20)	☐
	Large (N48)	☐	Small (N8)	☐

Distance from test card to eyes _____ centimetres

COMMENTS ON EYES _____

_____

_____ ***Referred:*** Yes ☐ No ☐

SCREENING FORM

Name **Age**

Address/area

Tested by **Date**

DISTANCE VISUAL ACUITY

Both eyes	6/18	☐	3/60	☐
	6/60	☐	< 3/60	☐
Cannot be tested: believed sighted		☐		
believed blind		☐		

NEAR VISION

	None	☐	Medium (N20)	☐
	Large (N48)	☐	Small (N8)	☐

Distance from test card to eyes _____ centimetres

COMMENTS ON EYES _____

_____

_____ ***Referred:*** Yes ☐ No ☐

SCREENING FORM

Name **Age**

Address/area

Tested by **Date**

DISTANCE VISUAL ACUITY

Both eyes	6/18	☐	Pinhole: Not improved	☐
	6/60	☐	6/18	☐
	3/60	☐	6/60	☐
	< 3/60	☐	3/60	☐
Cannot be tested: believed sighted		☐	< 3/60	☐
believed blind		☐		

NEAR VISION

None	☐	Medium (N20)	☐
Large (N48)	☐	Small (N8)	☐

Distance from test card to eyes _____ centimetres

COMMENTS ON EYES _____

_____ ***Referred:*** Yes ☐ No ☐

SCREENING FORM

Name **Age**

Address/area

Tested by **Date**

DISTANCE VISUAL ACUITY

Both eyes	6/18	☐	Pinhole: Not improved	☐
	6/60	☐	6/18	☐
	3/60	☐	6/60	☐
	< 3/60	☐	3/60	☐
Cannot be tested: believed sighted		☐	< 3/60	☐
believed blind		☐		

NEAR VISION

None	☐	Medium (N20)	☐
Large (N48)	☐	Small (N8)	☐

Distance from test card to eyes _____ centimetres

COMMENTS ON EYES _____

_____ ***Referred:*** Yes ☐ No ☐

SCREENING FORM

Name **Age**

Address/area

Tested by **Date**

DISTANCE VISUAL ACUITY

Both eyes	6/18	☐	Pinhole: Not improved	☐
	6/60	☐	6/18	☐
	3/60	☐	6/60	☐
	< 3/60	☐	3/60	☐
Cannot be tested: believed sighted		☐	< 3/60	☐
believed blind		☐		

NEAR VISION

None	☐	Medium (N20)	☐
Large (N48)	☐	Small (N8)	☐

Distance from test card to eyes _____ centimetres

COMMENTS ON EYES _____

_____ ***Referred:*** Yes ☐ No ☐

FORM FOR PATIENT **to take to nearest health centre or hospital**

Name **Age**

Tested by ____________________ Area ____________ Date __________

Distance visual acuity ____________

Near vision ____________

Comment on eyes and/or on problem signs ____________________________

____

____

FORM FOR PATIENT **to take to nearest health centre or hospital**

Name **Age**

Tested by ____________________ Area ____________ Date __________

Distance visual acuity ____________

Near vision ____________

Comment on eyes and/or on problem signs ____________________________

____

____

FORM FOR PATIENT **to take to nearest health centre or hospital**

Name **Age**

Tested by ____________________ Area ____________ Date __________

Distance visual acuity ____________

Near vision ____________

Comment on eyes and/or on problem signs ____________________________

____

____

FORM FOR PATIENT **to take to nearest health centre or hospital**

Name **Age**

Tested by ____________________ Area ____________ Date __________

Distance visual acuity ____________

Near vision ____________

Comment on eyes and/or on problem signs ____________________________

____

____

ATTACHMENT R

REPORT OF LOW VISION RELATED ACTIVITIES, MALAWI, JAN-APRIL 1996

LOW VISION PROGRAMME MALAWI

Karin van Dijk - Advisor on Low Vision and Blindness
Education of the Blind
P.O.Box 5192
Limbe
[illegible]

Mr. Y. Antonio - MACOHA
Mr. Kanjoloti, O.M.A., Chikwawa District Hospital
Mrs O. Kalonga, O.M.A. Blantyre
Mrs H. Kazembe - LSHS
Mrs. R. Lewdon, Optometrist, QECH
Mr. Linyanga - Education of the Blind
Mr. Mapemba - Malawi Blind Union
Mr. Mwalija, MACOHA
Mr. Ngosi, Special Education Officer - Ministry of Education
Mrs. C. Witte, Country Director IEF (International Eye Foundation)

June 11, 1996

Dear member of the low vision task-force,

Please find enclosed the minutes of the low vision task-force meeting of June 10, 1996.

The date of the sixth low vision task-force meeting is:
Monday September 9, 1996, at 9.00 am
at MACOHA head office, Kidderminster Avenue, in Limbe.

Looking forward to seeing you all on September 9.

Yours sincerely,

[illegible]

[illegible] Chimbe, Secretary Registrar, MACOHA
Dr. M. Chihambo, KCH; Sight Savers
Mr T. Malaidza - Director Education of the Blind

Minutes of the low vision task-force meeting of June 10, 1996

Members present
Mr. Kanjoloti, O.M.A., Chikwawa District Hospital
Mrs. Kazembe - Coordinator O.M.A. training Ilongwe
Mr. Limyanga - Education of the Blind
Mr.Mpemba - Secretary National Union of the Blind
Mr. Mwalija, MACOHA
Ms. K. van Dijk - low vision advisor

Apologies
Mrs Lowdon
Mrs . C. Witte
Mr. Antonio

Welcome to all members, especially to Mrs Kazembe, who recently returned from studies in Community Eye Health in London.

Minutes of the previous meeting were approved.

Progress report

* The healthy eyes activity book for primary schools
This new book has been translated in Chichewa by Mrs Kazembe. It is expected to be ready by the end of the year. Funding for large scale production is sought.

* HSA training in Chikwawa district
16 HSA's and 15 primary school teachers have been trained (IEF funding), and another 16 HSA's through Sight Savers funding, so far.
Results from the first groups are being collected. Mr Kanjoloti said he had e.g. 30 good referrals from 1 HSA, of whom 5 had cataract.
Discussions with IEF will be held on training of more HSA's.

Contact has been made with the MACOHA officer in the area, for inclusion in the next training.

* CBR Machinga

8 field workers were trained in rehabilitation of visually impaired people. A total of 3 days was spent on Primary Eye Care, screening and low vision (facilitators Mr Kanjoloti and Ms K. van Dijk). The field workers are expected to start working in June. Follow training is planned for the end of 1996.
In each of the 8 Traditional Authorities where they will be working, a one day training was held of community leaders. The Itinerant Teacher of the area was also involved.
Contact with the O.M.A., Mr Chaliji, is being established.

* Summary of other Low vision programme activities:
  - visits to some resource centres, Lulwe and ITP's for:
    + assessment of low vision children by O.M.A.
    + prescription of magnifying glasses by O.M.A.
    + follow up on functional assessment and other low vision work of specialist teachers

Statistics can be found in the January - April 1996 report.

- Teaching of 12 teachers in low vision by Mr K. van Dijk in Kenya, for the Kenya low vision project.
- Organising of 4 low vision workshops by the low vision advisor at the CBM Africa conference in Mombasa.

* Distance and near charts, the low vision assessment books, pinholes, occluders, pointers and writing stands + miscellaneous record forms are all printed in Malawi.
A first trial of the symbol chart will be ready shortly.

* Production of magnifiers at the optical Nkhoma Mission Hospital is starting now a technician has been trained in Botswana.

* The Zomba and 5 Machinga Itinerant teachers received a week training in low vision in May. These were the last specialist teachers to receive the basic low vision training.
Follow-up training for all specialist teachers will take place between October and December 1996.

* More O.M.A.'s, especially those working in the IT districts will receive training in low vision assessment and refraction. Many children in the ITP's have now to wait for months before assessment. This training should make low vision assessment available nearer the ITP's.

Budget 1997

* Agreed was to ask 50 MK for a pair of glasses and 50 MK for a magnifier, when prescribed through the low vision programme (Nkhoma) from 1997.
A system for cost recovery will be studied.
Poor pupils will still receive glasses and magnifiers free.
The CBR programmes can order glasses and magnifiers for low vision clients through Nkhoma and will pay the 50 MK per item.

* The different CBR programmes will budget money for assorted low vision materials, like the Low vision kit (2 books), charts, writing stands, record forms.
The low vision programme will have most items produced in large quantities, so they can be bought for a very low price.
Also money will be budgeted for glasses and magnifiers.
Each programme will look at its needs for 1997.

* **Draft guidelines**
Comments were given on the draft guidelines for admittance of low vision children to the various Education of the Blind programmes.
Only minor changes were suggested.
A final draft will be discussed at Montfort College, before sending a final version to the Ministry.
The members of the Low vision taskforce will receive a copy.

Miscellaneous

* The O.M.A. training in Lilongwe is incorporating low vision in their curriculum. Material needs will be further discussed.

* A list of common myths and beliefs concerning blindness and use of vision will be circulated by K. van Dijk.

* Mr Mapemba reported on the progress of the Malawi Union of the Blind.
3 key members received training in fund raising in Zimbabwe in February this year.
And 2 members will be sponsored to attend the World Blind Union General assembly in Canada later this year, while the African Blind Union will come and give leadership training.
MUB is seeking funding.

* Mrs Kazembe reported on the WHO prevention of blindness workshop held in Lilongwe beginning of June. People from 17 countries participated.
main recommendation was to train more personnel, especially ophthalmologists and cataract surgeons.
The training of a kind of assistant optometrist will be worked out further.

Next meeting
Monday September 10, 1996 at 9.00 am, MACOHA, Limbe.

REPORT ON LOW VISION RELATED ACTIVITIES
Malawi Low Vision programme January - April 1996
Partner organisation: Education of the Blind

By: Karin van Dijk
[illegible]

Introduction

The first report after the annual report of 1995, on the progress in the Malawi low vision programme.
While the children in the2 blind schools and the 15 resource centres were screened, clinically assessed and refracted, the children in the Itinerant Teaching programmes are being assessed in 1996. A more difficult task since they are scattered over many schools and kilometres.
Also a start is being made with the prescription of magnifying glasses for reading.
And a new tutor started work at Montfort College. He will also be teaching low vision in future at the college.

Main activities

- Visits to Blantyre and St Patricks Secondary School, Blantyre ITP, Zomba ITP, Salima ITP, Nsiyaludzu resource Centre, Lulwe school for the Blind, Mpatsa - Matundu - and Makande resource centres.
  Most visits were made with an O.M.A.'s and more emphasis was placed on trying to get children to read print through prescription of magnifying glasses (in the blind school and resource centres)
  Most children visited in the ITP's were seen for the first time and most time was spent on clinical assessment, refraction and referral for treatment where needed.
  More details on the ITP children are found in the Appendix.

