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**SIGHTREACH:
AN EYE CARE PROGRAM
FOR THE UNDERSERVED AND CHILDREN**

**MATCHING GRANT
REPORT OF ACTIVITIES
July 1, 1996 to Dec. 31, 1997**

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ACRONYMS

AAO	American Academy of Ophthalmology
APO	Asociación Panamericano de Oftalmología
CBM	Christoffel Blindenmission
DIP	Detailed implementation plan
FUDEM	Fundación para el Desarrollo 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	Itinerant 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

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. Ninety-five percent of ophthalmologists in Latin America live and work in major urban centers leaving rural populations and residents of smaller cities with little or no access to eye care services. Older, established ophthalmologists have lucrative practices in the urban centers that cater to wealthy paying patients. Younger doctors and recently graduated residents rarely have enough money to buy a complete set of equipment to open a private practice. Therefore, many younger ophthalmologists hold multiple part-time jobs in urban hospitals, optical shops and/or other doctors' practices 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 willing to work in rural areas, smaller cities, or poor peri-urban areas lacking eye care services. The basic (diagnostic) package has been available for approximately \$5,000. The IEF provides support through 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.

This project offers a sustainable solution to the imbalance of eye care in Latin America. SightReach provides a practical incentive to provide ocular attention under-served areas by promoting private sector services. It also fosters a public health conscience by encouraging outreach activities and increased contact with populations previously without 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 15 million children are blind in the world from a variety of causes. 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 children seen by a general health worker do not get referred due to ignorance of what can be done or where children should be sent.

Through the use of existing IEF field infrastructure and staff and partner NGOs, this project

seeks to develop and strengthen pediatric ophthalmology by providing primary, secondary, and tertiary training in this field. 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 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 with experience in vitamin A, onchocerciasis and eye care projects. In Africa, IEF has a long history of support for eye care projects in Malawi and had also begun new activities in the recently independent country of Eritrea. Since that time, activities have been halted in Eritrea due to an inability to negotiate a country agreement. 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

ChildSight focuses on strengthening pediatric ophthalmology skills in eight countries in Latin America, Eastern Europe, and Africa. Through this program, IEF has:

- 1) Surveyed the causes of blindness in children,
- 2) Trained pediatric ophthalmologists through:
 - a) sponsoring visits by US sub specialists and
 - b) sponsoring fellowships for ophthalmologists at other institutions
- 3) Held workshops for teachers and other health care personnel on common childhood ocular problems and how to conduct visual acuity screening. The children identified as needing specialized ophthalmic care in these screenings are referred to ophthalmologists

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 ACCOMPLISHMENTS

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).

Honduras: To date, seven ResPack clinics have been established. Since last report, one new participant, Dra. Silva Solomon has become part of the program, and two other participants, formerly inactive, obtained their equipment. Two new clinics have been opened since last report.

Dr. Claudia Silva-Solomon established her clinic in Siguatepeque, 2 hours from Tegucigalpa. The clinic is located within the Hospital Evangelic de Siguatepeque, the only hospital in the area. Dra. Silva Solomon is very involved with the hospital staff. She provides trainings for the other doctors on ophthalmic complications of common diseases, has formed "teams" with other doctors to give patients a more thorough follow-up, and teaches basic eye care to the students in the hospital's nursing program. In addition, Dra. Silva Solomon has been very active in community education, hosting weekly radio programs on ocular health.

Dr. Xiomara Garay has opened her clinic in periurban Tegucigalpa, Colonia Miraflores. She is working within a non-profit Catholic clinic, San Roque, run by the Aposteles de Salud. The Aposteles de Salud is an organization which has established 15 clinics throughout the country. The other clinics are small establishments with only 1 general practitioner or health worker. These smaller clinics refer patients in need of specialists into the centro San Roque.

A third, Dr. Maria Luisa Rojas received her equipment in January of 1997, but had been studying in Mexico on a corneal fellowship until September 1997, and so has been delayed in establishing her ResPack Clinic.

Two operating microscopes have been provided to Drs. Silva and Cisneros, in Siguatepeque and Choluteca respectively. These two doctors have proven themselves to be very committed to providing eye care in underserved areas.

In El Salvador, Dr. Alfredo Levisohn has opened his clinic in Sonsonate, 2 hours to the west of San Salvador. He resides in Sonsonate Monday through Friday, working in a Social Security Hospital in the mornings. Dr. Levisohn also sees patients and conducts examinations in a charity hospital in Chalchuapa on Saturdays. The only reimbursement he receives is to cover food and gasoline for the day.

In Ecuador, two more participants have established their clinics since the last report. Dr. Victor Carrión has opened his clinic in Calderon, a marginal barrio of Quito. Dr. Jose Viteri opened his clinic in Chillogallo, located south of Quito, in a community medical center. The total number of participants remains at five, but now all have active clinics. One, Dr. Manuel Alvarez, has a microscope. Dr. Alvarez has begun attending patients at another clinic he established in San Rafael, a suburb of Quito, Centro Ophthalmologico Nueva Vision. His work at this clinic gives back to the community in which he was raised and conducts an enormous amount of outreach work. He provides shelter free of charge to patients that have traveled a great distance for surgery.

Please see attachment A for maps of the ResPack countries and attachment B, statistics on patients served by ResPack doctors.

Table A on the following page summarizes the ResPack participation to date by country and level of participation. Of the total number of participants twenty (95%) have purchased the basic diagnostic equipment package essential for basic practice. Seven of the participants, (30%) have purchased operating microscopes essential to perform major surgeries. An additional 9 participants have access to operating microscopes through a partner institution that enables them to perform surgeries, critical to establishing a sustainable practice. In total, 15 participants, (65%) are performing surgeries as part of their services in their ResPack settings. The last column, population served, estimates of the populations in the areas served by these ResPack sites. Asterisks indicate individuals who have discontinued service at their ResPack clinics. Each of these four individuals provided service for two years in the Since writing this report, a questionnaire was developed to interview each participant to gather information and data on the participant's established practices. Information on service statistics, financial data, and population served will help describe how the program contributed towards the goals of establishing eye care services in underserved areas. This information will also be useful in developing case studies on this approach to supporting business practices.

TABLE A

Country	No.	Participant Name	Date Accepted	Basic Equip.	Micro	Surgical capability	Practice Estab.	Pop. Served
GUATEMALA	1	Orlando Oliva	4/94	7/94	7/94	x	9/94	200,000
	2	Sidney Morales	4/94	7/94	7/94	x	1/95	350,000
	3	Gonzalo Cruz	7/94	12/94	12/94	x	4/95	500,000
	4	Paul Cifuentes	12/94	5/95		x	2/96	250,000
	5	Maria Eugenia Sanchez	3/96	7/96		x	7/96	800,000
	6	Antonio Hernandez	4/94	8/95	8/95	x	8/95	200,000
HONDURAS	7 *	Sergio Zuñiga	9/94	11/94			2/95	50,000
	8	Jorge Cisneros	11/94	1/95	6/96	x	1/95	50,000
	9*	Denis Espinal	7/94	10/94			12/94	50,000
	10*	Ricardo Rivera	9/94	4/95			8/95	50,000
	11*	Doris Alvarado	11/94	12/94		x	2/96	50,000
	12	Claudia Silva Solomon	10/96	1/97	4/97	x	2/97	150,000
	13	Daniela Salinas	1/95					
	14	Luisa Rojas	4/95	9/96				
	15	Xiomara Garay	1/95	9/96		x	8/97	50,000
	16	Daphne López	8/95					
ECUADOR	17	Rosemary Guamán	6/95	6/95		x	5/96	120,000
	18	José Viteri	5/95	6/95		x	2/97	30,000
	19	Victor Carrión	6/95	6/95		x	2/97	50,000
	20	Jorge Rivera	3/95	6/95		x	6/95	150,000
	21	Graciela Ruiz	2/95					27,000
	22	Manuel Alvarez	4/95	1/96	1/96	x	3/96	50,000
EL SALVADOR	23	Alfredo Levisohn	6/96	12/96		x	12/96	250 000
SUMMARY				95%	30%	70%	83%	3,427,000

* no longer active participants in the ResPack program

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

In this reporting period, two clinic management workshops were held. In February, 1997 the first of this series was held in Quito, Ecuador. It was the first workshop of this type held in Ecuador. Conducted by Ellen Parietti, MPH and Orlando Oliva, MD, this workshop was the most successful yet at applying the basic principles of clinic management to participants' real situation.

Dr. Oliva presented information on the establishment of a successful clinic while fulfilling the social responsibilities of an ophthalmologist, and an introduction to basic principles of accounting. Ms. Parietti then presented these concepts in depth and went step by step through the clinic management workbook covering topics such as projected costs, projected income, recuperation of equipment expenses, and how to establish prices. See attachment C, Ecuador Trip Report, Ellen Parietti, February 1997.

A third clinic management course for Honduras was held June 14th, 1997. All of the worksheets regarding the calculation projected costs and income were covered step by step. See attachment D, Honduras Trip Report, Ellen Parietti, June 1997.

Objective 3: Increase Outreach of Eye Care Services

Donations of pharmaceutical and surgical supplies: 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 with limited income. More than \$150,000 worth of pharmaceuticals have been directed to ResPack participants to support their work.

Cataract kits. Through a grant from the William Carrigan Endowment, IEF has provided SightReach participants with 280 cataract kits. These kits contain intraocular lenses, suture, viscoelastic, and pilocarpine, the most expensive items necessary to perform a cataract operation. Many SightFirst participants had patients in need of cataract operations, yet unable to pay the cost of the surgery materials. The provision of these items will make it possible for the ophthalmologists to perform sight saving operations on these patients. At the same time, it will help them expand their practice; these same patients will hopefully refer neighbors and friends to have their cataracts operated.

Focus groups in ResPack communities. Ellen Parietti and Orlando Oliva conducted several focus groups in communities in Guatemala and Honduras. All were communities where ResPack doctors had clinics were located except for two, in which there were no eye care professionals. The goal was to understand better peoples' beliefs regarding eye health and thereby improve both the clinic services and outreach services. Focus group participants showed a pronounced unfamiliarity with eye care professionals. They were unable to discern between ophthalmologists, optometrists, opticians, and other spectacle vendors. Although access to ocular care was widely desired, community members didn't feel that the

higher prices charged by specialists were justified. In addition, many people either knew people or had personally purchased glasses at considerable cost and either had problems with them or subsequently broken them. These findings indicate the need for community education regarding eye care practitioners and their respective capabilities, educational preparation, services offered, and equipment used. See attachments E & F, Trip Reports for Guatemala and Honduras, September 1996.

Educational materials and Snellen charts: Guatemalan Regional Coordinator, Orlando Oliva, MD designed educational materials targeted at patients, teachers, and parents of children. Topics include strabismus, cataract, diabetic retinopathy, ocular problems in children, glaucoma, and pterygium. These pamphlets were distributed to ResPack participants along with Snellen charts for use in conducting ChildSight workshops in their local schools.

Previously, ChildSight workshops were held in conjunction with various health care workers located throughout the country. There was no established referral system for children identified as having a visual disability. In remote areas, children identified as needing evaluation by a specialist had to wait until an eye brigade could be arranged from the hospital, sometimes months

Insuring linkages between screenings arranged by public health officials and providers of eye care services has arisen as an issue critical to the success of such programs. Children screened as a result of successive ChildSight workshops will be in close proximity to ResPack doctors, and therefore be insured prompt follow-up care. To date, two ChildSight workshops have been held in conjunction with ResPack doctors in Guatemala. The educational materials, Snellen charts, and visual acuity screening has increased awareness of the importance of ocular health throughout ResPack communities.

Table B on the following page is a cumulative summary of progress related to objectives. Overall, the number of participants are fewer than those anticipated in the DIP. Experience indicates that considerable time is required to recruit, equip, and train ophthalmologists and many initial applicants are not suitable to the inclusion criteria established.

TABLE B

COMPONENT #1: ResPack

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	Remaining 9 months
1. Provide access to equipment packages Guatemala Honduras Ecuador El Salvador	6 participants; 6 estab. practices 10 participants; 7 estab. practices 6 participants; 5 estab. practices 1 participant; 1 estab practices	difficulty financing equipment purchases; interest rates approaching 40%, economic upheaval in Central America	Obtain financing to facilitate equipment purchases. Support successful participants with additional equipment needs
2 Provide training: practice mgt. (PM) & equipment maintenance (EM). Guatemala Honduras Ecuador El Salvador	comp. PM x 2; EM x 2 comp. PM x 3; EM x 2 EM x1 PMx1 PM x1	limited # of new participants in need of training.	obtain business planning consultant institutionalize practice management course
3. Increase outreach of eye care services Guatemala Honduras Ecuador El Salvador	outreach conducted; cataract campaigns some outreach conducted; educational outreach & campaigns conducted	participants unfamiliar with outreach activities; community ability to pay for services; need for materials for surgery	support follow-up of ChildSight screening with secondary screening/referrals secure source of low-cost eyeglasses for children, support national screening effort with MOH & MOE

Component Two: ChildSight:

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

Surveys have been conducted in all program countries. IEF plans to publish this data in coordination with other data collected from around the world. The possibility of repeating the survey in Honduras and Guatemala is currently being investigated in order to ensure that data is comparable with other surveys consistent with the WHO protocol data base. This will allow a pooled group analysis to contrast data between countries and regions.

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

In Honduras, there continues to be much activity surrounding visual acuity screening implemented by the ChildSight program. The National Committee for the Prevention of Blindness continues to conduct follow-up screenings for children identified as needing the attention of an ophthalmologist. Please see attachment G, Taller Anual del Comité de Prevención de la Ceguera.

The IEF and the National Committee for the Prevention of Blindness has signed an agreement with the Ministries of Health and Education to implement visual acuity screening in schools on a national level. See attachment H, copy of the agreement, and attachment I, plan for the implementation of the screening program. Manuals for the training of teachers have been designed by the NCPB, see attachment J. They will begin in two departments, and expand throughout the country in subsequent phases.

In Guatemala, a second set of ChildSight workshops are being held. Originally, IEF trained rural health workers affiliated with local NGOs as well as health professionals from the Ministry of Health (MOH). The participants of these workshops, however, were not obliged to conduct screenings. Some organizations did hold screenings, many did not. Some screenings were held in sites without access to an ophthalmologist and follow-up has proved difficult. Eye camps were arranged for these areas, but some areas had to wait for months for a doctor to visit. IEF has decided to concentrate a second set of ChildSight workshops in areas where ResPack doctors reside so the people will have accessible follow-up care. The first two in this second set of trainings have been held in Sanarate. Please see attachment K.

Albanian workshops to train general practitioners in eye care are being arranged as part of a family physician training program. This program is funded by the European Union and others and focuses on re-training general practitioners, responsible for the provision of health care to the majority of Albania's population. Each workshop will consist of 1-2 days of instruction on eye care basics. Each workshop will consist of 1-2 days instruction on basic eye examination, care, and referral that can be accomplished by family physicians. Task Force members, a sub-group of the National Blindness Prevention Committee composed of active ophthalmologists, will be instructors. A second training

activity considered is cross training between the Department of Ophthalmology and the Departments of Pediatrics and Nursing of the University Hospital, Tirana. This practical training would consist of short theoretical topics relevant to each specialty and practical observation and practice integrated into the rotations of the Department of Ophthalmology. Task Force members would also be active in coordinating these exchanges. See attachment L, Trip Report, John Barrows, Tirana, Albania, February 1997. Training of Trainers will begin in February 1998 with the visit of Dr. May Khadem of Health for Humanity to provide technical assistance. Please see attachment M, Health for Humanity's Report of Activities January - September, 1996 for more information regarding the PHARE program.

Bulgaria has completed the four workshops outlined in the objectives to "strengthen collaboration between pediatricians and ophthalmologists for early diagnosis and treatment of eye diseases in children." The first of these workshops was held for the Southern region in Plovdiv in August 1995. The second was for the Northern region, held in Pleven in June 1996. The last two workshops have been held since the last reporting period. The eastern region's workshop was held in Varna in October 1996 with 58 ophthalmologists and pediatricians in attendance. The Sofia workshop was held in February 1997 for the western and central region and hosted 200 ophthalmologists, pediatricians, and micropediatricians. The meetings were comprehensive with topics ranging from genetics, retinopathy of prematurity, and pediatric metabolic diseases and eye pathology to "The Experience of Families with Children with Visual Impairments in Bulgaria." Both workshops were enjoyed thoroughly by all participants. See attachment N, ChildSight workshop Pleven, Bulgaria, and attachment O, ChildSight workshop Varna, Bulgaria.

In Malawi, an evaluation of the OMAs (Ophthalmic Medical Assistants) trained by the ChildSight program was conducted in June 1997 by Jill Keefe and Karin Van Dijk. This evaluation consisted of a non-random evaluation of children who had either been prescribed or had incorrectly not been prescribed glasses by the OMAs. Refractive errors, fitting and size of frames, and documentation accuracy were analyzed according to attachment P, Evaluation of Malawi's low vision programme.

Evaluation of children in the ITP (Itinerant Teacher Programs) was delayed 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

In Eritrea, relations with the government proved to be exceedingly difficult. A country agreement with IEF was never signed, hampering our ability to implement workshops and training. In January 1997, IEF, along with other members of the NGO community decided to "cut their losses," in effect, and leave Eritrea. IEF continues to collaborate with Dr. Desbele Gebreghiorgis in his efforts to establish a National Plan for the Prevention of Blindness, but no longer supports an office nor support staff in Eritrea.

Objective 3: Strengthen tertiary centers' capability in pediatric ophthalmology.

Honduras - Dr. Robert Sargent, a pediatric ophthalmologist from the Colorado Children's Hospital in Denver, visited the San Felipe Hospital in Tegucigalpa to share his experience and train staff. Dr. Sargent attended patients with staff in the clinic, performed surgeries, and held lectures with ophthalmology residents and staff ophthalmologists at night. See attachment R, Dr. Sargent's Report on his visit to Honduras and Guatemala. See attachment S, Gomez's report on Dr. Robert Sargent's visit to Honduras.

Guatemala - Dr. Maynard Wheeler, pediatric ophthalmologist with the Connecticut Children's Medical Center, accompanied Dr. Robert Sargent to hold pediatric trainings in Guatemala. Due to logistical problems and tensions that exist between the two ophthalmology residency programs in Guatemala, it was decided to send two pediatric ophthalmologists in order to hold surgery and clinical trainings in each institution separately. The two visiting ophthalmologists rotated hospitals. The two programs, from Roosevelt Hospital and Robles Hospital, joined in the evenings for lectures held in a third location provided by Alcon Pharmaceutical where the visiting doctors both held presentations and question and answer sessions. Please see attachments R, Dr. Sargent's Report on his visit to Guatemala, attachment T, Dr. Wheeler's Report on his visit to Guatemala, and attachment U, report by Dr. Oliva on the pediatric ophthalmology visits.

In addition, ChildSight is supporting Dr. Ana Raquel Hernandez in her pediatric ophthalmology fellowship at the Fundación Oftalmológica del Valle in Cali, Colombia. She will finish her training in February 1998 and will return to Robles Hospital in Guatemala City to work in their pediatric department. Please see attachment V, Ana Raquel Hernandez, Pediatric Ophthalmology Fellow, Reports of Activities and abstract of her research: Use of Intraocular Lenses in Children.

Albania - IEF co-hosted with Health for Humanity the visit of pediatric ophthalmologist Dr. Edward Parelhoff to Vlora in November of 1996. During his visit he attended patients daily in the clinics with hospital staff, presented and taught pediatric surgical techniques to the ophthalmologists, presented lectures on pediatric ophthalmology, and conducted post-operative rounds. Included in the surgeries performed were four strabismus cases, the first ever to be performed in Vlora. His visit was also key in the identification of areas for improvement such as clinic management. See attachment W, Trip Report, Albania, Dr. Edward Parelhoff

Bulgaria: Professor Marilyn Miller, MD held the fourth Pediatric Ophthalmology workshop for ophthalmologists, pediatricians, and neo-natologists. Approximately 200 physicians from university eye and pediatric centers from around the country participated. Topics presented focused on retinopathy of prematurity (ROP) and congenital anomalies. Prevalence of ROP is rising as technology improves in saving the lives of premature infants. Unfortunately, with the increased use of incubators, infants are exposed to increased levels of oxygen, contributing to ROP. Training is required to insure appropriate levels of oxygen in the incubators, and babies' ocular health should be monitored. Please see attachment X, Bulgaria Trip Report, Victoria Sheffield, February 1997

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	Remaining 9 months
1 Complete surveys Albania Bulgaria Eritrea Malawi Guatemala Honduras	completed (3/94) completed (9/95) completed (1/95) completed (3/94) completed (5/94) completed (2/95)	completed by C Gilbert S. Lewallen M Eckstein Lewallen/Courtright F. Hermes F Hermes/Benavides	re-do Guatemala's results write article/presentation
2. Conduct 4 workshops Albania Bulgaria Eritrea Malawi Guatemala Honduras	comp #1(2/96)#2(2/97) comp. #1(8/95)#2(6/96)#3(10/96) #4(2/97) none comp #1(6/95)#2(7/96)#3(10/95)#4(11/95) comp. #1-4 (2/95) #5-6(7/97) comp. #1-4 (10/94) #5-8(3-4/95)	lack of basic infrastructure political country agreement none none none	#3-4 #4 none additional follow-up further screenings w/ Respack Drs. assist in the development of natl screening program.
3. Strengthen tertiary centers/ Albania Bulgaria Eritrea Malawi Guatemala Honduras	Beci/Kearnan/Levinson/Parelhoff Miller/Day/Miller O'Neill Steinkuller Sanchez/Sargent/Wheeler/Hernandez Sargent	dependent of improving infrastructure limited ophthalmic staff limited ophthalmic staff	Kearnan (2) Miller/Day to be determined Buckley ophthalmologist to India , establishment of self-sustaining eye glass factory

B. Technical support

The following technical support was received during this reporting year:

-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 continued to make active steps toward establishing of a self-sufficient eye glass workshop and an eye bank in Tegucigalpa. The signing of a formal agreement between the IEF and the Ministry of Education regarding the institutionalization of visual acuity screenings for primary school children grade one.

-Dr. Maynard Wheeler volunteered his time as a pediatric surgeon in Guatemala seeing patients, giving lectures, & performing surgeries with the pediatric staff in Robles and Roosevelt hospitals

-Dr. Robert Sargent visited both Guatemala and Honduras in the capacity of pediatric ophthalmologist seeing patients, giving lectures, and performing surgeries with ophthalmologists in Robles & Roosevelt hospitals in Guatemala, the San Felipe Hospital in Tegucigalpa, Honduras

-Dr. Edward Parelhoff volunteered his time as a pediatric surgeon in Albania seeing patients, performing surgeries, giving lectures, and sharing his experience with the ophthalmologists in Vlora

-Brian Johnson of Skyline Medical, Inc gave technical assistance with the preparation of the container equipment shipment to Albania's Eye Care program.

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, El Salvador, and Nicaragua 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), FUEDEM-Fundación para el Desarrollo de la Mujer Salvadoreña (El Salvador), and individual ophthalmologists from Guatemala, Honduras, Ecuador, and El Salvador. In the last visit to Nicaragua, meetings were held with the director of the National Center for Ophthalmology and their residents.

Companies with which IEF has 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; R H Burton, Echo Medical Instruments; Haag Streit International and

InterMed Sales Corp. Companies with which IEF has 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.

IEF has begun to explore new ways of partnering with the private sector that go beyond the traditional donor/charity relationship. IEF Executive Director, Victoria Sheffield has recently undertaken negotiations with Alcon Pharmaceutical Company executives in an effort to establish a sustainable method of attaining affordable ophthalmic products for our program doctors. Although IEF has consistently received valuable donations from Alcon, these donations, do not take the place of an ongoing need for reliable access to affordable medicines and surgical supplies. Currently, American companies' hold on the intraocular lens (IOL) market is being challenged by affordable, high quality lenses produced by factories in developing countries. Soon to reach the market are affordable sutures from India, another product line previously dominated by American companies. Ms. Sheffield is proposing that Alcon establish affordable pricing to developing countries, in order to develop a more sustainable, mutually beneficial relationship between Alcon and their customers in developing countries and insure themselves a place in the new, more competitive market.

IEF is also pursuing creative partnerships with corporations, optical shops, and other organizations to provide eyeglasses for children screened as a result of our ChildSight workshops as well as the Honduran National School Screening program. New contacts are being pursued in the hopes that sustainable, mutually beneficial relationships will develop.

D. New Professional Staff

There have been two changes in the position of Matching Grant coordinator in the Honduras office. Dr. Marylena Arita had been covering these responsibilities. Last October, Dr. Arita became responsible for Vitamin A programming in the Honduras office. In November, Dr. Zulema Alvarez was hired as Matching Grant Coordinator. Dr. Alvarez was granted a 9 month contract, expiring in the end of July 1997. Ms. Claudia Alcerro has been hired as of August 1, 1997 to take over this position and is the current coordinator.

E. Evaluation

IEF has an evaluation has been scheduled for late March/April 1998. In addition to further documenting project accomplishments, largely process oriented, IEF will attempt to quantify accomplishments in terms of the outputs resulting from the investments of resources and training. The evaluation will also help identify activities IEF can continue to support individuals and organizations effectively in the future, and explore new directions for supporting organizational and financial sustainability technical assistance.

III. CHANGES MADE IN PROGRAM DESIGN

March 1, 1997 IEF received permission from USAID official, Cathy Bowes, to expand the scope of the ResPack portion of our SightReach program. At that point, three years into the program, became clear that there would be limited additional participation from Guatemala, Honduras, Ecuador and El Salvador. Limited numbers of people fulfill the participant selection criteria, and all who were interested were currently enrolled in the program. IEF received many inquiries from neighboring countries with excellent candidates wanting to provide services in rural communities, but without any support to do so. Since March 1997, five new applications have been received, three from Nicaragua and two from Venezuela. Two applications from Nicaragua have been accepted and the participants are seeking financing.

IV. CONSTRAINTS, UNEXPECTED BENEFITS, AND LESSONS LEARNED

A. Component One-ResPack

Constraints:

Economic Factors: Many individuals serving the very neediest populations are unable to participate in the ResPack program due to the financial responsibilities inherent in the purchase of equipment. Interest rates from banks are near to 40% for loans in parts of Latin America, making financing impossible for young ophthalmologists setting up practice. Latin America's economy has taken a downturn, making it even riskier to finance a large equipment purchase. In some areas, the population is so poor ophthalmologists cannot be assured their clinics will generate enough income to pay bank installments. In Nicaragua, for example, recent graduates from the ophthalmology residency program are obligated by the Ministry of Health to serve in rural parts of the country. These rural locations do not possess ophthalmic equipment with which to give a thorough ophthalmic exam. These doctors state that they would like to purchase new equipment but are uncertain of their ability to finance the purchase.

Agreement for ResPack Participants: The agreement signed by ophthalmologists upon entrance into the ResPack program is not legally binding. IEF has no recourse if people do not open their ResPack clinics or proceed to locate their equipment in a location outside of program criteria. IEF field personnel have found it difficult to enforce IEF's policy on participation without being able to take legal action, nor is it certain whether IEF would want to take any legal actions.

Four participants in Honduras were obliged to close their ResPack clinics. Ricardo Rivera had his clinic in La Entrada de Copan and reported that he was losing money by keeping his ResPack clinic open in an area without sufficient clientele. Sergio Zuñiga was forced to vacate his clinic (located in a small hospital) due to the wishes of the building's owner to replace him with doctor that admitted patients for overnight stays, thereby generating more income.

Dr. Zuñiga had been attending patients at another Res-pack clinic in Colonia Kennedy with Doris

Alvarado, and felt that he was fulfilling his commitment to IEF. After a year of the arrangement, it was discovered that Drs. Alvarado and Zuñiga were using some of the ResPack equipment in an up-scale clinic within Tegucigalpa. The fact that the ResPack equipment had been moved to another location without informing IEF was contrary to the IEF agreement to participate. The use of ResPack equipment in locations not considered in need is considered by IEF as an unfair advantage over other competing ophthalmologists unable to purchase equipment with ResPack assistance or struggling under the ResPack program in other rural, poorer, and less lucrative locations. This creates a problem for IEF's image within the Latin American Ophthalmic community. It was decided to terminate IEF's relationship with these individuals. It is recognized, however, that Drs. Zuñiga and Alvarado both provided valuable services in their ResPack clinics for two years.

Dr. Dennis Espinal maintained his ResPack clinic in Danlí, Honduras for two years. He closed his clinic in March 1997 for personal matters. His clinic in Danlí had been very successful, but familial reasons obliged him to remain full time in Tegucigalpa.

Benefits:

Cataract Kits Through a grant from the William Carrigan Endowment, IEF has been able to provide kits containing essential supplies for cataract surgery for 240 patients. Through donations received from manufacturers, this number has increased substantially. See attachment Y, lists of patients receiving donated cataract materials.

Currently in Central America, surgical materials can be obtained only through distributors who import surgical supplies from the exterior, charging healthy profits. This makes the costs of materials and therefore cataract surgery more expensive for everyone. IEF has plans to use our contacts to procure quality supplies at low cost and re-sell them in Guatemala and Honduras with a modest mark-up. These supplies would be sold for 75% less than what most distributors charge, providing access to affordable surgical supplies and at the same time generating income for the IEF office.

Donations: Dr. Maynard Wheeler facilitated the donation of a Weck ophthalmology operating microscope from the Connecticut Children's Medical Center. IEF awarded this donation to Dr. Claudia Silva Solomon, working in Siguatepeque, Honduras. Dr. Silva is living and working full time in Siguatepeque. She has shown great dedication to the prevention of blindness in the region, conducting a large amount of outreach work in the short time she has been in her site. She appears twice monthly on a radio program speaking about the prevention of blindness, gives lectures in the hospital to other doctors on cases that need to be referred to ophthalmologists, and gives nurses in training similar lectures. These activities have led to a much higher quality of care for those patients with illnesses with ocular complications.

Sustainability of Programming: The IEF intends to continue offering workshops on ophthalmology clinic management by institutionalizing them with the Pan American Association Ophthalmology

Ellen Parietti and Orlando Oliva presented the Clinic Management Workshop at the Brazilian Ophthalmology Congress, jointly sponsored by the PAAO and held in Sao Paulo in September of 1996. The course is to be offered in the next PAAO Congress to be held in Orlando, Fla see attachment Z, Trip Report, Ellen Parietti, Brazil, Sept. 1996.

Lessons Learned:

Hospital partnerships: Many of the successful participants in the ResPack program have established their clinics within a hospital. The administrative and organizational infrastructure hospitals offer provide immeasurable support. Financial management, equipment and maintenance, publicity, security and a variety of other infrastructure issues are managed by the hospital, freeing ophthalmologists to dedicate themselves more directly to eye care.

Flexibility: Any non-binding agreement with ophthalmologists must be made with the knowledge that doctors, like any other businessperson, will make decisions based upon a variety of factors including family matters and financial survival

B. Component Two-ChildSight

Lessons Learned & Constraints:

Periodic changes in the structures of the MOE and the MOH for political reasons represents a constant source of delays on joint projects. Leadership changes have meant the need to re-educated personnel on the project and related issues. Valuable time is been lost, and dedicated individuals who have been on board since the beginning get very frustrated.

Malawi: Integration of a narrowly focussed program on childhood surgery presents problems to a National Program with few resources. Childhood blindness is usually approached by preventative measures such as Vitamin A Distribution programs rather than through expensive childhood surgery. In Malawi there was some resistance at the start of this initiative because it was felt to be competing with priority problems, ie. adult cataract blindness. It is also clear, that where possible, integrating ChildSight into low vision and rehabilitation programs is necessary. Many children identified in screening are in need of glasses and other low vision services rather than corrective surgery.

Albania: In Albania, the basic barriers to improving eye care services was the lack of basic infrastructure (equipment and manpower) and poorly trained ophthalmologists. Over the past years, Albania has been in a reconstruction phase of development. Much of the support provided through ChildSight was to help the University Hospital and the National Blindness Prevention Committee address the basic problems which needed to be addressed before they could concentrate on the sub-specialty of ophthalmology.

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. Training of trainers is scheduled for April 1, 1998.

V. OTHER ACTIVITIES

A. IEF sponsored the attendance of four ophthalmologist to last year's meeting of the American Academy of Ophthalmology. These individuals included three doctors from Honduras, Dr. Jorge Cisneros, Dr. Alberto Ehrler, and Dr. Claudia Silva Solomon, and a Bulgarian, Dr. Blaga Chilova, Professor at the University Eye Hospital in Plovidiv.

B. The IEF held a round table in the PAAO Congress held in Cancun, Mexico on how to integrate prevention of blindness work into ophthalmologists' professional development. Various heads of ophthalmology departments attended along with many residents from different programs. All contributed their opinions and experiences. See attachment AA, III Latin American Congress on the Prevention of Blindness.

C. The IEF, in conjunction with Health for Humanity, has sent a shipment of ophthalmic equipment to Albania for the second time. This second shipment was to strengthen 3 satellite clinics in secondary cities of Albania. The eye care centers are now sufficiently equipped to give patients a thorough examination. See attachment AB, Invoice of Albanian shipment of donated ophthalmic equipment

D. Traditional Healer Symposium: Blantyre, Malawi. The IEF, in collaboration with the Task Force of the WHO/PBL Partnership Committee, supported a symposium on the need for collaboration between African traditional healers and biomedical eye care workers. Traditional healers (TH) are respected, integral members of their community. They are also the most commonly consulted and most accessible health care providers in African communities. Collaboration between TH and biomedical personnel is important to assist in the referral and counseling of patients as well as the decrease of harmful traditional practices. General statement of consensus and recommendations can be found in attachment AC.