- Worked with Mr Linyanga, the new tutor and Mr Kophazi, Specialist teacher at Montfort Demonstration school on assessment and the teaching of print to low vision children.

- Teaching the low vision module to newly arrived teachers, who are trained to be specialist teachers at the blind school and resource centres. The whole training (6 months) is funded by the Ministry of Education
  Mr Linyanga is already assisting in the teaching.

- Had near vision charts and various recording forms printed locally

- Gave advice to the first adult low vision client who phoned me, after losing vision due to a car accident.

- Visited Malumulo Hospital and the CBM supported optical workshop in Makwasa.

- Gave follow-up training of 1 1/2 days to the 7 O.M.A.'s trained in refraction and low vision last year. Emphasis was on the achievement of 1995 and the prescription of magnifying glasses.

- Gave an afternoon training in low vision at staff of the eye ward in Queens Elizabeth Central Hospital in Blantyre.

- Held discussions with MACOHA people on low vision input in CBR Machinga training.

- Fourth low vision task force meeting was held, which concentrated on looking of resources related to low vision (like charts, low vision devices) needed in eye care, education and rehabilitation programmes.

- Talks were held with Steve Graham, a paediatrician at Queens Elizabeth Hospital to give advice on testing changes in visual acuity of children of 6 months - 5 years. This in relation to a try out of Ethambutol for treatment of TB. This might cause (quick) loss of visual acuity and in those cases treatment needs to be stopped immediately.
  Further talks are planned for May.

- Participation at 2 meetings aimed at developing a policy on Special Education for Malawi at Mont fort College.

- Trained 25 Kenyan teachers in functional assessment and vision training at a seminar organised by the Kenya low vision project at Thika School for the Blind, Kenya.

- Attended the CBM co-workers conference in Mombasa and organised the 4 low vision workshops.

- Trained 8 CBR workers, who will be based in Machinga district in low vision.

- Finalised the training curriculum on primary eye care and vision screening, developed on the basis of the IEF (international Eye Foundation) supported pilot programme in Chikwawa.
  More HSA's are being trained in the district. Training is done using the curriculum.

STATISTICS January - April 1996

1. **Resource centres/blind schools**

A number of children have been re-checked with emphasis on prescription of magnifying glasses. The categories below are used to classify the children.

1.	Blind	Braille user
2.	Low vision	Braille user + can use sight for e.g. mobility/ functional literacy
3.	Low vision	Print user, with an optical low vision device
4.	Low vision	Print user, without an optical low vision device
5.	Normal vision	

These statistics are only on low vision children in the programmes.

2 to 3/4: means that all these children are still/or have been using braille for school work, but are learning print/have learned now. Some children will be able to use print exclusively on future, while others will continue needing braille, as they can only manage (very) large print with an optical low vision device.

Centre/school	Categories						
	1	2	3	4	5	2 to 3	2 to 4	Total
Lulwe		3				7	3	13
Matundu		1 (a)		1		4		6
Mpatsa							1	1
Makande		1 (a)		3		1		5
Nsiyaludzu		3 (a 1)		10				13
Salima		1			1 (b)	1	4 (a 1)	7
St Patricks						2	2	4
Blantyre Sec.		4 (c 3)				4		8
		13		14	1	19	10	57

(a) Needs an operation (cataract/optical iridectomy), then re-assessment of distance and near visual acuity.

(b) Once glasses have arrived

(c) Have not been assessed for optical low vision devices yet.

2. **Data on the itinerant teaching programmes**
These cover both 1995 and 1996.

Assessing children in the ITP's has only started recently. Many children are still awaiting clinical assessment and refraction, due to:

- (1) [illegible] of O.M.A.'s who have had training in assessing low vision children)
- limited skills equipment of O.M.A.'s in district hospitals in the ITP districts. This should improve, as those O.M.A.'s will receive training in low vision assessment and refraction on September 1996.

The aim is to have all children in the ITP's assessed by an O.M.A this year.

These statistics are based on the forms both specialist teachers and O.M.A.'s have sent. There are certainly more children assessed, but data are not available yet at this moment as some teachers and/or O.M.A.'s have not sent in all their forms yet.

A. **Children both assessed by the specialist teacher and an O.M.A.**

A total of 186 children in the ITP's have had assessments by teacher and O.M.A. as known at this moment.
133 of these fall in category 5, which is normal vision. Category 5 reflects the number of children screened by the teacher, who proved to have normal vision before and/or after assessment by the O.M.A.
These children are, presumably, not visited by the teacher.
Most low vision children fall in category 4, where they can read without the help of an optical low vision device.
The total number of low vision children (cat 2 - 4, 2 to 3 and 3 to 4)) is 49
4 are totally blind (cat 1).
Low vision is almost 38 % of the total number assessed.

ITP	Categories							
	1	2	3	4	5	2 to 3	2 to 4	Total
Blantyre	1	1		1	9	1		13
Chikwawa		1		3				4
Lilongwe				9	29			38
Machinga		1		6	3			
					18			28
Rumphi	3				12			15
Salima		4 (a 3)	4	9	3			20
Zomba				9	3 (e)			
					56 (f)			68
Total	4	7	4	37	133	1		186

* Of the 28 from Zomba ITP with VA 6/12 - 6/6 7 achieved this acuity through correction of a refractive error, the other 21 needed no glasses.
All 3 of Zomba ITP with VA of 6/18 needed correction to achieve this.

(e) These are children with Visual acuity 6/18
These are given separately, since they are just above the low vision definition of < 6/18 and need careful assessment to make sure they can manage without the assistance of a specialist teacher (likely for most cases).

(f) These have visual acuity from 6/12 - 6/6. These have normal vision.

B. Children only screened by the specialist teacher and not by an O.M.A. yet.

A total of 227 have been screened and data recorded and sent by the teachers.
Before assessment by the O.M.A 92 already fall within the normal vision range (cat 5).
A possible 118 are low vision.
If again about 38 - 40 % of the 227 proves to be low vision, a number of about 90 children might be really low vision. This is of course only a rough estimate. The number might be much higher/lower.

ITP	Categories							
	1	2	3	4	5	2 to 3	2 to 4	Total
Blantyre				3				3
Machinga	9	1		50	26 (g)			
					38 (h)			124
Salima				9	5 (g)			
					3 (h)			17
Zomba	8			55	8 (g)			
					12 (h)			83
Total	17	1		117	92			227

(g) These are children with Visual acuity 6/18 as screened by the teacher.
(h) These have visual acuity from 6/12 - 6/6 as screened by the teacher. These have normal vision.

ATTACHMENT S

JOHN M. BARRROWS, MALAWI, JUNE 19-27, 1996

FILE
ChildSight

Trip Report
John M. Barrows, Director of Programs
Malawi, June 19 - 27, 1996

Purpose:

1. Review administrative policies
2. Review CS/VA project activities
3. Review STAFH project activities
4. Review ChildSight project activities
5. Review inventory and outstanding procurement

Activities:

Administrative:

- *Salary increases for staff.* Staff in Nchalo expected two increases in their salaries. One increase is the merit increase. Currently, there are six staff remaining that expect their merit increase (a minimum of 10% as stated in the current personnel policy and contract). All others have received a merit increase. Additionally, staff are expecting a cost of living (COL) increase to meet the increased cost of living due to the devaluation of the Kwacha and the inflation (it is unclear whether it is closer to 19% or 90% depending upon who you talk to). Apparently, the MOH has also recently announced salary increases up to 20%-30% further fueling the need for an increase, but the MOH has not yet provided these increases and in some cases have not even paid staff for several months at the old rates. Since April 1994, there have been salary increases for IEF staff ranging from 20% to 30% twice annually in response to the devaluation of the Kwacha (MK6/US$1 to MK15 to US$1) increased prices and inflation. It appears that staff are expecting the same percentage increases twice annually to continue.

Currently, staff expect the following:

1) COL -- an annual cost of living increase provided twice annually during April and October,
2) merit increase of not less than 10%,
3) Christmas bonus equal to one months salary before tax,
4) leave grant equal to MK150 for senior staff and MK300 for junior staff,
5) severance payment pro-rated (amount?)
6) housing allowance of 15% (some enjoying a subsidy greater than 15% (some of which can receive the cash in lieu of the payment),
7) option to cash in 10 days of paid leave,
8) medical costs at Montfort Hospital for self and immediate family.

The current proposals for large twice annual salary increases are unjustified and administratively onerous to track. Christine has consulted two other PVOs concerning salary levels and raises to determine what is a reasonable policy regarding responding to inflation and other general benefits.

Mr. Chipwaila was asked to provide salary levels for all staff over the past two-three years in order to determine the rate of salary increases against. A review of the increases show that the average increases cannot be maintained and given the fact that the Kwacha is stabilized and inflation is closer to 20%, a much smaller COL increase will be provided. It was presented to all staff in Nchalo that there will be a 15% increase for Junior staff and 10% increase for senior staff retroactive to April 1st.

It is also recognized that IEF policies need revision. Recommended changes are limiting merit increases to 10% maximum; a once per year COL increase; calculation of merit bonus, Christmas bonus, severance, housing benefits based on the average income during the year and not on the last increase received. Revision to the option to cash in 10 days paid leave per year will be at the discretion of the Country Director.

To gain a better understanding of general inflation at the household level Christine has begun to monitor the costs of certain common foods and household products (ufa, oil, beer, soap etc). This "food basket" approach will be used to determine increased costs periodically and suggest adjustments to salaries annually.

- *Lost check:* The National Bank proposed to split the loss resulting from the forged check in the amount of MK16,000. While the bank has to date been unable to find the forged check, IEF's explanation for control of the check book is weak. Splitting the loss settles the matter.

- *Vehicles:* Condition of the vehicles is poor. In Blantyre the Toyota Cressida station wagon is now in working condition after another large repair bill. The Toyota sedan is undergoing some minor repairs. Christine proposes to sell both vehicles and purchase one new vehicle with higher ground clearance. The sale of the two vehicles would go towards operating costs.

The Toyota 4x4 in Nchalo is in poor condition and at least two of the six motorcycles are in poor condition requiring constant repair costs. It was determined that the MTE should be completed to assess whether the project merits a no-cost extension to complete its objectives. If USAID is likely to grant the extension, then budgeting for a new vehicle needs consideration. In the meantime, the existing vehicles will have to be used conservatively. Concerning a possible vehicle replacement, it may not be necessary to have a larger 4x4, but instead a small Suzuki jeep-like vehicle for supervision purposes only. Carrying people seems to be only a function of the continuous training sessions. It should be determined whether this continuing training is necessary and whether it should continue with the same frequency.