VI. BUDGET REVIEW

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

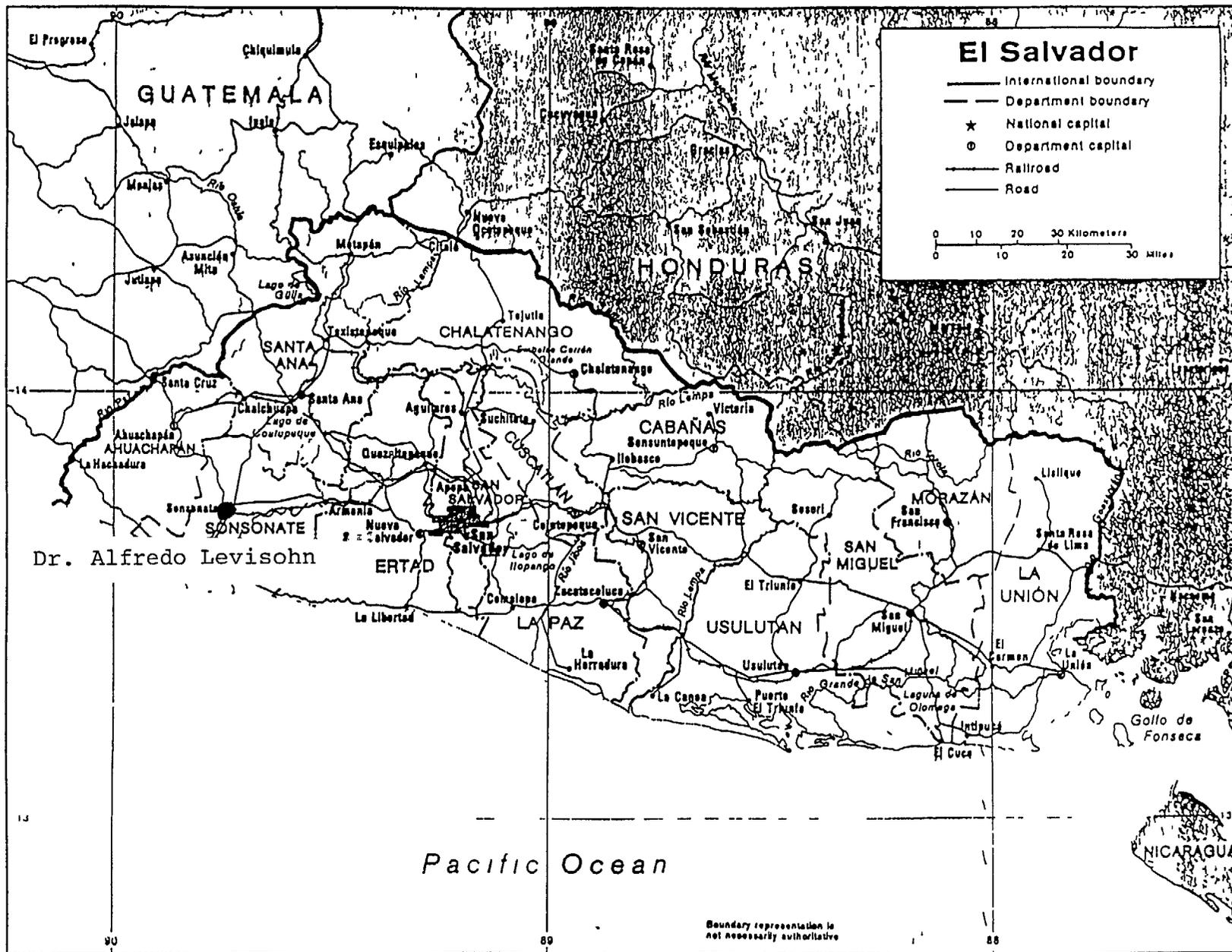
Spending at Headquarters has progressed at a rate according to budget. As a consequence of extending the Cooperative Agreement for two years while maintaining a constant rate of expenditure at headquarters, the original headquarters budget has been exceeded. IEF will request under a separate letter whether formal concurrence is required to amend the Cooperative Agreement.

Expenditure of the field budget is underspent with approximately 50% of the budget spent through December 1997. There have been minimal expenses from El Salvador due to start-up problems, and smaller than anticipated expenses in Albania, Bulgaria, and Ecuador. Eritrea's spending was limited to the first years of the Cooperative Agreement. Once it became clear that there would not be a country agreement established between IEF and the MOH, the budget for Eritrea was re-budgeted to support other country activities.

The expenditure of combined headquarters and field budgets is slightly underspent with approximately 75% of the USAID budget spent through December 1997. Still pending are the receipt of field reports and major expenditures for publication of materials. IEF has met match requirements, and with the no-cost grant extension will continue program activities through August 1998. It is anticipated that all funding will be spent by the end of the extended grant period.

Please see attachment AD, pipeline analysis to date.

Attachment A: Maps of ResPack Countries



Base 504510 8-80 (545437)



Dr. Gonzalo Cruz

Dra. Maria Sanchez

Dr. Sidney Morales

Dr. Orlando Oliva

Dr. Antonio Hernandez

Dr. Paul Cifuentes

NORTH
PACIFIC OCEAN

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Attachment B: Statistics of ResPack Participants

**ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, ZACAPA
PROGRAMA RESPACK
DR. ORLANDO OLIVA
I.E.F.**

MES	PRIMERA CON.	RECONSULTAS	TOTAL
1994			
SEPTIEMBRE	22	10	32
OCTUBRE	18	16	34
NOVIEMBRE	24	7	31
DICIEMBRE	38	18	56
TOTAL	102	51	153
1995			
ENERO	38	27	65
FEBRERO	48	11	59
MARZO	62	33	95
ABRIL	39	21	60
MAYO	58	24	82
JUNIO	40	16	56
JULIO	39	14	53
AGOSTO	26	5	31
SEPTIEMBRE	22	9	31
OCTUBRE	37	17	54
NOVIEMBRE	30	22	52
DICIEMBRE	35	25	60
TOTAL	474	224	698

**ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, ZACAPA
PROGRAMA RESPACK
DR. ORLANDO OLIVA
I.E.F.**

MES	CAT.	PTERIG.	CHALAZ.	OTRAS	TOTAL
1994					
SEPT.	0	0	0	0	0
OCT.	0	1	0	0	1
NOV.	1	1	2	0	4
DIC.	0	0	0	0	0
TOTAL	1	2	2	0	5
1995					
ENERO	0	0	0	0	0
FEB.	0	2	1	0	3
MARZO	2	2	1	0	5
ABRIL	1	1	1	0	3
MAYO	0	0	0	0	0
JUNIO	1	0	0	0	1
JULIO	0	0	0	0	0
AGOSTO	0	1	0	0	1
SEPT.	0	0	0	0	0
OCT.	0	1	0	0	1
NOV.	2	0	1	0	3
DIC.	1	0	1	0	2
TOTAL	7	7	5	0	19

ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, ZACAPA
PROGRAMA RESPACK
DR. ORLANDO OLIVA
I.E.F.
AÑO 1996

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO	24	22	46
FEBRERO	24	17	41
MARZO	34	11	45
ABRIL	19	12	31
MAYO	13	6	19
JUNIO	32	20	52
JULIO	30	15	45
AGOSTO	43	8	51
SEPTIEMBRE	25	16	41
OCTUBRE	9	14	23
NOVIEMBRE	24	8	32
DICIEMBRE	23	10	33
TOTAL	300	159	459

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, ZACAPA
PROGRAMA RESPACK
DR. ORLANDO OLIVA
I.E.F.
AÑO 1996

MES	CATAR.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO	0	0	0	0	0
FEB.	2	1	2	0	5
MARZO	0	1	0	1	2
ABRIL	2	0	0	0	2
MAYO	1	1	0	0	2
JUNIO	1	0	0	0	1
JULIO	0	2	1	0	3
AGOSTO	0	0	0	0	0
SEPT.	2	0	0	0	2
OCT.	0	0	0	1	1
NOV.	3	0	0	0	3
DIC.	2	1	0	0	3
TOTAL	13	6	3	2	24

ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, ZACAPA
PROGRAMA RESPACK
DR. ORLANDO OLIVA
I.E.F.
AÑO 1997

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO	40	39	79
FEBRERO	21	6	27
MARZO	30	22	52
ABRIL	24	11	35
MAYO	42	11	53
JUNIO	39	6	45
JULIO	55	15	70
AGOSTO	39	23	62
SEPTIEMBRE	30	15	45
OCTUBRE	20	7	27
NOVIEMBRE	39	16	55
DICIEMBRE	38	16	54
TOTAL	417	187	604

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, ZACAPA
PROGRAMA RESPACK
DR. ORLANDO OLIVA
I.E.F.
AÑO 1997

MES	CAT.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO	2	1	1	0	4
FEB.	5	2	1	1	9
MARZO	2	0	0	0	2
ABRIL	1	0	1	0	2
MAYO	3	1	0	0	4
JUNIO	4	1	0	0	5
JULIO	3	1	0	0	4
AGOSTO	3	2	0	1	6
SEPT.	1	1	0	0	2
OCT.	3	1	0	2	6
NOV.	2	1	0	2	5
DIC.	0	0	0	0	0
TOTAL	29	11	3	6	49

**ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, IZABAL
PROGRAMA RESPACK
DR. SIDNEY MORALES
I.E.F.**

MES	PRIMERA CON.	RECONSULTAS	TOTAL
1995			
ENERO	75	150	225
FEBRERO	88	151	239
MARZO	132	172	304
ABRIL	112	156	268
MAYO	87	159	246
JUNIO	116	101	217
JULIO	89	40	129
AGOSTO	96	35	131
SEPTIEMBRE	100	25	125
OCTUBRE	110	36	146
NOVIEMBRE	80	38	118
DICIEMBRE	70	15	85
TOTAL	1155	1078	2233

**ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, IZABAL
PROGRAMA RESPACK
DR. SIDNEY MORALES
I.E.F.**

MES	CAT.	PTERIG.	CHALAZ.	OTRAS	TOTAL
1995					
ENERO	20	10	0	0	30
FEB.	39	7	0	0	46
MARZO	6	6	0	0	12
ABRIL	19	6	0	0	25
MAYO	44	8	0	0	52
JUNIO	40	6	0	0	46
JULIO	18	5	1	0	24
AGOSTO	20	6	0	0	26
SEPT.	21	4	2	1	28
OCT.	16	9	1	0	26
NOV.	24	10	0	0	34
DIC.	15	2	0	0	17
TOTAL	282	79	4	1	366

ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, MORALES, IZABAL
PROGRAMA RESPACK
DR. SIDNEY MORALES
I.E.F.
AÑO 1996

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO	61	11	72
FEBRERO	113	24	137
MARZO	88	19	107
ABRIL	89	13	102
MAYO	96	14	110
JUNIO	111	21	132
JULIO	140	12	152
AGOSTO	151	22	173
SEPTIEMBRE	30	5	35
OCTUBRE	100	19	119
NOVIEMBRE	75	16	91
DICIEMBRE	66	17	83
TOTAL	1,120	193	1,313

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, MORALES, IZABAL
PROGRAMA RESPACK
DR. SIDNEY MORALES
I.E.F.
AÑO 1996

MES	CAT.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO	5	5	1	4	15
FEB.	14	10	-	2	26
MARZO	24	1	1	9	35
ABRIL	13	3	2	1	19
MAYO	24	5	0	2	31
JUNIO	17	0	2	2	21
JULIO	23	2	0	0	25
AGOSTO	17	4	1	3	25
SEPT.	6	0	0	0	6
OCT.	14	7	4	2	27
NOV.	10	5	3	0	18
DIC.	20	3	0	2	25
TOTAL	187	45	14	27	273

CLINICA OFTALMOLOGICA, MORALES, IZABAL
PROGRAMA RESPACK
DR. SIDNEY MORALES
I.E.F.
AÑO 1997

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO	106	32	138
FEBRERO	91	15	106
MARZO	61	5	66
ABRIL	91	21	112
MAYO	106	18	124
JUNIO	115	17	132
JULIO	163	50	213
AGOSTO	64	11	75
SEPTIEMBRE	117	21	138
OCTUBRE			
NOVIEMBRE			
DICIEMBRE			
TOTAL			

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, MORALES, IZABAL
PROGRAMA RESPACK
DR. SIDNEY MORALES
I.E.F.
AÑO 1997

MES	CATAR.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO	13	1	2	1	15
FEB.	10	4	4	4	26
MARZO	7	7	5	7	26
ABRIL	12	4	6	5	27
MAYO	25	0	4	2	31
JUNIO	19	6	4	4	33
JULIO	22	6	5	3	36
AGOSTO	4	0	0	0	4
SEPT.	21	2	3	1	27
OCT.					
NOV.					
DIC.					
TOTAL					

**ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, HUEHUETENANGO
PROGRAMA RESPACK
DR. GONZALO CRUZ
I.E.F.**

1995

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO			
FEBRERO			
MARZO	24	2	26
ABRIL	20	5	25
MAYO			
JUNIO			
JULIO			
AGOSTO	26	4	30
SEPTIEMBRE	22	2	24
OCTUBRE	21	2	23
NOVIEMBRE	32	3	35
DICIEMBRE	39	4	43
TOTAL	184	22	206

* DURANTE LOS MESES QUE APARECEN EN BLANCO (MAYO-JULIO) NO HUBO CONSULTA DEBIDO A QUE EL DR. CRUZ EFECTUO UNA ROTACION POR PARTE DE EL HOSPITAL ROOSEVELT EN SARASOTA, FLORIDA.

**ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, HUEHUETENANGO
PROGRAMA RESPACK
DR. GONZALO CRUZ
I.E.F.**

1995

MES	CATAR.	PTERIG.	CHALAZ.	OTRAS	TOTAL
1995					
ENERO					
FEB.					
MARZO	0	0	2	0	2
ABRIL	0	0	0	0	0
MAYO					
JUNIO					
JULIO					
AGOSTO	0	0	2	0	2
SEPT.	0	0	0	0	0
OCT.	0	0	2	0	2
NOV.	0	0	2	0	2
DIC.	0	0	1	0	1
TOTAL	0	0	9	0	9

* DURANTE LOS MESES QUE APARECEN EN BLANCO (MAYO-JULIO) NO HUBO CONSULTA DEBIDO A QUE EL DR. CRUZ EFECTUO UNA ROTACION POR PARTE DE EL HOSPITAL ROOSEVELT EN SARASOTA, FLORIDA.

ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, HUEHUETENANGO
PROGRAMA RESPACK
DR. GONZALO CRUZ
I.E.F.
AÑO 1996

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO	62	3	65
FEBRERO	57	4	61
MARZO	63	12	75
ABRIL	68	12	80
MAYO	60	14	74
JUNIO	72	14	86
JULIO	50	15	65
AGOSTO	63	17	80
SEPTIEMBRE	66	14	80
OCTUBRE	75	18	93
NOVIEMBRE	61	17	78
DICIEMBRE	59	14	73
TOTAL	756	154	910

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, HUEHUETENANGO
PROGRAMA RESPACK
DR. GONZALO CRUZ
I.E.F.
AÑO 1996

MES	CAT.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO	0	0	2	0	2
FEB.	0	0	2	0	2
MARZO	5	1	1	0	7
ABRIL	5	0	1	0	6
MAYO	3	1	1	0	5
JUNIO	4	1	1	0	6
JULIO	4	1	0	0	5
AGOSTO	5	0	0	0	5
SEPT.	4	1	1	0	6
OCT.	4	0	1	0	5
NOV.	5	0	0	0	5
DIC.	3	0	1	0	4
TOTAL	42	5	11	0	58

ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, HUEHUETENANGO
PROGRAMA RESPACK
DR. GONZALO CRUZ
I.E.F.
AÑO 1997

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO	75	40	115
FEBRERO	97	30	127
MARZO	105	34	139
ABRIL	97	32	129
MAYO	110	29	139
JUNIO	118	36	154
JULIO	77	40	117
AGOSTO	65	44	109
SEPTIEMBRE			
OCTUBRE			
NOVIEMBRE			
DICIEMBRE			
TOTAL			

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, HUEHUETENANGO
PROGRAMA RESPACK
DR. GONZALO CRUZ
I.E.F.
AÑO 1997

MES	CAT.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO	5	0	1	0	6
FEB.	4	0	2	0	6
MARZO	4	0	1	0	5
ABRIL	5	0	1	0	6
MAYO	6	1	1	0	8
JUNIO	5	0	1	0	6
JULIO	3	0	0	0	3
AGOSTO	2	0	0	1	3
SEPT.				0	
OCT.		0		0	
NOV.		0	0	0	
DIC.		0		0	
TOTAL				0	

**ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, JUTIAPA
PROGRAMA RESPACK
DR. ANTONIO HERNANDEZ
I.E.F.**

MES	PRIMERA CON.	RECONSULTAS	TOTAL
1995			
ENERO			
FEBRERO			
MARZO			
ABRIL			
MAYO			
JUNIO			
JULIO			
AGOSTO	49	1	50
SEPTIEMBRE	54	4	58
OCTUBRE	53	4	57
NOVIEMBRE	49	7	56
DICIEMBRE	41	1	42
TOTAL	246	17	263

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, JUTIAPA
PROGRAMA RESPACK
DR. ANTONIO HERNANDEZ
I.E.F.

1995

MES	CATARA	PTERIG.	CHALAZ.	OTRAS	TOTAL
1995					
ENERO					
FEB.					
MARZO					
ABRIL					
MAYO					
JUNIO					
JULIO					
AGOSTO					3
SEPT.					2
OCT.					1
NOV.					1
DIC.					3
TOTAL					9

ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, JUTIAPA
PROGRAMA RESPACK
DR. ANTONIO HERNANDEZ
I.E.F.
AÑO 1996

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO	57	7	64
FEBRERO	42	16	58
MARZO	40	7	47
ABRIL	22	7	29
MAYO	39	6	45
JUNIO	34	11	45
JULIO	38	9	47
AGOSTO	26	2	28
SEPTIEMBRE	30	10	40
OCTUBRE	21	5	26
NOVIEMBRE	30	12	42
DICIEMBRE	17	2	19
TOTAL	396	94	490

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, JUTIAPA
PROGRAMA RESPACK
DR. ANTONIO HERNANDEZ
I.E.F.
AÑO 1996

MES	CATARA	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO	2	0	0	0	2
FEB.	1	1	0	0	2
MARZO	2	0	0	0	2
ABRIL	2	0	0	0	2
MAYO	1	1	0	1	3
JUNIO	5	0	0	0	5
JULIO	2	0	0	0	2
AGOSTO	2	0	0	0	2
SEPT.	2	0	0	0	2
OCT.	1	0	0	0	1
NOV.	2	0	0	0	2
DIC.	0	0	0	0	0
TOTAL	22	2	0	1	25

ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, JUTIAPA
PROGRAMA RESPACK
DR. ANTONIO HERNANDEZ
I.E.F.
AÑO 1997

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO	52	10	62
FEBRERO	36	9	45
MARZO	30	7	37
ABRIL	31	2	33
MAYO	35	8	43
JUNIO	36	4	40
JULIO	30	2	32
AGOSTO	21	9	30
SEPTIEMBRE	22	7	29
OCTUBRE	25	5	30
NOVIEMBRE	0	0	0
DICIEMBRE	0	0	0
TOTAL	318	63	381

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, JUTIAPA
PROGRAMA RESPACK
DR. ANTONIO HERNANDEZ
I.E.F.
AÑO 1997

MES	CAT.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO	1	0	0	0	1
FEB.	3	0	0	0	3
MARZO	1	0	0	0	1
ABRIL	1	0	0	0	1
MAYO	1	0	0	0	1
JUNIO	2	0	0	0	2
JULIO	1	0	0	0	1
AGOSTO	2	0	0	0	2
SEPT.	0	0	0	0	0
OCT.	0	0	0	0	0
NOV.	0	0	0	0	0
DIC.	0	0	0	0	0
TOTAL	12		0	0	12

ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, SAN PEDRO SAC., SAN MARCOS
PROGRAMA RESPACK
DRA. MARIA EUGENIA SANCHEZ
I.E.F.
AÑO 1996

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO			
FEBRERO	62	0	62
MARZO	34	3	37
ABRIL	17	2	19
MAYO	46	7	53
JUNIO	13	0	13
JULIO	45	8	53
AGOSTO			
SEPTIEMBRE			
OCTUBRE			
NOVIEMBRE			
DICIEMBRE			
TOTAL			

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, SAN PEDRO SAC., SAN MARCOS
PROGRAMA RESPACK
DRA. MARIA EUGENIA SANCHEZ
I.E.F.
AÑO 1996

MES	CATARA	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO					
FEB.	0	0	0	0	0
MARZO	0	0	0	1	1
ABRIL	0	1	0	0	1
MAYO	0	0	0	0	0
JUNIO	0	0	0	0	0
JULIO	1	1	1	0	3
AGOSTO					
SEPT.					
OCT.					
NOV.					
DIC.					
TOTAL					

ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, SANARATE
PROGRAMA RESPACK
DRA. MARIA EUGENIA SANCHEZ
I.E.F.
AÑO 1997

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO			
FEBRERO			
MARZO	7	0	7
ABRIL	19	5	24
MAYO	13	2	15
JUNIO	18	6	24
JULIO	26	4	30
AGOSTO	26	4	30
SEPTIEMBRE	19	3	22
OCTUBRE	17	1	18
NOVIEMBRE	5	0	5
DICIEMBRE	10	0	10
TOTAL	160	25	185

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, SANARATE
PROGRAMA RESPACK
DRA. MARIA EUGENIA SANCHEZ
I.E.F.
AÑO 1997

MES	CAT.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO					
FEB.					
MARZO	0	0	0	0	0
ABRIL	0	0	0	0	0
MAYO	0	0	0	0	0
JUNIO	0	0	0	1	1
JULIO	0	0	0	2	2
AGOSTO	0	0	0	1	1
SEPT.	0	0	0	0	0
OCT.	0	1	0	0	1
NOV.					
DIC.					
TOTAL					

ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, BARBERENA, SANTA ROSA
PROGRAMA RESPACK
DR. PAUL CIFUENTES
I.E.F.
AÑO 1996

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO			
FEBRERO			
MARZO			
ABRIL	22	0	22
MAYO	31	1	32
JUNIO	48	9	57
JULIO	42	7	49
AGOSTO	28	7	35
SEPTIEMBRE	25	4	29
OCTUBRE	31	5	36
NOVIEMBRE	29	7	36
DICIEMBRE	7	5	12
TOTAL	263	45	308

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, BARBERENA, SANTA ROSA
PROGRAMA RESPACK
DR. PAUL CIFUENTES
I.E.F.
AÑO 1996

MES	CATARA T.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO					
FEB.					
MARZO					
ABRIL	0	0	0	0	0
MAYO	0	0	3	1	4
JUNIO	0	0	0	2	2
JULIO	2	1	0	0	3
AGOSTO	0	0	0	3	3
SEPT.	0	0	0	2	2
OCTUBR E	0	0	0	2	2
NOV.	0	0	0	1	1
DIC.	0	0	0	1	1
TOTAL	2	1	3	12	18

ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA, BARBERENA, SANTA ROSA
PROGRAMA RESPACK
DR. PAUL CIFUENTES
I.E.F.
AÑO 1997

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO	42	2	44
FEBRERO	28	14	42
MARZO	32	10	42
ABRIL	33	9	42
MAYO			
JUNIO			
JULIO			
AGOSTO			
SEPTIEMBRE			
OCTUBRE			
NOVIEMBRE			
DICIEMBRE			
TOTAL			

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA, BARBERENA, SANTA ROSA
PROGRAMA RESPACK
DR. PAUL CIFUENTES
I.E.F.
AÑO 1997

MES	CATARA T.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO	0	0	0	0	0
FEB.	0	0	0	2	2
MARZO	0	0	0	2	2
ABRIL	0	0	0	1	2
MAYO					
JUNIO					
JULIO					
AGOSTO					
SEPT.					
OCTUBR E					
NOV.					
DIC.					
TOTAL					

58

**ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA,
PROGRAMA RESPACK
DR.
I.E.F.
AÑO**

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO			
FEBRERO			
MARZO			
ABRIL			
MAYO			
JUNIO			
JULIO			
AGOSTO			
SEPTIEMBRE			
OCTUBRE			
NOVIEMBRE			
DICIEMBRE			
TOTAL			

ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA,
PROGRAMA RESPACK

DR.
I.E.F.
AÑO

MES	CATARA T.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO					
FEB.					
MARZO					
ABRIL					
MAYO					
JUNIO					
JULIO					
AGOSTO					
SEPT.					
OCTUBR E					
NOV.					
DIC.					
TOTAL					

**ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA,
PROGRAMA RESPACK
DR.
I.E.F.
AÑO**

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO			
FEBRERO			
MARZO			
ABRIL			
MAYO			
JUNIO			
JULIO			
AGOSTO			
SEPTIEMBRE			
OCTUBRE			
NOVIEMBRE			
DICIEMBRE			
TOTAL			

**ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA,
PROGRAMA RESPACK**

**DR.
I.E.F.
AÑO**

MES	CATAR.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO					
FEB.					
MARZO					
ABRIL					
MAYO					
JUNIO					
JULIO					
AGOSTO					
SEPT.					
OCT.					
NOV.					
DIC.					
TOTAL					

**ESTADISTICA DE PACIENTES ATENDIDOS
CLINICA OFTALMOLOGICA,
PROGRAMA RESPACK
DR.
I.E.F.
AÑO**

MES	PRIMERA CON.	RECONSULTAS	TOTAL
ENERO			
FEBRERO			
MARZO			
ABRIL			
MAYO			
JUNIO			
JULIO			
AGOSTO			
SEPTIEMBRE			
OCTUBRE			
NOVIEMBRE			
DICIEMBRE			
TOTAL			

**ESTADISTICA DE CIRUGIAS EFECTUADAS
CLINICA OFTALMOLOGICA,
PROGRAMA RESPACK**

**DR.
I.E.F.
AÑO**

MES	CATAT.	PTERIG.	CHALAZ.	OTRAS	TOTAL
ENERO					
FEB.					
MARZO					
ABRIL					
MAYO					
JUNIO					
JULIO					
AGOSTO					
SEPT.					
OCT.					
NOV.					
DIC.					
TOTAL					

Attachment C: Trip Report, Ecuador February 1997, Ellen M. Parietti

Trip Report
Ecuador, Jan. 30-February 7, 1997
Ellen M. Parietti

Objectives:

1. Hold the "Manejo Gerencial" workshop for the ResPack participants.
2. Meet with prospective new candidates for the ResPack program.
3. Follow up with Drs. Viteri & Carrion

Thursday, January 30

Meeting with Dr. Proaño

Went over the agenda for the workshop, got slide carousals, etc.

Friday, January 31

Meeting with Dr. Viteri. Last time we met (early June 1996) he was about to install his ResPack clinic in Chillogallo, a town just south of Quito which has almost become part of the capital due to urban sprawl. As of this meeting, he had still not established the clinic. Dr. Viteri attributed the delay to the previous occupants refusing to vacate his office space. The owner kept promising it would be free soon, and he kept waiting. When asked as to the location of the equipment, he reported it had been left in storage since he received it in February 1996. He repeated the complaint to me voiced in my first visit that "he thought the slit lamp came with a table, and didn't know what to do when it did not." This complaint is ridiculous in the light that the table is always sold apart, and no one else had a problem with arranging for a table. Orlando reminded him of the how exorbitantly expensive it would be to include this option. He seemed unfazed. (Slit lamp tables cost around \$1000 new.) He also indicated that he was having problems with the Khosla lensometer, that it had never worked, he had simply not noticed until now since he had the equipment in storage. (We were told later by another participant, that Viteri had established a clinic in the center of Quito with his equipment.) The complaint regarding the lensometer was quite frustrating to hear and I indicated that I did not think there was much we could do at this point, given the time that had passed. He did not pursue the matter. He seemed to blame IEF for the slit lamp table and the lensometer as if it were IEF's fault. I took it as an attempt to distract attention from the delay.

Coincidentally, the office space problem has just been resolved this very week, and Dr. Viteri will be initiating his ResPack clinic on Tuesday of next week (February 4th.) Orlando Oliva and I made an appointment to see him that same day. His hours in

Chillogallo will be 7 to 9:30 am every Tuesday, Wednesday, and Friday Dr Viteri also indicated that he would be attending the Manejo Gerencial Workshop that was to be held the following day.

Dr. Proaño indicated that it was like "pulling teeth" to get Dr. Viteri to meet with us and attend the workshop. Although he was quite cordial in our meeting, I do believe he would not have come without pressure.

Saturday, February 1

MANAGEMENT OF THE OPHTHALMIC CLINIC VOZANDES HOSPITAL

This workshop was originally programmed for two days, but we extended the workshop by 3 hours on Saturday so we could get it done in one day.

The workshop was attended by 13 people: 5 people from the ResPack program, and the 8 from the family practice residency program of the Vozandes hospital. The director of the community clinic where Jorge Rivera works is part of this residency program. As I had told him I wanted to listen to the varied experiences of the doctors who had established their clinics. Since Dr. Alaevar, director of the community center, expressed interest in the workshop for herself and her residents, and Jorge in turn thought that their participation would be positive.

I. **The round table discussion** was held where everyone introduced themselves, said where their clinic is (or was) and how the finances were managed. (Note: the exchange rate at this time was 3650 sucres=US\$1)

A 2nd year resident of the family practice residency had her own clinic before joining the postgrad. She closed it once she joined, but had noted a significant decline in the number of patients. She feels that she would have had to close the clinic if she had not entered the residency. She said that lots of people arrived without the ability to pay. In addition to these people, a lot of friends and family came to the clinic and she found it hard to make much money.

Monica is also a second year resident. She had also had a clinic before beginning her post-grad program, but she used to get a lot of friends and family as well. She expressed the fact that her clinic was financially challenged as well.

Dra. Suzana Alaevar is the director of the Sangloquí community clinic where Dr. Jorge Rivera has his ResPack clinic. Suzana is a family practitioner. She is currently working in two different clinics besides being in the post-grad. She works in a Vozandes satellite

clinic for family practitioners. This clinic is one of 3 pioneer clinics for Vozandes. The idea is to start pioneer clinics throughout Quito, and then throughout the country. The clinics must be self-sufficient after a certain time period. Right now, the Vozandes hospital pays for their salaries.

She works in the community clinic in Sangloqui with Dr. Rivera. The area is a lower income community, still heavily dependent upon the agriculture. Quito has grown to the point where it is only 45 minutes from Sangloqui, yet Sangloqui remains a rural community. They are struggling to stay afloat, the doctors who work in the clinic are very dedicated and they take a cut in their pay if the people have been unable to pay. She says it is very hard because all the prices keep going up, the rent, materials, etc. However, every day the public is less able to pay because of the crisis. They are finding it hard to decide how much they should raise the prices because as the prices rise, the patients stop coming.

Jorge Garcia is a 1st year family practice resident. He has had his own consulting practice for 5 years. Right now he has less time to attend patients due to his duties in the residency. He shares his office space with two other specialists: an odontologist and an x-ray technician. They all share a secretary as well, which they have had for 5 months. He needs help with financial matters because the rent keeps going up, but the patients can't keep paying. Residential rents are stabilized, yet commercial rates are not.

Rosemary Guamán- Has her ResPack clinic in Loja center, which opened in May 1996. She is enjoying a great deal of success in Loja and is very happy with her situation. Her husband handles the finances of her clinic, so she said she doesn't worry about them. It has become clear that Dr. Guamán is very driven to expand her clinic. As she seems to be making surprisingly great progress, these comments are somewhat surprising and perhaps not entirely true. She did say that they did a small marketing study before opening her clinic by investigating what other ophthalmologists and specialists charged. (There are 3 other ophthalmologists in Loja..see "concerns" section.) They all charge about 40,000 sucres, so she decided to charge less and maybe increase the prices later for the people who could afford it. The most she ever charges is 30,000, and less when they can't afford it. All of the ophthalmologists and family practice docs agreed that this was how they decided what to charge. She also related how she has been doing outreach work in neighboring towns 3 weekends out of every month. She recently purchased an Isuzu trooper to help her with these activities. She has "Atención Oftalmológica Móvil" stenciled on the side. When she goes to the more rural towns, she never charges more than 15,000 sucres. She works in a building with 6 other specialists. Right now they are paying 250,000 sucres per month. They are looking to buy a building on their own.

Dr. Viteri. He reported that he was working in the Hospital of the Seguro Social. Furthermore, he had also been working in a clinic shared with 3 other ophthalmologist near la Marina (a bus terminal which is a center of a lot of activity.) This clinic is called

Clinica la Merced. There was always only one ophthalmologist on duty at a time. He said they (the ophthalmologists) shared the costs of the equip In the same office space there are other specialists. These other docs share with the rent, lights, & secretary. They charge 30,000 for the consult there. (In comparison, for example, Vozandes charges 40,000 and is not thought to be expensive. Dr. Proaño charges 60,000 in his private clinic.

Vilma 2nd yr. Family practice never has had a private clinic. Enrique Garcia -husband works there as the

Manuel Alvarez -ResPack participant with his clinic in Machachi, located about 40 km from Quito. He told us about 2 of the places that he works: 1) his ResPack clinic in Machachi (the family health center.) He is there three days a week for 2 hours (Monday, Tuesday, and Thursday) in addition to each 4th Sunday. He is an associate of a group . He pays 200,000 sucres every month. Secretary there 18-20 patients per month. 20,000 sucres is the charge.- Before there was 35-40. Lately, they have stopped coming. He has started to go out to educational places, the water company. He performs about 1 cataract surgery per month, 1 per /month in Machachi. Tries to operate on more than one at a time in order to save on costs for materials. Some would go to waste if not used.

Outreach work: He goes out to rural areas to do outreach 3 weekends a month. The 1st to the coast, where he is from originally, the 2nd for rural areas, the 3rd el Embalde el norte, los rios , the 4th he sets aside to be with his family.

The other time he works in a private clinic in Yaroqui. It's a non-profit foundation funded by Germany and the government of Ecuador. They pay him a monthly salary. They charge 8000 sucres for the office visit. He operates there as well. He sees roughly 25 patients a day, 5 cataract surgeries, 5 pyterigioms. They charge 400-500,000 for cataract surgeries, and pterygium is 25-30,000. The director chooses the price. His mensual of 300,000 rises with time. The foundation has several different CBM consultants for prevention of blindness in Latin America.

He has his own private clinic in San Rafael, " Nueva Vision." He tries to apply the same principles there. He told us more about this in our separate meeting with him. (see mtg. with Manuel.)

Victor Almeida- He has a family practice clinic which is under contract with the government. He gives lots of physicals to students. San Pedro Salud Educacional he charges 5-6 thousand sucres (\$1.37-\$1.64). At night, 5-6pm, has his private office in his home. Before the recent economic crisis, he used to charge 20 thousand sucres (\$5.50), but has had to reduce his prices to 15 thousand (\$4.10). There are many neighborhoods with people of very few economic resources. (for ex. Turubamba domicilio)

Andrea- Family Practice resident. She currently works afternoons in a health clinic for low income patients, part of the Ministry of Health. They even provide home visits. They charge a nominal fee of 1000 sucres=27cents. It is subsidized by the government. She personally sees between 20 to 30 patients every afternoon. The clinic has approximately 300,000 clients, and a staff of 40 physicians. The Ministry of Health also has a network of pharmacies that work in conjunction with the clinics.

Jorge Rivera - participant in the ResPack program. He works in a total of 4 places:
#1 He is a staff ophthalmologist at Vozandes hospital. He works there 4 hours a day and gets a monthly salary of around \$250. They charge 40,000 sucres for an ophthalmology appointment. (\$11)

#2 & #3: He attends patients in two satellite centers for Vozandes hospital. They are in marginal neighborhoods, and the prices are lower: 12000 sucres & 15000 sucres paid per patient, but 30% for hospital, other 5% for something else

#4 He has his private ResPack clinic in Sangloqui. His clinic is part of a larger community clinic composed of other doctors: general practitioners and specialists. He usually has between 20-35 patients per month. Lately, the economic crisis is truly taking it's toll. During his worst month he had 5 patients. He charges 20-25,000 sucres per visit. All of the finances are handled by someone else. He pays the clinic 35% of the earnings of his clinic. He is at a distinct advantage to those who actually pay a fixed amount monthly either in rent or to the clinic. (The month he only had five patients he didn't lose money.)

Proaño: Currently, he just works in his private clinic by himself. He had previously been very involved with Vozandes hospital and other charity efforts. Because of his health and personal reasons, he has discontinued this work. Right now, he is happy, but doesn't have the security that comes from an institutional appointment. If you get sick, you would always receive the income from an institutional appointment. On the other hand, dedicating yourself exclusively to the private clinic leaves you more exposed to severe economic ups & downs. However, every ophthalmologist also needs to cultivate an independent career and practice. He recommends combining the two things.

Lupe- Resident in the family practice postgrad program. Before entering the program, she worked with the "Centro de Muchacho Trabajador." It's a foundation, and NGO specializing in preventative medicine. She used to see 8-10 patients a day. Each paid 10,000 sucres (\$2.75) The foundation paid the doctors a percentage (30%)

Orlando Oliva- He told of his Respack clinic in Zacapa. HE sees 50-60 patients per month. He charges the equivalent of \$8 for the visit. The clinic is self sufficient. He pays his parents back for the loan they gave him to buy the equipment. He is doing well and told them that the optica portion of his clinic really helps him financially.

II. Orlando presented the Respack program to the workshop participants not familiar with the program.

III. Orlando gave a slide presentation on the following topics:

- PROFESSIONAL CONSIDERATIONS
- AVOIDING PITFALLS WHEN ESTABLISHING YOUR CLINIC
- ADMINISTRATIVE ORGANIZATION OF THE OFFICE
- ACCOUNTING & ADMINISTRATION FOR THE OFFICE
- CHARGING PATIENTS
- FIXED & VARIABLE COSTS

Topics touched upon in the slides which provoked extended discussion include:

1. The extension of professional courtesy: Attending doctors and their immediate families free of charge, or at cost of consumables. They concluded you should both provide it and enjoy its benefits while visiting other doctors.
2. "Ghost work": Working on another doctor's patient without the patient's knowledge. Should be strictly avoided. The doctor should always be very open with the patient as to who is doing the work. If the ophthalmologist needs assistance, they should always ask another doctor to assist him. This should always be acknowledged to the patient and should be very open.
3. Don't be afraid to refer to another person with greater expertise in a specified area.

LUNCH BREAK

IV. Ellen used the practice management manual to calculate the actual finances of a hypothetical clinic. The actual figures used were agreed upon by the participants.

Worksheets were used to calculate the following:

- Fixed Costs
- Variable Costs for office visits & minor surgery
- Variable Costs for cataract surgery
- Recuperation of Diagnostic Equipment Cost
- Recuperation of Surgery Equipment Costs
- Projected Expenses
- Projected Income
- Projected Expenses, Income, and Earnings

These exercises proved to be very instructive. Due to the fact that the figures used were

the suggested prices from a variety of individuals (some were high & some low) this was not a real estimate. Actual figures from one person's clinic may be more useful for calculating finances, since the numbers used were agreed upon through compromise and were not uniform.

Dr. Proaño said that he believes that you should not charge less than the costs of supplies used in a cataract operation for you labor. For example, if the consumables are \$100, charge \$100 for your honorarium.

Conclusions from this exercise:

REDUCE YOUR FIXED COSTS as much as possible:

The purchase of a microscope proved to decrease your margin of earnings for the participants. The number of cataract surgeries they are performing now- no more than 5 per month- do not justify the cost of the equipment. The minimum the doctors can charge raises dramatically when one must calculate the cost for recuperation of a \$5000 scope plus \$1000 in surgical instruments. Dr. Proaño recommended that the participants rent the operating room along with the microscope until they built up the number of cataract operations they were doing. In addition to the recuperation of the cost of the equipment, when a doctor performs only one operation, they lose the medicine/ supply that contains enough for multiple operations. Keeping this in mind, the variable costs / cataract surgery rises because you end up spoiling the remaining materials potentially useful for other cataract surgeries. For example, if you divided the cost of a vial of anesthetic by 5 for other operations and were unable to use it, you would need to take the cost of the entire vial into account for the calculation of the variable costs of for the cataract surgery.

Another way of reducing your fixed costs is to share your office space among other doctors. All of the Ecuadoran ResPack participants form parts of groups of specialists who share the costs of rent, electricity, water, secretary, etc. They also receive a greater number of referrals from other doctors, and receive visibility with those patients of other doctors.

REDUCE YOUR VARIABLE COSTS· The participants put the cost of an IOL at \$45 when calculating the variable costs associated with a cataract surgery. The costs of pilocarpine and viscoelastic were also very high. Orlando and I told them that cheaper supplies were available and that would save a lot of money. Dr. Proaño's original comments were negative. He said that he had seen many cheap IOLs shatter or chip when the patients were treated with lasers. When dealing with a patient's vision, he said, it is better not to cut corners with the IOL. It would be like cooking a cake with margarine. Orlando stated that he personally had excellent results with Aravind lenses, which cost \$10, and Roosevelt hospital used them for all of their patients. We also discussed the discounts available for participants through Rafi for viscoelastic and pilocarpin. All the participants seemed to be eager to take advantage of this

opportunity. We will send down the information for Dr. Proaño to distribute to the participants.

V. Discussion among ResPack Participants: The only non-ResPack participant present was Suzanne (from Sangloqui). We asked them what seemed to be the attitude among their ResPack communities with regards to ocular health.

-Suzi said that children don't like to wear glasses because they are teased relentlessly. In fact they will consistently leave them at home or even destroy them. They reported a general unwillingness to purchase and wear glasses. This may be that they don't see them as a good investment (they won't help their vision, etc) but there are also cultural beliefs circumventing their use. People believe that their eyes are getting weaker as they are using the glasses. The workshop participants feel that these feelings stem from cultural beliefs, and that there needs to be education for children and parents in this field. As there is a high amount of illiteracy among the indigenous groups, they felt it important to get video messages.

They proposed a three tiered approach to spread education regarding ocular care:
1st with general practitioners so they can communicate this information to their patients.
2nd with teachers so they can screen children and educate them.
3rd with parents so they understand the importance of caring for the visual health of not only their children & themselves, but also their parents.

I raised the point that it was a bad idea to spread information on the importance of glasses if the people could not afford to purchase them. The participants acknowledged this as a challenge, but said some can afford to buy glasses, and they should be able to benefit. Further, Dr. Proaño said that he was applying for Seeing 2000 money, and that part of that money could be used for a project dealing with the provision of glasses. I expressed the fact that the money is intended strictly for surgery, but he assured me this project would be within the bounds of the project.

Dr. Viteri said that his Khosla lensometer was broken. He states that he never used it and that it was broken. I asked him why he had never contacted us, and he did not have an answer other than that he had never used it. I told him we were at a very advanced date to try and return it (he received it over a year prior). He was bothered by this and truly seemed to think that we should replace it. (Having been informed by others that he had been using the equipment, I was unmoved.) Then Rosemary said that her indirect ophthalmoscope which she had given to us to return last time came back from Welch Allyn with another problem having to do with the light. She wanted us to take it back again. I asked her why she didn't tell me before, and she didn't have an answer. I told them I would like to help them, but we are not the distributor and are not responsible for dealing with these problems, and further, it is not our job. We cannot do anything if they do not alert us in a timely manner about these problems.

Contacts with the ResPack participants:

Manuel Alvarez: Machachi Monday, Tuesday and Thursday 2-4pm and the last Sunday of each month from 9 to 12. Machachi: 231-4173 cell. 09 46-7334 He also has a radio program called "prevention of blindness" ½ hour every Sunday..

Jorge Rivera-home number: 46-41-93 Sangloquí

Viteri: Chillo Gallo Tuesdays, Thursdays, 7-9 656-412 511-945

**Rosemary: Loja Monday, Tuesday, Wednesday, & Thursday 3-7 (8-11:30 Monday)
Home: 7562553 clinic: 7562902**

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Meeting with Dr. Cesar Naranjo

He is living and working in Tulcán, near the border with Colombia near Cali. It is 5 hours north of Quito and has 100,000 habitants. There is no other ophthalmologist there. He is assigned to that site with the Social Security system. His wife is also there- she is an anesthesiologist. He works in that hospital, but because you must be a member of the Social Security System, only 10% of the population has access to service. He understands that he will need to be working in Tulcán for 3 years, and that it is a serious arrangement.

Monday, February 3, 1997

Meeting with Dr. Proaño

1. Evaluation of the workshop:

- He said he would go over the manual and make corrections
- the participants actually want recommendations on how much they should charge.
- very helpful for them to realize what all needs to be considered in considering prices

2. Convenio:

We discussed the best way of enforcing a "gentlemen's agreement." He said that a good way would be to say on the convenio that if the 3 years in an underserved area were not completed that a letter would be written to the Tribunal de Honor del Colegio de Medicos Provincial, and the Federación Medica del Ecuador (better, because it's on a national level) which would basically serve as a vote of disconfidence. He rejected the idea of sending a letter to the Ecuadoran Society of Ophthalmology saying that he did not think they had any power. He does not belong. We would also like to add something stating that the IEF reserves the right to charge the costs incurred in procuring and sending their equipment.

3. Educational Materials:

Dr. Proaño is enthusiastic about producing the educational materials in a video format to accommodate the illiterate. I explained to him that we would like to formulate written material first, as it is much cheaper to do. Then in the future if we have had success we can look for funding for video. There is an institute at HCJB that specializes in this and we could get a really good deal. We want to make sure the materials developed would be able to be used in all of the Latin American countries, and that they would be easy to reproduce.

4. New ResPack Candidates:

In addition to Cesar Naranjo, Dr. Proaño had also heard news that a Doctora Gladys Zuñiga in Quayaquil was interested in participating in the program. She was referred to Dr. Nelson Matamoros who lives in Guayaquil, and Dr. Proaño hadn't heard any further news. Dr. Proaño gave us their phone numbers. Matamoros: 04-282-882.

5. Victor Carrión: I wanted to try and find Victor, who had received his equipment a year ago and had not established a clinic nor been in contact with Dr. Proaño. Orlando and I wanted to set out to find Dr. Carrion. Dr. Proaño said he hadn't heard anything from him in months after trying to contact him several times. Recently, family members who had accepted him into their family-run clinic, Sta. Lucia, had thrown him out of the practice because he kept referring his patients to his own private clinic which he had set up in his home. The director of this clinic, Dr. Ramiro Almeida, called Dr. Proaño to let him know of Carrión's unethical behavior. We called Dr. Almeida to get Victor's address. He said he lived at the intersection of Av. Tarqui and 12 de Octubre above a shoe store.

6. Snellen Charts: We wanted to provide Snellen Charts for the participants so they could distribute them to teachers in area schools. They could be produced for \$195 for 1000. (20 cents a piece) This is cheaper than in Guatemala.

7. Seeing 2000: Dr. Proaño is interested in presenting a project on behalf of his own clinic. It would not be associated with Vozandes.

8. Ecuadoran postgrad programs:

The University Estatal (run by the gov't) is going broke.

Seguro Social- is almost going broke (IESS) The residents are still going to the hospitals to learn from the doctors, but they won't have an official title of "ophthalmologist." They are not getting paid. They get by financially by helping the older doctors in their offices.

Meeting with Dr. Victor Carrión:

Orlando and I went to the address Dr. Almeida had provided, Av. Tarquí & 12 de octubre. Asking neighbors, we easily found the location of the clinic. There are no signs advertising it's presence, but everyone knew where it was. We had to ring a bell for his son to let us through metal doors on the street level, then we climbed stairs to a small corridor which served as his waiting room. Dr. Carrión greeted us in the hallway wearing a white coat. For a moment he did not recognize us, but then immediately got nervous. We asked him how progress had been in regards to establishing his ResPack clinic. He said he had not been able to find a safe place to establish his clinic in Calderón, the site we had visited last June. He said the store next to the site he was going to use had been broken in to. (Later he said that the store below the last site declined to offer him the space) He said that the equipment was in storage, in boxes, and that he was "en eso" (currently looking for options.) We asked if we could come in and Dr. Carrión complied. Just inside his door, in his living room or sala, he had all of the equipment set up. He had a large desk with 2 chairs in front of it, the slit lamp on a table, his lensometer on the desk, the Keeler indirect ophthalmoscope and the trial lens set on another setting. He also had a showcase where all the medicine donated to him was displayed. His diploma was on the wall behind his desk. He said that this was not his clinic, that it was just a room in his house. We were incredulous that he had the gall to lie to us as if we were idiots. We asked him to stop trying to deceive us and be frank.

He insisted that he was about to establish his clinic in Calderón. We told him if he did not open his clinic within one month that we would write a letter to the Federación Medica del Ecuador, and possibly charge him the shipping for his equipment to Ecuador. He repeated several times that he was going to establish the clinic. March 3 is the time limit we set. He asked us about the possibility of getting a microscope through us on our way out. I told him we would not be involved with providing anymore equipment to him unless he proved himself a serious Respack participant. See photos attached.

Tuesday, February 4, 1997

Visit to Dr. Viteri's Respack clinic in Chillogallo

We visited on the first day Viteri was attending patients in the clinic. He had 2 patients there and we had to wait close to an hour to see him. He did in fact have everything set up and functioning. He wanted to get more equipment through us and I told him he would need to prove himself as a serious ResPack participant as well.

Visit with FUNDACO's Sara Risser and Dr. Roberto Contreras

Fundaco stands for "Fundación Acción Comunitaria". Sara is also the director of MMI (Medical Missions International) for Ecuador. They are working with ophthalmologists throughout the country and had need for Ecuadoran ophthalmologists to work with them and take care of the surgery, etc. We told her about some of our ResPack doctors that are in areas where they work.

Sara recommended doctors in other cities that might be helpful contacts for us.

Dr. Ríos in Guayaquil 04-247-657

Dr. Rene Cabrera in Cuenca: 07-821-679

Felipe Chiriboga (he had been a participant, but later retired b/c Proaño said he didn't want to work in an underserved area.)

She also recommended that the Sociedad Ecuatoriana de Oftalmologia be involved in the clause in the convenio as a recipient of a letter of disconfidence. When we said that Dr. Proaño didn't see them as very powerful, she laughed and said that is because they kicked him out. Dr. Proaño tells the story this way: he was working for two pharmaceutical companies; each were testing a drug on oncho. Dr. Contreras, (Peru) director of the Panamerican, asked him to stand up at the Panamerican and present the findings of his study in the congress. Proaño refused, saying the results were confidential. They were all very upset with him, and basically shunned him. These are also the people that threw him out of the Soc. Ecuatoriana de Oftalmologia. Who really knows.

She and Roberto Proaño had a falling out long ago his relationship with MMI. They had paid for him to go to Canada and specialize, giving him lots of support. Apparently, upon his return he was not in agreement with the way MMI ran things in Ecuador. He was openly against the campaigns they held in rural areas. (He said they didn't have participation of Ecuadoran Ophthalmologists, Sara disagrees with this.)

Meeting with Dr. Manuel Alvarez

Orlando and I went to San Rafael to see Dr. Alvarez's new non-profit project "Neuva Vision." Dr. Alvarez lives there with his wife (an anesthesiologist) and their 2 children. They had us for a delicious dinner, and then showed us the facilities of the center. Manuel has a sister who was left a widow. He gave her room to set up an optical shop in a clinic in Quito, so she gives space to Manuel rent-free there in San Rafael. He runs a clinic that is totally non-profit. He can afford to do this because of his low costs. He also has a surgery ward there.

He has just constructed an area on his property, which is behind the clinic, where people coming from far away can stay rent free. There are separate sleeping rooms being constructed, a large bathroom with a shower, and a large kitchen where people can prepare their own food.

Manuel's father died when he was a small child, and he said he grew up with very little money. He said that is why he wants to help poor people. Ximena Velastequi told us that she went to his house at one time and was alarmed to see the conditions in which he was living. He married while he was still in college. He used to walk miles in order to save the money that would be spent on the bus.

He needs a slit lamp for the clinic in San Rafael. He said he originally applied for San Rafael to be his ResPack site, but then Jorge Rivera said that he wanted to put in for Sangloqui, and San Rafael is very nearby. He said that Dr. Proaño simply told him he could not apply for San Rafael.

Wednesday, February 5, 1997

There were national strikes and all transportation was stopped, including traffic.

Meeting with Orlando Oliva

1. Pediatric Ophthalmologist: The two most outstanding observations were:
 - a) People at both Robles & Roosevelt hospitals basically felt that Dr. Wheeler was a little more accessible than Dr. Sargent. Dr. Wheeler also seemed more reasonable when discussing differences in procedure and had better Spanish skills.
 - b) The Guatemalans have a high level of experience with cataracts. They did not feel that Wheeler & Sargent had as much experience as themselves, and the US doctors also commented on this. As the Guatemalans still express a desire for more capacitation in this area, I feel we should look for a specialist, hopefully a Latin American doctor who has great expertise in this area and experience dealing with dark irises.
 - c) The level of the instruction was a little low overall for the people who specialize in pediatric ophthalmology. The instruction was great for the residents, but for those with as few years of experience, they would have liked to see some more difficult concepts discussed.

d) In conclusion, they would like the next trip to include instruction of a greater difficulty level to work exclusively with the pediatric ophthalmologists, and a specialist in cataracts.

2. MAP- cataract kits: After discussing the difficulty involved with getting donations of materials for the cataract kits, Orlando suggested we simply try to buy the most important and most expensive parts and send them down. We shouldn't worry about the smaller items which are causing a slow-down. The items he would like included include IOLs, Pilocarpine, Viscoelastic, & Suture.

3. Educational Materials- The material should be geared for 2 separate audiences based on content:

1) the general public: which would contain information of ptiregium, cataract, glaucoma, diabetic retinopathy, and visual health.

2) Teachers/parents of children: Visual health, strabismus, lazy eye, signs that a child has vision problems.

The cost for preparing these items are as follows:

The ResPack participants will be given the ones for the general public
20 participants x 8 topics x 400 copies = 40,000 copies

\$250/ topic x 8 topics = \$2000

4. New Ecuador Candidates- we contacted Dr. Gladys Zuñiga & Dr. Rios in Guayaquil and arranged a meeting with them for the following day in Guayaquil.

Thursday, February 6, 1997

Meeting with New Candidates in Guayaquil

Dr. Ríos: He is a retired doctor who no longer has any sustained contact with younger ophthalmologists, and therefore would not be a good contact for us to have in Guayaquil. He was mainly interested in getting information for his son Robin who went to the Dominican Republic to study with Dr. Battle. He remains there, and may go to do a subspecialty in Chicago.

Gustavo Moreno trained in Barcelona. He is currently working in a Catholic hospital. It is subsidized by the government. They see a great number of patients there on a daily basis. He goes out to Ventanas once a month. There are no ophthalmologists there. He has a trial lens set and a retino-ophthalmoscope. He would like to establish his ResPack clinic there, but needs to raise the money. He is close to raising it; he will let us know.

Gladys Zuñiga: She also works with Dr. Moreno in the Catholic Hospital. She was trained in Medellin, Colombia. She would like to establish a ResPack clinic but cannot decide where at this point. She said there was a lot of need near Guayaquil which I do not doubt, but we said we were looking for somewhere with less access to care. (You can see miles and miles of slums in Guayaquil and I would like to consider doing something there, but we need to consider it first. They both work with Nelson Matamoros. We got his address to inquire whether he would like to serve as a sort of contact for IEF in Guayaquil. Orlando had spoken with him in Brazil and he did not seem so interested, perhaps because he was busy with other things.

We went to see Dr. Matamoros at his clinic where he works in Guayaquil, la Clínica Kennedy. He was gone on travel, but I left my card and said I would contact him.

CONCERNS:

1. How did Rosemary Guaman come to establish her clinic in Loja where there are already 3 ophthalmologists??
2. Certain candidates have shown lack of initiative in opening and operating their ResPack clinics. Desire/Initiative should be considered before accepting people as ResPack participants.

Attachment D: Trip Report, Honduras June 1997, Ellen Parretti

HONDURAS TRIP REPORT

June 10-15th, 1997

Ellen M. Parietti, MPH

Objectives:

1. Hold meeting with participants of the ResPack program to decide the role of certain participants, and opinions on the program and lessons learned.
2. Meet with the Director of Apostles de Salud, visit their facilities and explore possible collaboration between the IEF and the center in opening an eye facility.
3. Meet with the National Committee for the prevention of blindness and the Ministry of Education to discuss progress on plan to institutionalize the visual acuity test for first graders nationwide.
4. Meet with American Embassy Legal Counsel Nick Giacobbe on Vicky Alvarez Case.
5. Distribute cataract kit materials to appropriate participants.
6. Visit Claudia Silva Solomon in her Respack clinic in Siguatepeque
7. Give Manejo Gerencial Capacitation to the Honduran Participants who had not yet received it.

Activities:

1. Meeting with Dr. Orlando Molina from Asociacion Apóstoles de la Salud

Dr. Raúl Gomez and I visited Dr. Molina in the association headquarters located in their main hospital center in Colonia Miraflores, Tegucigalpa: Hospital & Clinica San Roque. The association has 15 satellite clinic centers located throughout the country. Attached find the list of clinics with the name of the chief doctor and their locations.

The hospital center in Colonia Miraflores has a variety of specialist available, the majority of which attend patients in the centers only on weekends. These specialists include: internal medicine, pediatrics, gynecology, orto pat. otorino, radiologist, dentist. The satellite centers usually have only a general practitioner. The people that need to be seen by specialists are referred into the capital.

The center was begun in 1984 with the help of CIDA. (The Canadian International Development Agency.) In 1994 they became totally self-sufficient after a gradual transition process. In the 15 satellite clinic sites, 40 Lempiras is charged for the general consult with medicines included. In Clinica San Roque, in the capital, 80L is the charge for a consult with the general practitioner and 100L for specialists.

Raul had the idea that they would be interested in buying equipment for some of the satellite centers, and we could help them work towards becoming self-sufficient. Apparently, they have already reached the self-sufficient stage, and they do not have the funds to be paying

the \$5000 for the equipment up front. They would be interested in having an ophthalmologist come and be a part of their hospital, even a part of their satellite clinics. They have a very active program for diabetics and would really like to be able to offer eye care services to them.

It would be good to offer as eligible ResPack sites some of the Apóstoles de Salud cities. Although it is not a full medical center, the ophthalmologists might still be able to take advantage of some of the resources that a similar center can contribute such as office space, night guard, established clientele base, name recognition & prestige associated with the center, and references.

2. Visit to Dr. Jorge Cisneros in Choluteca

Jorge Cisneros was unable to attend the meeting due to a prior engagement in San Pedro Sula. I traveled to Choluteca to see him in order to solicit his opinions & comments on the current ResPack situation in Honduras, and to see how his SightFirst campaign was going. Dr. Cisneros was very generous with his opinions and commentary. He expressed his regret at not being able to attend the meeting, but gave me a letter (attached) in which he communicated some of the issues addressed in the attached letter sent out by Dr. Gomez (also attached). I left him a copy of the questionnaire which was to be filled out at the meeting. He will forward it later.

The suggestions he made to improve the Respack program were as follows:

- 1) Choose the participants better. Don't let anyone sign up who wants to have their primary site as the cities. Worry more about quality than quantity.
- 2) Get financing so that the people can pay their equipment in installments. Every month or every three months they need to make payments. That way, they aren't really the owners until the equipment is paid for at the end of the time period. The equipment has to stay in the appropriate spot until the time period of 3 or 4 years is up. If they leave early, the equipment is no longer theirs. In certain sites, it would be good if they could include the microscope in the basic package. Interest rates are very high right now: 40% in banks, 24% in cooperativas. It is very difficult to procure a loan from cooperativas. One must be a member for 3 years or so, constantly investing money in an account to be eligible for such a loan.
- 3) Participants should receive the training in Manejo Gerencial Worksheets and be required to figure out exactly how much they will need to charge to get by. They will be forced to realize that they need to work hard to promote their clinic, etc. In the past, people just sort of signed up hoping that they would earn money not realizing how difficult it is. It is easy to feel clueless and fail without any orientation.
- 4) There should be more of a tie with the Ministry of Health. The IEF (or participant)

should establish a tie with the nearest hospital. They can refer patients there- maybe the hospital can provide some type of support; or the doctor can see patients there one day a week; something that would make them identify themselves with the hospital. Make the ophthalmologist feel a sense of duty to the community, that makes them feel good.

5) Visual acuity screening for children: MOH, MOE, & ophthalmologists: it should all be orchestrated through the MOH. The MOH should create "plazas" for ophthalmologists in the rural towns. That way people could attend patients in the hospitals in the mornings, and then have their private clinics there in the afternoons.

6) Motivation- if we will be establishing a new program in another country, for example, in Nicaragua, we should bring in a ResPack doctor such as Jorge who can explain to them what they have accomplished in their ResPack sites. (this also provides them a forum to present what they have done.) The new participants need to know that it is a challenge, and that it is not easy, but that you really can make a difference in these communities that have gone without eye care. If people aren't motivated, nothing will ever change. New participants also need to understand that it is not a big money making enterprise; it is sort of a non-profit set-up.

7) Dr. Navarette should be a part of the decision process. This way we would know the true intentions of the people. (Dr. Navarette knows what they really want to do.) This would help us coordinate with the MOH as well. He could influence which plazas open up throughout the country.

Requests:

He need the following equipment for his clinic:

cryo, new instruments for cataract surgery, caja for autoclave, and an ultrasound.

In his clinic, he used to charge only 45L (= \$3.50) Recently, he started charging 80L (\pm \$6) (He keeps 45L and the rest goes to the Catholic hospital.) He said that many of the people who could pay the 100L at Sta. Lucia were going to Clinica San Francisco. He says that according to his calculations, the real cost of the consult is between 180-200L. The surgeries are what are really saving him right now financially. He does 40-50 people per month. ??? He has done 52 of the 100 SightFirst cataract surgeries.

3. Visit to Dra. Claudia Silva in Siguatepeque

Dr. Silva is a full time resident time in Siguatepeque and attends her SightReach clinic daily. She has established her clinic in the Evangelical Hospital, an institution which enjoys a great reputation, is very clean and well organized. Claudia says she is very happy there, enjoying the support the institution offers her: a secure place for her equipment, help from the institution such as a maintenance man for electrical problems or adjustments to furniture,

secretary, referrals from other doctors, the chance to give integrated care to diabetic patients, the chance to share her knowledge with other colleagues of other specialties, and the reputation of the center.

She has been building her clientele for the past 3 months gradually, and has seen 200 people to date. Forty percent of these patients are from Siguatepeque, the other 60% are from outside of the dept. of Comayagua. A lot of the people who are arriving at her clinic used to go to El Salvador for care. This has been a quicker start-up than any other participant has enjoyed. Claudia attributes it to the reputation of the Hospital Evangelico and the referrals from other doctors. The highway that runs by Siguatepeque has a lot of car accidents so she has been performing a lot of oculoplastic surgery, (eye lid reconstruction, etc) something she didn't expect she would get to use very much. (She completed a year of training in oculoplastics in Mexico at the Association for the Prevention of Blindness.)

Claudia had a meeting with CBM a few months ago to seek their support for her clinic, but they preferred to wait until she established herself before establishing a formal relationship. They decided that meanwhile, Dr. Perry could act as her sponsor. He has proved to be a great contact and Claudia is looking forward to having a close & productive relationship with him.

Dr. Silva has been very active in educating the community on the importance of eye care. She does a recording two times a month for a radio program. The topics she has covered so far include: Conjunctivitis, diabetic retinopathy, eye trauma, and red eye. She holds trainings for her colleagues in the Hospital Evangelico on which types of patients need to be referred to an ophthalmologist. The Hospital Evangelico has a 3 year nursing school where she is teaching the students eye care basics. Dr. Silva says that the nurses have been very good students and have caught many cases which need followup by an ophthalmologist.

The day before my visit to Siguatepeque, Claudia's home had been burglarized. Claudia naturally was upset, but was receiving a lot of support from her colleagues in the hospital. No one wants her to get discouraged and leave. The following day she found a new home, a small but very secure apartment. She assured me that she would not lose heart. Withstanding the burglary, her experience in Siguatepeque was proving to be a positive one, and she feels it to be the right place for her now.

As an aside, she mentioned to me that her involvement in the National Committee for the Prevention of Blindness has not been what she would like it to be due to a lack of courtesy on the part of current active members. Claudia has expressed her interest in participating on several occasions. She has never been informed of upcoming meetings. In addition, she spent a full week as a translator for Canadian opticians who visited at the request of the committee. She was never thanked nor acknowledged in any of the publications on the event, while others who did not invest time in the activity took all the credit for the activity. This, in addition to current problems involving the eye bank, has left Claudia with mixed feelings

about the Committee.

4. Meeting with the National Committee for the Prevention of Blindness

Present:

Ellen Parietti, Dr. Raul Gómez, Dr. Zulema Alvarez, Dr. Doris Alvarado, & Dr. Mario León Gómez

Convenio:

An agreement has still not been signed with the government making official the institution of 1st grade visual acuity screening. This is due to a conflict with the way the Committee was to be represented in the convenio. Due to the fact that the Committee still does not have it's Personaria Jurídica, it cannot be recognized as a legitimate organization. It is a difficult document to obtain. The agreement as it stood only recognized the MOH, the MOE, and the IEF as the parties involved. The NCPB didn't like that because they were not recognized, so they wanted to put in the Rotary Club (one of the members- Jimmy Dackarett- is a Rotarian) to represent the NCPB. Raúl was against this because the whole screening program began even before the NCPB was formed, and the Rotarians didn't have anything to do with it. This whole disagreement dragged on, meanwhile, there was a large structural change in the MOE which changes the whole project. Now, an agreement needs to be reached on the appropriate way to institute the project, new cost estimates need to be drawn up, and new officials need to be convinced of the feasibility and need for the project.

Another concern members had about signing the agreement was the lack of funds to implement the project; that it was useless to sign the agreement if we knew we couldn't complete all the steps.

One member of the MOE had suggested that we just start with one department, complete the whole process, and then use that success to bring in more funding for the other departments.

Raul stated that plenty of projects are undertaken without signing an agreement with the government. He thinks we should start to implement the program in at least a few districts without the agreement, and be raising funds meanwhile. Dr. Gomez thought that they should start in the departments of greatest need as cited in the "Libro Negra" a book ranking the places where people's basic needs go unmet; La Paz, Lempira. Opinion was split as to what should be the priority: greatest need & lowest population would be the cheapest and perhaps highest profile. I thought we should do the screening in a place where they have ophthalmologists for follow-up purposes. We would get better quality results from a place where the children could get follow-up from an established ophthalmologist instead of having to depend upon brigades by the NCPB.

The cost of the screening (in total) comes out to only 3Lemiras a child; less than US¢25.

Raúl suggested charging the children for their vision screening to offset the cost of the project. Zulema resisted, stating that the majority of the population is so poor they can't eat an egg for breakfast, they shouldn't be forced to pay. It would make poor kids feel bad. Raúl decided to do a pilot project in the poorest school in Tegucigalpa as a sort of pilot project. (This idea originated as a revenue-generating idea for the IEF in private schools.) This activity was scheduled to take place Wednesday, June 18 with the help of the IEF nurses.

Fundraising Efforts:

Premiere: They are arranging a "premier" at the Cine Plaza to raise funds for the NCPB. They buy showings of movies, and sell all the tickets for 50L. (A normal movie price is 25L; the movie house gets 30L because extra work and perhaps lower earnings, and the organization gets 20L.) They need to sell 400 tickets.