- *Procurement:* A second laptop for Christine is necessary as the demand for computers has increased with staff becoming more familiar with their use. A laser printer in the Blantyre office would be very useful but not absolutely necessary. However, given the number of persons using the Blantyre office, both Blantyre staff (3) and Nchalo (2) and improvements in reporting and document preparation a new printer would give IEF added efficiency, reduced cost, and professionalism.

CS/VA:

- *MTE.* The guidelines for the MTE were reviewed and discussed. A SOW for the evaluation was modified and left for comments. Preparation for the MTE will include:

  - MTE KPC survey is underway and scheduled to be completed by July end. It is unclear how the sample for the survey was made and should be clarified in the report. The previous baseline survey EpiInfo questionnaire file was modified for imputing MTE KPC data. The modifications need to be tested before all data is imputed. The possibility of hiring a consultant (Dr. Kumwenda) was raised to assist with data entry and preliminary analysis.
  - preparation by intervention all process data on activities undertaken.
  - completion of a knowledge questionnaire (VA, diarrhoea, breastfeeding, EPI, HIV/AIDS, FP methods) among HSAs, Health Assistants, Health Inspectors, and VHVs. Eighty of 105 HSA have completed the questionnaire.
  - quality assurance assessment of health workers (EPI,VA). There is a planned national immunization day (2 days) that will focus on polio immunization. During this time VACs will also be distributed. A modified MAP quality assurance assessment form was discussed that could be used by the VHVs who will be the primary distributors of vaccine and VACs.

- *Training.* The training schedule was reviewed. Concerns raised were that training was being undertaken without any assessment of training needs. All training already scheduled will take place. However, all other planned training will be put on hold in order to provide time to prepare for the MTE and to assess the overall training program. Of particular concern is the lack of a supervision schedule and any measure of health worker performance.

The possibility of sending Ifeoma Umulo from Nigeria to Malawi for 1 month was proposed. Ifeoma could be given the task of reviewing all training curriculum, preparing the curriculum into a standardized format and notebook, and making recommendations for a supervision component. Considerations for the MIS might also be included in the SOW, especially considering that the previous system has withered and the newer MfE effort is in vogue and a possible substitute.

- *IGA.* One of the income generation projects was visited. The village of Lazarus recently completed a large (20" x 60") chicken coup to house 300 egg laying hens for income generation. The committee was composed of highly motivated individuals including IEF VHVs. The concept is to produce eggs for sale (1 egg day x 52 weeks? x 300 hens) and leverage the funding in the form of small loans. Christine had concerns that there was not enough shared expectations concerning how generated money would be used. There is also considerable inputs required: vaccine and layers mash. The IGA could be either a large success or failure.

ChildSight:

- *Collaboration with Karin van Dijk, CBM Low Vision Consultant.* Karin prepared a list of possible follow-up activities for continuation of the IEF/CBM ChildSight and Low Vision activities. These activities include: 1) printing screening and referral slips, 2) train new HSAs and teachers, 3) follow-up training for HSAs and teachers, 4) train new OMAs in refraction, 5) provide more equipment to trained OMAs, 6) print training curriculum and E-charts.

Outstanding activities to be completed are the transport of previously identified children during the blind school surveys for refraction and or surgery. There is also the need to organize Grace Funsani, Eye Care Coordinator's, time to conduct necessary follow-up of training and referrals. All existing referrals have been entered into the computer program created by Joe Canner.

IEF is willing to commit or consider committing itself through remaining ChildSight funding and through CS/VA funding to 1) print new referral slips $500, 2) train new HSAs and teachers in Nchalo and Ngabu after assessing the quality of the first training activities, 3) follow-up training on the first 16 HSAs, 4) possibly train HSA in Nsange, 5) contribute towards the costs of training new OMAs in objective refraction (those in the southern region only), 6) contribute towards the costs of printing training curriculum and small E-charts. In addition, IEF is committed to paying the costs of transporting identified children from their homes to surgery sites (KCH or QECH).

It was decided that before new training be considered an assessment be done of the previous training. Rosemary Lowdon will be contracted 5 days to assess HSA, teacher, and OMA training. CBM will also be evaluating the Low Vision Program in June or July 1997 which could be coordinated with IEF. CBM will also support an ophthalmologist, Dr. Brian Savach (sp) coming from Botswana beginning January 1st, 1997. The Zairian ophthalmologist is scheduled to come to Malawi QECH beginning August 1st.

- *Seeing 2000.* The Seeing 2000 proposal submitted by Dr. Moses Chirambo was reviewed with Karin to identify overlap with the activities discussed above. Karin was surprised that she was not consulted by Moses as many if not most of the proposed activities describe the existing attempts to establish screening, referral, and surgery for children under the IEF/CBM activities. A copy of the proposal was provided to Karin to make herself a copy and to review for a meeting on Sunday.

It was agreed that we should identify areas of overlap between existing activities and those proposed so that Dr. Chirambo can be asked to clarify questions in writing. Overlap can be dealt with by concentrating by geographic areas and or concentrating on completion of existing activities or maintaining existing activities and concentrating on the sustainability of the referral activities. It is clear that the proposal will require some adjustment so as not to duplicate the existing activities, provide credit to the existing projects, and ensure the budget is properly spent.

Dr. Chirambo was consulted on Friday 24th concerning coordination and the issues of overlap. He suggested a meeting be held between IEF, CBM and himself to develop a workplan.

UNICEF Grants:

- *MfE.* Meets were held with Kristine Jones responsible for the UNICEF grants. The Monitoring for Empowerment (MfE) activity in into its 6th round of monthly data gathering. Chikwawa district has a high rate of returned forms compared to other areas. The modified forms to include other health data has been collected at least twice. A visit was made to one of the health centers to see an HSA who is very active in data collection. On his own initiative, he was tracking data on graphs (a photo was taken of 4 months of cumulative data). Mr. ..... District MCH Coordinator also accompanied us and was able to provide information on the use of the MFE system. He claimed that out of the 103 HSAs 87 were actively involved in monthly monitoring. (The discrepancy may be due to the fact that many HSAs are not yet posted to health center/station sites). Mr..... was also under the impression that not all HSAs were consistently reporting monthly data, but there was a general impression that the HSAs liked the system. Mr. .... was not very articulate concerning how the system was actually working nor was he very useful in discussing his own impressions on the system (strengths and weaknesses). He had nothing to add concerning the appropriateness or inappropriateness of indicators or frequency of reporting data.

The plan for evaluating the system were briefly discussed. The plan for evaluating mechanisms for communicating results to communities was not drafted. Suggestions were:

I. Design/adaptation to Chikwawa District
- review HSA questionnaire and add performance observation
- calculate time required
- calculate resources needed and possible solutions to decentralize supply of forms
- outline options for feedback to community
. use of TFT as method for feedback
. use VHC action plans
. checklist for VHC actions and villager perception/knowledge of MFE/VA Plans
. monitor health data

II. Outputs will be:
- descriptive information on HSA/supervisor performance:
. # reporting timely
. # complete and accurate reports (including observation)
. explained purpose
. weighed/recorded properly
. determined age correctly
. etc,
. # developed/kept summary for HC use

. # provided feedback to community (days/hrs) by method
. average time required to complete monthly activities
. average amount of time between when reports are sent to supervisor (HSA/HA/district/national) and feedback is received back on reports
. other initiatives resulting from monitoring
- modified TFT curriculum for HSAs to use in providing feedback to VHCs on monitoring data including village action plans
- VHC knowledge of health information
- checklist to monitor VHC use of action plans that may be extended to community members understanding of monitoring data
- community members knowledge of health information
. drafted sustainability indicators

The donated UNICEF computer is currently in the office pending a decision on who will use the computer at the Chikwawa district hospital.

- *Gardening*. The recently drafted Gardening DIP was read. A review of the DIP was begun but not finished. Overall the DIP is still very ambitious with multiple activities and a very limited time period.

The need to conduct a nutrition survey was reviewed. The HKI/VITAP rapid survey was suggested as an instrument to use for a baseline and post-intervention survey.

The number of villages was reduced to 7 villages and 42 gardens. Suggestions are to monitor # gardens, vegetables sown, germination rates; vegetables product produced, harvested and consumed in household; promote only high content vitamin A-rich vegetables; de-emphasize seed replication; expand the nutrition curriculum to all micronutrients and not only VA; de-emphasize cooking time as a problem; introduce cooking demonstrations activities; emphasize maximizing available foods and adding oil end energy foods; monitor sale vs consumption rates if possible. The hiring of a Coordinator was underway during the visit.

STAFH Project:

- *DIP*. Several meetings were held with Robyn Delehanty to discuss a number of issues. The DIP and the design and organization of the baseline survey was discussed. A recent issue was raised by Ruth Kornfield STAFH Behavior something in Lilongwe concerning the DIP objectives and indicators. It was suggested, quite late in the process of writing the DIP, to eliminate the general population indicators since the project is targeting specific target populations. These target populations are 1) employees, 2) STD patients/providers, 3) single women of reproductive age (includes commercial sex workers), 4) HIV positive people, 5) Kapachira Falls catchment area, 6) youth AIDS clubs, 7) men/women of reproductive age around villages with a community based distributor.

Because the indicators may be changed to eliminate or de-emphasize the general population indicators, the Cooperative Agreement may need to be amended to reflect these changes. At a minimum a letter from USAID is necessary concurring with the changes.

Other issues discussed were: 1) there is a clear distinction between the CS/VA project and the STAFH project as requested by USAID Mission, 2) BLM will participate but only beginning in year two, 3) HOPE wants continued involvement in SUCOMA but not at an operational level, 4) the Montfort counseling center has increased the number of consultations and has become more viable perhaps due to increased support from the resident doctor, 5) care counseling technique training is being provided to IEF staff and project participants, 6) the home care kits for use by volunteer home care providers are increasingly scarce. These kits contain ORS, gloves, aspirin, Fansidar and soap. Gloves especially are scarce and essential to protect the HCP form infection. A specific in-kind donation should be solicited from Johnson and Johnson for this purpose.

A meeting of STAFH staff was held to review these issues and gain an update on activities of each staff (Mr. M'Manga FP/STD Coordinator, Mr. F. Mbutuka, HIV/AIDS Coordinator, and Mr. P. Chibisa, Assistant HIV/AIDS Coordinator).

- *Baseline survey.* The baseline survey is still not designed. It is proposed that Diana Cammack, a consultant living in Lilongwe be hired to review HOPE's and SCF's baseline surveys by the 12th, design the survey and get feedback y the 19th, and begin field testing by the 2nd. Most of this would be done in the absence of Robyn while she is in Vancouver attending the AIDS conference but will be under the supervision of Christine in her absence. A meeting with Diana was held on Friday 24th before departure to discuss the SOW and contracting arrangements.

WVI:

A letter from World Vision/Malawi requesting that IEF send staff to participate in a workshop was discussed with Mr. Chipwaila. The purpose of the workshop was very unclear and clarification was requested before the attending the meeting. The purpose is related to a 2 million Canadian$? grant WVI received from Canadian government for a micronutrient and health initiative concentrating on iron and iodine. Supposedly, WVI is attempting to request proposals for smaller grants to implement iron and iodine projects but no RFA or clarification of purpose has been made available. There is a proposal outline that was faxed to the IEF office. Further contact is planned.

PHR:

Requested Lily to email Partnerships for Health Reform (PHR) project for information on its new small grants project for investigating on health reform issues. Small grants will be competitively awarded up to $25,000 for applied research projects.

Persons seen or contacted:

IEF:
Christine Witte
Mr. Chipwaila
Robyn Delehanty
Kristine Jones
All other IEF staff

PVO/MOH:
Karin van Djke
Dr. Moses Chirambo
Mrs Rose Namarika, WVI, Micronutrient and Health Program; Blt p 670311; f 672030
Ll p 743993; f 742894
Diana R. Cammack, PhD, consultant, P.O. Box 1607, Lilongwe; 743983

MOH:
Health center staff (MA, HA) ???
Mr. Luhanga, DHI, Chikwawa district

Attachments:

Knowledge questionnaire for health workers
Training schedule
Notes with Karin van Dijk
Resume of Diana Cammack (filed)
STAFH DIP (filed)
Samala Moyo (Anti-AIDS Club Newsletter) (filed)

ID #: 050

IEF/MALAWI CHILD SURVIVAL PROJECT
KNOWLEDGE ~~PRACTICE~~ QUESTIONNAIRE
FOR HSAs, HAs, HIs and VHVs

Interview date ___/___/__

Interviewer name: _____

Village and T/A: _____

1. Name: _____

2. Age: ___ ___ (years)

3. Schooling completed: Standard ___ ___ Form ___ ___

4. What is vitamin A good for?
(Circle all answers given)
1 don't know
2 prevent blindness/nightblindness
3 prevent diarrhea
4 prevent ARI
5 prevent malaria
6 nothing
7 other (specify: _____)

5. What foods contain Vitamin A?
(Circle all answers given)
1 don't know
2 green leafy vegetables such as pumpkin leaves/amaranth
3 yellow fruits such as mangos
4 meat/fish
5 breast milk
6 egg yolk
7 none
8 other (specify: _____)

6. How often should a child receive a vitamin A supplement?
(Circle one answer only)
1 don't know
2 every _____ months
3 every _____ years
4 never

7. How much vitamin A does a child under 12 months get: _____

8. How much vitamin A does a child over 12 months get: _____

9. Within what period of time after birth should a woman receive a vitamin A supplement? **(Circle one answer only)**
   1 don't know
   2 within _____ days
   3 within _____ weeks
   4 within _____ months
   5 never

10. How much vitamin A should a woman get: _____

11. Demonstrate how vitamin A supplementation is done
   1 correct
   2 incorrect (Problem: _____)

12. When should a mother begin to feed her baby food or water? **(Circle one answer only)**
   1 don't know ------> **GO TO #13**
   2 immediately after birth ------> **GO TO #13**
   3 after _____ days
   4 after _____ weeks
   5 after _____ months
   6 never

13. Why should a mother avoid giving her baby food or water before this time? **(Circle all answers given)**
   1 don't know
   2 prevents diarrhea
   3 improves health
   4 save money/food
   5 other (specify: _____)

14a. If a mother has a child under six months with diarrhoea what should she give the child? **(Circle all answers given)**
   1 don't know
   2 breastmilk
   3 food
   4 water
   5 ORS
   6 sugar-salt solution
   7 rice water
   8 fruit juice
   9 other (specify: _____)

14b. If a mother has a child six months or older with diarrhoea what should she give the child? **(Circle all answers given)**

1 don't know
2 breastmilk
3 food
4 water
5 ORS
6 sugar-salt solution
7 rice water
8 fruit juice
9 other (specify: _____)

15. When should the mother with a child who has diarrhoea take the child to the health centre?

1 don't know
2 child is dehydrated, has sunken eyes, loose skin...
3 blood in stool
4 large volume of stools
5 always
6 other (specify: _____)

16. Demonstrate mixing and dosing of ORS

1 correct
2 incorrect (Problem: _____)

17. What immunizations should a child receive?
(Circle and fill in blank for all answers mentioned)

	Ideal age for dosage			
Vaccine	#1	#2	#3	#4
BCG	_____	_____	_____	_____
DPT	_____	_____	_____	_____
Polio	_____	_____	_____	_____
Measles	_____	_____	_____	_____

18. What are benefits of immunization?

1 don't know
2 prevent diseases
3 other (specify: _____)

19. When should a child not receive an immunization?

1 don't know
2 child is already ill
3 other (specify: _____)

20. What vaccine should a woman of childbearing age receive?

1 don't know -----> **GO TO #23**

21. How many doses of TTV should a woman have?
1 don't know
2 _____ doses

22. For what reason should a pregnant mother received TTV?
1 don't know
2 to protect both mother and child against tetanus
3 to protect the mother only against tetanus
4 to protect the child only against tetanus
5 other (specify: _____)

23. How is HIV/AIDS transmitted from one person to anothe?
(Circle all answers given)
1 don't know
2 from infected mother to child in womb
3 sex with infected person
4 contaminated razor blades and needles
5 other (specify: _____)

24. How can someone avoid getting infected with HIV?
(Circle all answers given)
1 don't know
2 abstain from sex
3 stick to one partner
4 use a condom
5 avoid used razor blades and needles
6 other (specify: _____)

25. What methods are available to prevent pregnancy?
(Circle all answers given)
1 don't know
2 tubal ligation
3 vasectomy
4 injections (depo-provera)
5 pill
6 IUD
7 condoms
8 foaming tablets/gel
9 other (specify: _____)

26. Where should a woman go to get one of these methods?
(Circle all answers given)
1 don't know
2 CBD
3 nearest health centre
4 Chikwawa District Hospital
5 other (specify: _____)

27 Demonstrate use of condom
1 correct
2 incorrect (Problem: _____)

M E M O R A N D U M

From : Genner Chipwaila,
Project Manager - Child Survival (IEF),
P.O. Box 142, Nchalo, Malawi.

To : Dr Christine Witte,
The Country Director - IEF,
P.O. Box 2273, Blantyre, Malawi.

Copy : Mr John Barrows,
Director of Programs - IEF,
7801 Norfolk Avenue,
Bethsdda, MD 20814 - U S A.

Date : 20th May, 1996

UPDATED IEF (CHILD SURVIVAL) PLANNED ACTIVITIES 1996 - CHIKWAWA, MALAWI

Due to sharing of IEF activities between Child Survival and STAFH Projects the planned activities for 1996 have been updated as seen on the attached copy.

Submitted to you for information.

international eye foundation

Child Survival Project (Chikwawa)

1996 Activities

I Child Survival and AIDS [Up to March]

January, 1996

- Monitoring for empowerment 8th - 10th.
- Planning Vitamin A Education in schools 16th - 26th.
- Poultry training for IGA (Mbewe EPA) 17th - 18th.
- Planning workshop for volunteers 18th - 19th.
- U5 and Maternity Clinic exit interviews; 18th - 31st (Chikwawa, St. Montfort and Ngabu).

February

- HSA interviews for performance evaluation; 12th - 29th.
- Review of breastfeeding activities; 19th - 23rd (Ngabu).
- Drought Survey by SCF (UK). - Mr Mekiseni from 19th.
- Peer educators training; 19th- 23rd (bargirls).
- Computer refresher course for 4 IEF staff; 26th - 1st March (Sucoma).
- Staff meeting; 16th.
- MoH/IEF Coordination meeting 21st - 23rd.
- District AIDS drama competitions, Ngabu, Chikwawa, Nchalo, 24th.

March

- Traditional healers training on AIDS and PEC from 5th to 28th March in Gaga, Chapananga, Kakoma, Ndakwera, Makhwira, Maperera, Nchalo, Dolo.
- Ceremony on orphans support with clothes 6th.

March (cont'd)

- Drama shows on AIDS; mid - March.
- Distribution of commodities to communities in Chapananga.
- Program Advisory Committee meeting 6th March; IEF offices.
- Staff meeting 15th.
- DRF training for extension workers (HAs) - 19th to 21st; Lengwe [5].
- International Vitamin A Core Group meeting; 17th to 24th.

II Child Survival

April

- DRF refresher course for volunteers; 1st to 3rd. [6]
- CBD refresher course 17th to 19th (Chikwawa). [20]
- PEC screening - Ngabu area.
- Drought study and report writing.
- IGA supervisory visits.

May

- Staff meeting 9th.
- MoH/IEF Coordination meetings; 22nd - 24th [90].
- Vitamin A promotion by drama 13th - 28th (5 communities).
- VHV/VHC trainings; Gola area 20th - 24th [90].
- Draft Manual for vitamin A training for Ext. workers.
- Mid-Project planning Survey (Design, Translate, Pretest, Train); 27th - 31st [5].
- Project Managers meeting; 24th, Blantyre.

June

- Mid-project survey; 3rd to 28th.
- TBA (old) refresher course; 10th - 15th (Ngabu) [15].

June (cont'd)

Poultry keeping refresher and sales management course; 10th - 13th (Lengwe).

TBA (old) refresher course; 24th to 29th (Nchalo) [15].

- Ward attendants refresher course on C/S; ~~11th - 13th~~ (Ngabu), 19th - 21st (Chikwawa).

- Breast feeding promoters training; 11th - 13th and 19th - 21st (Maperera).

- Project manager's meeting; 7th, Blantyre.

- Staff meeting; 18th.

July

Mid- level Managers initial training; 2nd - 4th [30].

- TBA initial training; 9th July - 2nd August (Chikwawa).

- Breastfeeding promoters training; 10th - 12 and 17th - 19th (Chikwawa).

HSAs training in PEC; 11th - 12th Ngabu; [25].

HSA Training in DRF (Lengwe) [6].

- Production of survey report; 22nd - 26th.

HSA refresher course on C/S 24th - 26th.

- Staff meeting; 24th.

- Project Manager's meeting; 5th, Blantyre.

August

- Programme Advisory meeting 2nd.

- Breastfeeding promoters training; 5th - 7th and 12th - 14th (Makhwira).

- HSA training in PEC; 8th - 9th (Nchalo), 15th - 16th (Chikwawa).

- Staff meeting; 23rd.

- DRF/IGA supervision.

- Project Manager's meeting; 2nd, Blantyre.

- Mid-Project evaluation; 26th - 30th.

September

- MoH/IEF Coordination meetings 4th - 6th.
- Production of evaluation report.
- DRF/IGA supervision.
- TBA initial training; 2nd - 27th (Chikwawa).
- Breastfeeding promoters training; 9th - 11th, and 16th - 18th (Ndakwera).
- HSA refresher courses on C/S; 11th - 13th (Nchalo), 25th - 27th (Ngabu).
- Staff meeting; 27th.
- Project manager's meeting; 6th, Blantyre.
- Provision of Immunization clinic Shelter - Phwazi.