Other people to invite: They should form a fundraising committee and invite philanthropists, people of economic & political power, & "Damas Voluntarias." It was also discussed that the Lions should be invited to participate along with the OPS. Maybe they could help with the screening of children.

Meeting Times: The need for a fixed meeting time was expressed so that interested individuals (especially those who had to travel to be present) could plan to be there. Right now, the core group sort of arrange and cancel meetings last minute. This has served to exclude others from participating and has led to hurt feelings in some instances.

Optica: Wayne Cannon phoned about a month ago to say that the fundraising efforts were going well and that he was interested in finalizing plans for the optica such as who would handle it administratively, etc. They need to define this ASAP.

Brigades: the next Brigada scheduled by the NCPB was set for Cedros. They said they need an automatic refractometer to help out on these campaigns.

5. Meeting with Dra. Zulema Alvarez, Honduran coordinator for the SightReach program

Reviewed various concerns she had regarding:

- 1) gas reimbursement coupons- She was worried because Raul had given her coupons for a full tank of gas when her trips did not add up to that amount. (I explained to her she should fill it up and then she wouldn't need to be reimbursed later on for other trips.)
- 2) lack of access to office after hours- Raul hasn't issued her a key and she didn't like to depend upon other people to open the office for NCPB meetings.
- 3) Raul didn't seem to want to extend her contract. I explained that this (and the above item) fell under Raul's discretion and that although I would discuss her concerns with Raul, the decision was up to him.

6. Meeting with Lic. Betulia Cárcamo and Lic. Reina Montalván from the Ministry of Education

They had missed the NCPB meeting, and so they were briefed on what was discussed related to the screening project. They were adamant that a convenio should still be pursued because without it, there would be nothing to force principals to implement the plans in their schools. If they don't want to, they don't have to. They also thought that implementing the plan in just one school was folly because it had already been done. They thought the committee should put all their forces behind signing the agreement and implementing the plan as designed. The longer they wait to sign the convenio, the more changes will take place in the MOE, and who can know whether the people in charge will still be interested in implementing it. The idea that it shouldn't be signed without generating the money as well was also dismissed. They said many plans worked that way; you can never generate a huge chunk of money at once.

They also explained to me what changes had taken effect in the structure of the MOE. They used to have a director for each department for preschool, primary, secondary, etc. Special Education is now included with Curriculum Development. Now they only have one director for each department. This new system has its advantages. It is more efficient. The project will be quicker and cheaper to implement.

New estimates on materials and training costs will need to be brought up. The estimates were to be available Monday, June 16th. Zulema Alvarez was to collect them and communicate them to me and the NCPB.

7. Met with Dr. Raul Gomez and Dr. Orlando Oliva

Orlando flew into Tegucigalpa from Guatemala for the meeting Saturday morning. An agenda for the meeting was drawn up and what our stance should be regarding each candidate, the conditions for the acceptance of future candidates into the program, and a change Orlando executed in the convenio.

It was determined that the major problems with Respack Honduras began when sites in periurban areas of Tegucigalpa were approved for clinic sites. This caused two problems:

- 1) people who were located in rural sites felt as though they were being unjustly required to suffer the hardships and sacrifices involved in establishing their clinics outside of the city. People lost heart quickly when at first they were facing economic losses. They didn't suffer through this as a group like other country programs have.
- 2) The people in the periurban areas "got greedy." They came to see periurban areas as too much of a hardship, and were drawn to set up in even more profitable areas.

We decided the following sites to be eligible for SightReach clinics:

Danli La Paz Choloma

Juticalpa	Sta. Barbara	Puerto Cortez
Catacamas	La Lima	Tocos
Comayagua	Trujillo	

We discussed what the ramifications were to be if the non-compliant participants seemed

8. Meeting with Respack participants.

Invited:

Ricardo Reichmann
Denis Espinal
Doris Alvarado
Xiomara Garay
Jorge Cisneros
Claudia Silva
Sergio Zuñiga

Attended:

Doris Alvarado
Sergio Zuñiga
Claudia Silva
Xiomara Garay

Staff present:

Dr. Raúl Gomez
Dr. Orlando Oliva
Ellen Parietti

The meeting was initiated before Xiomara had arrived. Participants were asked to fill out the attached questionnaire to help evaluate the program. Raúl told the participants this meeting was not being held to chastise Respack participants, but to evaluate the accomplishments and setbacks; try to learn from their experiences. We would also decide what the proper next steps would be for those people not in compliance with the convenio.

Unfortunately, Doris and Sergio took very defensive positions. Doris contradicted the information she gave me in Cancún about her Respack clinic in the Colonia Kennedy, presumably because Sergio was present. In Cancún she stated that she alone was maintaining the Clinica Kennedy; she alone was paying rent on the physical space and had all of her equipment there. In this meeting, both she and Sergio maintained that both of them had half of their equipment in the Colonia Kennedy, and half in the luxury clinic in Colonia Florencia.

Attachment E: Trip Report, Honduras October 1996, Ellen Parietti

Honduras Trip Report
October 10, 1996-October 17, 1996
Ellen M. Parietti

Objective: Focus Groups
Meet with Vicky Alvarado & FIO/Honduras' lawyer
Meet with NCPB re: funds for publication of eye screening manual, optica, &
Discuss replacement for Marylena's Matching Grant Duties
Establish a list of priorities for coming year

Focus Groups were held at the following places:

Friday Oct. 12, 1996: La Entrada de Copan
Sunday Oct. 13: Colonia Kennedy
Monday Oct. 14: Choluteca
Tuesday Oct. 15: Siguatepeque
Wednesday Oct 16: Danlí

Transcripts of the focus groups are on attached pages

Friday, October 11 we left to go to La Entrada de Copán. We made our contact there, and when the focus group was scheduled for the next day, we continued on to Santa Rosa where we tried to arrange a focus group with neighbors of Renato's family. (Renato is a Child Survival coordinator in Teguc. with FIO.) Being a Friday afternoon when we got there, we found the neighbors unmotivated. Renato didn't have any success pulling together a meeting.

Saturday, October 12 we conducted the focus group in La Entrada de Copán. For this focus group, our contact was the mayor of La Entrada. He had one of his office employees arrange a workshop with her neighbors.

Tuesday October 15
Replacement for Marylena's Matching Grant activities

When discussing with Raúl and Marylena the possibilities of a replacement for Marylena's mg activities, both said they had a good candidate in mind. She is a physician and has worked with the ministry of health for many years. She is also volunteers medical services in a Catholic clinic. Both Raúl and Marylena thought she would be good for the position as she is very given to her work and would be a good addition to the comité. An interview with her was arranged to take place just before the NCPB meeting. Pay would be acceptable

to her.

Interview with Zulema Alvarez: She is an MD, her experience is mainly in the clinical setting. She worked in a very rural for 9 months. They had a cholera outbreak during which she worked practically non-stop for 2 months. In addition to taking care of patients in the clinics, she did a great deal of education. This year they didn't have any cholera. She seemed very given to her work, she seemed to be a very good person. My concern was that she didn't have any "program" sort of experience, and that she was a little shy. The following day, I spoke with Raúl & Marylena about this. They said perhaps it was best to advertise the position and let outsiders apply.

Meeting of the National Committee for the Prevention of Blindness:

1. Doris Alvarado gave a slide presentation on the "Advances of the National Committee for the Prevention of Blindness." Their work with the Optica, Eye Bank, and outreach work was highlighted. New initiatives planned include the training of general physicians in basic ophthalmology.

2. Optica- They reported, as Raúl had told me, that the President of the Republic had not yet written a letter in support of the Optica because they wanted more information on Help the World See. He was reticent to give them support in raising money before he was sure it was a legitimate organization. I told them that I had spoken with Wayne Cannon to communicate this to him the previous week. Dr. Cannon said that in fact a letter from the president of the Republic was not called for and a letter from the Minister of Health would suffice. During this conversation, we discussed the concern I felt at Dr. Juan Carlos Silva's tact. I explained to Dr. Cannon how I felt I had been given so many different representations of the source of funding for the project that I was confused. Dr. Cannon explained that all of the money was raised by Helping the World See. HWS is now seen as a partner of PAHO, so he said that perhaps he was representing the HWS's \$ as PAHO's, which was fine with him. He derives PAHO's credibility from the relationship. Dr. Silva was also very nervous as to what IEF's intentions were with the project. Dr. Silva was nervous that IEF wanted to take all of the credit for the It was decided that Dr. Juan Carlos Silva should send a letter to the committee expressing PAHO's involvement in the project for use in getting the letter of support.

3. MOH/MOE School child screening project- I reported that IEF would support the printing of the manuals, but that we wanted to do it for just 1 or 2 departments and have the screenings start there, as a pilot program, before printing all of the other manuals. The Comité was in agreement with this. \$10,000 would be needed for this project. Originally \$16,000 was allotted for the optica, but as all of that money is not needed, \$10,000 can be used to print the materials, and then if Wayne Cannon is actually making progress towards raising money for the Optica, we can give \$6,000 toward that. The pyramid in capacitation was discussed. Who would give the trainings, etc. Personnel would be needed on a fixed basis for the training of teachers. The doctors from the comité

were originally intended to do this, but the time demands would probably be too great. I suggested training second year peace corps volunteers to participate. The idea was received very positively.

Tuesday, October 15, 1996
7pm, Hostal Las Lomas, Tegucigalpa

Ellen's meeting with Vicky Alvarado

Vicky told me that she was most disappointed that HQ didn't let her know ahead of time that FIO was going to let her go. (She expected Raúl to act as he did.) She feels that Lily in her last trip to Honduras lied to her and believes that IEF knew 3 months before she did.

IEF had called in a functionary of the Ministry of Trabajo to calculate compensation for people whose contracts were not being renewed. All of the people except for Vicky accepted this compensation. Vicky went to the Ministry of Trabajo to have her "calculation" done as to what she was entitled to. They came up with a different total than that done in IEF. Calculations of what employees are entitled have a subjective element to them, so differences are not uncommon. The difference in the two calculations centers around an issue of "pre-aviso." People who are permanent employees of an institution are entitled to "pre-aviso," a prescribed period of two months where people are permitted to take one day per week to explore employment in the anticipation of a lay-off. Since their contract was ending, Raúl Gomez put everyone affected on "pre-aviso." Raúl & FIO's lawyer say that this was not in fact required because no one was considered a permanent employee, but a contractual one. Raúl wanted to treat their employees well, and that is why pre-aviso was given.

Vicky claims that she is entitled to the monetary equivalent of her two months of pre-aviso because she was given her vacation during her pre-aviso. This is not allowed under Honduran law. (Vacation is un-paid in Honduras.) Vicky was supposed to start her vacation in late August, but due to John Barrow's trip, it was post-poned to begin the first week in September. So, if she was entitled to pre-aviso, this would be a violation of the work code. However, since she was not technically a permanent employee according to FIO's lawyer, this may be seen as irrelevant.

NOTE: Other employees whose contracts were not renewed also were given their vacation during this pre-aviso period.

Reasons as to why the FIO employees were not considered permanent employees has been

presented in different ways. According to Vicky, all employees are considered permanent after a certain period- she told me 6 months.

Raúl has said that if a certain "project" for which she was contracted was completed, she would be finished. He states that by giving her the letter ahead of time notifying her that her contract would not be renewed, it implied that others would be staying. This would then imply that the project was not finished, yet her employment was being terminated ..entitling her to pre-aviso.

FIO's lawyer did not mention this to me, but said that her contract proves that she was a contractual employee, not a permanent one.

Raúl says that Vicky was the one to initiate legal action, by saying that she was going to get a lawyer when Raúl wanted to stick with the calculation provided by the Min. of Trabajo in FIO. Vicky says that Raúl said that she would need to deal with his lawyer.

Destruction of IEF Documents: Personnel in the FIO office reported that the day went into the FIO office while Raúl was gone and began burning documents. In response to this accusation, Vicky says that she was merely cleaning out her office. As there was a lot of paper, she decided to burn it. After she had started, the cleaning woman suggested that she simply leave it because the garbage was to be picked up the next day, and there was a lot of wind so the ashes were being blown. Vicky didn't have a problem with that and so she left it, stating that only a small portion was burnt and the rest left for trash. She questions why, if the people there thought the documents were important, why they didn't save them before the garbage was collected. Furthermore, she states that the survey which was burnt was old. She says that Jeff Brown said that any information collected longer than 1 year before was no longer useful, and in any case, they had all the information in a report. She further states that she took no manuals that were property of the IEF. She also reports that some of her private belongings turned up missing. She says her witnesses will testify to this. These witnesses are the same people which IEF has a signed statement from, testifying to which documents were burned. On this paper, they state they were ignorant of any wrong-doing.

FIO's lawyer feels that FIO does not need to pay pre-aviso, but they want to settle out of court because it would be very costly to fight it out in court. There was a court date set for Friday, October 18th, but the lawyers were going to go to see where each side was standing (The last meeting between lawyers ended when Vicky's lawyer saw her contract for the first time. He said he wasn't fully aware of the terms of the contract.) When the lawyer knows what they are asking for, they will try to come to an agreement.

Vicky said that she was worried about IEF's future with a director like Raúl, and she wishes that IEF investigated him better before hiring him. She obviously felt like she had made a large investment in IEF/Honduras and wasn't treated as a valued employee. She said that she had been waiting on a letter of recommendation from John, but didn't know now if she

would get it considering all that had been said. I said that John had expressed a desire to speak with her, and that he would probably be calling her. Vicky seemed that she would like that. Her home phone number is [REDACTED]

Currently Vicky is employed as a consultant for the United Nations until January or February. After that she has a standing job offer at the alcalde (mayor's office.) She said she would rather work somewhere else, though. She wants a job reference from John. Vicky is very well connected, having a brother in law who was president of the Republic.

FIO's lawyer stated that circulating a letter about Vicky would be a bad legal move, opening a box a worms. Strongly advised against it.

The following morning (Wednesday), Vicky delivered copies of IEF's Ministerio de Trabajo calculation, and the one which was calculated for her when she herself visited the Ministerio de Trabajo one week afterwards. She showed the difference between the two, (the amount of money which she is requesting from IEF) and said that if she would receive that, then she would forget everything and drop the case.

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Thursday Oct 17: meeting with IEF's lawyer

I met with the lawyer IEF contracted to deal with the dispute they are having with Vicky Alvarez. The lawyer explained to me that IEF/Honduras was in the right concerning the preaviso, saying that Vicky was not entitled to pre-aviso in the first place, so the action of filing for back pay citing the illegal nature of granting vacations during preaviso was unfounded. He thought it wrong that she was trying to get money she isn't entitled to.

In addition, Vicky could be held criminally liable for destroying the survey. The fact that Vicky says she didn't destroy anything meaningful and that she was "simply cleaning out her office" is no excuse. You cannot use ignorance as a defense. She could be prosecuted.

Never-the-less, he conceded that it would be a difficult & expensive process, so it would be best to try and resolve this through negotiation without a judge. In their last meeting, Lic X showed Vicky's lawyer a copy of V. Alvarez's contract. He is alleged to have said that he had never seen it before, and conceded that according to it, she was not in fact entitled to preaviso. He was then going to attend their first meeting to see where they stood now that her lawyer had reviewed the contract. He would then try to reach a friendly agreement.

Thursday Oct 17: Visit to Hospital San Felipe

1. donations: Raúl Gomez and I went to the Hospital San Felipe and dropped off a donation of 576 Ocumeters of Gentamicin to the sala de ojos. I also re-confirmed the need & desire for the OPMI-2 microscope shipped upon my return.

2. Ehrler: I was able to review plans for the AAO, and communicate information needed for the preparation of the pediatric ophthalmology workshop.

3. Respack participants: I had the opportunity to visit with many of the Respack participants while visiting the sala. I saw Sergio Zuniga, Doris Alvarado, Luisa Maria Rojas, Denis Espinal.

4. Eye bank & Optica Installations: I visited the part of the hospital that is to be dedicated to the establishment of an eye bank and the Optica. The Optica will have a street-front location for easy public access. I also thanked Maura Chavarria for all of her efforts on behalf of the eye bank.

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LA ENTRADA, COPAN

8 people (2 men, 6 women)

This meeting was arranged with the employees of the alcalde of La Entrada. The group consisted of neighbors and friends of the two women. The group could be considered middle to upper middle class. All the families had a reliable source of income and probably earn roughly ___L/ month.

The most common health problems confronted by this group included:

1. Bronchial problems
2. Pterygium, nasal passage problems
3. Colds, fever, pterygium
4. Cardiac problems, low blood pressure
5. Sinusitis, irritated eyes
6. asthma

Where do they go for health care:

1. Private in La Entrada
2. Private clinic in La Entrada
3. Private Clinic in San Pedro Suladistance 2 1/2 hours
4. Private Clinic in Guatemala City, Guatemala.....distance 10 hours
5. Private Clinic in San Salvador, El Salvador.....distance 9 hours
6. Private Clinic in Chiquimula, Guatemala.....distance 9 hours

They say they don't go to the Centro de Salud because they say they lose time, and the physician that attends the clinic is not a specialist. They use the centro for preventive health for their children, vaccinations.

They go to foreign countries for operations because they say it is cheaper and the medical attention they receive is better. It is cheaper even considering the travel expenses. One man had an eye operation in San Salvador and another operation in Guatemala. These operations cost less than 1/2 the price that it would have cost in Honduras.

For a general medical doctor in La Entrada, Lps. 60 to Lps 100 (about \$4)

For a specialist, Lps. 150, 200, 250 (about 19)

They say there are no specialists in La Entrada. After a brief discussion, one person said that there had been an eye doctor, but that he had left. They said that he had been very expensive. (note: this woman did not go personally, but her mother had told her this.) The people who were aware that there was an ophthalmologist in town were under the impression that he was very expensive.

(This doctor was a ResPack doctor, Ricardo Reichman Rivera)

Four of the six people who said that they did have eye problems had not gone to seek care. Their reasons they gave for not going to seek attention were:

1. they had not come to the point where they did not consider themselves as in a lot of pain

- 2.their functioning wasn't impaired to the eye problem
- 3.they had heard that a doctor wouldn't operate a pterygium because it wasn't advanced enough, so they were waiting. (This woman's pterygium was beginning to cover her pupil.)
- 4.they were scared of what the doctor would tell them.
- 5.they knew that they would need glasses and didn't have enough money to pay for them
6. even if they could pay the consult, they couldn't pay for the medicines or the glasses

When asked if their family members suffered from eye problems:

1. an uncle of 79 years can not see. He lives with nephews and nieces 3 hours from La Entrada. Since they have kids of their own and are poor, no one has money to take him to a doctor and have him treated.
2. Four people have mothers whom use glasses.
3. One mother, mentioned above had been operated upon for pterygium 3-4 times.
4. One woman's husband had red and irritated eyes, but had never gone to the doctor because of economic reasons.

Reasons Given For not seeking help with a doctor:

1. Economic
2. Time
3. Descuido
4. Fear

Price Considered Fair for Consult:

L 100 \$8

General Commentary of Participants:

1. They say the majority of doctors have turned commercial
2. The cost of a consult isn't as big a problem as is the medicine or glasses
3. the pharmacists are better than the majority of doctors.
4. They only go to the doctor when they are left no other alternative (the farmacist's suggestions haven't worked and they have already tried home remedies) or if it is clear that the ailment is grave.

Natural Remedies used for Eye Care

Flor de Manita

Rosa de jamaica

Granadilla- you need to let the seeds soak in water for a while and let them swell up with water before squeezing them into your eyes. (Help irritated eyes and is said to remove pterygium.)

CONCLUSIONS:

- 1.community education should be conducted by Respack doctors in their sites.
- 2.would be interesting to investigate all of the market forces in this area.

DANLI, EL PARAISO
October 16, 1996

Renato & I went to Danlí without having a contact in place for organizing a focus group. I looked for Peace Corps Volunteers with which to organize a group but was unsuccessful. Several probable contacts told us there were no current volunteers. We visited tobacco companies and tried to arrange a meeting with the employees, but management wasn't in favor of it. We went by the hospital to see if we could arrange a meeting, but were also unsuccessful. Finally, we decided to make visits to other doctor's offices (general doctors and specialists) in the area to get an idea of what they were charging.

Prices for Office Visits:

Private Optical shop L30

General Doctor's office L40

Pediatrician L50

Dentist L60

Ophthalmologist (Denis Espinal) L80

Official exchange rate \$1=L12.56 October 17, 1996

The Lions Club The Lions Club of Danlí helps poor people to get glasses. People from Danlí are investigated to make sure they are in fact in need, but those arriving from villages are not due to personnel shortage and the fact that most people in those villages are needy. To obtain glasses, the person pays L50.00 (\$3.88) and with this, they are given a referral to the Matamoros clinic (a private optical shop) where they are examined, and they also get a pair of glasses. (A referral alone costs L30.00 usually.)

The Danlí club helps 15 people a month. There are 6 Lions clubs in Honduras. They all have this program.

SIGUATEPEQUE- Two groups were held in Siguatepeque, one was a community banking group, the other was held in the waiting area of the community clinic.

Banco Communal

A Peace Corps Volunteer invited us to hold a focus group with her community banking group. Fourteen women participated in the focus group, all active in the banking program. This group could be considered lower to middle economic level.

These women considered the most serious health problem to be Bronchitis and Diarrhea in children.

Twelve of the women said that their eyes gave them problems such as headaches. The majority attributed this to the sun. No one in the group had sunglasses, but they felt this would help a lot.

Three women in the group had their eyes examined. One went to the Hospital San Felipe in Tegucigalpa, (2hrs. by bus) one went to the Hospital Evangelico in Siguatepeque, the third went to the Optica Buena Vista, also in Siguatepeque.

One of the women received eye glasses as a consequence of her visit, but they broke and she never had them fixed.

Thirteen of the 14 women reported using the health center whenever they had any health problem. One of the women uses a private general practitioner.

In the community clinic, they charge 20 Lempiras (\$1.50) while in private clinics, the doctors charge from 30-50L (US\$2.30-\$3.85). Both private doctors and the community clinics give you prescriptions to purchase on top of these charges.

The women stated there were no specialists in Siguatepeque, but they sometimes came on Saturdays. They charge L80 (US\$6.15). When they need to see a specialist, they usually make the trip to Tegucigalpa and pay the 24L (US\$1.85) for the roundtrip busfare.

When asked what would be a fair price to see an ophthalmologist, there was agreement that L50 would be fair. (\$3.85) They felt that the L80 that the Hospital Evangelico charged was too much. If the medicine were to be included, they felt that L100 would be reasonable. (\$7.70)

Three women said that they had purchased ocular medicines in a pharmacy without the guidance of a health professional, the others stated that it was too risky to do that with the eyes which are so delicate. More common was the use of natural remedies for less serious problems, such as irritation of the eyes. Chamomile tea and rosewater was used to alleviate irritated eyes, and breast milk was used on children when their eyes seemed to have an infection. They simply squeezed a little milk right into their eyes, and they feel that the antibiotics present in the breastmilk takes care of the infection. This was also reported to be a common cure for ear infections.

Only two of the women felt that their children needed to be seen by an ophthalmologist. One of these children had two different colored eyes and felt that the lighter one couldn't see distance as well as the darker one. One other woman said her child brought his notebook very close to his face to see.

Community Clinic

There were a total of six women in this group, all could be characterized as lower socio economic level.

These women stated the most serious health problems as being the flue, diarrhea, high blood pressure, asthma, vomiting, brochial sinusitis. These were chronic problems they were repeatedly seeking care for.

All of the participants said that they always used the community clinic for their health care needs. They found the private clinics to be too expensive charging form 30-60 Lempiras (\$2.30-\$4.62) and then sending them to the pharmacy for the medicines. In the health center (cesamo) many times they gave them the medicine.

The participants had never gone to a specialist in Siguatepeque. When they need to see one, they go to the Hospitals in Tegucigalpa such as Materno Infantil and San Felipe.

When they can't get an appointment in the Community Health Center they go to the pharmacy where the pharmacist will help guide them as to the best medicine to buy for a given condition.

When asked if they had problems with their eyes, three replied positively.

-one has pterygium; was seen in the clinic and was told she required an operation.

-two ad irritated eyes and headaches. One of these women was told she needed eye glasses but didn't buy them because they were too expensive. The other woman was given eye glasses which bothered her, and was prescribed eye drops which cost L13 (nearly \$1) which didn't work either.

The cesamo has an optometrist which visits every once in a while, so they were all seen there at the health center.

One woman's husband was operated on at San Felipe for a detached retina, and the women agreed that for a serious eye problem they would go there.

A fair price for an ophthalmologist's visit was put at L50 by the women if it included the medicine.

None of the participants used home remedies for their eyes since they were delicate, but all said they would buy medicine in the pharmacy if they needed relief from an irritation.

Attachment F: Trip Report, Guatemala September 1996, Ellen Parietti

TRIP REPORT
GUATEMALA
September 22-27, 1996
Ellen Parietti

PURPOSE: Conduct focus groups to help ResPack participants learn more about the communities's beliefs regarding eye health and thereby improve both the clinics and the service.

SUMMARY:

Four focus groups were held to explore people's perceptions of their needs in regards to eye care, the importance they give it in relation to other health needs, what they think a reasonable fee is. Two groups were held in ResPack sites, Zacapa and Barberena, and two in areas not attended by ResPack doctors, San José Pinula and Sanarate, twenty minutes and one hour respectively from Guatemala City.

Most of the participant's opinions and comments did not come as a surprise. Many had complaints about their eyesight or itching/redness and expressed a desire to have an eye care professional in their community. However, they also expressed a reluctance to pay for specialized care. The majority of participants thought that ophthalmologists should only charge what other general practitioners or public clinics charged. Cost was identified as one of the main reason for not seeking care with an ophthalmologist. Many felt that even if they could pay the cost of the visit, they wouldn't have the money for the eyeglasses so the visit would be a waste of money. Some people who purchased spectacles experienced problems with them and no longer use them. These experiences contribute toward the reluctance to spend the considerable amount of money required.

Zacapa, Monday, Sept. 23, 1996

The first focus group was in Zacapa's main Catholic church with participants recruited from the parochial clinic. There were 7 participants; 6 women and 1 man. The nurse from the clinic was present and announced to the participants that "visual health care was the most important sort of health care there was", and that she referred people to Orlando often.

Every one of the participants reported problems with their eyes. Two of these went to Robles Satellite Clinics. They were satisfied with the care they received

San José Pinula, Tuesday, Sept. 24, 1996

Eleven workers from a country club were gathered for a group discussion. They were employees that worked in the kitchen (7), clerical employees (2) & bar employees (2). This meeting was arranged by the doctor that the club has contracted to take care of the employees. The club pays for 1/2 of the consult. I feel that there was tension in the air and the group did not speak freely because a) their boss sat in on the conversation, and b) the

doctor was present as well. At one point in the discussion, there was a bitter accusation of sexual misconduct toward the doctor. It became apparent at that point the tension in the air was affecting to some extent people's participation

Barberena, Wednesday, Sept. 25, 1996

The priest of this community was contacted and said that he would arrange a meeting of people. When we arrived, however, he was involved with a large meeting. All of the Franciscan priests throughout the country were gathered in his church. The priest was leading the meeting and was unavailable to facilitate a group meeting. The Parochial clinic was providing attention, however, and we arranged to speak with the people one on one as they left their appointments. We used the questionnaires that had been preliminarily designed (see attached.) We saw this as an opportunity to gather some information without losing the whole day. Clients were asked if they had received an eye examination at some time. Based on their answer (yes or no) they were given a questionnaire.

FINDINGS:

1. When asked how much people could afford to pay for an appointment with an oculist, they often repeated the price they pay at local clinics. People don't realize that a specialist needs to charge more than a generalist or a clinic. (Even when we explained they had additional education and special equipment and needed to compensate for that, they didn't seem to think that should make a difference.) They just replied, "Well, if you don't have the money, you can't pay more." The reluctance to pay more may also be influenced by campaigns by non-ophthalmologists who have come into the area performing VERY inexpensive screenings (\$1) with the purchase of eye glasses.
2. When asked if they had eye problems almost all said yes...90%. Complaints ranged from problems seeing to itchy eyes, etc. When asked if they had sought care only a minority had (20%). Those who did not seek care gave a variety of reasons. Economic was the primary reason, ignorance of resources, distance, fear of diagnosis were others. Basically people didn't see it as important a problem and therefore didn't want to devote a greater amount of resources. They keep putting it off. They see other needs as more pressing. A very common response was "even if we had enough to pay the bus and appointment, we wouldn't be able to afford the glasses."
3. When asked if they had health problems, they went on & on with a litany of health problems. Only one woman mentioned her eyes on her own, and she had a bad problem with pterygium in both eyes.
4. When asked where people would go if they had problems with their eyes, they mostly all

responded the general health clinic they were accustomed to going. Only very young people living near the capital said they would go there.

5. People were unaware of the illnesses that could cause visual deterioration such as diabetes, high blood pressure, etc.

6. Many people stated they had trouble with the lenses they were prescribed. Proper followup was not given. This led to a feeling among these people that they could not be helped, even when they were proactive in dealing with a problem.

7. There were two people in focus groups that had sustained trauma to their eyes and did not seek medical care. One was a young man who sought help with a traditional healer, and another was a woman who did not seek care until years later when her eye began to "sink."

8. The basic way people judged if they had vision problems (especially women) was if they could thread a needle or sew without problems.

9. Many people use traditional medicines to heal pterygium, itching & burning.

PROBLEMS:

1) I asked that focus groups be arranged through the community church because I wanted to speak with a group of people outside of a health care setting. I wanted to include the experiences of people with varied health experiences. Unfortunately, in two of these instances, the meetings were set up through the parochial clinic. This skewed the findings in two ways: 1) all of the participants have identified one center for health care where they go in time of need and 2) the parochial clinic is offers services only to the needier members of the communities.

2) In one of the communities, they knew Orlando was an ophthalmologist.

3) Half of the people interviewed were lower socio-economic groups.

4) Didn't get enough info about why old people didn't get cataract operations.

RECOMMENDATIONS

1. Education about what differentiates an ophthalmologist from a general doctor.

2. Educate the general practitioners in the area on which patients should be referred to them.

3. Educational posters how diabetes & high blood pressure can effect your vision.

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4. Affordable glasses need to be made available.
5. Emphasize follow-up care available with local ophthalmologists.
6. Visit management of at-risk employees and seek a contract.

LESSONS LEARNED:

1. Holding groups in areas near current ResPack clinics is good publicity; it makes people aware, and heightens their awareness to eye health.
2. Parochial Clinics are a commonly used health center, very trusted by the community. Many times overlooked.
3. When working with Churches: Be careful about advocating ResPack doctors to parochial clinic clients. We are seen as speaking in the name of the church when telling people about ResPack clinics. We would be exploiting the trust the people feel for their church. The ResPack candidates are not obliged to help all people who are unable to pay.
4. Insist that all authority figures leave....nurses, bosses, etc.
5. When questioned specifically about their eyes, 85-90% will reply that they have a problem. When asked first what health problem bothers them most, they rarely mention eyes; only when they truly have a serious problem.
6. Peace Corps volunteers are good contacts to use. For future groups, I suggest that groups be arranged through them. The advantages to this:
 - a) They many times work with established groups; no need to pull one together.
 - b) They have no affiliation with the health care center.
 - c) They are feel comfortable with North Americans and don't see them as someone who is giving things out for free.
 - d) Peace Corps Volunteers are good contacts to have in the communities. They can refer people in need of ophthalmic attention to the ResPack doctors.

**TALLER ANUAL DEL COMITE DE PREVENCION
DE LA CEGUERA**

Fecha . Sábado 8 de Marzo de 1997

Local . Restaurante Turicentro, Carretera a Valle de Angeles,
Tegucigalpa, M.D.C.

Para:

- 1.- Señorita Ellen Parietti
Coordinadora del Proyecto
Matching Grant. (FIO-USA)
- 2.- Doctor. Raúl Gómez
Director Fundación
Internacional de Ojos
Honduras
- 3 - Los miembros del comite que
no pudieron asistir al taller.

TALLER ANUAL DEL COMITE DE PREVENCIÓN DE LA CEGUERA

Fecha Sábado 8 de Marzo de 1997

Local Restaurante Turicentro, Carretera a Valle de Angeles,
Tegucigalpa, M D C.