October

- Breastfeeding promoters training; 9th - 11th and 16th - 18th (Kakoma).
- TBA refresher course 21st - 25th (Chikwawa).
- VHV/VHC appraisals (South, Central and North) re-train/refreshers.
- DRF/IGA supervision.
- Staff meeeting; 25th.
- Project manager's meeting; 4th, Blantyre.

November

- DRF/IGA supervision.
- HSAs refresher course; 6th - 8th, and 20th - 22nd (Chikwawa).
- VHV appraisals (South and Central and North) re-train/refreshers.

November (cont'd)

- Breastfeeding promoters training; 13th - 15th and 20th - 22nd (Chapananga).
- TBA (old) refresher course; (Chikwawa) 15th - 20th (15).
- Programme Advisory Committee meeting; 27th - 29th.
- Staff meeting; 29th.
- Project manager's meeting; 1st, Blantyre.

December

- VHV/VHC re-train/refreshers.
- DRF/IGA review; 2nd - 20th.
- Completion of unfinished activities from August to November; 2nd - 20th.
- Project Manager's meeting; 6th, Blantyre.
- Staff meeting 20th.
- Plan of action for 1997; 18th - 20th December.

- END -

John

Meeting With Karin van Dijk: 6/10/96

Claire Gilbert did blind school survey, wrote a nice report and a list of kids identified for surgery. Problem: not all kids have been operated on: need more follow-up.
IEF would pay for transport of kids to surgery centers.

IEF also funded finding kids in rural Chikwawa. For this, HSAS were trained in PEC. Objective: Find curable blindness/ low vision children.

OMA/ Chikwawa: Steve Kanjeloti

Karin trained 3 HSA supervisor who are still employed by IEF (= Community Health Supervisors)

Last year: trained: - 16 HSAs (+ 16 HSAs by SightSavers)
- 13 Teachers

Planned for April '96: Train another 16 HSAs

What needs to be done:

1. Guidance to Grace Funsani
   - How often to vist HSAs
   - Collect forms + data entry
   - Photocopy forms immediately and enter originals to HSAs (HSAs keep originals to check who got refereed
   - Ask HSAs to make a lot of referrals: form needs to be designed
   - Collect patients slips from Steve (OMA) to cross check whether they match with referrals from HSAs

2. Enter forms to EPI Info to analyse:
   - type of problem (change codes, age group)
   - how many referred
   - how many did go
   - how many are incurable
   - Give feed-back to HSAs quarterly.

Activities that could be funded by ChildSight:

1. Screening form (minus pinhole) and referral slips need to be printed (5,000 each or more) Karin would like 2-3,000 of each form for Machinga and Salima (total).

2. Should organize another round of training for HSA in screening/ referral (2 days) + School teachers (1 day) in Ngabu, Nchalo (Train HSAs in those areas where there are referral possibilities for eye care and rehabilitation (incurable cases) exist; Chikwawa is done).

3. Consider integrating HSA training in PEC into 6 week training curriculum (need data from Chikwawa to convince MOH/Lilongwe level).

4. Go to Nsanje for HSA training (CBM ophthalmologist will go there beginning Jan 97): Nsanje has 2 resource centers plus one blind school for incurable cases (one north, one south of Nsanje); also, MACOHA has one center.

   1 OMA has been trained: he should organize HSA training (with help by Steve or CS Community Health Supervisors)

5. OMA training: 6 (Zomba, Machinga, Mangochi, Rhumpi, LLW, Ncheu; generally one OMA per district; there are 24 districts in Malawi, after this training, 21 districts would have one) more in September (can buy most things and get receipts for allowances in August!); train in:
   - refraction
   - assistant of low vision (buy most things + receipts for allowances followed)

6. Equipment:
   - for OMA training (in September)
   - M.Chirambo's training center (retinoscopes)
   - Glasses (lenses, frames for Chikwawa, Nsanje)

7. Print Curriculum: print 200
   put IEF's and CBD's logo on cover page

8. Print small E- charts: (Karin printed 200)
   can print more (one for each HSA and one for primary school teachers: need lots

Final Evaluation of Child Sight: Find out what AID wants to do; maybe some of it can be combined with CBM's evaluation

CHECKLIST FOR ASSESSING QUALITY OF LOW VISION ASSESMENT AND REFRACTION

Concerning O.M.A.'s trained in October '95 and again in February '96

Please check:

1. Objective refraction: is retinoscope used:
   - effectively (compare O.M.A.'s result with your own)
   - how often (e.g. on all children assessed/ on other clients ?)

2. Subjective refraction (their result - your result)

3. Prescription of distance glasses: - useful: has VA improved?
   - do they fit properly, right size frame, etc?
   - are they used by the child
   - are they used for the right activities: distance or distance and near both

4. Prescription of magnifying glasses - useful: can child achieve smaller print/symbols
   - are the glasses used
   - do they fit properly
   - can child use them correctly:
     + for reading
     + for writing

5. Correct filling in of refraction forms: what is missing, if anything?

6. Time spent on low vision work:
   - integrated with other visits/work?
   - a lot of extra or not? Can it be managed in the workload

ATTACHMENT T

TRIP REPORT, JOHN F. O'NEILL, ASMARA, ERITREA JANUARY 12 - FEBRUARY 4, 1996

University Ophthalmic Consultants
Research and Educational Foundation
OF WASHINGTON

4910 Massachusetts Avenue NW
Suite 210
Washington, DC 20016
Telephone 202 686-6800
Facsimile 202 686-6668

Trip Report - John F. O'Neill, M.D.

Asmara, Eritrea
January 25 - February 4, 1996

PURPOSE

This report is for the consultation visit to the Birhan Eye Hospital and the week spent with Dr. Desbele Gebreghiorgis at the request of the International Eye Foundation. The purpose of the trip was to fulfill the IEF's matching grant SiteReach program's ChildSite component with the specific objective of "enhancing the capacity of the host country ophthalmologists to provide clinical and surgical care for children with ocular disease". Other trip objectives included observation and personal experience in the clinical and surgical activities of the Birhan Hospital, review of the ophthalmic technicians' training program and the technicians' surgical experience, observation of the availability of intraocular lenses through the Fred Hallows Foundation IOL Laboratory, didactic lectures for the faculty and staff of the eye hospital, and appropriate surgical consultation. One additional benefit of the trip, related to Dr. and Mrs. O'Neill's personal friendship with the American Ambassador and Mrs. Houdek, was the establishment of communication and a support relationship with the American Embassy in Asmara.

Contacts made during the Asmara and Masawa trips included:

Dr. Desbele G.G., Director, Birhan Eye Hospital
Dr. Ghenet Meresie, Associate ophthalmologist, (wife of Dr. Desbele)
The six graduate OMA technicians at Birhan Eye Hospital
Glenn Anders, Director, USAID Eritrea
Rita Malkki, Coordinator, IEF Program Masawa
Ann Hershey, Director, Africare Program, Masawa
The Ambassadors of Germany, Egypt, and Israel

Numerous Eritrean government officials, including:
Isaias Afwerki, President, State of Eritrea
Sabat Efram, former Minister of Health, current Minister of Defense
The Minister of Justice
Dr. Bereket, President, Constitutional Commission
Dr. Waldo-Ab, President, University of Asmara
Dr. Jacqueline Langeslag, official, Ministry of Health

Housing accommodations through the period in Asmara were at the residence of the American Ambassador and Mrs. Houdek.

SUMMARY OF ACTIVITIES

Most of the objectives of the ChildSite component of the SiteReach Program were met during the week participating with Dr. Desbele and the Birhan Eye Hospital. I had the opportunity to examine many of the hospital in-patients who had been operated the previous week by both Dr. Desbele and Dr. Ghenet and also by the senior ophthalmic medical assistants. My involvement through the week was primarily with in-patients and surgical patients in the operating room and minimally with any out-patient activities. The entire period was spent at the Birhan Eye Hospital.

As I became familiarized with the in-patient activities, I initially observed several operative procedures in the surgical suite. I later joined Dr. Desbele in several other procedures and, during the last two and a half days, operated independently with the senior ophthalmic technicians assisting. I presented several lectures having to do with surgical techniques and specific pediatric ophthalmologic problems to the eye hospital staff and the senior ophthalmic technicians.

At the end of the clinical week, I travelled to Masawa with Ambassador Houdek where we met with Rita Malkki, several Eritrean officials, and Ann Hershey, Director of Africare.

CONCLUSIONS AND RECOMMENDATIONS

I was most impressed with the character, quality, and industry of the medical personnel with whom I worked during this week at the Birhan Eye Hospital. Dr. Desbele, Dr. Ghenet, and the six senior ophthalmic assistants are not only extremely dedicated but also very hard working. Over the past several years, they have brought about an amazing accomplishment by clearing out the large surgical backlog which included almost 13,000 operative procedures. I am enclosing a copy of the statistics for the month of January 1996. During this time more than 3,000 out-patients were treated and almost 300 surgical procedures performed in a hospital which is only minimally staffed and sparsely equipped.

There is a great and continuing need for examining equipment, surgical supplies and medications, and adequate lighting for the operating room. Underlying these basic physical requirements is the very major need for additional trained professional staff. Dr. Desbele himself is stretched very thin. He functions as director of the hospital, surgeon-in-chief, primary triage officer, director of the senior ophthalmic assistants' training program, teacher, administrator, liaison with the MOH, and leader of their movement for a national eye health program.

My primary recommendation for the IEF and any other support mechanisms which can be mobilized is to assist Dr. Desbele in any and every way possible. It became very obvious to me that one of his major needs to function more efficiently in his many roles is reliable and timely transportation. He often had to wait extended periods for a driver from the motor pool to provide transportation. On days when surgery started before the motor pool opened, he and Dr. Ghenet would walk a considerable distance from their lodging to the hospital. It became apparent that one of the first priorities was to have a vehicle available for the hospital's use and for Dr. Desbele in particular to increase his efficiency and economy of his time. I realized this was one area where I could help their work by arranging for the purchase of a vehicle for Dr. Desbele and the Birhan Eye Hospital. Attached are copies of a grant request for sufficient funds to purchase a vehicle for the Birhan Eye Hospital and follow-up correspondence.

Another specific and immediate need is for current teaching materials for general ophthalmology and specialty areas. Numerous clinical and surgical instruction manuals as well

as teaching monographs and texts are available in the USA. If these were sent to Eritrea, they could provide continuing education for the Birhan Eye Hospital's professional staff.

Brief discussions were also held between Dr. Desbele and Mrs. O'Neill in her role as President of the Eye Bank Association of America. These exploratory discussions addressed the methods of making corneal tissues available, preserving tissues, and their use for corneal grafts, training, and research.

Enclosures:

Correspondence with O'Neil Foundation
List or procedures at Birhan Eye Hospital during January 1996

Date.31.1.1996A.D.
Number.43/26/96

BERHAN OPHTHALMIC HOSPITAL
ASMARA_____ERITREA

Here we atached the following monthly report

of BERHAN OPHTHALMIC HOSPITAL work activity of the monyhh January 1996 A.D.

1st. Total out patients examined.....3085

2nd.New out " " 1675

3rd.Repeated out " " 1410

4th.In patients discharged..... 265

5th. Major surgical opration done.....292

6th.Minor " " " 44

7th.Laboratory examined.....2174

8th.X-ray " 4

Prepaired by
SEYOUM GHEBREHIWET

MEDICAL DIRECTOR
Dr.DESBELE GHEBREGHERGHIS

University Ophthalmic Consultants
Research and Educational Foundation
OF WASHINGTON

4910 Massachusetts Avenue, NW
Suite 210
Washington, DC 20016
Telephone 202/686-6800
Facsimile 202/686-6668

April 5, 1996

John O'Neil and Family
W. O'Neil Foundation
5454 Wisconsin Avenue
Bethesda, Maryland 20815

Request for Financial Support for the Berhan Eye Hospital, Asmara, Eritrea - Dr. Desbele Ghebregherghis, Medical Director

Dear John and the O'Neil Family,

I recently returned from a 10 day trip to Asmara, Eritrea. The International Eye Foundation, which is based in Bethesda, has been providing training and assistance in eyecare for third world countries for 25 years and has recently established a program in Eritrea. They requested my assistance to inspect their current operation, assess the country's eyecare resources, and introduce newer surgical procedures and techniques by instruction in the operating room and lectures. After seeing their great need, I am requesting your assistance.

Eritrea has only recently gained independence from Ethiopia and is working hard to join the modern world. Although their resources are extremely limited, the entire country appears committed to improving the quality of life.. Their needs are so great and the mission so broad that it includes everything from writing a new, democratic constitution to addressing the most basic of human needs by developing their food supply, modern sanitation, education, and healthcare. Having had the opportunity in recent years to work with eyecare programs in a number of very needy third world countries, I was most impressed by the Eritrean's independence, energy, and resourcefulness, and their basic goodwill toward all of their people.

Although the greatest cause of blindness in third world countries is cataracts which require surgical treatment, there are many other causes of visual impairment which are preventable. For example, vitamin A deficiency is a major cause of ocular damage in children. The International Eye Foundation has a cooperative program with USAID in Eritrea to combat this threat to vision. Other serious problems include the numerous infections due to bacterial, viral, and parasitic organisms, many different types of injuries, and the numerous debilitating conditions related to malnutrition and premature aging. Each of these conditions contribute to the mass of people requiring care through the Berhan Eye Hospital.

Dr. Desbele, the Medical Director, was for many years the only trained ophthalmologist in this country of 3.5 million people and he faces the overwhelming task of providing eyecare for the entire population. Because of the very large

number of visually impaired and blind in Eritrea, Dr. Desbele has had to make the most of his meager resources and has established a very innovative program by training a number of young, dedicated technicians. These men and women work both as his assistants at the hospital and are also being prepared to function alone in the countryside where they will provide basic eyecare. They are being trained to do thorough eye examinations, to provide many types of treatment, and to perform certain surgical procedures including non-complicated cataract operations. I examined many of their patients and can attest to the effectiveness of their training and the great good that is being accomplished in the absence of a staff of trained ophthalmologists. I am told that the word *berhan* means light or vision in Amharic. The Berhan Eye Hospital, although greatly lacking in equipment and supplies, is certainly a model of industry and dedication. This small group has performed almost 13, 000 operations over the past several years and are aching to learn newer techniques to be better able to care for their people.

I mention both their great needs and their resourcefulness and witnessed it in so many different ways. Their small surgical suite has three operating tables at which Dr. Desbele can both work and supervise the technicians. They have, however, only a single functioning operating light which had to be moved back and forth between the tables to provide sufficient light for the surgery. Even while I was operating with them, there were interruptions to move the portable light source between the tables. It is both a humbling and very energizing experience to work with a physician who practices the same type of medicine that I have through my professional career, but by necessity performs with only the barest essentials of medications, instruments, equipment or even lighting. My time in Eritrea was of great mutual value and I gained considerable insight into the many needs of this very poor country.

John, I have never been very good at fund raising or begging for money, but I remember so well your generosity in helping Dr. Gerard Frederique and the eyecare program in Haiti when I was at Georgetown and was responsible for our residents working in Haiti. With that in mind, I come to you again and would welcome the opportunity to discuss the needs of these worthy people with you or your family on a more personal basis. Their most pressing needs appear to be basic operating room instruments, medications, and supplies. This would include one, but preferably two, portable operating room lights. Another area of great need is for a vehicle to help transport the severely visually impaired people to and from the hospital from their outlying areas and also for Dr. Desbele and his technicians to reach the outlying clinic facilities which they are developing. My specific request for your consideration of assistance is in the amount of $45,000 to be administered through the International Eye Foundation and to be used exclusively for this program for the visually impaired and blind in Asmara, Eritrea. Of course, <u>any</u> assistance which you might make available for their special needs would be greatly, greatly appreciated.

With my kindest regards,

John O'Neill

John F. O'Neill, M.D.

Enclosure and photographs

University Ophthalmic Consultants
OF WASHINGTON
A Professional Corporation

MICHAEL A. LEMP, M.D.
Corneal & Anterior Segment Diseases
Cataract & Implant Surgery
Refractive Surgery

JOHN F. O'NEILL, M.D.
Pediatric Ophthalmology
Adult Strabismus

DOUGLAS E. GAASTERLAND, M.D.
Glaucoma
Anterior Segment Laser Surgery
Cataract & Implant Surgery

CHUNG S. CHOI, M.D.
General Ophthalmology

PAUL C. KEENAN, JR., M.D.
Corneal and Anterior Segment Disease
Cataract & Implant Surgery
Refractice Surgery

WILLIAM J. SHIELDS
Administrator

Northwest Washington Office
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Northern Virginia Office
Prosperity Plaza
9320 Hamaker Court, Suite B-103
Fairfax, Virginia 22031
Telephone: 703-573-9688
Facsimile: 703-207-9396

Maryland Pediatric Office:
1114 Generals Hwy., Rte. 178
Annapolis, MD 21401
Annapolis area: 410 224-2865
DC Metro area: 301 970-2529
Facsimile: 410 224-6404

RESEARCH
Dry Eye Studies
Ocular Hypertension Treatment Study (OHTS)
Advanced Glaucoma Intervention Study (AGIS)
Advanced Contact Lens Designs

April 30, 1996

The O'Neil Family
The W. O'Neil Foundation
5454 Wisconsin Ave., #730
Chevy Chase, MD 20815

Dear John, Helene, Helene O'Neil Cobb and all of the family and staff who participate in your marvelous work.

May I say for myself, the International Eye Foundation and most of all for Dr. Desbele and his people at the Berhan Eye Hospital that your especially generous gift is like a Godsend to help relieve their pressing needs.

I am convinced from the short time that I spent working and operating with their hospital staff, that they will make your contribution worth many times the actual dollar amount by their dedicated hard work and commitment to improving the lives of their people.

You have made me very proud of what our people can do to help those in need, and proud of the O'Neil name - no matter how it is spelled.

With my great respect, best wishes and fond regards,

Sincerely,

John F. O'Neill, M.D.

ATTACHMENT U

PHOTOGRAPH OF ELECTRICIAN'S WORKSHOP IN LOJA, ECUADOR

Electrician's workshop in Loja, Ecuador

ATTACHMENT V

LETTERS EXPRESSING INTEREST IN PARTICIPATING IN RESPACK PROGRAM

MINISTERIO DE SALUD
CENTRO NACIONAL DE OFTALMOLOGIA

Managua, 21 de Mayo de 1996

Sra.
ELLEN M. PARIETTI, MPH
PROGRAM OFFICER
INTERNATIONAL EYE FOUNDATION

Fué muy importante para mí conocerte y que pueda haber una puerta abierta para tratar de resolver algunos problemas.

La información que me facilitastes presenta programas muy interesantes y creo que se pueden desarrollar aquí en Nicaragua.

Se le transmitió la información a los Residentes de Oftalmología, que cursan su especialidad en el "Centro Nacional de Oftalmología", único centro formador de especialistas, y están interesados en el proyecto que ustedes presentan de ayuda a los Médicos Oftalmólogos recien egresados, ya que una vez que ellos se gradúan de médicos especialistas en Oftalmología son trasladados a sus lugares de origen ó alguna comunidad donde no hay esta especialidad. El Ministerio de Salud no tiene condiciones ni presupuesto en estas áreas para comprar equipos y puedan desarrollarse plenamente como profesionales, resolviendo de alguna manera el problema a sus pacientes.

Al igual estoy interesada personalmente en un programa de Oftalmología Pediatrica, como le expliqué, quiero formar este servicio en el "Centro Nacional de Oftalmología", y como ustedes tienen experiencia, según este documento talvez me podrían ayudar.

Cualquier información, remitirla al Fax # (505)224660 y/o apartado postal No. 3202, Managua, Nicaragua.

Adjunto lista de Médicos interesados en el Proyecto.

Cordialmente,

Dra. Maria José Córdova Alvarez
Directora
Centro Nacional de Oftalmología

CONTIGUO A LA POLICLINICA CENTRAL
Managua, Nicaragua

224

MINISTERIO DE SALUD
CENTRO NACIONAL DE OFTALMOLOGIA

LISTA DE LOS MEDICOS INTERESADOS EN EL PROYECTO

DR. JOSE VILCHEZ	GRADUADO
DR. JOSE CASTILLO	6 MESES P/GRADUARSE
DRA. MARIBEL MERCADO	6 MESES P/GRADUARSE
DR. FRANCISCO SAENZ	18 MESES P/GRADUARSE
DR. WILBERTO OCHOA	18 MESES P/GRADUARSE
DRA. MA. JOSE CORDOVA A.	GRADUADA

CENTRO NACIONAL DE OFTALMOLOGIA MINISTERIO DE SALUD DIRECCION MANAGUA NICARAGUA

CONTIGUO A LA POLICLINICA CENTRAL
Managua, Nicaragua C A
Teléfonos:

PANAMA, 15 JULIO, 1996.

Sra.
Ellen Parietti
The International Eye Foundation
Bethesda - USA
E. S. D.

Muy estimada Ellen:

Reciba un afectuoso saludo y a la vez aprovecho la ocasión para desearle muchos éxitos en sus actividades diarias. Recibí su mensaje y el Fax correspondiente para ingresar al Programa SightReach. Realmente tengo gran interés en participar en este Programa y realizar una gran labor social a personas con patologia oftalmológica con escasos recursos económicos.