Asistentes

1. Dra. Doris Alvarado (Presidenta del Comitè de Ceguera)
- 2 Ing JimmyDàcarett (Vicepresidente)
- 3 Dr Mario Leòn Gòmez (Fiscal)
- 4 Dra. Hadızabel Burgos (Vocal)
- 5 Dr. Juan C. Boquin (Residente de Oftalmologìa, invitado)
- 6 Dr. Roberto A Matamoros (Residente de Oftalmologìa, invitado)
- 7 Dra. Yolany Velasquez (Residente de Oftalmologìa, invitado)
- 8 Dra. Belinda Rivera (Residente de Oftalmologìa, invitado)
- 9 Dra. Geraldina Elizabeth Amador Zùniga (Residente de Oftalmologìa, invitado)
- 10 Dra. Zulema Alvarez Galo (Vocal, FIO)

AGENDA

- 09 00 a m Saludo - Introduccìon
- 09 30 a m Presentacìon de los avances del Comitè.
- 09 45 a m Revisìon del Plan de Accìon
- 10 15 a m Receso
- 10.30 a m Resumen de los avances del convenio
- 10 45 a.m Experiencias e inquietudes respecto al Comitè
- 11 00 a.m. Plan de Accìon para 1997
- 12 00 a m Almuerzo

DESARROLLO DE LA AGENDA

Bienvenida,
por la Dra Doris Alvarado

Información recolectada sobre las actividades realizadas en Choluteca y San Pedro Sula
por la Dra. Zulema Alvarez

En Choluteca por Dr. Jorge Cisneros :

- Se realizaron 21 cirugias de catarata, completamente gratis (Optica de luz y Amor y Club de Leones)
- Se realizan las consultas normales, trauma, cuerpo extraño

En San Pedro Sula:

La Dra. Denia Argueta del Instituto Hondureño de Seguridad Social

- En Octubre y Noviembre de 1996, como Comité, realizó un curso de capacitación a 30 enfermeras

REVISION DEL PLAN DE ACCION

A continuación presentamos los siguientes cuadros del Plan de Acción del Comité para 1996. Las flechas rojas indican lo que se cumplió

PLAN DE ACCION DE ABRIL 1995 A ABRIL 1996
COMITÉ COORDINADOR NACIONAL PARA LA PREVENCIÓN DE LA CEGUERA

OBJETIVOS ESPECÍFICOS	META	ACCIÓNES	RECURSOS	M E S E S												
				A	M	J	J	A	S	O	N	D	E	F		
A. PREVENCIÓN	100%	1. Redactar una (solicitud formal al Dr. Danilo Velasquez para la obtención de datos sobre incidencia y prevalencia)	Archivos OPS, MSP	X												
1. Recopilar información estadística a nivel nacional sobre la incidencia y prevalencia de las enfermedades que producen ceguera prevenible, como amiblopa, catarata, glaucoma, lesiones oculares y retinopatía diabética, mediante la formulación de una estrategia que nos permita controlar la ceguera.		2. Obtener información de diferentes fuentes como MSP, Facultad de Ciencias Médicas, IESS y otras	MSP, IESS Fac. Medicina Hospitales FO, etc.		X											
		3. Presentación de la información obtenida										X				

- El plan de 1996 es muy ambicioso
 - Respecto a la prevención de la incidencia y prevalencia de enfermedades que
- NO HAY ESTUDIOS

El Dr. León Gómez refiere que en Junio a Noviembre de 1996 se hizo un estudio donde se comprueba que si hay ciegos por Glaucoma y son enfermedades prevenibles. Podría hacerse un estudio en este sentido

El Dr Roberto refiere sobre un estudio de Retinopatía Diabética que se cumplió parcialmente

→ Se capacitaron 200 Médicos Generales que iban a comenzar el servicio social

Las charlas a los residentes de pediatría no se realizaron

Las charlas a los pediatras de Tegucigalpa y San Pedro Sula no se realizaron

→ El Comité participó en dos Congresos para Médicos Generales

- 1 - Hablando de las principales enfermedades oculares que conllevan a la ceguera y que son prevenibles
- 2 - Dando a conocer el Comité

→ Otras Capacitaciones:

- Diabéticos
- Personal de INFRACNOVI en enfermedades oculares
- Maestros de Educación Primaria
- Voluntarios Comunitarios

Brigadas Nacionales:

- Juticalpa
- Campamento
- Yuscarán

Aclaración realizada por Dra Hadizabel Burgos respecto a la exposición de Dra Alvarado respecto a los avances del Comité

La investigación que realizó INFRACNOVI con apoyo del Dr Espinal

- 1 - Diseñó totalmente las estrategias de detección
- 2 - Realizó la capacitación para voluntarios comunitarios la FIO, al conocer los resultados los contrató, el Dr Godoyse interesó en la toma de Problemas Visuales. Se capacitaron 80 personas
- 3 - Se hizo la programación, el diseño de la estrategia de la capacitación, el diseño de la cartilla y luego se diseñó el estudio para maestros

BECAS

Ser el enlace escribirle al Dr. Silva

ACTIVIDADES ACTUALES

- Proyecto toma de agudeza visual a los niños de primer grado de Honduras
- Convenio Internacional para la forma de Agudeza Visual a los niños de primer grado de Honduras
- Optica de Luz y Amor.
- Respecto al Comité.
 - Continuar la promoción de la personería jurídica
 - Resolver el problema del espacio físico
 - Organización por equipos de trabajo

PLANIFICACION PARA LA PROXIMA REUNION

- Jueves 10 de abril de 1997 en la FIO a las 7 00 p m
- Calendarizar el Plan de Acción
- Recolectar todos los documentos para la personería Jurídica
- Mandar papeles a San Pedro Sula e informar actividades

RESUMEN DE LOS AVANCES DEL CONVENIO

- (Se envia fotocopia del proyecto y del convenio c/u)

En este momento el convenio esta siendo revisado por personeria jurídica del Ministerio de Educaciòn

PLAN DE ACCION PARA 1997

ESTUDIOS DE INVESTIGACION

Promover la investigaciòn en salud ocular

TEMAS DE PRIORIDAD

- Catarata
- Glaucoma
- Retinopatìa diabètica

IDEAS

- 1 - Programar un evento para su presentaciòn
- 2 - Buscar un mecanismo para dar a conocer a los mèdicos del servicio social los temas de interès en salud ocular y al mismo tiempo un estìmulos para especializarse en optalmologia
Por ejemplo (Dr Leòn Gòmez comenta que se hizò un estudio comparativo sobre hipertensiòn ocular en en la paz estudio que bien podrìa continuarse
- 3.- Coordinar con docentes de Medicina preventiva
- 4.- Investigar en la Asociaciòn Pediàtrica la fecha del Congreso de Pediatria para dar a conocer el Comitè.

Para eso se puede mandar una carta a la Asociaciòn Pediàtrica

- 5 - Escribir a la Facultad de Medicina o Decano de Medicina

Attachment H: Convenio Signed by the Honduran MOH, MOE, and IEF



República de Honduras
Secretaría de Educación

CONSIDERANDO: Que una finalidad del Modelo Educativo, es ampliar la cobertura, disminuir los índices de deserción, reprobación, marginalidad escolar y mejorar el rendimiento académico de los alumnos y el grado de escolaridad nacional.

CONSIDERANDO. Que la Secretaría de Educación, ha coordinado acciones para el cuidado primario de ojos a nivel nacional, con la Fundación Internacional de Ojos y el Club Rotario como Proyecto Piloto, obteniendo resultados positivos en la detección de agudeza visual y problemas de visión que afectan el proceso educativo de niños y niñas.

CONSIDERANDO Que existe gran cantidad de niños y niñas que presentan dificultades para aprender, por razones sensoriales.

POR TANTO ACORDAMOS:

1. La Secretaría de Educación, La Fundación Internacional de Ojos y el Club Rotario, se comprometen a impulsar conjuntamente las acciones en relación a la salud ocular específicamente en la detección de agudeza visual para niños y niñas del primer grado de las escuelas oficiales de Honduras.
2. La Fundación Internacional de Ojos, El Club Rotario y la Secretaría de Educación, se comprometen a la monitoria de la prueba de agudeza visual a los niños y niñas de primer grado
3. La Secretaría de Educación se compromete a emitir un acuerdo para la aplicación obligatoria de la prueba de agudeza visual a los niños y niñas de primer grado.
4. LA SECRETARIA DE EDUCACION, LA FUNDACION INTERNACIONAL DE OJOS Y EL CLUB ROTARIO, se comprometen a elaborar y hacer cumplir un Reglamento que regulará la implementación del Convenio de Toma de Agudeza Visual en niñas y niños de primer grado
5. La Secretaría de Educación se compromete a apoyar técnicamente a la Fundación Internacional de Ojos y al Club Rotario, en las estrategias de capacitación.
6. La Secretaría de Educación, La Fundación Internacional de Ojos y el Club Rotario, se comprometen a buscar mecanismos de coordinación con la Secretaría de Salud.

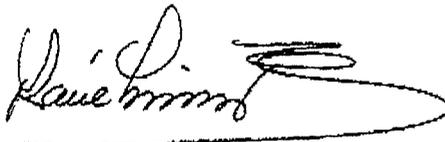


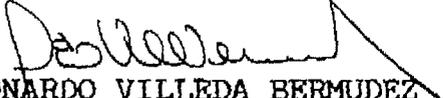
República de Honduras
Secretaría de Educación

7. La Fundación Internacional de Ojos y el Club Rotario, se comprometen a propiciar asistencia técnica, supervisión y buscar alternativas de solución, en el proceso de capacitación a docentes a través de los Centros de Aprendizaje Docente CAD.
8. El Club Rotario, coordinará acciones con el Departamento de Oftamología y el Programa de Residencia de Oftalmología, para propiciar apoyo técnico en el proceso de capacitación.
- 9.- La Secretaría de Educación, incorporará a la Sección de Informática los cuadros de datos estadísticos relativos a la aplicación de la agudeza visual en las Escuelas Primarias del país
10. La Fundación Internacional de Ojos y el Club Rotario, se comprometen a divulgar los resultados del proyecto a nivel nacional e internacional a través de distintos medios
11. Las acciones conjuntas se desarrollaran de acuerdo al Proyecto "Salud Ocular para la Niñez Escolar de Primer Grado de Honduras", y en base a la planificación de actividades, implementándose el mismo en varias etapas, iniciándose en el Departamento de Francisco Morazán y progresivamente extendiéndose en todo el país.
12. El presente Convenio se podrá rescindir a voluntad de las partes debiendo notificarlo cualquiera de las mismas por escrito con 90 días de anticipación
13. Este Convenio entrará en vigencia a partir de la fecha de su suscripción.

Y para su debido cumplimiento se suscribe el presente Convenio, en la ciudad de Tegucigalpa, Municipio del Distrito Central, a los dieciséis días del mes de diciembre de mil novecientos noventa y siete


ZENOBIA RODAS DE LEÓN GÓMEZ
SECRETARIA DE ESTADO EN EL
DESPACHO DE EDUCACIÓN


RAUL GÓMEZ
DIRECTOR FUNDACION
INTERNACIONAL DE OJOS


LEONARDO VILLEDA BERMUDEZ
PRESIDENTE CLUB ROTARIO TEGUCIGALPA
La educación es el alma de los pueblos
Francisco Morazán



República de Honduras
Secretaría de Educación

CONVENIO INTERINSTITUCIONAL DE COOPERACION ENTRE LA SECRETARIA DE EDUCACION, LA FUNDACION INTERNACIONAL DE OJOS Y EL CLUB ROTARIO DE TEGUCIGALPA, EN REPRESENTACION DEL COMITE NACIONAL DE PREVENCION DE LA CEGUERA.

Nosotros, ZENOBIA RODAS DE LEON GOMEZ, Licenciada en Administración Educativa, actuando en mi condición de Secretaria de Estado en el Ramo de Educación, nombrada para tal cargo mediante Acuerdo No. 01-94, de fecha 27 de enero de 1994, del Poder Ejecutivo, quien en lo sucesivo se denominará "LA SECRETARIA DE EDUCACION" el Doctor RAUL GOMEZ, actuando en mi condición de Director Nacional y Representación Legal de la Fundación Internacional de Ojos, organización sin fines de lucro, con personalidad jurídica obtenida mediante Resolución No. 161-89, de la Secretaría de Gobernación y Justicia el 22 de septiembre de 1989 quien en lo sucesivo se denominará "LA FUNDACION INTERNACIONAL DE OJOS" y LEONARDO VILLEDA BERMUDEZ, en mi condición de Presidente y Representante Legal del Club Rotario de Tegucigalpa, Asociación Civil y sin fines de lucro, reconocida como persona jurídica mediante Acuerdo del Poder Ejecutivo por intermedio de la Secretaría de Gobernación y Justicia número mil ciento diez (1,110) de fecha doce de enero de mil novecientos cuarenta y cinco, quien en adelante se denominará "EL CLUB ROTARIO", en representación del COMITE NACIONAL DE PREVENCION DE LA CEGUERA, mientras se reconozca su Personería Jurídica, todos mayores de edad, hondureños y de este domicilio, con facultades suficientes para celebrar este Convenio, el cual se registrá por las condiciones y clausulas siguientes:

CONSIDERANDO: Que la Constitución de la República en el Capítulo VIII de la Educación y la Cultura, Artículo 151 expresa: "La Educación es función esencial del Estado para la conservación, el fomento y la difusión de la cultura, la cual deberá proyectar sus beneficios a la sociedad sin discriminación de ninguna naturaleza".

CONSIDERANDO: Que la Secretaría de Educación, desarrolla el modelo pedagógico Escuela Morazánica, mediante el cual se permite la participación de todos los sectores de la sociedad sin discriminación, al igual que el respeto a los derechos de los niños y niñas como un bastión importante del sistema educativo nacional

CONSIDERANDO: Que en la actualidad la Secretaría de Educación impulsa las políticas de Educación Especial, a través de la estrategia de integración de las personas con discapacidad en el Sistema Educativo Nacional y que dentro de las acciones que desarrollan estan previstos procesos para la prevención, detección y atención de problemas.

"La educación es el alma de los pueblos"
Francisca Morazán

Attachment I: Proyecto Toma de Agudeza Visual a Los Niños de
Primer Grado de Honduras

PROYECTO TOMA DE AGUDEZA VISUAL A LOS NIÑOS DE PRIMER GRADO DE HONDURAS

REALIZADO

BAJO LA DIRECCION DEL DR. RAUL GOMEZ,
DIRECTOR FUNDACION INTERNACIONAL DE OJOS.

ELABORADO POR:

1.- LIC. BETULIA CARCAMO

2.- LIC. REINA ONDINA MONTALVAN.

DEL DEPARTAMENTO DE EDUCACION ESPECIAL
DEL MINISTERIO DE EDUCACION

3.- DRA. ZULEMA ALVAREZ.

ENCARGADA DEL PROYECTO MATCHING GRANT.
FUNDACION INTERNACIONAL DE OJOS.

Proyecto

SALUD OCULAR PARA LA NIÑES DE PRIMER GRADO DE HONDURAS

Justificación del proyecto

a) Situación actual

Honduras es un país con 5 millones de habitantes, de los cuales según la O.M.S. Organización Mundial de la Salud, el 10 % adolece de algún tipo de discapacidad, ya sea Mental ó sensorial visual. De éste porcentaje de la población la más afectada es la niñez.

En Honduras nó existen estudios representativos que permitan conocer la magnitud del problema de salud ocular, sin embargo en un estudio pequeño se demuestra que el 9.48 % de los niños en edad escolar presentan alguna alteración en la Agudéza Visual que va desde lo leve, corregible con ayuda visual; hasta las alteraciones severas de la Agudéza Visual. (Estudio: Prevalencia de Transtornos Visuales en niños de uno a diez años en Honduras realizado por INFRACNOVI y el Servicio de Oftalmología del Hospital San Felipe en 1995)

El 22% de los alumnos de primer grado, repiten su primer año escolar por lo menos 3 veces, desconociendo el maestro las causas. por lo que se hace necesario capacitar a los docentes, para que puedan prevenir, detectar, atender, y remitir oportunamente cualquier dificultad visual que afecte el aprendizaje de los niños; evitándo así la reprobación, deserción y repitencia escolar.

b) Situación prevista al terminar el proyecto

Con la ejecución de éste proyecto esperamos que a finales del año 2,000, la totalidad de los niños matriculados en primer grado habran sido evaluados con la prueba de Agudeza Visual.

El proyecto contempla que para lograr los objetivos se capacitarán a 28 maestros del departamento de Capacitación Central, quienes a su vez capacitarán a 6,688 niños de primer grado para que ellos sean los responsables de realizar la prueba de Agudeza Visual a los niños de primer grado. De ésta manera estaremos contribuyendo a llevar la calidad de atención Educativa a los niños y niñas de Honduras.

II - Descripción del proyecto

La Secretaría de Educación a través de la Sección de Educación Especial, conjuntamente con la Fundación Internacional de Ojos, Comité Nacional de Prevención de Ceguera, y en coordinación con la Secretaría de Salud Pública; presenta el siguiente Proyecto

a- A través de éste proyecto se pretende capacitar a los docentes de primer grado de todo el país.

El proceso de capacitación se realizará en tres etapas

Se realizará usando la Estructura de Capacitación establecida por la Secretaría de Educación a través del C.A.D. Centros de Aprendizaje Docente.

Se utilizará una Metodología autoinstruccional donde se le entregará a cada maestro un Manual que contiene el aprendizaje de la toma de Agudeza Visual.

A fin de darle la atención debida al proceso se ha planificado la ejecución del proceso iniciando con un grupo de seis (6) departamentos

- 1- Francisco Morazan.
- 2- Lempira
- 3- Intibuca
- 4- La Paz
- 5- Santa Bárbara
- 6- Comayagua
- 7- Francisco Morazán

La capacitación se realizará en forma progresiva dándole cobertura a todo el país en el término de tres años.

La Capacitación se hará en tres niveles:

Nivel I ó Central

La FIO y Oftalmólogos del Comité de Prevención de la Ceguera, y Personal de Educación Especial del Ministerio de Educación. Realizarán la Capacitación de 28 Técnicos del Personal de Capacitación de la Secretaría de Educación, en el manejo del manual autoinstruccional, su estudio, y aprendizaje de la Toma de Agudeza Visual a los alumnos.

NIVEL II

Este nivel Central capacitará a 1533 coordinadores del CAD de Educación Primaria, utilizando los módulos autoinstruccionales

NIVEL III

Los coordinadores del CAD capacitarán a 6,688 maestros de primer grado, proporcionando el material autoinstruccional y carteles para la prueba de Agudeza Visual.

Igualmente se utilizarán los recursos e instancias locales de la secretaría de Educación para dar seguimiento y supervisión conforme se vayan desarrollando las etapas, el producto esperado es que los niños y niñas de primer grado del Sistema Educativo sean evaluados en su agudeza visual, estableciendo coordinación con la secretaría de Salud - FIO - Comité de Prevención de la Ceguera, alcaldías e instituciones afines a nivel local para dar solución a la problemática encontrada.

b- BENEFICIARIOS PREVISTOS

- 271,076 niños y niñas de primer grado
- 6,688 maestros de primer grado
- 28 técnicos del personal de Capacitación de la Secretaria de Educación
- 1533 coordinadores del CAD.

III- OBJETIVO GENERAL

Mejorar el rendimiento académico de los niños y niñas de Honduras.
Hacer una evaluación Nacional de la Salud Ocular de nuestros niños y niñas de primer grado mediante la toma de la Agudeza visual.

OBJETIVOS ESPECIFICOS

- # 1- Oficializar la toma de la Agudeza Visual, mediante la firma de un convenio Interinstitucional, con la participación del Ministerio de Educación, la Fundación Internacional de Ojos y el Comité de Prevención de la Ceguera.
- # 2- Sensibilizar al maestro y capacitarlo sobre la importancia y la repercusión del Proyecto de Salud ocular en la Educación.
- # 3- Aplicación de la toma de Agudeza Visual a 271,000 alumnos de primer grado.

IV - RESULTADOS

Resultado del Objetivo #1

Establecer como Política Educativa Nacional la Aplicación Obligatoria de la Prueba de Agudeza Visual a todos los niños de primer grado.

Resultado del objetivo # 2

- 1) Docentes con el conocimiento, la habilidad, la destreza de aplicar con responsabilidad la prueba de Agudeza Visual.
- 2) Maestros concientes, y con la mejor disposición de resolver las dificultades de Salud Ocular encontrados en los niños y niñas de primer grado de Honduras.

Resultado del Objetivo # 3

se espera que todos los niños de primer grado de Honduras, hayan sido evaluados con la prueba Visual y que sean remitidos y atendidos oportunamente, con la mejor solución de su problema

v- ACTIVIDADES

Actividades para cumplir con el objetivo #1

- 1- Elaboración, revisión y aprobación del Convenio Interinstitucional.
- 2- Firma del Convenio.

ACTIVIDADES PARA CUMPLIR CON EL OBJETIVO N^o. 1

- Elaboración de un convenio inter institucional para la toma de la Agudeza visual a los niños de primer grado de Honduras.

Para ésta actividad se realizan permanentes reuniones entre el ministerio de educación la fundación internacional de ojos y el comité de prevención de ceguera.

Realizando las revisiones respectivas y aprobación del convenio, previa firma.

- Redacción del proyecto de la toma de agudeza visual con participación del ministerio de salud, fundación internacional de ojos, comité de prevención de ceguera.
- Planificación de la firma del convenio local, protocolo, prensa, organización del brindis, redacción y tiraje de las tarjetas, carpetas conteniendo el convenio, programas, lista de invitados.

ACTIVIDADES PARA CUMPLIR CON EL OBJETIVO N^o. 2

Elaboración del material Educativo pertinente que consiste en.

- a.- Folleto autoinstruccional está redactado con el objeto principal de sensibilizar al maestro e identificarlo con los problemas de salud ocular.
- b.- Realización de las capacitaciones comenzando con el nivel I, haciendo mucho énfasis en sensibilizar a los maestros.

Se realizará en forma viva, con un nó vidente que comparta su experiencia personal con los maestros en la primera capacitación a los 28 técnicos del nivel central.

Se trata de implementar ésta misma actividad a todo el país.

ACTIVIDADES PARA CUMPLIR CON EL OBJETIVO NO. 3

Obj. Aplicación de la toma de la Agudeza visual a 271,000 alumnos de primer grado.

a.- Capacitación de 28 técnicos del nivel central

Personal de F10, Dr. Gómez, Dr. Alvarez

Personal del Ministerio de Educación. Lic. Betúlia Cárcamo, Lic. Reina Ondina Montalván.

Personal del comité de prevención de ceguera, Dra. Alvarado.

Oftalmólogos: Dr. Erhler

Se organizará un taller para capacitar 28 técnicos del nivel central

Se educará sobre:

- Anatomía del ojo
- Enfermedades oculares más comunes
- Prevención de enfermedades oculares

Duración 1 día ;de 8:00 a.m. a 4:30 p.m. (8 horas)

Fecha. Lunes 7 de julio de 1997

Asistentes: 35 personas

Local. Edificio Inice

SE PLANIFICA LA CAPACITACION DE LOS PRIMEROS 6 DEPARTAMENTOS PARA 1997

- 1.- Francisco Morazán
- 2.- Comayagua
- 3.- Choluteca
- 4.- Lempira
- 5.- La Paz
- 6.- Santa Bárbara

CAPACITACION DE FRANCISCO MORAZAN

Vamos a capacitar 178 maestros coordinadores de CAD

Harémos grupos ó equipos de 30 maestros coordinadores de CAD

Los cuales van a ser atendidos por 3 técnicos; utilizando un total de 9 técnicos

(Dándole a los 9 técnicos almuerzo y merienda)

Al interior de la organización C/ técnico trabajará con 10 coordinadores de CAD.

Tiempo probable 25-26 julio 1997

(Revisar calendario escolar).

SIMULTANEAMENTE

EN JULIO (CHOLUTECA)

MANDARIAMOS

3 TÉCNICOS CAPACITARAN A 90

COORDINADORES DE CAD

TRABAJANDO EL EQUIPO

1 TÉCNICO P1 30 MAESTROS

SUPERVISARA - T2 CISNEROS
- T2 GÓMEZ

AGOSTO ESTARIAN CAPACITADOS # 1742
MAESTROS DE 1^{ER.} GRADO

SEPTIEMBRE ALUMNOS 1,688

JULIO 1997 SIMULTANEAMENTE

COMAYAGUA

123 COORDINADORES CAD

IRIAN 4 TECNICOS

CAPACITARIAN

1 TECNICO P1 30 COORDINADORES CAD

3 GRUPOS DE 31 Y 1 DE 30

SE REALIZARIA JULIO 1997

LOS COORDINADORES CAD A LOS MAESTROS DE
1^{ER.} GRADO EN AGOSTO DE 1997

SEPTIEMBRE SE TOMARÍA PRUEBA DE AGUDEZA
V. 14,412

LA PAZ

60 COORDINADORES DE CAD

TRABAJARIAN CON 2 TÉCNICOS

EQUIPO DE 30 COORDINADORES DE CAD POR
TECNICO EN EL MES DE JULIO 1997

EN AGOSTO SE CAPACITARIAN LOS MAESTROS
DE 1^{ER.} GRADO.

EN SEPTIEMBRE SE EVALUARIA LA POBLACION
DE 6,165 NIÑOS

SANTA BARBARA

101 COORDINADOR DE CAD

MANDARIAMOS 4 TECNICOS A SANTA BARBARA

ORGANIZANDO EQUIPOS DE 25

1 TENDRA 26

MES DE JULIO DE 1997

CAPACITACION

MAESTROS DE 1^{ER.} GRADO AGOSTO

P1 SEPTIEMBRE 12,901 NIÑOS YA EVALUADOS

LEMPIRA

MANDAMOS 2 TECNICOS MES DE JULIO

EQUIPOS DE 34 COORDINADORES DE CAD EL
TECNICO.

AGOSTO SE CAPACITAN 9,547 MAESTROS DE
1^{ER.} GRADO LUEGO.

SEPTIEMBRE YA EVALUADOS 9,427 ALUMNOS
DE 1^{ER.} GRADO

Proyecto toma de Agudeza Visual a los niños de primer grado de Honduras

PRESUPUESTO

L. 1 p. 1

Para ejecutar el siguiente proyecto se necesitan un total de L 433.301 00

Para invertir en la elaboración de material L 10,000 Dolares que serán aportados por la FIO.

Elaboración de Material

Levantamiento, diagramación, e ilustración de la Guía.....	5,000
Tiraje de 30,000 módulos	L.39,900.00
8 resmas de papel tamaño oficio.....	L.520,00
Tiraje de 8,000 cartillas de Snellen	L.80,000.00

costo total <i>TRIMERA LATA</i>	L.125,420.00

Costo para fortalecimiento institucional

Reuniones para coordinación y firma del convenio entre fundación Internacional de Ojos. Secretaría de Educación y Ministerio de Salud	L 3,500.00
Supervision y Seguimiento a nivel Nacional	L 23,381.00

11 2000 - - - - - 1706

Supervision y Seguimiento

11 2000 - - - - - 1706

VII- EVALUACIÓN Y MONITOREO DEL PROYECTO

Los indicadores a utilizar en el proyecto serán:

Los indicadores de Proceso:

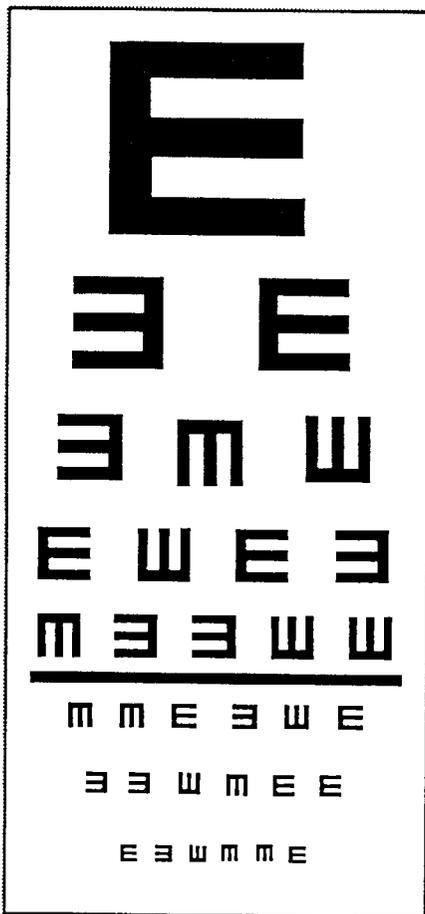
- 1- Fecha y firma del Convenio.
- 2- % y Numero de Técnicos Capacitados.
- 3 - Porcentaje y Numero de Coordinadores del CAD capacitados.
- 4- Porcentaje y Numero de Maestros de primer grado capacitados.
- 5- Material Educativo producido.
- 6- Porcentaje y Numero de Material Educativo distribuido.
- 7 -Carteles de Snellen producidos
- 8- Porcentaje y Numero de Carteles de Snellen distribuidos
- 9- Porcentaje y Numero de Niños evaluados con su toma de Agudéza Visual
- 10- Porcentaje y Número de Escuelas que han completado la toma de Agudéza Visual a los niños de primer grado.
- 11- Porcentaje y Número de datos de la toma de Agududeza Visual ingresados al sistema de Cómputo.
- 12- Porcentaje y Número de niños con Problemas de Agudeza Visual.
- 13- Porcentaje y Número de niños referidos para recibir atención a sus problemas de Agudeza Visual.
- 14- Porcentaje y Número de Niños que yá recibieron tratamiento a su problema de Agudeza Visual.

Los indicadores de Efectividad

- 1- Porcentaje y Número de tomas de Agudeza Visual referidos en forma correcta.
- 2- Porcentaje de reprobación Escolar en alumnos de primer grado en las zonas integradas al proyecto.

Attachment J: Manual Prueba de Agudeza Visual, Republica de Honduras,
Secretaria de Educacion

REPUBLICA DE HONDURAS
SECRETARIA DE EDUCACION



**MANUAL
PRUEBA DE AGUDEZA VISUAL**

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Proyecto

SALUD OCULAR PARA LA NIÑES DE PRIMER GRADO DE HONDURAS

justificación del proyecto

a) Situación actual

Honduras es un país con 5 millones de habitantes, de los cuales según la O.M.S. Organización Mundial de la Salud, el 10 % adolece de algún tipo de discapacidad, yá sea Mental ó sensorial visual. De éste porcentaje de la población la más afectada es la niñez.

En Honduras nó existen estudios representativos que permitan conocer la magnitud del problema de salud ocular, sin embargo en un estudio pequeño se demuestra que el 9.48 % de los niños en edad escolar ppresentan alguna alteración en la Agudéza Visual que vá desde lo leve, corregible con ayuda visual, hasta las alteraciones severas de la Agudéza Visual. (Estudio: Prevalencia de Transtornos Visuales en niños de unõ a diez años en Honduras realizado por INFRACNOVI y el Servicio de Oftalmología del Hospital San Felipe en 1995)

El 22% de los alumnos de primer grado, repíten su primer año escolar por lo menos 3 veces, desconociendo el maestro las causas por lo que se hace necesario capacitar a los docentes para que puedan prevenir, detectar, atender, y remitir oportunamente cualquier dificultad visual que afecte el aprendizaje de los niños evitándo así la reprobación, deserción y repitencia escolar.

b) Situación prevista al terminar el proyecto

Con la ejecución de éste proyecto esperamos que a finales del año 2.000, la totalidad de los niños matriculados en primer grado habrán sido evaluados con la prueba de Agudeza Visual.

El proyecto contempla que para lograr los objetivos se capacitarán a 28 maestros del departamento de Capacitación Central, quienes a su vez capacitarán a 6,688 niños de primer grado para que ellos sean los responsables de realizar la prueba de Agudeza Visual a los niños de primer grado.

De ésta manera estaremos contribuyendo a llevar la calidad de atención Educativa a los niños y niñas de Honduras.

II- DESCRIPCION DEL PROYECTO

La secretaría de Educación a través de la Sección de Educación Especial conjuntamente con la Fundación Internacional de Ojos , Comité Nacional de Prevención de la Ceguera, y en coordinación con la Secretaría de Salud Pública; presenta el siguiente Proyecto.

a-A través de éste proyecto se pretende Capacitar a los docentes de primer grado de todo el país.

El proceso de Capacitación se realizará en tres etapas

* Usando la estructura establecida por la secretaría de Educación a través del C.A.D. Centros de aprendizaje docente.

Con una Metodología autoinstruccional donde se le entregará a cada maestro un manual para el aprendizaje de la toma de Agudéza Visual.

A fin de darle la atención debida al proceso se há planificado la ejecución del proyecto iniciando con un grupo de 4 departamentos; realizandolo en forma progresiva ;dándole cobertura a todo el país en el termino de tres años

NIVEL I ó CENTRAL

* Capacitación a nivel Central

28 técnicos del personal de Capacitación de la Secretaría de Educación

Esta capacitación a nivel central será realizada por personal de la FIO, Educación Especial del Ministerio de Educación, y Comité de Prevención de Ceguera.

NIVEL II

Este nivel Central capacitará a 1533 coordinadores del CAD de Educación Primaria, utilizando los módulos autoinstruccionales

NIVEL III

Los coordinadores del CAD capacitarán a 6,688 maestros de primer grado, proporcionando el material autoinstruccional y carteles para la prueba de Agudéza Visual.

Igualmente se utilizarán los recursos e instancias locales de la secretaría de Educación para dar seguimiento y supervisión conforme se vayan desarrollando las etapas; el producto esperado es que los niños y niñas de primer grado del Sistema Educativo sean evaluados en su agudeza visual, estableciendo coordinación con la secretaría de Salud - FIO - Comité de Prevención de la Ceguera. alcaldías e instituciones afines a nivel local para dar solución a la problemática encontrada.

b- BENEFICIARIOS PREVISTOS

- 271,076 niños y niñas de primer grado
- 6,688 maestros de primer grado
- 28 técnicos del personal de Capacitación de la Secretaria de Educación
- 1533 coordinadores del CAD.

III- OBJETIVO GENERAL

Mejorar el rendimiento académico de los niños y niñas de Honduras.

Hacer una evaluación Nacional de la Salud Ocular de nuestros niños y niñas de primer grado mediante la toma de la Agudeza visual.

OBJETIVOS ESPECIFICOS

- # 1- Oficializar la toma de la Agudeza Visual, mediante la firma de un convenio Interinstitucional, con la participación del Ministerio de Educación, la Fundación Internacional de Ojos y el Comité de Prevención de la Ceguera.
- # 2- Sensibilizar al maestro y capacitarlo sobre la importancia y la repercusión del Proyecto de Salud ocular en la Educación.
- # 3- Aplicación de la toma de Agudeza Visual a 271,000 alumnos de primer grado.

IV -RESULTADOS

Resultado del Objetivo #1

Establecer como Política Educativa Nacional la Aplicación Obligatoria de la Prueba de Agudéza Visual a todos los niños de primer grado.

Resultado del objetivo # 2

- 1) Docentes con el conocimiento, la habilidad, la destreza de aplicar con responsabilidad la prueba de Agudéza Visual.
- 2) Maestros concientes, y con la mejor disposición de resolver las dificultades de Salud Ocular encontrados en los niños y niñas de primer grado de Honduras.