Desde hace 2 años estoy laborando fuera de la capital en la ciudad de Santiago en la Provincia de Veraguas, República de Panamá. Esta ciudad se encuentra a 250 Km de la capital y tiene una población de 250,000 habitantes, donde la gran mayoria no son asegurados, son campesinos cosechadores y bastante personas indigenas. La patología ocular es frecuente por las condiciones del clima tropical que existe y las labores cotidianas. Predomina la catarata, el pterigion y el trauma ocular con patologia corneal bacteriana y/o micótica que amerita transplante corneal. Hay mucha labor por realizar y gente por captar y tratar. Necesito su apoyo para adquirir el equipo necesario para montar una clínica ocular que consta de: Lampara de hendidura, oftalmoscopio indirecto, retinoscopio, ultrasonido ocular en modo A y en modo B, auto-keratorefractómetro, lensómetro, 1 caja de pruebas y medicaments. Para la cirugia de estos pacientes se requiere:un microscopio quirúrgico, lentes intraoculares y instrumental para la cirugia de catarata, glaucom y pterigión.

Agradeciendole por permitirme participar en esta noble causa aprovecho la oportunidad para manifestarle las seguridades de mi aprecio personal. Me puede ubicar facilmente y dejarme el mensaje a mi Beeper Telf 263-5044 y me envían el mensaje.

Atentamente

Inés Durán de Saavedra

Dra Ines Duran-de Saavedra
Cirujano Oftalmologo
R

Guatemala, julio de 1996.-

Dra. Ellen Parietti
Dr. Orlando Oliva
FUNDACION INTERNACIONAL DEL OJO
PROGRAMA RESPACK.

Estimados Señores:

De la manera más atenta me dirijo a Ustedes con el fin de solicitar información sobre su Programa Respack, que actualmente se esta desarrollando en comunidades rurales de distintos paises con profesionales oftalmólogos.

Para hacerles de su conocimiento, mi nombre es Sonia Isabel Serna Agudelo, colombiana, y curso el 3er. año de Residencia de Oftalmologia en el Hospital "Rodolfo Robles V.", de la ciudad de Guatemala, C.A. Siendo de este modo como pude enterarme de la existencia del Programa Respack, y hago extensivo mi interés para poder tener acceso a los beneficios que la Fundación ofrece a los profesionales de la especialidad, que cuando se inician no cuentan con todo el equipo especial para atender a los pacientes que lo necesitan. Pienso que es muy acertada la proyección del Programa Respack hacia la comunidad, por lo cual hago la solicitud para que este pudiera hacerse efectivo en Colombia tanto para beneficio personal, como para otros profesionales que tengan el deseo de servir a nuestra comunidad.

Quiero hacer constar mi deseo para que mi inquietud sea tomada en cuenta, agradeciendo anticipadamente la atención que se le de a la presente y el envio de cualquier información al Hospital "Rodolfo Robles V.", en Guatemala.

ATENTAMENTE

Sonia Isabel Serna A.

DRA. SONIA ISABEL SERNA A.
Residente de 3er. año de Oftalmología
Hospital "Rodolfo Robles V.", Guatemala

ATTACHMENT W

TRIP REPORT, ELLEN PARIETTI, BOGOTA , COLOMBIA

Visit to PAHO Self-Sufficient Primary Eye Care Program
Bogota, Colombia
June 7, 1996
Ellen Parietti

Background:

During his visit to Honduras, Dr. Juan Carlos Silva, regional representative for the Prevention of Blindness Committe of the World Health Organization discussed a Self-Sufficient Primary Eye Care Project with the Committee for the Prevention of Blindness.

This project was first started in Belize with the Belize Council for the Visually Impaired (BCVI). Joan Musa was working with Help the World See (an American NGO based in San Francisco) to establish a self-sufficient primary eye care project including an eye glass factory. Juan Carlos Silva met Wayne Cannon, an optometrist and founder of Help the World See, in Belize. The PAHO and Help the World See has subsequently worked together in Colombia and Bolivia establishing duplicate projects with another underway in Peru. (Help the World See has been in charge of the procurement of equipment.)

The Honduran Committe for the Prevention of Blindness has since continued to demonstrate interest in establishing this project in Tegucigalpa, particularly for access to low-cost spectacles. Raúl Gómez visited the project in Bogota a year ago, but was given only sketchy details about the project along with the budget for the project. Honduras's Committee has continued to contact Dr. Silva for more details on the project and the appropriate steps to follow in order to establish the project. Dr. Silva has been consistently difficult to contact. When I had been able to talk with him, he was very vague about details, stating that as soon as we could committ money to the project, we would be able to discuss things in a deeper manner.

I told him that IEF wouldn't be able to put forth all of the money for the project, perhaps we could put forth money for the laboratory equipment. Did we need four sets of diagnostic equipment as suggested in the budget? Dr. Juan Carlos Silva said that we could make it work out with out a problem. Between PAHO, Help the World See, and IEF we could start the project. Involving more organizations would only complicate matters. PAHO would put forth money for an initial inventory (of frames & lenses), and Help the World See would put forth money for installation and training.

Bogota's Project:

The Primary Eye Care Program in Bogota is run by the "Centro Colombiano de Salud Visual" (CCSV). The office, along with the eye glass factory is located in Fundación Cardio Infantíl's (FCI) building. FCI donated the office and laboratory space to CCV, and collaborates in many other ways. Originally a pediatric cardiac hospital, FCI has expanded to cover a full range of care not only children, but people of all ages.

The primary eye care project team consists of two salaried optometrists, two technicians in the laboratory, and a manager. All are paid a salary by the CCSV. The manager may or may not need be full time.

The optometrists are currently working in nursing homes, screening elderly patient as part of a contract with the government which provides eye care (and a pair of glasses) to this population. The optometrists screen the patients in the nursing homes, and fit them with glasses if need. Those in need solely of glasses never come in to the center. Glasses are ordered and delivered to them. If the patient is identified as in need of attention from an ophthalmologist, they are brought into the Fundación Cardio-Infantíl where they are seen by an ophthalmologist and operated upon if necessary. Money for the operations are paid by the government, so the relation between CCSV and FCI is mutually beneficial.

The Colombian project began in late 1993 but really started to work in 1994. In this earlier period there were 4 optometrists. The government had given CCSV a contract to screen children, so they had all the optometrists out in the field screening children. The government's policy on health care has changed, so the CCSV has had to adapt over time.

The eye glass production center is located in a basement floor across the hall from Dr. Silva's office and the manager's office. It housed in a large rectangular room. As one enters the room, there is a glass case with the different frames to choose from. Behind that, there is a desk for the lab techs where they deal with paperwork from orders placed and pickup. Along the periphery of two walls there are counters holding the equipment including edging machines, lensometer, blocking machine, pattern maker, tinting machines, etc. On shelves beneath the equipment are stores of lenses and frames. Along the back wall there is a glass cabinet containing more frames.

In the laboratory work two young women who make the glasses according to specifications noted on order sheets. They also take care of collecting the money when people come to pick up their spectacles. As the FCI now sees all classes of patients (paying, non-paying, and insured) they also produce more expensive glasses. One pair I saw cost $58 because they had a special kind of tint. The average pair produced cost $14 more or less. There is a system for people putting down-payments, etc. Dr. Silva said that usually two people are trained for the laboratory. If one leaves, the remaining one can help the new employee. In Bogota, they are currently training a woman. The person who preceded her had been pocketing money.

The manager, Helena Shlesinger, does a weekly check to make sure all the money is in order. It is also her responsibility to keep up the supplies of frames and lenses. Beyond the lab itself, she arranges the schedules for the optometrists, and works out schedule of patients for the doctors at FCI.

Wayne Cannon is visiting Honduras this week to see which organization should run the project. He appreciates the fact that IEF knows much more about the Honduran situation than does PAHO or Help the World See.

I contacted Marylena Arita in Honduras before the trip to make sure any questions the Comite had could be answered. Among her questions were what the extrent of support from WHO. To this, J.C.Silva responded that the lab personnel would be trained in Colombia. Funding for this was still to be decided. Marylena also asked whether WHO had funds to give out, and how they could be applied for. To this, Dr. Silva said that his position had just been asigned to a new section. He is now a part of the Health Services Program, whereas he was previously in Health Promotion. The Health Services Program has a good deal of money, and Dr. Silva feels that he can present the proposal for the Honduras project and receive funding for it.

The Committee requested a copy of a proposal used by other countries when putting together their project, but Dr. Silva wouldn't provide it. He showed me them from afar, but would not let me review them, saying it wouldn't be fair to the organizations. He said that in the past the proposals had been informal.

The project in Bolivia is being administered by PROSALUD. In Peru, it will be with a government hospital. These organizations will offer the support of their infrastructure for the first 3 months or so while the project becomes self-sufficient.

Dr. Silva liked the idea of working w&ith IEF because we have worked with screening before. San Felipe will most probably need to have an agreement with the project so it can take care of surgeries. This can all be discussed after Wayne Cannon's visit. NOTE: J.Silva wants me to wait for us to make contact with Cannon until the future. (Silva wants all communications to go through him.) He admitted he was acting "jealous" of the project but said that PAHO had been burned before and he wanted to make sure they were going to get credit for their work.

Steps to take:

1. Contact Joan Musa has to say about Help the World See and the project in general.

2. J.C. Silva would like the IEF to submit a budget for how much money they would be able to commit towards the project so he could ask the remaining amount from PAHO and Help the World See.

3. Check to see if we can get the necessary equipment at prices lower than those offered through Help The World See. (J.Carlos was especially interested in seeing this.)

4. A meeting should be held with the Honduran Association of Ophthalmologists to evaluate resistance to the project. In Bolivia, Ophthalmologists were resistance to the project, fearful that it would affect their income from glasses. It was agreed that the project would utilize only certain frames as opposed to a whole range of styles.