Resultado del Objetivo # 3

se espera que todos los niños de primer grado de Honduras, hayan sido evaluados con la prueba Visual y que sean remitidos y atendidos oportunamente, con la mejor solución de su problema

v- ACTIVIDADES

Actividades para cumplir con el objetivo #1

- 1- Elaboracion , revisión y aprobación del Convenio Interinstitucional.
- 2- Firma del Convenio.

Actividades para cumplir con el objetivo # 2

- 1- Elaboración del material Educativo pertinente

VII- EVALUACIÓN Y MONITOREO DEL PROYECTO

Los indicadores a utilizar en el proyecto serán:

Los indicadores de Proceso:

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Proyecto toma de Agudeza Visual a los niños de primer grado de Honduras

PRESUPUESTO

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costo total L.125,420.00

Costo para fortalecimiento institucional

Reuniones para coordinación y firma del convenio entre fundación Internacional de Ojos. Secretaría de Educación y Ministerio de SaludL 3.500.00

Supervision y Seguimiento a nivel NacionalL 23,381.00

Tegucigalpa, 10 de abril de 1997

DR
RAUL GOMEZ
DIRECTOR DE LA FUNDACION
INTERNACIONAL DE OJOS (FIO)
SU OFICINA

Estimado Dr Gómez

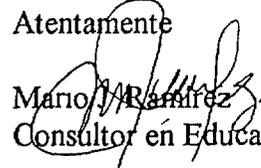
En esta oportunidad le estoy entregando la versión final del Manual para la Prueba de Agudeza Visual, el cual incorpora las sugerencias de las diferentes personas que participaron en el proceso de elaboración

Aprovecho para reiterarle mi agradecimiento por la confianza depositada en mi criterio profesional para la elaboración de dicho material el cual fue satisfactorio realizarlo personal y profesionalmente

Es oportuno a la vez, manifestarle mi disposición profesional para servirle en un futuro cercano en trabajos similares o en procesamiento de datos, encuestas o pruebas que tengo entendido su institución realiza con cierta frecuencia

Con mis más altas muestras de respeto

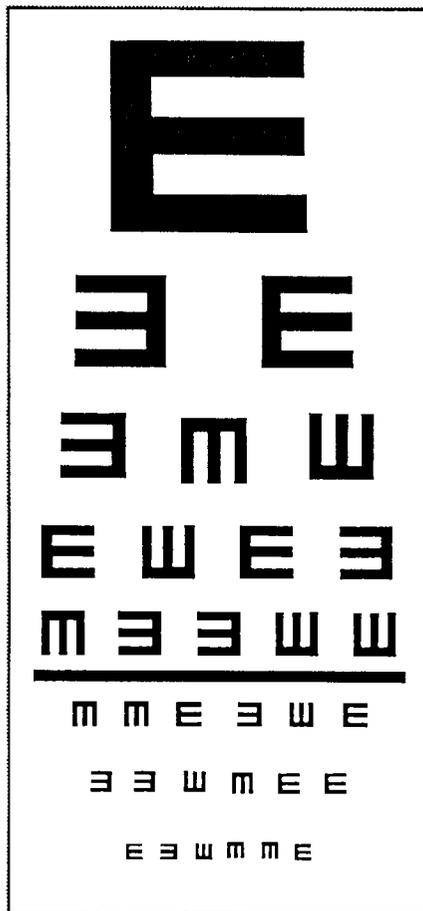
Atentamente


Mario J. Ramírez
Consultor en Educación

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REPUBLICA DE HONDURAS
SECRETARIA DE EDUCACION



**MANUAL
PRUEBA DE AGUDEZA VISUAL**



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PRESENTACION

Estimadas Maestras

Estimados Maestros

Constituye para mi, un verdadera satisfacción poner en sus manos el presente documento didáctico pedagógico “Manual para la Aplicación de la Prueba de Agudeza Visual” que es un recurso valioso que sin duda ustedes sabrán aprovechar en el máximo de sus potencialidades para detectar en forma temprana los problemas visuales que pueden tener las alumnas y los alumnos a su cargo, y de esta manera, tomar la medidas preventivas y correctivas oportunamente, a fin de minimizar los obstáculos en el aprendizaje de los niños y las niñas.

“El Manual para la Aplicación de la Prueba de Agudeza Visual” es producto del esfuerzo mancomunado entre La Secretaría de Educación que me honro en presidir, La Fundación Internacional de Ojos, FIO y El Comité Nacional para la Prevención de Ceguera, instituciones empeñadas en contribuir a mejorar las condiciones de salud ocular de los niños y las niñas que asisten diariamente a la escuela y de quienes depende el futuro de nuestro país.

La Secretaría de Educación está muy consciente que la salud y la educación, son dos elementos de los cuales depende que hayan buenos ciudadanos, por tal razón, esfuerzos como el presente deben ser apoyados en toda la magnitud de su valor

Estimados colegas, les invito para que hagan el mejor uso posible de este documento y de esa manera, no sólo estarás apoyando los esfuerzos de esta Secretaría, sino, asegurando un futuro más saludable para los niños y las niñas que Honduras tanto necesita

¡Salud colegas maestras y maestros!

Licenciada. Zenobia Rodas de León Gómez
Ministra de Educación

INTRODUCCION

Estimado maestro

Estimada maestra

El presente manual metodológico tiene como propósito proporcionarle información sobre la Anatomía del ojo humano, así como guiarle paso a paso para aplicar eficientemente la Prueba de Agudeza Visual a sus alumnas y alumnos, para detectar oportunamente los problemas de visión que puedan estar obstaculizando el aprendizaje

El Manual está organizado en tres partes

PRIMERA PARTE.

Le proporciona información básica sobre la Anatomía ocular.

SEGUNDA PARTE

Le guiará paso a paso para la aplicación de la prueba de Agudeza Visual

TERCERA PARTE

Contiene información sobre algunos consejos útiles para la prevención de la ceguera

METODOLOGIA

La metodología del manual es auto instruccional Es decir, que usted por si mismo, será capaz de aprender y aplicar la Prueba de Agudeza Visual, así como adquirir información sobre la anatomía de los ojos Sin embargo, estudiar el manual en compañía de otra persona, sin duda tendrá mejores resultados

El contenido del manual está presentado mediante una serie de "lecturas cortas", las que debe examinar detenidamente hasta comprenderlas bien Cada lectura tiene definido sus objetivos específicos de aprendizaje

Para obtener el máximo provecho de este manual, es muy importante que siga paso a paso todas las instrucciones que para su comodidad están ubicadas en el lado izquierdo de cada página y responda por escrito las preguntas que aparecen después de cada lectura.

Las preguntas tienen el propósito de reforzar o retroalimentar su aprendizaje y constituyen una forma de autoevaluación que le permitirán controlar el logro de los objetivos de aprendizaje Cada vez que usted responda adecuadamente cada pregunta, significa que está progresando en su aprendizaje

Si tiene dificultad de entender algo cuando esté estudiando el manual, siempre tiene la oportunidad de volver a leerlo cuantas veces crea necesario hasta que pueda responder apropiadamente las preguntas y comprender su contenido.

Adicionalmente, el texto está acompañado de ilustraciones relevantes, las que además de dar una apariencia más atractiva al material, tienen el propósito de proporcionarle información gráfica y reforzar su contenido.

PRIMERA PARTE

ANATOMIA DEL OJO

INSTRUCCIONES**OBJETIVO:**

Al finalizar esta lectura estará en condición de: Reflexionar sobre la importancia que tienen los ojos para las personas.

- 1 Lea cuidadosamente la siguiente porción de texto.

LECTURA # 1**“Una mañana de colores”**

Ese día me desperté más temprano que lo acostumbrado. La oscuridad de la encerrada habitación se disipaba poco a poco por la claridad que penetraba entre las rendijas del techo. De pronto me sentí impulsado a salir al balcón y respirar el aire fresco de la mañana.

Abrí la ventana. La claridad me cegó por un momento. El instinto me hizo colocar una mano ante mis ojos para protegerlos, tratando de evitar que la luz me deslumbrara. Poco a poco mis ojos se acostumbraron a la luz del día y pude apreciar las gotas de rocío que se deslizaban lentamente sobre los pétalos rojos de las rosas, el verde de las hojas, el vuelo ondulatorio de una mariposa amarilla, y a lo lejos, el leve movimiento de los árboles mecidos por el viento.

Aspiré profundo mientras apreciaba con alegría todo el esplendor de la naturaleza con su vestido multicolor. En ese momento me sentí la persona más feliz del universo, porque mis ojos me permitían disfrutar de ese maravilloso espectáculo. Luego me pregunté: ¿Qué sería de mí si no tuviera ojos, o si mis ojos no estuvieran sanos? Sin duda, no podría disfrutar las maravillas de la naturaleza y muchas cosas más que le dan sentido a mi existencia. También me di cuenta que, no obstante lo importante que son mis ojos, no se nada de ellos y probablemente, no estoy haciendo por ellos, lo que ellos hacen por mí. ¡Mis ojos le dan color a mi vida!

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2. Responda las siguientes preguntas.
- ¿Qué significan para usted sus ojos?
 - ¿Qué conocimiento tiene usted acerca de los ojos?



INSTRUCCIONES

OBJETIVO:

Al finalizar esta lectura estará en condición de: Identificar algunas partes externas de la Anatomía del ojo humano.

- 1 Lea cuidadosamente la siguiente porción de texto.

LECTURA # 2

Soy el ojo derecho.

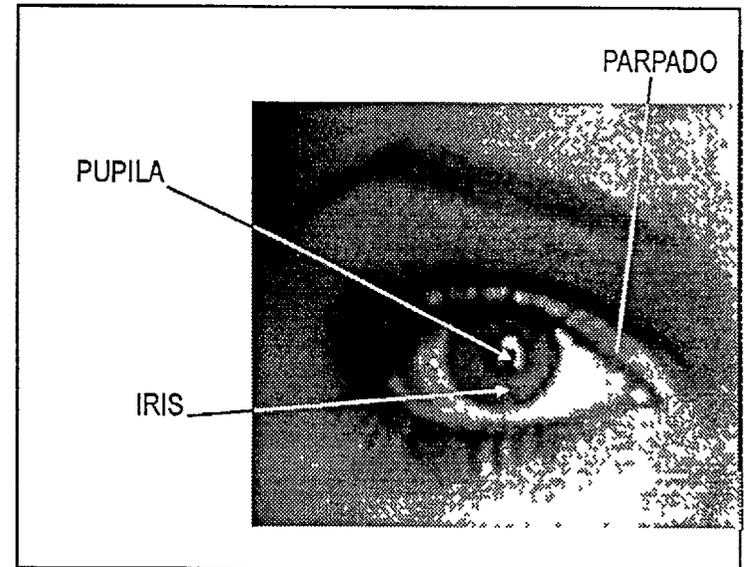
¡Hola amiga! ¡Hola amigo!. Yo soy el ojo derecho

¿Te has preguntado alguna vez cuántos sabes tu de mi vida. ¿De lo que hago? ¿De lo que siento? Probablemente sabes menos de lo que te imaginas. Eso no importa, porque ahora te daré la oportunidad de saber algo más acerca de mí.

Debes prestar mucha atención, porque cuánto más me conozcas mejor puedes cuidarme y mejor puedo servirte.

Aquí en confianza te diré que me siento muy orgulloso de ser uno de los órganos más importantes del cuerpo humano. Vivo muy feliz en una casita llamada órbita. No es más que un hueco en los huesos de la cara, pero para mí es la mejor casa del mundo. Al par mío vive en la otra casa mi hermano gemelo. Es el ojo izquierdo. Nos llevamos muy bien y trabajamos juntos en equipo. Como se dice, el mal del uno es el mal del otro. Nos alegramos juntos, reímos juntos, lloramos juntos, en fin, somos la pareja perfecta. Como somos gemelos, hacemos lo mismo y tenemos lo mismo.

Tenemos nuestro propio personal de protección y de aseo que son los párpados. Ellos se encargan permanentemente de mantenernos limpios y húmedos. Si no fuera por ellos estaríamos secos y eso nos provocaría la muerte. Además, los párpados nos protegen de la luz excesiva y de cualquier daño o lesión que provenga del exterior. No se que haríamos sin los párpados, son nuestros guardianes permanentes.



- 2 Responda las siguientes preguntas
 - a. ¿Cómo se llama el hueco que está en el hueso de la cara, donde está ubicado el ojo?
 - c. ¿Qué funciones desempeñan los párpados con relación a los ojos?
 - d. ¿Qué puede ocurrir si los párpados no lubrican el ojo con las lágrimas?

INSTRUCCIONES

- 1 Lea cuidadosamente la siguiente porción de texto

OBJETIVO:

Al finalizar esta lectura estará en condición de: Identificar algunas partes de la anatomía interna del ojo humano.

LECTURA # 3**El ojo izquierdo.**

¡Hola amiga! ¡Hola amigo! Soy el ojo izquierdo Hermano gemelo de mi vecino, el ojo derecho. No lo van a creer, pero a pesar de vivir tan cerca uno del otro y que sólo tenemos la nariz de por medio, nunca nos hemos visto en la vida, sin embargo, nos llevamos muy bien porque hacemos el trabajo juntos

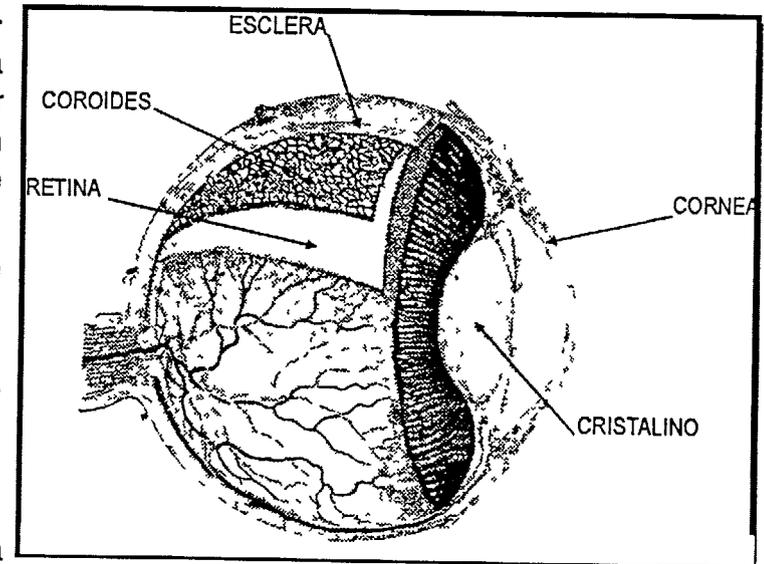
Yo te enseñaré algunas cosas más de las que ya te enseñó mi hermano

Al igual que mi hermano, soy un órgano maravilloso del cuerpo humano, puedo registrar colores, apreciar distancias, realizar enfoques muy rápidos. Si no fuera por nosotros, no podrías apreciar el color de las rosas, mirar las estrellas en el infinito, ni leer tu revista favorita

Ojo es nuestro nombre más común por que el cual tú nos conoces, sin embargo, la parte redonda de nuestro cuerpo tiene un nombre más elegante que es "Globo Ocular" ¿Qué les parece? Bonito nombre, ¿verdad?

Pues bien, déjenme decirles que "El Globo Ocular", lo tenemos formado por tres capas de afuera hacia adentro que son La Esclerótica y La Cornea, la Uvea y la Retina Estudiemos cada una de ellas

a La Esclerótica y La Córnea Es la capa exterior del ojo y por lo tanto la más visible Es muy dura,



INSTRUCCIONES

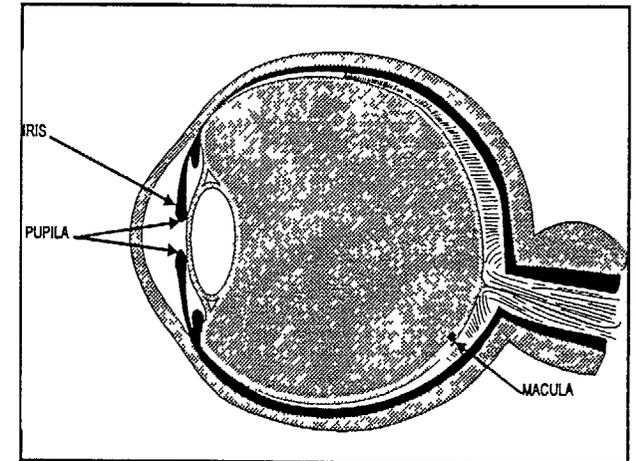
por eso le da consistencia al ojo Sirve de protección y es la base para las otras estructuras Esta capa es la que está en contacto permanente con el párpado

La Córnea, es la parte transparente, por tal razón los rayos de luz penetren en mi interior Se asemeja al vidrio de un reloj.

La Esclerótica, es blanca y opaca. En la Esclerótica se insertan los músculos oculares y está atravesada en su parte posterior por el nervio óptico y vasos sanguíneos

b La capa siguiente es la Uvea Está conformada por varias partes, sin embargo, sólo les hablaré de una de ellas... El Iris.

Sin duda, más de alguna vez te han dicho algún piropo como "¡Qué hermosos ojos negros tienes!", o "¡Me encantan tus ojos verdes!". Por supuesto, mi hermano y yo nos ponemos felices. Pues bien, cuando mencionan el color de los ojos, en realidad se están refiriendo a **El Iris**, que dependiendo de la cantidad de pigmento que tenga, así es el color.



El Iris es muy importante para nosotros, porque regula el paso de la mayor o menor cantidad de luz hacia nuestro interior, a través del orificio central llamado **pupila** Entre el Iris y la Córnea hay un espacio llamado cámara anterior. Esta cámara está llena de un líquido con apariencia de agua llamado **Humor Acuoso**

c La más interna de las capas es **La Retina** Es realmente una continuación del cerebro Su constitución es de origen nervioso y en ella se encuentran los receptores sensibles a la luz que son los conos y los bastones

La Retina cubre la mitad posterior del ojo Con el resto de La retina se percibe la visión periférica La zona de visión central con la que ves los colores es llamada "**Mácula**". Significa que cualquier lesión o daño en la "Mácula" nos pone en problemas porque se produce un grave trastorno de la visión y no podemos cumplirte.

Estas son algunas de las partes internas que tenemos. Desde luego que hay otras como los

INSTRUCCIONES

cuerpos ciliares, procesos ciliares, músculos ciliares, etc, sin embargo, para ser justo, no debo olvidar dos partes que son muy importantes: El Cristalino y el Humor Vítreo

El Cristalino es la lente del ojo. Es completamente transparente, de estructura biconvexa (con curvatura hacia afuera en ambos lados) y está colocado inmediatamente detrás de El Iris. Es la parte más dinámica del enfoque de la visión. Es el que te permite ajustar tu enfoque visual en determinada dirección.

El Humor Vítreo, es una sustancia de consistencia gelatinosa, normalmente es casi transparente que rellena la parte posterior del ojo. Está ubicado entre El Cristalino y La Retina.

- ¿Que les parece?- Como pueden darse cuenta no somos cualquier cosa. Estamos formados por diferentes partes. Cada una de ellas cumple una función importante.

¡Siéntete dichoso que gracias a nosotros, tu puedes gozar del privilegio de la visión!

2. Responda las siguientes preguntas
 - a. ¿Cuáles son las capas que forman el Globo Ocular?
 - b. ¿Por qué la Córnea permite el paso de la luz al interior del ojo?
 - c. ¿Qué función desempeña la Esclerótica en el ojo?
 - d. ¿Qué función desempeña El Iris?
 - e. ¿Que puede pasar si la Mácula sufre una lesión?
 - f. ¿Que función desempeña el Cristalino en el ojo?

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SEGUNDA PARTE

LA PRUEBA DE AGUDEZA VISUAL

INSTRUCCIONES

Los números fraccionarios y siglas que pueden registrarse según el resultado de la prueba son los que a continuación se describen:

- 20/20
- 20/25
- 20/30
- 20/40
- 20/50
- 20/70
- 20/100
- 20/200

2. Conteste las siguientes preguntas:
 - a. ¿Qué es la Prueba de Agudeza Visual?
 - b. ¿Qué es el cartel de Snellen?
 - c. ¿Qué es la hoja para registro de agudeza visual?
 - d. ¿Cuál número fraccionario de los listados en la cartilla de Snellen representa el mayor grado de agudeza visual.
 - e. ¿Qué sigla representa el menor grado de agudeza visual o de visión?
3. Observe cuidadosamente su cartilla de Snellen y compruebe que tiene los números fraccionarios descritos anteriormente.

C.D (Cuenta dedos)

M.M. (Movimiento de mano)

P.L. (Percepción de la Luz) Grado mínimo de visión.

N.P.L. (No percibe la luz) Ausencia de visión.

El grado máximo de agudeza visual o de visión es 20 sobre 20 (20/20) y el grado mínimo es "No Percibe la luz" (N.P.L)

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INSTRUCCIONES

OBJETIVO:

Al finalizar esta lectura estará en condición de: Explicar el significado de los diferentes números fraccionarios que representan los grados de agudeza visual en la Cartilla de Snellen.

- 1 Lea cuidadosamente la siguiente porción de texto

LECTURA # 5

Los grados de agudeza visual.

De acuerdo a la Cartilla de Snellen, todos los grados de agudeza visual o de visión se representan por números fraccionarios como. 20 sobre 20, 20 sobre 50, 20 sobre 200, etc Estas fracciones tienen su interpretación de la manera siguiente.

El numerador, significa la distancia en pies a la que la persona que se está examinando está ubicada con relación al cartel.

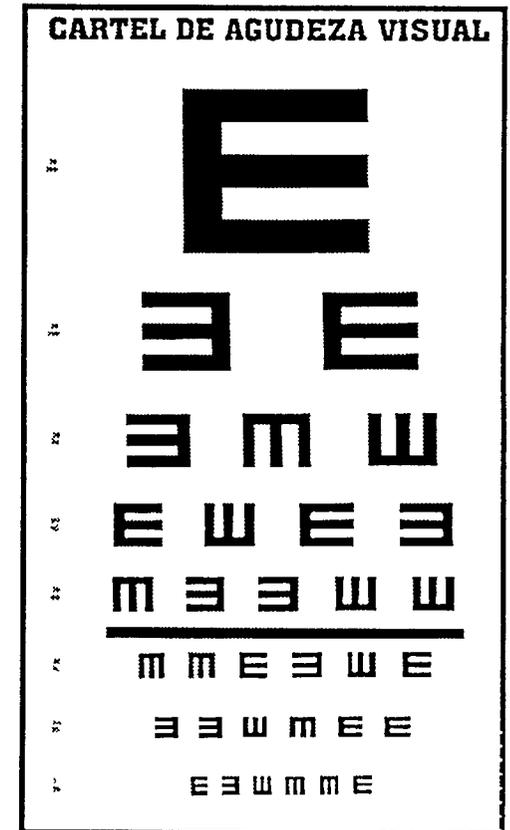
El denominador, significa la distancia a que ese símbolo debería ser visto por una persona de visión normal (Ejem. 70, 200, 20, etc)

Sí una persona sólo mira 20/70 significa que mira a 20 pies lo que los normales miran a 70 pies

2. Conteste las siguientes preguntas:
 - a. ¿Qué significa el numerador en una fracción determinada en cualquier grado de agudeza visual?
 - b. ¿Qué significa el denominador en una fracción determinada en cualquier grado de agudeza visual?
3. Interprete y explique el siguiente resultado de agudeza visual

Después de hacerle la prueba de agudeza visual a Roberto, los resultados fueron los siguientes

- O D (ojo derecho) 20/50
- O S (ojo izquierdo) 20/60



INSTRUCCIONES

1. Lea cuidadosamente y siga las instrucciones que a continuación se detallan para la aplicación de La Prueba de Agudeza Visual.

OBJETIVOS:

Al finalizar esta lectura estará en condición de:

1. Identificar las condiciones previas a la aplicación de la prueba de Agudeza Visual.
2. Identificar los materiales necesarios para la aplicación de la Prueba de Agudeza Visual.

LECTURA # 6

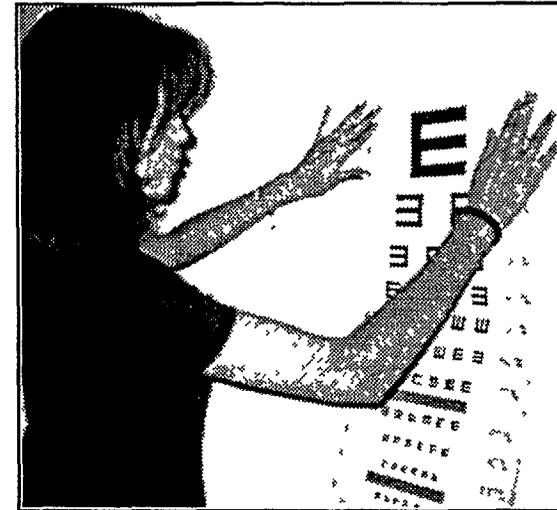
Condiciones, elementos necesarios y actividades previas.

Antes de efectuar La prueba de Agudeza Visual debe disponer de lo siguiente

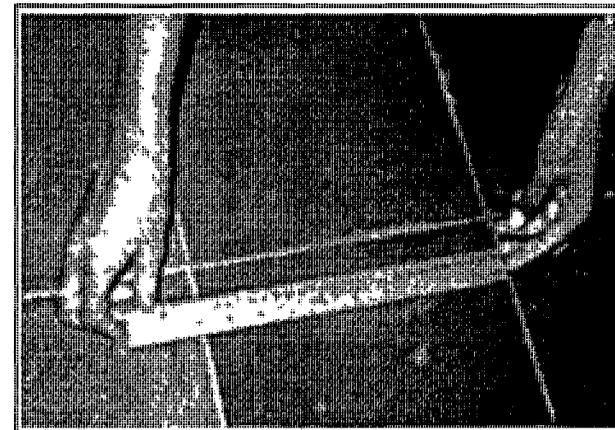
- a. Un lugar adecuado, suficientemente espacioso y con suficiente iluminación (preferiblemente luz natural) donde realizará la prueba.*
- b. la cartilla de Snellen.*
- c. hojas de registro de agudeza visual*
- d. un lápiz tinta o carbón.*
- e. tachuelas, grapas o cinta adhesiva.*
- f. un pedazo de tiza*
- g. una regla de 12 pulgadas. (Cada regla de 12 pulgadas equivale a 1 pie.)*

Actividades previas a la aplicación de la Prueba de Agudeza Visual.

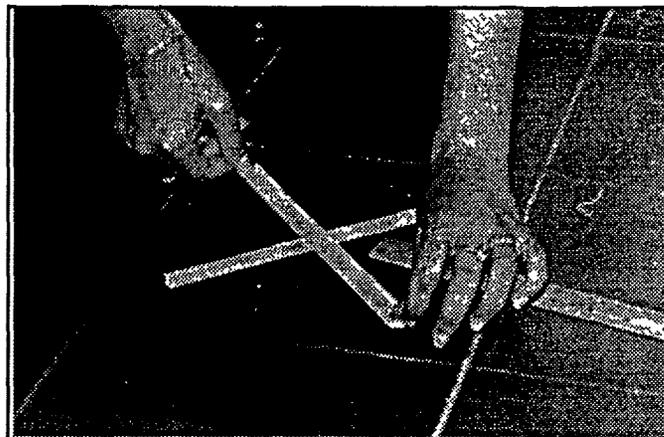
1. Pegue el cartel de Snellen en la pared y asegúrese que esté colocado a la misma altura de los ojos de las personas que va a examinar y que no hayan reflejos luminosos hacia el examinado.



2. Tome una distancia de 20 pies o 20 reglas de longitud entre el punto donde se colocará al alumno (a) y el cartel colocado en la pared. (utilice la regla para medir)



3. Marque con tiza o un pedazo de cinta adhesiva el punto exacto donde se colocará el alumno o alumna.



Ahora, ya está listo o lista para aplicar las pruebas a sus alumnos. ¡Buena Suerte!

INSTRUCCIONES

Objetivo:

Al finalizar la lectura usted estará en condición de: Aplicar sin dificultad la Prueba de Agudeza Visual.

1. Lea cuidadosamente la siguiente porción de texto.

LECTURA # 7

La Aplicación de la Prueba.

Usted está a punto de realizar una actividad de mucha importancia que le permitirá diagnosticar con la mayor certeza posible el grado de visión de sus alumnas y alumnos, mediante la aplicación de la **Prueba de Agudeza Visual**, en consecuencia, debe estar muy consciente que la tarea debe hacerla con la más absoluta seriedad profesional

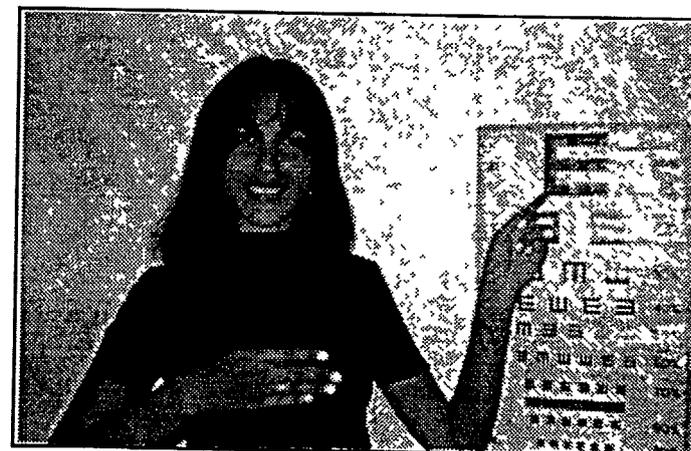
Recuerde que dependiendo del cuidado con que usted aplique la prueba los resultados serán buenos o malos. Desde luego, se desea que sean buenos.

Antes de proceder a tomar la prueba, debe tomar en cuenta las siguientes advertencias muy importantes.

- a Que todo niño o niña al ser sometido a cualquier tipo de prueba, manifiesta cierta ansiedad, inquietud o nerviosismo, lo cual es perfectamente normal, por consiguiente, hágalo sentirse en confianza. Entre más relajado esté el niño o la niña, los resultados de la prueba serán más confiables
- b Que todos los niños y las niñas deben tener limpias las manos antes de someterse a la prueba ya que las utilizarán para cubrirse los ojos en el momento oportuno.
- c Que la prueba se toma a cada ojo por separado. Primero al ojo derecho y después al ojo izquierdo
- d Al momento que el niño o la niña se cubra el ojo, debe hacerlo con la palma de su mano. Asegúrese que no haga presión sobre el ojo. Sólo debe cubrirlo bien y sin rotar la cabeza
- e Que la prueba debe aplicarse con y sin anteojos o espejuelos (En caso de que algún niño o niña use anteojos)
- f Que la identificación de los símbolos debe hacerla el niño o la niña sin vacilaciones, sin dudas. En el momento que usted observe cualquier duda o vacilación en el niño o la niña para identificar determinado símbolo, debe retroceder e indicar de nuevo el símbolo inmediato anterior y pedirle que lo represente.

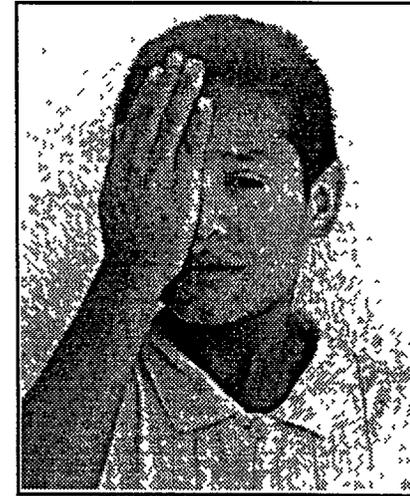
Tomando en cuenta los anteriores advertencias, puede proceder a aplicar la prueba, para lo cual debe seguir concienzudamente las instrucciones que a continuación se le presentan

1. Pida al alumno o alumna que se coloque en el punto indicado mirando hacia el cartel que está colocado en la pared. (Este punto usted lo marcó durante las actividades previas a la aplicación de la prueba)
2. Escriba claramente el nombre completo del alumno o de la alumna con sus datos generales en la hoja de registro.
3. Pídale que observe por un momento el cartel que está colocado frente a ella (o él) para que se familiarice.
4. Pídale que indique con su mano la posición del símbolo o los símbolos que ve en el cartel
5. Explíquelo claramente que usted le irá señalando uno a uno los símbolos en el cartel.
6. Explíquelo que el o ella deberá representar con su mano, la posición de cada símbolo que usted le señale, para comprobar que el símbolo ha sido correctamente identificado. (asegúrese que el alumno o la alumna comprende esta indicación. Si usted considera que tiene duda en comprenderla, explíquelo nuevamente hasta que la comprenda)



En este punto comienza la verdadera aplicación de la prueba

7. Pídale que coloque la palma de su mano derecha sobre el ojo derecho para cubrirlo. Recuerde que no debe presionar el ojo, sólo cubrirlo. (Muéstrelle como hacerlo). Con la mano que queda libre, representará la posición de cada símbolo que usted le señale.



8. Señale el primer símbolo (el más grande que aparece en la parte superior de la cartilla) y pídale que represente su posición con la mano. Si la identificación del símbolo es correcta, pase a la siguiente fila de símbolos.



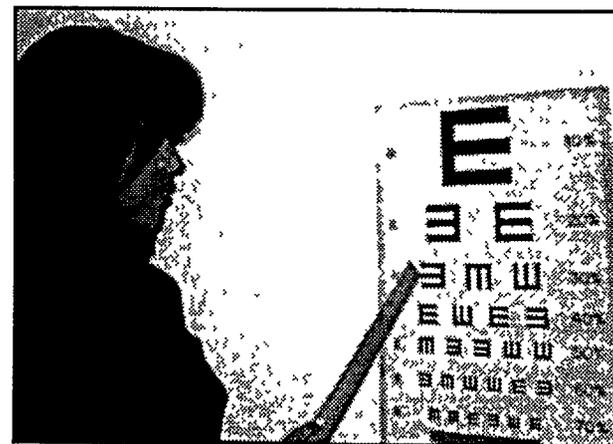
9. Señale el primer símbolo de la segunda fila. Pídale que represente su posición con la mano. Si la identificación es correcta, pase al siguiente símbolo de esa fila.



10. Señale el siguiente símbolo de la segunda fila. Pídale que represente su posición con la mano. Si la identificación es correcta, pase a la siguiente fila.



11. Señale el primer símbolo de la tercera fila.
Pídale que represente su posición con la mano. Si la identificación es correcta, pase al siguiente símbolo de esa fila.



Este mismo procedimiento debe hacerlo con cada símbolo de cada fila, hasta el momento en que usted observa que el alumno o alumna tiene dudas en identificar determinado símbolo.

Cuando el alumno o la alumna tiene dudas en identificar determinado símbolo de determinada fila, entonces señale de nuevo el símbolo inmediato anterior y pídale que lo represente. Si lo identifica correctamente, señale de nuevo el símbolo donde usted observó duda en identificarlo.

Si la duda vuelve a ocurrir, (como es seguro que ocurrirá) significa que hasta ese punto de la cartilla es donde el alumno es capaz de identificar símbolos sin dificultad, por lo tanto, ese es el máximo grado de agudeza visual para el ojo derecho. En ese momento, observe cuidadosamente el número fraccionario que está colocado antes de esa fila de símbolos.

Si el alumno es capaz de identificar más de la mitad de los símbolos de esa fila, la debe considerar restando los que ha fallado. Ejemplo O D. 20/50-2

12. Escriba en la hoja de registro, en la casilla correspondiente al ojo derecho (OD) de ese alumno, el número fraccionario que aparece al principio de la fila de símbolos hasta donde el niño o la niña fue capaz de identificar sin dificultad.



Una vez finalizada la prueba para el ojo derecho, proceda a aplicarla para el ojo izquierdo siguiendo exactamente los mismos pasos.

TERCERA PARTE

CONSEJOS UTILES

INSTRUCCIONES

OBJETIVO:

Al finalizar esta lectura, usted estará en condición de: Utilizar algunos consejos útiles para la prevención de la ceguera.

1. Lea cuidadosamente la siguiente porción de texto.

LECTURA # 8

Consejos útiles para la prevención de la ceguera.

1 Exija diariamente de sus alumnos una estricta higiene corporal, particularmente de las manos, la cara y especialmente de los ojos

Recuerde que las moscas son atraídas por la suciedad y pueden llevar las infecciones de una persona a otra.

2 Aconseje a sus alumnos y a sus alumnas que “no” usen trapos sucios para limpiarse la cara, ni frotarse los ojos con las manos sucias. Las infecciones del ojo generalmente se transmiten de una persona a otra.

3 Prevenga y hasta donde se le sea posible, vigile para que sus alumnos y sus alumnas durante estén en la escuela no utilicen objetos inadecuados para jugar como: piedras, palos, cal, arena, tierra, etc, que puedan ocasionarles graves daños a los ojos accidentalmente.

4. Instruya a las madres de familia para que proporcionen una dieta adecuada a los niños principalmente en la etapa de lactancia. Una dieta inadecuada puede ser causa importante de ceguera.



INSTRUCCIONES

OBJETIVO:

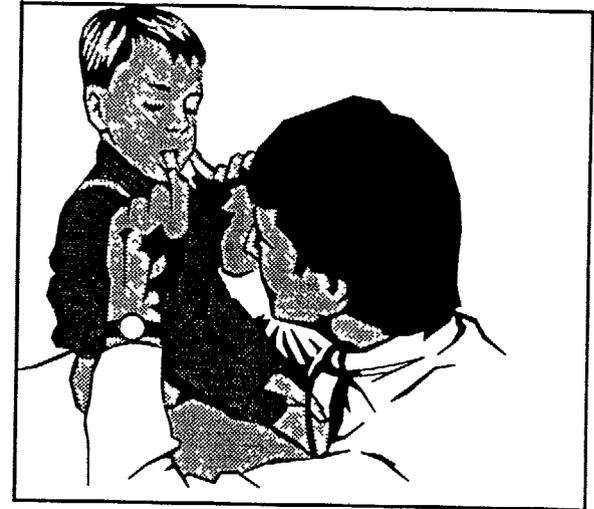
Al finalizar esta lectura, usted estará en condición de: Utilizar algunos consejos útiles para prevenir enfermedades oculares.

1. Lea cuidadosamente la siguiente porción de texto.

LECTURA # 9

Consejos útiles para prevenir enfermedades oculares.

1. Fomentar y enseñar a los miembros de la comunidad hábitos de higiene personal.
- 2 Promover un saneamiento ambiental satisfactorio mediante la adecuada eliminación de desechos.
3. Orientar a las madres y a los padres sobre la alimentación adecuada de sus familias y estimular para que cada familia cultive su propio huerto.
4. Concientizar a los miembros de la comunidad para que dispongan de un adecuado abastecimiento de agua potable o que hiervan el agua.
5. Orientar a las madres para que acudan a la vacunación de sus niños y sus niñas contra el Sarampión.



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El Manual para la aplicación de la Prueba de Agudeza Visual fue elaborado y publicado con el Patrocinio de La Fundación Internación de Ojos , FIO, como una colaboración para las maestras y los maestros de Educación Primaria de Honduras para beneficio de las niñas y los niños.

Dr. Raúl Gómez
Director de FIO

Asesoría técnica y revisión:

Dra. Dons Alvarado.

Comité Nacional de Prevención de Ceguera

Dr. Mario León Gómez

Comité Nacional de Prevención de Ceguera

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Profesora: Reina Ondina Montalván

Secretaría de Educación

Redacción, diseño, diagramación y metodología:

Mario J. Ramírez.

Consultor en Educación

Modelo: Heleci Anidomíng

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Attachment K: ChildSight Workshops in Sanarate, Guatemala

REPORTE DE TALLER DE CHILDSIGHT

SANARATE, EL PROGRESO

ESCUELA NO. 1: JUEVES, 3 DE JULIO DE 1997

ESCUELA NO. 2: MARTES, 22 DE JULIO DE 1997

DR. EDGAR ORLANDO OLIVA

CHILDSIGHT

Objetivo 2

Hacer 4 Talleres para Médicos, Enfermeras u otro personal de salud en 4 áreas para identificación, tratamiento y referencia de niños con problemas oculares

Estos talleres fueron llevados a cabo en un período de 2.5 horas cada uno, se contó con la presencia de 20 maestros participantes en la escuela No. 1 (3/Julio/97) y 18 maestros en la escuela No. 2 (22/Julio).

Se dieron pláticas dirigidas con ayudas de audiovisuales, modelos plástico del ojo y carteles de Snellen. Los temas impartidos fueron los siguientes:

- Anatomía y fisiología del ojo.
- Agudeza Visual.
- Enfermedades Oculares más comunes en niños.

Durante las conferencias hubo mucha participación por parte de los maestros acerca de problemas visuales que ellos han encontrado en sus alumnos y familiares, se hizo además una pequeña práctica para la toma de agudeza visual.

Al final hablamos sobre la forma en que podemos ayudar a los niños que sean detectados con problemas visuales, yo ofrecí evaluar sin costo alguno en la clínica de Sanarate a los que tengan disminución de la agudeza visual, conseguir un descuento alto de 20% para los que necesiten anteojos y además referir a los Hospitales Rodolfo Robles y Roosevelt a los que necesiten tratamiento quirúrgico.

Los maestros me preguntaron que si IEF podría ayudar con gastos a algunos de los niños a lo que respondí que investigaría esta posibilidad.

Se repartió además el siguiente material educativo:

- Ojo con su visión
- Glaucoma (Solapado Ladrón de la Visión)
- Qué es Estrabismo?
- Instructivo para el Examen de Agudeza Visual en visión lejana para capacitación de personal de atención primaria ocular.
- Cataratas
- Retinopatía Diabética
- Indicaciones de Posibles Problemas de la Vista en los Niños.
- Primeros auxilios para casos de emergencia de la vista.
- Ojo con su Visión!

Adjunto el programa y listas de asistencia de participantes.

SEGUIMIENTO

ESCUELA No. 1

Total de alumnos evaluados por los maestros: 700

Total de alumnos que necesitan evaluación por oftalmólogo: 51 ó 7.28%.

Total de alumnos que asistieron a la evaluación oftalmológica: 37, 5.28% de la población total, 72.55% de los que necesitaban evaluación, el porcentaje que no acudió fue por negligencia de los padres.

Diagnósticos en los 37 alumnos evaluados:

Quiste Dermoide	1
Ametropía	17
Conjuntivitis Alérgica	8
Blefaritis	1
Toxoplasmosis Inactiva	1
Niños Normales	4
Cataratas Congénitas	1
Estrabismo	3
Ambliopía	2

Conducta tomada con los 37 alumnos evaluados:

Receta de Lentes	16
Receta de Medicamentos	9
Referido a Hospital para Cirugía	3

ESCUELA No. 2

Total de alumnos evaluados por los maestros: 800

Total de alumnos que necesitan evaluación por oftalmólogo:
44 ó 5.50%.

Total de alumnos que asistieron a la evaluación oftalmológica: 33, 4.12% de la población total, 75% de los que necesitaban evaluación, el porcentaje que no acudió fue por negligencia de los padres.

Diagnósticos en los 33 alumnos evaluados:

Microftalmos	1
Ametropía	19
Blefaritis	1
Niños Normales	10
Estrabismo	3

Conducta tomada con los 37 alumnos evaluados:

Receta de Lentes	17
Receta de Medicamentos	1
Referido a Hospital para Cirugía	1

Attachment L: Trip Report, Albania February 1997, John Barrows

NOT FOR GENERAL DISTRIBUTION

Trip Report

John M. Barrows, Director of Programs

Tirana, Albania, February 22-28, 1997

I. Purpose:

- 1 Make arrangements to replace Garth Pollock.
2. Review all activities and plan remaining joint activities for 1997.

II. Schedule:

Arrival in Tirana was Saturday February 22nd accompanied by Dr. May Khadem, Health for Humanity, for a joint visit. Departure was scheduled on Friday 28th in the afternoon. Garth Pollock, representing both IEF and HH and Dr. Suleman Zhugli met us at the airport and worked with us throughout the week. The scheduled visits to Vlore and Shkodra were canceled due to the increasing violence.

Note that the departure from Tirana, was the day before planned large scale public demonstrations in central Tirana and elsewhere in the country, which later erupted in anarchy. All plans made during this week for 1997 were considered provisional depending on government and civil stability. Everyone we meet during the week was extremely preoccupied with weakening government control, open demonstration and violence, and fiscal crisis due to the collapse of the pyramid schemes. Nearly everyone in Albania invested in one or more of the schemes at some level.

III. Activities:

Administration

1 Shipment. The status of the most recent shipment of equipment sent by IEF for HH was reviewed. While the shipment arrived in port (Duess), it has still not cleared customs. Equipment, purchased by IEF for Health for Humanity, includes a diode laser and a Haag-Streit slit lamp with laser coated lenses, a yag laser, a phacoemulsification unit, books, journals, and audio tapes. All of the administrative procedures for clearing customs are under review by the government, resulting in the need for a general Agreement needed to function as a NGO in Albania. The language of the agreement was advised to be somewhat general in order to allow future shipments to clear customs without additional restrictions. In other words, "surgical supplies" would be sufficient to describe what kinds of materials might be sent to Albania in the future. Garth anticipates that the shipment will be processed very soon but advises that he will send a memorandum outlining guidelines to expedite future shipments. There are plans to equip three additional secondary centers in 1997.

2. Replacement of Garth: Garth is planning to leave Albania for Uganda to work on other activities. The immediate issue is replacing Garth and the important role he plays in representing both organizations. It was agreed that Ms. Mirela Protopapa, identified by Garth and already working for Garth as an assistant, officially replace him. Mirela will provide continuity for basic administrative tasks and is also well accepted by Dr. Zhugli and others at the hospital. Garth will write a job description. Joint support was discussed by IEF and HH for the remainder of project funding. Garth will be missed by everyone and deserves special recognition for his commitment to Albania during the past four years.

Residents/Staff Training:

1. A meeting was held at the hospital to discuss accomplishments, gain input on their perspective of important issues, and allow residents to air issues to their advisors.

Record keeping -- Garth has been working with Dr. Zhugli in development of simple form to record complete eye examination to be used at the hospital to maintain better records on patient diagnosis, treatment and referral. While, this appears simplistic, there are few records kept at the hospital that can provide meaningful data for hospital management use. There appears to be agreement that these forms are needed, but there does not appear to be strong reinforcement of their use. This is an area needing continuous improvement concentrating with the residents.

Equipment -- There continues to be need to improve equipment needs at the hospital and secondary centers. However, the existing equipment is being put to good use. There continue to be repair problems with some equipment, lack of spare parts, and the technical ability to make the repairs. The new Alliance slit lamp has a problem with the reostate and needs a new replacement; the perimeters sent in 1994 are still inoperable due to damage in transit.

Training -- There was agreement that training has greatly improved since starting both projects. The visiting Professors are appreciated and provide needed information and skills. The schedules of visiting Professors needs to be better coordinated to be consistent with the working hours of the residents and staff (visitors demand long hours and work on weekends).

Residents training. Currently there are 14 residents, but there was the suggestion that 10 is a better number considering space and teaching facilities while others felt that 20 was the optimum number. Dr. Zhugli felt the need for 10 in order to maintain a minimum level of quality in teaching. There was considerable discussion regarding how to make the residents more active and motivated by adopting a system whereby the resident learn the practice of complete examination by examining 1-2 patients before presenting their findings to their senior for feedback. Practice eyes can assist residents improve skills in use of equipment and in examination. An expanded library and hours of access to the library were requested.

There needs to be a system of rotations by the secondary centers through the UEC and continued emphasis on screening, complete examinations, referral and preventative measures. There was continued discussion of the new forms drafted by Garth and Dr. Zhugli. Many simply do not understand the importance of good record keeping. There was discussion that the record keeping be obligatory at the University Clinic but that it would be difficult to require from the districts. There was the suggestion to simply the form to a card size, insist on its use by residents, and review use after 3-6 months time.

Suggestions to improve understanding of the need for records were raised that include providing greater use of computer for record keeping and requesting that Dr. Paul Courtright, during his scheduled visit to plan the prevalence survey, provide a seminar on basic data use and epidemiology. Tirana and other districts could also begin keeping basic statistics to monitor numbers of patients seen, referrals made and improvements.

IAPB Congress/Budapest meeting -- Dr. Zhugli and 1-2 colleagues will attend the International Agency for Blindness Prevention (IAPB) regional eastern European meeting in Budapest, in conjunction with the European Ophthalmological Society, in June. This will provide the opportunity to know more about what other countries are doing and exchange ideas and concerns.

Workshops:

1 PHARE: Preliminary plans to provide basic eye training to the family/general physicians under the PHARE program was reviewed. The purpose of incorporating the eye care training into this program was to meet objectives for Childsight training. Although, the PHARE physicians are general and family physicians, they are the first contact the majority of persons have with the health system. The PHARE program, funded by the EU and others, will reach four districts, Shkodra, Vlore, Tirana, and Kurce. A total of 500 of 1,615 general physicians (31%) will be re-trained in pediatrics, gynecology, geriatrics and public health during 5 hour per day 5 day a week training. The scheduled rounds for training are:

<u>Round</u>	<u>Dates</u>	<u>Number to be trained</u>
1st	completed	
2nd	December 17 - March 15	currently ongoing
3rd	March 18 - June	102 (eye care training planned to start in this phase)
4th	June 4 - September	99
5th	September 5 - November	98
	Totals	298

It was accepted that the third phase allow 1-2 day module on eye care basics using the existing training facilities supported by PHARE. We discussed the possible need for a preliminary TOT for the Task Force members to become the trainers, but it was agreed that there are sufficient materials provided by IEF to design the training. The Task Force should be responsible for designing the module, organizing and conducting the courses. The basic topics should be basic eye care signs etc, common childhood problems and common adult problems (cataract identification, diabetes referral).

2. Pediatricians. The plans to provide basic eye training to the pediatric residents at the University Eye Clinic was reviewed. The purpose of incorporating the eye care training into this program was to meet objectives for Childsight training

Currently, the pediatrics program of the University Eye Clinic has more than 40 residents in training. Training is four years. Dr. Debechi, Chief Pediatrician (Dr Pascal Cullofja, Director of the Pediatric Hospital was out) was supportive of the idea and proposed that topics on eye care be introduced in the year three and four of the program. There could easily be exchanges between both departments. It was suggested that in one week, five lectures and 20-25 hours of practice could be arranged for qualified residents. Materials needed would be a vision chart, pen light and topics would include visual screening, basic eye examination, objective refraction, common childhood problems (amblyopia, squint, cataract etc), and referral.

There are also a meetings of the Pediatric Society during the year where up to 150 persons attend. These meetings could be potential vehicles for information dissemination. A group of core trainers to interact with pediatricians in training was also discussed. Members from the University Eye Clinic or the Task Force should provide the training.

3. NBPC support: A Task Force of the National Blindness Prevention Committee was formed to take greater responsibility and day to day actions to further program activities. It was planned to support 2-3 one day meetings in Tirana to support their planning and meeting activities.

The Task Force was created to be more independent of the National Committee and to undertake activities. Members of the TF were appointed by the Chairman of the NBPC and include Drs. Evis Konomi, Tirana, Elona Dhrami, Tirana, Elvira Dervishi, Vlore, Tatiana Ziu, Elbasam, and Astrit Beci, Schoder. A meeting was held 2/27 with TF members to discuss expectations, review the 1st NBPC meeting, discuss role and responsibilities.

It was generally agreed that the purpose of the TF was to take initiative, identify needs, be directly involved in implementation of activities such as training, and coordinate with the NBPC, other ophthalmologists, and donor supporters. At this point, the TF does not have the necessary official sanctioning by the NBPC, although it is supported by Dr. Zhughl and others

Dr. Elvira Dervishi summarized some of the activities to date accomplished in Vlore. With initial efforts of Garth, a screening activity was started children and adults. 1,500 first graders (6-7 years old) were screened of which 140 were identified with visual loss. Of these Dr. Dervishi examined these children and 60 needed refraction and other services. Of these children 20-30 had never had an eye examination. Of the 60 reviewed, 15 need some kind of surgery. The major problems seen were strabismus and cataract. Unfortunately, there was no anesthesia equipment available in order to conduct surgery. The experience was viewed as exciting and very valuable, but it was apparent that to continue such efforts requires considerable support of the TF and others. This can be considered one of the first outreach eye care efforts in Albania.

There was agreement 1) that a manager (Ms. Mirela Protopapa) was welcome and necessary, 2) investigate accessing 100 IOLs and create a revolving supply fund, 3) create an inventory of all supplies, equipment, instruments, 4) create and maintain a numbering system for patient waiting rooms, 5) support establishment of medical record keeping, and 6) facilitate where possible, visits to districts to stimulate interest in public health and surgical improvements.

4. Visitors: The plans for visiting ophthalmologists was discussed. One of the visits should be a pediatric ophthalmologist. Tentative plans are:

Mar - Apr Dr. Kong Oh will provide training in phacoemulsification and use of the yag laser. Drs. Susan Lewallen and Paul Courtright will provide a course on "Research survey methodology" and begin design the 5 district prevalence survey.

Apr 22-May 2 Orbis international was planning a visit for nurse training and sending a corneal specialist.

May 3-10 Dr. Tilen; general ophthalmologist, would provide training in small incision extracapsular surgery and use of the diode laser for treatment of glaucoma.

May end Dr. Michael Goldberg, would provide training in retina.

Drs. Alexandre from Germany and Verdie, an optometrist might also be scheduled to visit Albania. A follow up visit by Dr. Edward Parelhoff, pediatric ophthalmologist will be considered. All of these visits are provisionally scheduled given the uncertain financial and political situation in the country.

Other activities:

1. Review SEEING 2000 proposal: Health for Humanity was considering assisting the University Eye Clinic or the Albanian Ophthalmology Society apply for a Seeing 2000 grant from IEF. Ideas were discussed as well as feasibility and appropriateness of the funding to Albania's needs.
2. Blind school: The Blind School in Tirana was visited. The Chairman of the Blind People's Association, Z. Siman Tafai and the Vice Chairman and Director of the school, Z. Rameqan Kabashi were meet.

It was explained that the association has legal status and plans to assist blind children with shelter, food and skill straining, but they do not have funding. They do have contacts with European and Balkan countries. There was concern that contacts are not seriously considering their proposals for support. Both mentioned a "special program" of the MOH where the MOH is obliged to "re-diagnose" the blind and SVI for referral to services (physical and occupational therapy, possibly surgery and other corrective actions etc). They are seeking legislative action by the government to make these activities law.

3. AOS: A meeting of the Albanian Ophthalmological Society (AOS) was held on the last day of the visit. Several presentations were given, including a presentation by Health for Humanity and a brief presentation of IEF. Also discussed were the need for establishing standards for care and peer review.

Other meetings included:

1. A meeting was held at the USAID Mission with Dede Blain and
2. A meeting with PHARE officials was held to discuss training.
3. A meeting with Dr. Gusmanni, WHO Representative was held to discuss progress.
4. A meeting at the Soros Foundation office was held to discuss program progress and continued support for HH and Dr. Zhugli.

Persons Seen/meetings:

Mr. Garth Pollock, IEF and HH

Ms. Mirela Protopapa, IEF and HH

Dr. Zhugli, Chief, UEC

2/25 Residents and Staff University Eye Hospital

2/25 PHARE

2/26 Dr. Debechi, Chief Pediatrician

2/26 Blind school

2/27 Dr. Gusmani, WHO representative

2/25 Dede Blain and Cameroon L. Pippitt, USAID Mission

2/28 Albanian Ophthalmological Society (AOS)

2/28 Soros Foundation

2/27 Task Force:

Evis Konomi, Tirana

Elona Dhrami, Tirana

Elvira Dervishi, Vlore

Tatiana Ziu, Elbasan

Astrit Beci, Schoder

Equipment repair notes:

Bulb replacement needed for	Keller indirect (all pupil bulb)
	Keeler indirect (old England)
	Neitz (from Bob Butner's visit) IO-∞ (small pupil)
	Alliance slit lamp
Reostat	Alliance slit lamp

Note: anaesthesia equipment needs improvements The current systems are a Halls proximeter monitoring (check). There was a request for a pulse oximeter connectors and glucometer to monitor sugar levels and electrocardiogram.

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Attachment M: Health for Humanity Report of Activities,
January - September 1996



Health for Humanity

Improvement of Eye Services in Albania: 1996-1997

Report of Activities January - September 1996

This report covers the activities of the second year of the Eye Project. The first year funding and activities ended December 31, 1995. The second year was partially funded by Soros Foundations' Open Society Institute in June 1996. Of the \$228,798 requested, \$149,959 was funded. Thus far, Health for Humanity has filled in the gap, but a proposal for matching funds is being submitted to the Crow Foundation to permit the project to move forward as anticipated without further gaps. The project, whose scope is no less than the establishment of quality eye services and prevention programs for the entire country of Albania, has been conceived of as a five year program in order to fully establish and train Albanian institutions that will oversee the new level of eye care made available to the people of Albania.

Background

The project had a very productive and successful first year. The basic equipment needs at the University Eye Clinic (UEC) and two other eye centers, Vlora and Shkodra, were provided. The residency program at the University Eye Clinic was greatly improved through training by visiting volunteer professors, creation of a Learning Resource Center, establishment of new systems and protocols in patient examinations and record keeping, and exposure to educational opportunities abroad. Training was begun for the ophthalmologists in Shkodra and Vlora. Eye screening programs were initiated at all the schools in the three cities.

Because of the funding hiatus between December 1995 and June 1996, activities slowed greatly during this period. However, the Project Coordinator in Albania continued supportive efforts locally, particularly in Vlora where efforts in screening children continued spontaneously. During this period, medical supplies and donations continued to be solicited for the project and the Albanian resident who had come to the US for training finished his training program at Northwestern University. He has not yet returned to Albania, but we are hoping that when he does, he will make his contribution to the development of Ophthalmology there.

In this second year, the remaining equipment needs at the University Eye Clinic and basic needs at three new eye centers, Korca, Gjirokastra, and Peshkopi, will be met. In this year and the year to follow, the majority of the basic training needs of the Albanian ophthalmologists will be completed. In the final two years of the project the gains of the previous three years will be consolidated, while the focus will shift to further strengthening the Albanian institutions that will oversee eye care needs in the future with a major effort in preventive and screening programs.

Objectives and Activities for 1996-1997

Developing Institutional Capacity of the University Eye Clinic as a Training and Academic Center

1. Academic training Four ophthalmologists recruited by HH will provide training for one week each at the University Eye Clinic for residents and practicing ophthalmologists.

Originally training visits were scheduled for two weeks (ten working days). The normal schedule for the hospitals is 7:30-3:00, or about six and half hours daily. The visiting doctors felt that this schedule did not utilize their time to the fullest. Also, when the budget was revised, it was felt that shorter visits with more intensive training (i.e. six ten-hour working days) would result in approximately the same amount of training time at much lower cost.

It should also be noted that the residents at the University Eye Clinic are off between July and September, so it was not possible to schedule training for them during the summer

Training visits carried out to date this year

- 1 Dr Michael Goldberg June 14-22, 1996

Since Dr Goldberg was the first volunteer of this funding cycle, he spent the majority of his time reviewing the lessons of the past year. He made some excellent observations and recommendations that the project has now instituted. Since this was his second visit, he had an opportunity to evaluate the change and was pleased with the progress of the project. A copy of his report is attached

Training visits scheduled

- 2 Dr Sarantos from Greece October 4-12, 1996
- 3 Preventive Ophthalmology Seminar probably in February or March
(tentative schedule, details to be determined)
- 4 Retina laser specialist probably in April or May

2 Equipment for the University Eye Clinic The basic equipment needs of the UEC will be completed

The International Eye Foundation, because of its outstanding efforts last year, will continue to work with HH on this aspect of the eye project. Completing the equipment needs at the UEC requires acquisition of the following

- a Argon or diode laser After considerable research and consultation with Dr Zhugli, reviewing the advantages and disadvantages of each system, it was decided that the best choice for Albania would be the new green diode laser which has the advantage of both systems and is extremely portable, weighing approximately 15 pounds. This has now been ordered and will be available in November
- b Phacoemulsification unit This is being secured through HH. This system will permit Albania to develop capability to offer "state of the art" cataract surgery and thereby join her sister nations in Europe in this capacity
- c Yag laser Originally, a B-scan ultrasound was scheduled for purchase this year while a yag laser was scheduled to be purchased next year. However, after consultation with the staff at the University Eye Clinic, it is clear that the need for the yag laser is far more urgent than the need for a B-scan ultrasound unit. Although a yag laser tends to be much more expensive, it appears that we will be able to procure a refurbished laser at reasonable cost. The IEF is still in the process of negotiating the best price and service agreement
- d The Learning Resource Center will continue to receive the following
 - Books in subspecialty areas to be ordered at the end of October 1996 at the American Academy of Ophthalmology when Dr Zhugli comes to attend the meeting
 - Journals *Ophthalmology*, 2 copies of *Archives of Ophthalmology*, and *British Journal of Ophthalmology*
 - Audio tapes *Audio Digest of Ophthalmology*

The entire shipment, together with equipment for the other three centers will be shipped by the end of December 1996

3 Medical Records A simple records system will be developed and fully functioning by the end of this funding year

Visits to Korca and Gjirokastra will necessarily have to wait until the equipment has arrived and has been installed

- 2 Equipping Three New Secondary Eye Centers Basic equipment will be provided for Korca, Gjirokastra, and Peshkopi followed by training programs to develop capacity for these centers to address the eye care needs of their regions

The equipment list may be found in the original proposal. Again, the International Eye Foundation is working closely with HH on this aspect of the project. The IEF is working hard to obtain the best value for the funds available. The smaller items have already been ordered. Some of the larger items are still being negotiated. The entire shipment will leave for Albania before the end of December 1996.

- 3 Rotations at the University Eye Clinic Three month rotations will be arranged at the UEC for doctors from Shkodra and Vlora

After consulting with the doctors who will be rotating, they preferred to have shorter but more frequent rotations (one or two weeks at a time). The first of these will begin in October with one doctor each from Vlora and Shkodra attending.

- 4 Developing Institutional Capacity of the Albanian Ophthalmological Society

- a Two weekend seminars will be held in cooperation with the UEC and the AOS covering such topics as quality assurance, peer review, continuing medical education, credential standards

The first of these seminars will be held the first weekend of October. To reduce costs, they will be day-long seminars. In this AOS meeting, the eye exam record will be introduced. One of the goals in introducing this is to accustom the AOS to its role as legislator of standards for the ophthalmic community. If adoption of the eye exam record is achieved, it will be the first time that the AOS ventures into its role of quality assurance and peer review.

- b A national conference for Albanian ophthalmologists in coordination with the AOS utilizing visiting professors recruited by HH will be held at the UEC next year.

The conference is now tentatively planned for September 1997. The AOS will also take up this issue in its upcoming meeting. Dr. Zhugli will be attending the American Academy of Ophthalmology (AAO) meeting in Chicago at the end of October where further consultation and plans for this meeting will occur.

- c In cooperation with the AOS, five Albanian ophthalmologists or residents will be sponsored to participate in international or regional ophthalmology conferences.

With the support of the Soros grant, three Albanian ophthalmologists attended the International Ophthalmologic Conference held in Athens, Greece this June. One of the key results, apart from the participation in the different sessions, was linking and building ties with Greek physicians. This October, the first Greek volunteer will be coming to Tirana to support the project. HH is particularly happy with this development as it begins to create the links for sustaining and continuing improvement of eye care more locally.

As mentioned before, Dr Sulejman Zhugli, Chairman of the Department of Ophthalmology, will be attending the AAO meeting in Chicago this October. After the conference, he will be going to Youngstown, Ohio for one week to receive training in the phacoemulsification technique of cataract surgery from Dr Oh, one of the volunteer ophthalmologists from the first year of the project.

- d The Learning Resource Center (LRC) at the UEC will be made available to the members of the AOS for its conferences and educational activities.

This is one area that requires improvement. All the furniture and equipment have been purchased and installed, including the equipment acquired by the AOS. But ideal use of the LRC has not been achieved. Meetings are held there, but independent use of the center by the residents is low. One of the problems is timing. The residents are very busy during the day when the secretary is present and authorized to permit use of the center. When the residents are free, it is later in the day when the secretary has gone. The project is going to experiment with rotating the residents to be in charge of supervising and directing the use of the center. Journal clubs and study circles can also be formed among the residents to make better use of the new periodicals and books, as well as the well-stocked video library.

Once the problem of accessibility of the LRC is addressed, it will also benefit the members of the AOS who would only be available to use the center after hours.

Preventive Ophthalmology Programs

Development of the Institutional Capacity of the National Blindness Prevention Committee (NBPC)

- 1 A one-week seminar/workshop on research methodology, particularly in the development and evaluation of surveys will be held for the UEC, members of the AOS, and the NBPC. Dr Paul Courtwright, head of the department of Preventive Ophthalmology at the University of British Columbia has offered to assist HH with this activity which will take place sometime early next year as part of the visiting professor program at the UEC.
- 2 A national survey on the causes of blindness in Albania will be carried out in cooperation with the NBPC and the UEC. Since this portion of the project was not funded, we are still hoping to be able to obtain matching funds for this activity which is crucial to long term planning for the country.

Most other activities in the area of preventive ophthalmology were originally scheduled for the third year of this five-year project. However, there have been some advances in this area that are quite noteworthy at this time. As a result of the screening/survey carried out in Vlora and Shkodra last year, the physicians there have decided to begin continuous yearly screening of all first graders.

Vlora is the more ambitious of the two regions. The ophthalmologists have undertaken the goal of carrying out a screening campaign, not only throughout the city of Vlora, but in all the villages surrounding Vlora as well. Rural village doctors are trained once at the end of each month, at what has now truly become a regional eye center, when they come into the city to receive their salaries. The campaign will begin in October after the last training session. The forms and materials have been adapted from last year's work.

Shkodra will undertake to organize the screening of all urban first graders in school in collaboration with the two school doctors assigned to the urban schools. This will be a continuous service throughout the year.

Both approaches are commendable as they spontaneously arose from these developing regional centers themselves and bode well for sustainability. They will also provide valuable information about the feasibility of these plans for other regions given the circumstances in Albania. In support of these screening programs and in preparation for the other regions, a simple manual has been prepared for non-ophthalmologists. It is now in the final stages of revision and will be tested in photocopy form before being printed.

Summary

We are very pleased with the progress to date even though the project lost significant momentum because of the hiatus in funding. At the present time, available funds are not adequate to meet all the objectives of the project. Health for Humanity has applied to a grant from the Crow Foundation and continues to explore other potential funding sources.