ATTACHMENT X

BUDGET PIPELINE

TABLE C: Headquarters & Countries Budget INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 06/30/96

	BUDGET		ACTUALS		BALANCE		
	AID	PVO	AID	PVO	AID	PVO	TOTAL
I. PROGRAM MGMT							
a.) Salaries	106	11	85	46	21	-35	-14
b.) Fringe Benefits	18	3	25	15	-7	-12	-19
c.) Travel, Transportation & Per Diem	108.5	18	86	14.5	22.5	3.5	26
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	212.5	12	48	18	164.5	-6	158.5
SUBTOTAL	445	44	244	93.5	201	-49.5	151.5
II. PROCUREMENT							
a.) Consultations	144	50	52.5	0	91.5	50	141.5
b.) Supplies	4	1721	6	218.5	-2	1502.5	1500.5
SUBTOTAL	148	1771	58.5	218.5	89.5	1552.5	1642
III. INDIRECT COSTS							
SUBTOTAL	107	335	53	6	54	329	383
TOTAL HEADQUARTERS/COUNTRI COSTS	700	2150	355.5	318	344.5	1832	2176.5

TABLE C: Headquarters (Regional) Budget INTERNATIONAL EYE FOUNDATION

Matching Grant Expenses through 06/30/96

FY 93 DIP Guidelines

	BUDGET		ACTUALS		BALANCE		
	AID	PVO	AID	PVO	AID	PVO	TOTAL
I. PROGRAM MGMT							
a.) Salaries	67	11	73	44	-6	-33	-39
b.) Fringe Benefits	18	3	24.5	14	-6.5	-11	-17.5
c.) Travel, Transportation & Per Diem	34.5	18	33	13	1.5	5	6.5
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	22.5	12	6	16	16.5	-4	12.5
SUBTOTAL	142	44	136.5	87	5.5	-43	-37.5
II. PROCUREMENT							
a.) Consultations	23	2	2	0	21	2	23
b.) Supplies	4	1	0.5	45.5	3.5	-44.5	-41
SUBTOTAL	27	3	2.5	45.5	24.5	-42.5	-18
III. INDIRECT COSTS							
SUBTOTAL	31	9	24	5	7	4	11
TOTAL HEADQUARTERS COSTS	200	56	163	137.5	37	-81.5	-44.5

SUPPORT WITH BUDGET NARRATIVE - CASH $ IN THOUSANDS

TABLE B: Country Budget For All Countries INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 06/30/96

	BUDGET		ACTUALS		BALANCE		
	AID	PVO	AID	PVO	AID	PVO	TOTAL
I. PROGRAM ELEMENTS							
a.) Salaries	39	0	12	2	27	-2	25
b.) Fringe Benefits	0	0	0.5	1	-0.5	-1	-1.5
c.) Travel, Transportation & Per Diem	74	0	53	1.5	21	-1.5	19.5
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	190	0	42	2	148	-2	146
SUBTOTAL	303	0	107.5	6.5	195.5	-6.5	189
II. PROCUREMENT							
a.) Consultations	121	48	50.5	0	70.5	48	118.5
b.) Supplies	0	1720	5.5	173	-5.5	1547	1541.5
SUBTOTAL	121	1768	56	173	65	1595	1660
III. INDIRECT COSTS							
SUBTOTAL	76	326	29	1	47	325	372
TOTAL PROGRAM COSTS	500	2094	192.5	180.5	307.5	1913.5	2221

SUPPORT WITH BUDGET NARRATIVE - CASH $ IN THOUSANDS

TABLE B: Country Budget For GUATEMALA INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 06/30/96

	BUDGET		ACTUALS		BALANCE		
	AID	PVO	AID	PVO	AID	PVO	TOTAL
I. PROGRAM ELEMENTS							
a.) Salaries	10	0	5	0	5	0	11
b.) Fringe Benefits	0	0	0	0	0	0	0
c.) Travel, Transportation & Per Diem	18	0	21	1	-3	-1	18
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	40	0	9	1	31	-1	60
SUBTOTAL	68	0	35	2	33	-2	89
II. PROCUREMENT							
a.) Consultations	20	6	10	0	10	6	38
b.) Supplies	0	275	1.5	82	-1.5	193	0
SUBTOTAL	20	281	11.5	82	8.5	199	38
III. INDIRECT COSTS							
SUBTOTAL	16	52	8	0	8	52	24
TOTAL PROGRAM COSTS	104	333	54.5	84	49.5	249	151

SUPPORT WITH BUDGET NARRATIVE - CASH $ IN THOUSANDS

TABLE B: Country Budget For HONDURAS INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 06/30/96

	BUDGET		ACTUALS		BALANCE		
	AID	PVO	AID	PVO	AID	PVO	TOTAL
I. PROGRAM ELEMENTS							
a.) Salaries	6	0	0.5	0	5.5	0	11
b.) Fringe Benefits	0	0	0	0	0	0	0
c.) Travel, Transportation & Per Diem	15	0	12.5	0.5	2.5	-0.5	18
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	30	0	7	0	23	0	60
SUBTOTAL	51	0	20	0.5	31	-0.5	89
II. PROCUREMENT							
a.) Consultations	20	6	9.5	0	10.5	6	38
b.) Supplies	0	275	1	23	-1	252	0
SUBTOTAL	20	281	10.5	23	9.5	258	38
III. INDIRECT COSTS							
SUBTOTAL	13	52	5.5	0	7.5	52	24
TOTAL PROGRAM COSTS	84	333	36	23.5	48	309.5	151

SUPPORT WITH BUDGET NARRATIVE - CASH $ IN THOUSANDS

TABLE B: Country Budget For ECUADOR INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 06/30/96

	BUDGET		ACTUALS		BALANCE		
	AID	PVO	AID	PVO	AID	PVO	TOTAL
I. PROGRAM ELEMENTS							
a.) Salaries	5	0	0	0	5	0	11
b.) Fringe Benefits	0	0	0	0	0	0	0
c.) Travel, Transportation & Per Diem	10	0	0	0	10	0	18
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	20	0	3	0.5	17	-0.5	60
SUBTOTAL	35	0	3	0.5	32	-0.5	89
II. PROCUREMENT							
a.) Consultations	15	6	1.5	0	13.5	6	38
b.) Supplies	0	275	0	29	0	246	0
SUBTOTAL	15	281	1.5	29	13.5	252	38
III. INDIRECT COSTS							
SUBTOTAL	9	52	1	0.5	8	51.5	24
TOTAL PROGRAM COSTS	59	333	5.5	30	53.5	303	151

SUPPORT WITH BUDGET NARRATIVE - CASH $ IN THOUSANDS

TABLE B: Country Budget For EL SALVADOR INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 06/30/96

	BUDGET		ACTUALS		BALANCE		
	AID	PVO	AID	PVO	AID	PVO	TOTAL
I. PROGRAM ELEMENTS							
a.) Salaries	3	0	0	0	3	0	11
b.) Fringe Benefits	0	0	0	0	0	0	0
c.) Travel, Transportation & Per Diem	5	0	0	0	5	0	18
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	20	0	0	0	20	0	60
SUBTOTAL	28	0	0	0	28	0	89
II. PROCUREMENT							
a.) Consultations	20	6	0	0	20	6	38
b.) Supplies	0	275	0	0	0	275	0
SUBTOTAL	20	281	0	0	20	281	38
III. INDIRECT COSTS							
SUBTOTAL	8	52	0	0	8	52	24
TOTAL PROGRAM COSTS	56	333	0	0	56	333	151

SUPPORT WITH BUDGET NARRATIVE - CASH $ IN THOUSANDS

TABLE B: Country Budget For ALBANIA — INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 06/30/96

	BUDGET		ACTUALS		BALANCE		
	AID	PVO	AID	PVO	AID	PVO	TOTAL
I. PROGRAM ELEMENTS							
a.) Salaries	3	0	0	2	3	-2	11
b.) Fringe Benefits	0	0	0	1	0	-1	0
c.) Travel, Transportation & Per Diem	7	0	9.5	0	-2.5	0	18
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	23	0	14	0.5	9	-0.5	60
SUBTOTAL	33	0	23.5	3.5	9.5	-3.5	89
II. PROCUREMENT							
a.) Consultations	9	6	9.5	0	-0.5	6	38
b.) Supplies	0	155	1	34.5	-1	120.5	0
SUBTOTAL	9	161	10.5	34.5	-1.5	126.5	38
III. INDIRECT COSTS							
SUBTOTAL	7	31	6	0	1	31	24
TOTAL PROGRAM COSTS	49	192	40	38	9	154	151

SUPPORT WITH BUDGET NARRATIVE - CASH $ IN THOUSANDS

TABLE B: Country Budget For BULGARIA — INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 06/30/96

	BUDGET		ACTUALS		BALANCE		
	AID	PVO	AID	PVO	AID	PVO	TOTAL
I. PROGRAM ELEMENTS							
a.) Salaries	3	0	2	0	1	0	11
b.) Fringe Benefits	0	0	0	0	0	0	0
c.) Travel, Transportation & Per Diem	6	0	6	0	0	0	18
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	19	0	7	0	12	0	60
SUBTOTAL	28	0	15	0	13	0	89
II. PROCUREMENT							
a.) Consultations	11	6	5	0	6	6	38
b.) Supplies	0	155	1.5	0	-1.5	155	0
SUBTOTAL	11	161	6.5	0	4.5	161	38
III. INDIRECT COSTS							
SUBTOTAL	7	28	4	0	3	28	24
TOTAL PROGRAM COSTS	46	189	25.5	0	20.5	189	151

SUPPORT WITH BUDGET NARRATIVE - CASH $ IN THOUSANDS

TABLE B: Country Budget For ERITREA — INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 06/30/96

	BUDGET		ACTUALS		BALANCE		
	AID	PVO	AID	PVO	AID	PVO	TOTAL
I. PROGRAM ELEMENTS							
a.) Salaries	3	0	0	0	3	0	11
b.) Fringe Benefits	0	0	0	0	0	0	0
c.) Travel, Transportation & Per Diem	7	0	0.5	0	6.5	0	18
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	19	0	0.5	0	18.5	0	60
SUBTOTAL	29	0	1	0	28	0	89
II. PROCUREMENT							
a.) Consultations	11	6	5	0	6	6	38
b.) Supplies	0	155	0	1.5	0	153.5	0
SUBTOTAL	11	161	5	1.5	6	159.5	38
III. INDIRECT COSTS							
SUBTOTAL	7	31	1	0	6	31	24
TOTAL PROGRAM COSTS	47	192	7	1.5	40	190.5	151

SUPPORT WITH BUDGET NARRATIVE - CASH $ IN THOUSANDS

TABLE B: Country Budget For MALAWI — INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 06/30/96

	BUDGET		ACTUALS		BALANCE		
	AID	PVO	AID	PVO	AID	PVO	TOTAL
I. PROGRAM ELEMENTS							
a.) Salaries	6	0	4.5	0	1.5	0	11
b.) Fringe Benefits	0	0	0.5	0	-0.5	0	0
c.) Travel, Transportation & Per Diem	6	0	3.5	0	2.5	0	18
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	19	0	1.5	0	17.5	0	60
SUBTOTAL	31	0	10	0	21	0	89
II. PROCUREMENT							
a.) Consultations	15	6	10	0	5	6	38
b.) Supplies	0	155	0.5	3	-0.5	152	0
SUBTOTAL	15	161	10.5	3	4.5	158	38
III. INDIRECT COSTS							
SUBTOTAL	9	28	3.5	0.5	5.5	27.5	24
TOTAL PROGRAM COSTS	55	189	24	3.5	31	185.5	151

SUPPORT WITH BUDGET NARRATIVE - CASH $ IN THOUSANDS