In the first four months of this funding cycle, the following achievements stand out:

- The spontaneous efforts in expanding and continuing eye screening efforts at the schools in Vlora and Shkodra are very significant and outstanding highlights. Such grass-roots efforts demonstrate that the physicians in these regional centers are taking ownership of the project -- the greatest sign that such efforts are likely to continue after the termination of the project.
- Adoption of the new eye examination recording system is also a significant breakthrough, at once introducing a new more thorough standard and at the same time permitting closer evaluation and follow-up of patients. The outcome of this will unquestionably be a higher quality of care and prevention of vision loss.
- The plans for rotations through the eye clinic by ophthalmologists from the secondary eye centers is also a very encouraging development as it institutionalizes advanced training programs within the system available in Albania and permits ongoing training programs long after the project has ended.
- Of the total of nine volunteers for the year, two have already visited Albania, two are scheduled with definite dates; two are scheduled with tentative dates, and three are yet to be recruited.
- The eye equipment is still being selected and will be shipped by the end of 1996.
- Dr. Kong Oh and Dr. Michael Goldberg continue to be close and active supporters of the eye project. They have both made long-term commitments to assist the achievement of the objectives.
- In spite of severely restricted funds for personnel and administrative needs, to date the project has been able to secure donations of medical supplies worth over \$52,000. Some of this material has already been sent to Albania with volunteers. The remainder will be sent at the end of October with a HH contact who will be travelling to Albania.

Attachment N: ChildSight Workshop Pleven, Bulgaria: Program,
List of Participants, and Videotape Summary

International Eye Foundation

Eye Department, Higher Medical Institute Pleven

National Program "ChildSight"

Workshop Subject "Strengthening of collaboration between pediatricians and ophthalmologists for early diagnosis and treatment of eye diseases in children"

Participants Micropediatricians and Pediatricians from Northwestern Bulgaria

Dates July 11 - 13, 1996

Location Higher Medical Institute Pleven

PROGRAM

07/10/96	Wednesday
4 - 7 pm	Registration and accommodation of participants in Pleven Hotel
07/11/96	Thursday IInd Clinical base, Higher Medical Institute Pleven
8 - 9 am	Registration at Eye Department IInd Clinical Base
9 - 9 30 am	Inauguration
	Morning Session
9 30 - 10 00 am	Lecture "The role of non-governmental and non-profit organizations for child eye care and introduction of the International Eye Foundation" Prof Petja Vassileva
10 00 - 10 30 am	Lecture "Collaboration between ophthalmologists, micropediatricians and pediatricians for early finding, registratiuon and documentation of cases with eye pathology" Dr Ilchev, Eye Department Pleven

10 30 - 10.45 am	Coffee break	
10 45 - 11 15 am	Lecture "Experience of the Association of Parents of Children with Visual Impairments in Bulgaria"	Mr Dimitar Losanov Chairman
11 15 - 12 00 am	Discussions Remarks of Prof Moundjiev Chairman of Pediatric Department Pleven, Remarks from Regional Health Center, Pleven Remarks of the Chairman of County Council, Pleven etc	
13 00 - 14 00 pm	Dinner /Dining room of IInd Clinical Base/	
Afternoon session		Chairman Dr E Philipov, Assoc Prof
14 00 - 14 30 pm	Lecture "Genetics and eye diseases"	Dr Philipov, Assoc Prof, Head of Eye Department Higher Medical Institute Stara Zagora
14 30 - 15 00 pm	Lecture "Organization and role of genetic consultation"	Dr Simeonova, Assoc Prof Higher Medical Institute Pleven
15 00 - 15 30 pm	Discussion	
17 00 pm	Supper /Pleven Restaurant/	
07/12/96 Friday		
	Morning Session	
8 30 - 9 00 am	Lecture "Retinopathy of prematurity"	Dr Ch Balabanov, Assoc Prof Chairman Dr Jotova - Eye Department Higher Medical Institute Pleven

9 00 - 9 30 am Lecture "Newly born babies with higher risk and frequency of retinopathy of prematurity Retinopathy of prematurity and the most frequent factors for its development in the neonatal period"

Dr Rosmanova
Dr Jonov
Obstetrician Department
Higher Medical Institute Pleven

9 30 - 10 00 am Lecture "Pathology of eye lids"

Dr Pavlova - Eye Department
Higher Medical Institute Pleven

10 00 - 10 30 am Coffee break

10 30 - 11 00 am Lecture "Inflammatory diseases of anterior eye segment and adnexia" (conjunctiva, cornea, iris, ciliar body, lacrimal system)"

Dr Minkov
Eye Department
Higher Medical Institute Pleven

11 30 - 12 00 am Discussion

13 00 - 14 00 pm Dinner

Afternoon session

Dr Ilchev
Chairman

14 30 - 15 00 pm Lecture "Cataract, traumas and differential diagnosis of leucocorea"

Dr Balabanov, Assoc Prof
Eye Department
Higher Medical Institute Pleven

15 00 - 15 30 pm Lecture "Congenital glaucoma"

Prof Dr Jankov
Eye clinic for children
Medical University, Sofia

15 30 - 16 00 pm Discussion
19 00 pm Supper /Pleven Restaurant/

07/13/96 Saturday

Morning Session

Prof. Dr Moumdjiev
Chairman

8 30 - 9 00 am Lecture "Headache in children and eye pathology"

Prof Moumdjiev
Department of Child diseases
Higher Medical Institute Pleven

9 00 - 9 30 am Lecture "Metabolic diseases and eye pathology"

Dr Nedkova
Department of Child diseases
Higher Medical Institute Pleven

9 30 - 10 00 am Lecture "Sindrome diseases and the eye"

Dr. Ilchev
Higher Medical Institute Pleven

10.00 - 10 30 am Discussion

10 30 am Closing

**PARTICIPANTS IN THE WORKSHOP "CHILDSIGHT"
PLEVEN, 11-13 JULY**

- 1 Dr Anelia Georgieva Ananieva - Pleven
- 2 Dr Milcho Kostadinov Machev - Pleven
- 3 Dr Daniela Jivkova Peneva - Pleven
- 4 Dr Anelia Hohvafter - Wien
5. Dr. Nevin Tuna - Pleven
- 6 Dr Nikola Hristov Moundjiev - Pleven
- 7 Dr. Bhaeldin - Pleven
- 8 Dr Maria Nikolaeva Simeonova - Pleven
- 9 Di Tsarinka Georgieva Ivanova - Pleven
- 10 Dr Velina Petkova Gradishka - Pleven
- 11 Dr Roslanova - Pleven
12. Dr Vania Nedkova Nedkova - Pleven
- 13 Di. Evgenia Ivanova Barzashka - Pleven
- 14 Dr Silvia Pencheva Dancheva - Pleven
- 15 Dr Pavlina Ivanova Vlachova -Pleven
- 16 Dr Chavdar Balabanov - Pleven
17. Dr. Emilia Kirlilova Krivoshijska - Pleven
- 18 Dr. Galia Tsvetanova Filova - Pleven
- 19 Dr. Nikolina Mincheva - Pleven
- 20 Dr Emilia Asenova Jotova - Pleven
21. Dr Elena Mihajlova Pavlova - Pleven
22. Dr Zdravko Tsonev - Pleven
- 23 Dr. Lidia Kamenova - Pleven
- 24 Dr. Rumen Dimitrov Minkov - Pleven
- 25 Dr Dimitar Ilchev - Pleven
26. Dr. Achmed Vefic Jeniev - Pleven
27. Dr. Mariela Milcheva Oblashka - Pleven
- 28 Dr. Janeta Joshkova Pavlova - Pleven
- 29 Dr. Svetlana Aleksieva Angelova - Pleven
30. Dr Maria Dimitrova Ilcheva - Pleven
31. Dr Lilia Marinova Krusheva - Veliko Tarnovo
- 32 Dr. Violeta Vasileva Shivacheva - Veliko Tarnovo
- 33 Dr Stefan Petrov Kovachev - Sevlievo
- 34 Dr Jordanka Kaneva Nikolova - Levski
- 35 Dr. Valia Dincheva Nikolova - Montana
- 36 Dr. Antoaneta Blajeva - Montana

37. Dr Emil Philipov - Stara Zagora
38. Dr Amal Amro - Sofia
39. Tatjana Georgieva - Sofia - social worker
40. Dr Krassimir Kroumov - Lom
41. Dr. Ekaterina Ekimska - Veliko Tarnovo
42. Dr Miroslava Rasheva - Lom
43. Dr Sonya Niagolova - Drianovo
44. Dr. Mirella Bogdanova - Veliko Tarnovo
45. Dr Tichol Ticholov - Teteven
46. Dr Victoria Georgieva - Pavlakeni
47. Dr Daniel Shatarov - Belene
48. Dr Diana Lilova - Dolni Dabnik

SEMINAR „CHILDSIGHT“ - PLEVEN - JULY' 96
Videotape - 12 min SUMMARY

Dr Balabanov opens the seminar and wishes good luck to the participants

Prof Vassileva. (speaks of the role of the NGO's) I am a director of International Eye Foundation "Sight for all", which is already working on its second program in Bulgaria and there is one more starting any moment I am also co-president for Europe of the International Agency for Prevention of Blindness. Prevention of blindness is one of the problems, which ophthalmology has been facing for a long time. We - ophthalmologists, are one of the communities of specialists in the world with the strongest organization. The first specialized international congress held in the middle of 19th century, was in ophthalmology.

This is the second seminar "ChildSight". The first one was in Stara Zagora. But it is not only the meeting that matters. The important thing is what follows after the meeting.

The vice mayor of Pleven - speaks about the history and development of the town.

Dr. Moundjiev. I feel strongly about asking one question Prof Vassileva. She travels all around the world. From the point of view of the world practice what does she think of level of our ophthalmic help, the clinics in Sofia and the departments in the country.

Dr Filipov. Bulgarian Academic Pashev has a great contribution for the development of Bulgarian ophthalmology. The only monograph in Bulgarian medicine up to now and a first one in the world, was his monograph, called "Social ophthalmology".

The participants introduce themselves.

Prof Vassileva: Brilliant organization, but no motivation at all, except personal motivation, which, it is a pity, is not so strong in everybody, so that they can overcome the difficulties.

The International Eye Foundation is one of the first international NGO's. It dates back to 1961 and deals with the problems of the prevention of blindness. It has started as an international eye bank. Its history is long and very interesting. Its founder is one of the greatest eye surgeons - Harry King, one of the pioneers of the cornea transplantation in the US. He is also famous as the creator of the first eye bank.

Prof Vassileva briefly speaks about the activities of the IEF in Bulgaria, emphasizing on the Prevalence of Blindness Survey showing down pictures and slides.

Dr Ilchev. - The system, although it had drawbacks, existed until 4-5 years ago. Then it was totally destroyed. The Ministry of Health had to create a new system for organizing the preventive examinations and the observation of children from 0 to 18 years old.

Dr Simeonova. - I want to emphasize on the capabilities of the organization of the prevention of the genetic pathology - one of the main causes for blindness.

Dr. Plulipov - speaks about genetics, hereditary diseases

Dr. Yotova - speaks about retinopathy of prematurity - complicated cases

Dr. Rosmanova - According to some sources the relative and the absolute number of the ill people is increasing. Others oppose to this statement. According to McCormic, the frequency of the diseases must be defined and analyzed having in mind the geographic area, socio-economic and political image of a given community.

Dr. Yonov - They must not, of course, take the functions of the ophthalmic pediatricians, but they are those who have to alarm and to look for support for each eye pathology that has been found or in case of doubt of such one.

Dr. Balabanov - We are not on the level we should be.

Dr. Minkov - The most important thing is its detection and timely treatment.

T. Georgieva - We start a preliminary education in our school. For children from the country, whose preparation has for some reason been neglected, it takes 2 or 3 years, which means that the child gets ready to attend school at the age of 10. The aim of my work is to try to prevent this violation of the normal development of the child.

Dr. Balabanov - Trauma during the bearing of the child.

Dr. Balabanov - Separate violation of the hyper and hypo- functions, the combination.

Dr. Ilchev - The syndrome diseases are clinical entity, in which not only a separate organ is affected, but there is a disease of more organs and systems with a common etiologic moment.

Dr. Moundjiev - This is the reason why we should find means to raise the level of the medical culture.

Colleagues, I wish you a successful start in this field. We do have many problems, but this one is extremely important - the sight of our children.

Early proceedings and integrated education - two new forms of treatment of visually impaired children

Summary

The early proceedings and the integrated education are two comparatively new forms of education of visually impaired and blind children in Bulgaria. They have been put to practice for several years now. In our work we also use the foreign experience in this field - mainly American check-lists and programs, which we transform according to our standards. The advantages of this kind of education are many. The most important thing is that the child lives and receives education in natural environment - it does not need to be separated from his family and to become a part of a closed society of children with the same problem as its, which will obstruct its socialization when it graduates from school and enters the "real" world.

The early proceedings include visually impaired children from 0 to 6 years. Consultant's work in this field has three main directions:

1. Work with the family - parents, siblings of the child. After a child with visual disease is born, conversations are held, concerning the problems of the family. We give advice about the special needs, features and the schedule of this child - recommendations to the parents how to help to a maximum extent their child, a weekly curriculum for their work with the child (games) is prepared, the extent, to which to help the child when conducting a certain activity, creation of different habits in it to serve itself etc. They receive copies of Lily Nelson's guide "Show me how", in which parents can find and select different ideas and directions for engaging the child in activities based on mutual participation - parent-child for accomplishing certain goals.

2. Visits on weekly basis, during which the consultant works with the child - in the family or in the regular kindergarten (in case the child visits one). A separate individual program is prepared according to the age of the child, its needs (they are preliminary evaluated from the consultant), the prognosis of the disease (would it be necessary the child to be prepared to teach Braille). The program is prepared in different fields - sensor development, motor and cognitive development, tactility, development of speech and thinking, ability to take care of himself, socialization etc. The specialist chooses the proper ways, forms and methods, which he is going to make use of when accomplishing the program, according to the individual features and interests of each child.

3. In case the child attends a regular kindergarten, the consultant meets the personnel, informs them of the problems and the visual ability of the child, gives the respective explanations and recommendations, prepares some of the necessary materials for work of the children in the group. The contact between the consultant, early proceedings and teacher is on weekly basis.

When the child becomes 6 or 7, he/ she enters the group for education in categories - a natural continuation of the early proceedings. The consultants and the parents choose a proper school for the child. The specialist in integrated education meets the headmaster of the school and the teachers' staff and informs them of the disease of the child, his state at the moment, his prospects and his visual ability. A suitable place in the class-room is chosen for the visually impaired student. The consultant and the teacher present him, as well as the optic means he uses, to the class. The specialist in integrated education is as a guide to the child in the school building and yard. In the beginning of the school year he shows him the place of the sanitary rooms, the cafe, the recreation room etc., explaining him what landmarks to use in order to get to a given place.

After the consultant gets acquainted with the curriculum of the class, he prepares the necessary materials for adequate education of the given student - enlarged learning texts (or respectively texts in Braille), relief cards, models etc.

The contact between the specialist in integrated education, the student, the teacher and the parent is on monthly basis.

In Sofia School for Blind and Visually Impaired Children, in which I work, we organize weekends for children from the groups for early proceedings and integrated education. They include games, discotheque, lunch etc. Also, for some of the children, we organize individual consultations with psychiatrists and visual therapists, if this is necessary and the parents desire it.

We also organize parents' meetings - on them parents can mutually share their opinions, advice and ideas.

Up to now the results from the stated above forms of education prove their efficacy but still there are many problems. The main of them are:

1 Lack of adequate connection between the pediatric eye doctors and the specialized pedagogues. This broken chain reflects upon children and their parents.

2 Parents and regular teachers are prejudiced against the early proceedings and the integrated education - a fear of the new and the unknown,

3 Lack of the necessary means of optic refraction for resultative work,

4 For children who have been left from their parents, there is not a group where they can be visited and taught by specialists when they are 3 to 6 years old. For them this means loss of precious time and they must catch up later.

5 Not enough help for the children from the country - regular visits of the consultants to the given place cannot be provided due to lack of enough funds.

Tatjana Georgieva
Consultant in Early Proceedings
Sofia School for Blind and
Visually Impaired Children

Attachment O: ChildSight Workshop Varna, Bulgaria

**INTERNATIONAL EYE FOUNDATION
PASHEV CENTER FOR SIGHT**

WORKSHOP

for pediatricians, micropediatricians and ophthalmopediatricians

7-9 October, 1996

“Black sea” hotel - Varna

Theme:

**Pediatricians and micropediatricians - for early diagnosis and
treatment of eye diseases in our country**

**Organizers: International Eye Foundation
Chair of ophthalmology, Medical University - Varna
National program “Child Sight”**

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LIST OF THE PARTICIPANTS IN THE WORKSHOP "CHILD SIGHT" - 7-9

OCTOBER, VARNA

- 1 Plamen Hubanov - ophthalmologist, Varna
- 2 Iurka Pamukova - ophthalmologist, Iambol
- 3 Elida Vasileva - pediatrician - Iambol
- 4 Violeta Milcheva - pediatrician, Varna
5. Bojana Boianova - pediatrician, Bourgas
- 6 Janet Nikolova - pediatrician, Varna
- 7 Krasimira Georgieva - pediatrician, Razgrad
- 8 Vera Kamenova - pediatrician, Varna
- 9 Neli Rohleva - neonatologist, Targovishte
10. Rumiana Maneva - neonatologist, Silistra
11. Boriana Varbanova - pediatrician, Varna
12. Venislav Stoianov - pediatrician, Varna
13. Darina Minkova - pediatrician, Bourgas
14. Petranka Simeonova - pediatrician, Plovdiv
15. Zdravka Koleva - pediatrician, Varna
- 16 Rossitsa Ducheveva - ophthalmologist, Silistra
- 17 Maia Jivkova - ophthalmologist, Lom
- 18 Marina Hreleva - ophthalmologist, Varna
- 19 Daniela Demireva - ophthalmologist, Varna
- 20 Galina Fileva - ophthalmologist, Varna
- 21 Milena Milkova - ophthalmologist, Varna
- 22 Venata Kraicheva - pediatrician, Shumen
- 23 Ianislav Kolev - ophthalmologist, Varna
- 24 Maria Slavova - ophthalmologist, Varna
- 25 Biliana Nenkova - ophthalmologist, Varna
- 26 Hristina Tsoneva - ophthalmologist, Varna
- 27 Dimitrichka Dimitrova - ophthalmologist, Shumen

28. Antoaneta Boneva - ophthalmologist, Varna
- 29 Kamelia Baicheva - ophthalmologist, Varna
- 30 Rusanka Ivanova - pediatrician, Varna
- 31 Raina Sheinova - pediatrician, Targovishte
- 32 Ivanka Vladimirova - pediatrician, Aitos
- 33 Margarita Beneva - pediatrician, Varna
- 34 Viara Paskaleva - pediatrician, Shumen
- 35 Petia Stoicheva - ophthalmologist, Varna
- 36 Antonia Barbukova - ophthalmologist, Varna
37. E Kontrova - ophthalmologist, Varna
- 38 Margarita Todorova - ophthalmologist, Varna
- 39 Rossitsa Stoikova - pediatrician, Varna
40. Bili Aian - ophthalmologist, Varna
41. Ivan Gruichev - ophthalmologist, Varna
- 42 Toshov Mitov - ophthalmologist, Varna
43. Svetla Nikolova - ophthalmologist, Varna
44. Hristina Gruicheva - ophthalmologist, Varna
- 45 Emil Filipov - ophthalmologist, Stara Zagora
- 46 Tatiana Ivanova - pediatrician, Bourgas
47. Ivanka Valkova - pediatrician, orphanage, Varna
48. Elisaveta Elenkova - pediatrician, Varna
- 49 Nadejda Georgieva - pediatrician, Shumen
- 50 Dobrin Georgiev - ophthalmologist, Varna
- 51 Rusinka Petkova - pediatrician-neonatologist, Dobritch
52. Snejana Aleksandrova - pediatrician-neonatologist, Dobritch
- 53 Plamen Petkov - pediatrician, Dobritch
- 54 Dr Nikolina Petrova
55. Lidia Shirakova - psychiatrist, School for blind, Varna 55
56. Ianka Shtilianova - orphanage
- 57 Prof Petia Vassileva 58 Iordanka Koleva

MEDICAL UNIVERSITY - UNIVERSITY HOSPITAL "ALEKSANDROVSKA" -
SOFIA, CHAIR OF OPHTHALMOLOGY

TO
Prof Vassileva
IEF Country director for Bulgaria

Dear Prof Vassileva,

We have the pleasure to inform you that we do not consider it our duty to organize the seminar for pediatricians, micropediatricians and neonatologists you wrote us about. It is part of the plan of IEF "Sight for all", which you preside, so the organizational, financial and educational responsibilities are entirely yours. We have not participated in neither of the phases of the planning, organizing and carrying out of its undertakings. That is why we are not involved in its plans, decisions and actions.

If we are invited, we could possibly participate in the seminar with separate lectures, agreed beforehand.

The rest of the questions are a subject of your competence and liability.

Head of Eye Department

Prof Dr L Iankov, D Sci

Director of Chair Ophthalmology

Prof Dr Pr Guguchkova, D Sci

МЕДИЦИНСКИ УНИВЕРСИТЕТ - ДУБ "АЛЕКСАНДРОВСКА" - СОФИЯ

КАТЕДРА ПО ОФТАЛМОЛОГИЯ

бул. Св.Г.Софийски 1

тел. 51-87-03

факс: 52-53-79

Изх. № 269.....

София, 08.10.....1996 г.

ДО

ПРОФ.Д-Р П. ВАСИЛЕВА, ЧЛ.КОР. НА БАН
ДИРЕКТОР НА МОФ ЗА БЪЛГАРИЯ

Т У К

На Ваше писмо от 03.10.1996 г.

УВАЖАЕМА ПРОФ. ВАСИЛЕВА,

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Ако бъдем поканени, бихме могли да участваме във визирания курс, с отделни предварително съгласувани лекции.

Останалите въпроси са във Ваша компетенция и отговорност.

ЗАВ.ДЕТСКА ОЧНА К-КА:

проф.д-р Л. ЯНКОВ, ДМН

Р-Л КАТЕДРА ПО ОФТАЛМОЛОГИЯ:

проф.д-р П. ЗУТУЧКОВА, ДМН



[Handwritten signature]

MEDICAL UNIVERSITY - UNIVERSITY HOSPITAL "ALEKSANDROVSKA" -
SOFIA, CHAIR OF OPHTHALMOLOGY

TO

Prof Vassileva

IEF Country director for Bulgaria

Dear Prof Vassileva,

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If we are invited, we could possibly participate in the seminar with separate lectures, agreed beforehand.

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Head of Eye Department

Prof Dr L. Iankov, D Sci

Director of Chair Ophthalmology

Prof Dr Pr. Guguchkova, D Sci

МЕДИЦИНСКИ УНИВЕРСИТЕТ - ДУБ "АЛЕКСАНДРОВСКА" - СОФИЯ

КАТЕДРА ПО ОФТАЛМОЛОГИЯ

бул. Св.Г.Софийски 1

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факс: 52-53-79

Изх. № 269....

София, 28.10....1996 г.

ДО

ПРОФ.Д-Р П. ВАСИЛЕВА, ЧЛ.КОР. НА БАН
ДИРЕКТОР НА МОФ ЗА БЪЛГАРИЯ

Т У К

На Ваше писмо от 03.10.1996 г.

УВАЖАЕМА ПРОФ. ВАСИЛЕВА,

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Останалите въпроси са във Ваша компетенция и отговорност.

ЗАВ.ДЕТСКА ОЧНА КЛИНИКА:


проф.д-р Л. ЯНЧЕВ, ДМН

Р-Л КАТЕДРА ПО ОФТАЛМОЛОГИЯ:


проф.д-р П. ГУГУЧКОВА, ДМН 

Attachment P: Evaluation of Malawi's Low Vision Programme, June 1997

MALAWI LOW VISION PROGRAMME

EVALUATION

JUNE 1997

Jill Keefe
Senior Research Fellow, The University of Melbourne Department of Ophthalmology,
Australia

Karin van Dijk
Low Vision Advisor, Christoffel Blindenmissie, Malawi

BEST AVAILABLE COPY

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- prescription of non-optical and magnifying devices to improve near vision (e.g. for reading) was not done
- there was lack of systematic keeping of records, including exchange of information on relevant data between eye care, education and rehabilitation professionals

THE EVALUATION

The evaluation was carried out over two weeks in June, 1997. Visits were made to centres in central and southern Malawi (Appendix 1)

The evaluation was conducted three months prior to the end of the three year appointment of the CBM Low Vision Advisor, Karin van Dijk, and the "handing over" of the program which will then be coordinated by Mr Raphael Chigadula. The purpose of the evaluation was to determine the extent to which the objectives set in 1995 had been attained and to make recommendations for the continuation of the Low Vision Programme.

The evaluation was conducted by Dr Jill Keeffe, Senior Research Fellow in The University of Melbourne Department of Ophthalmology, Australia and Ms Karin van Dijk, Low Vision Advisor, Christoffel Blindenmissie, Malawi.

They were accompanied by Mr Raphael Chigadula, a tutor and low vision coordinator at Montfort College, Malawi and for three days by Mr Ngosi, Senior Education Officer, Special Education, Ministry of Education, Malawi. An outline of the main findings were presented to Mr Malaidza, Director of Montfort College and his teaching staff at the end of the two week evaluation period.

Data were collected through interviews, review of records and curriculum documents, and observation of teachers and OMAs working with children. The forms used during the evaluation are included in Appendix II.

In addition three visiting ophthalmologists, Dr Brian Hoar, Dr Kevin Wade and Dr Janette Lindsey and an optometrist in Malawi, Mrs Rosemary Lowdon, re-assessed some of the children with low vision in order to evaluate the examinations carried out by some of the OMAs between March and June 1997. Results of that evaluation are included in this report. A 1996 evaluation report on the assessment of children with low vision carried out by OMAs is included in Appendix III.

LOW VISION

The definition of low vision used in the Malawi Low Vision Programme is the World Health Organization definition of low vision (WHO, 1992)

A person with low vision is one who has impairment of visual functioning even after treatment and/ or standard refractive correction, and has a visual acuity of less than 6/18 to light perception, or a visual field of less than 10° from the point of fixation, but who uses, or is potentially able to use, vision for the planning and/ or execution of a task.

The important distinction between this functional definition and that used in ICD9-CM is that everyone with usable vision is included as having "low vision".

Prevalence

There are no data available which can be used to provide an accurate number of children who are blind or have low vision in Malawi. What is known from the work of Dr Moses Chirambo and Dr Clare Gilbert is that Malawi has one of the highest prevalence rates of vision impairment in children in Africa. Chirambo et al (1983) in a survey of children aged 0 to 5 years found a prevalence of vision impairment of 1/10 per 1,000. This survey was in southern Malawi and the data is from a survey conducted approximately 15 years ago.

Causes

The most common cause of impaired vision in Malawi is from corneal scarring and phthisis bulbi which are caused mainly by vitamin A deficiency, measles, trachoma or traditional eye medicines. The relative contribution of corneal scarring and other eye disease depends on the population sampled. This is illustrated by the data collected by Clare Gilbert in the results reported to the International Eye Foundation (1994) and the latest data available from the Low Vision Programme (LVP) (Table 1). The implications of the differences between the two sets of figures is that there are more likely to be children who are blind when the predominant cause is corneal scarring and phthisis bulbi than if there are significant numbers of children with cataract and retinal causes, particularly albinism. In Gilbert's survey there was less than 1% (1/218) of children who had albinism, whereas in the Low Vision Programme figures there were 32/213 (15%). The Low Vision Programme data include the two schools for the blind, RCs and ITPs.

Site of Abnormality	Gilbert (IEF)	
	N	%
Cornea/phthisis (corneal scarring, phthisis bulbi, staphyloma, other)	123	56.4
Lens (cataract, aphakia, other)	23	10.5
Retina (dystrophy, albinism, other)	17	7.8
Optic nerve	10	4.6
Glaucoma	9	4.1
Idiopathic Nystagmus		
Whole globe	25	11.5
Refractive error		
Other	3	1.4
Unknown		
Total	218	100

Table 1 Causes of impaired vision in children who are blind and have low vision in Malawi

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Site of Abnormality	LVP	
	N	%
Cornea/phthisis (corneal scarring, phthisis bulbi, staphyloma, other)	70	32.9
Lens (cataract, aphakia, other)	54	25.4
Retina (dystrophy, albinism, other)	42	19.7
Optic nerve	6	2.8
Glaucoma	3	1.4
Idiopathic Nystagmus	10	4.7
Whole globe		
Refractive error	7	3.3
Other	12	5.6
Unknown	9	4.2
Total	213	100

Table 2 Causes of impaired vision in children with low vision in special education programmes in Malawi

Site of Abnormality	LVP	
	N	%
Cornea/phthisis (corneal scarring, phthisis bulbi, staphyloma, other)	103	66.4
Lens (cataract, aphakia, other)	9	5.8
Retina (dystrophy, albinism, other)		
Optic nerve	3	1.9
Glaucoma	2	1.3
Idiopathic Nystagmus		
Whole globe	22	14.2
Refractive error		
Other	10	6.5
Unknown	6	3.9
Total	155	100

Table 3 Causes of blindness in children in EDB programmes

* Whole globe Root cause mentioned by the children for enucleation was predominantly measles and further complications

The data from Table 1 and from Table 2 and 3 cannot be directly compared due to differences in methodology in data collection. The areas on the table that warrant examination are the different proportions of children found to have vision loss from corneal, lens or retinal causes. The differences are likely to be due to the differences in the samples. There are more children who are blind or with profound vision loss from corneal disease in schools for the blind and resource centres. There is a greater proportion of children with low vision in itinerant programs than there are blind children. Obtaining data from a total or representative sample of education programs has important implications for planning.

OBJECTIVES OF THE LOW VISION PROGRAMME

Objectives were set in 1995. These were to

Assessment of Vision and Vision Training

- Advise on and coordinate relevant structures for
 - regular screening of visually impaired children in blind schools, ITP and RC
 - identification of and referral of children with low vision (and adults) to medical, educational and rehabilitation services through two pilot projects in Salima and Chikwawa (Lower Shire)
- Assist in screening all children in the current Education of the Blind programmes, and new children through training specialist teachers and OMAs in order to
 - identify children who are blind, have low vision or normal vision
 - refer children for medical and/ or surgical treatment, check-ups and refraction
 - advise on appropriate education and placement for each child
 - prescribe appropriate low vision devices and non-optical devices
 - train children in the use of low vision devices
 - train children in effective use of vision in areas such as ADL and O&M
- Provide appropriate test charts for visual acuity testing and other assessment tools for the first three years
- Provide identified children with low vision with appropriate training, support and low vision devices where needed

Training

- Facilitate the training of the following groups of people in relevant areas of low vision which includes the keeping of records
 - Education
 - selected tutors at Montfort College Education of the Blind
 - specialist teachers (VI) working in blind schools, ITP and RC
 - Rehabilitation and pre-school
 - MACOHA staff involved in CBR work with children
 - CROs and CBR volunteers
 - CBR workers at Machinga
 - Pre-school
 - Cheshire Home staff
 - MAP physiotherapists and assistants
 - staff of Association of Pre-school Playgroups and selected volunteers
 - Medical Services
 - OMAs
 - other relevant health and education personnel

- Train the following groups of people in training others in low vision
 - selected tutors at Montfort College
 - relevant MACOHA staff
 - staff of other mentioned organisation to train their own staff
- Develop appropriate training materials for the different target groups and areas described above
- Develop curricula on Low Vision for all training programmes at Montfort College - Education for the Blind
- Train one or two counterparts to establish Montfort College as the coordination centre of low vision services in the areas of education, early intervention (pre-school), related rehabilitation and medical services
- Train one Malawian specialist in low vision at the International Low Vision Training Programme in Sweden
- Train the five OMAs who conduct mobile eye clinics in the five health service areas in quality subjective refraction and assessment of low vision people (with emphasis on children) to establish a sound base for the work of the Low Vision Programme in education
- Train a technician at Nkhoma Mission Hospital in the production of low vision devices for a period of one month, or a period as needed, in either Kenya or Botswana

- Supervise the low vision work of specialist teachers
- Evaluate the effectiveness of all training

Resources

- Provide the five OMAs with the necessary tools for refraction and assessment
- Evaluate the correct use, frequency of use and choice of low vision device for each child
- Examine, advise on and assist in expanding the local production, distribution and sale of low vision devices
- Organise the production and distribution of large print materials
- Expand the four to six selected existing Resource Centres into Low Vision resource Centres to be used for specialised assessment, advice and continuing teacher training, and as distribution points for low vision devices
- Examine if and how the Visual Efficiency Training Programme can be used effectively in Malawi

Low Vision Task Force

- Set up and coordinate a Low Vision Task Force through the Malawi National Prevention of Blindness Committee

General

- Integrate as many children with low vision as possible into their home schools
- Maintain records of the relevant data for each low vision child at Montfort College as a resource for evaluation and research

RESULTS OF THE EVALUATION

All schools, centres and teachers visited made the evaluation team most welcome and cooperated with all our requests

At the beginning of each visit to a Resource Centre or ITP, the number of children with low vision were checked. There had been some students who had transferred and others had left. Previously there had been many students included in enrollment figures who have normal

vision (visual acuity 6/18) This was again checked to ensure that all children included in programmes have low vision or are blind The enrollment in individual ITPs was as low as four students but averages about six students, most of whom have low vision

Training

Evidence of the scope and effectiveness of training was judged by observation of the skills of teachers and others, discussion and examination of records

Curriculum Documents and Supporting Materials

The content of the training courses conducted in Malawi over the last two years have been documented in three training curriculums and two practical booklets so that similar courses can be conducted by others in Malawi Drafts of the curricula and teaching materials were prepared by Karin van Dijk and circulated for appraisal and comment by others working in the area of low vision The final version of these manuals and the teaching materials have been printed for use by other trainers There is now available a set of documents which are most appropriate for local (African) needs which should prove to be a useful guide for others who will continue to conduct training in Malawi The curricula and teaching notes and instructions will also be useful for courses in other developing countries

- 1 Vision Screening and Primary Eye Care, for training Health Surveillance Assistants (Community Health Workers) and CBR workers to identify people with visual problems and to give eye health education It has been used by the low vision programme and by OMAs in the eye care programme
- 2 Low Vision - training curriculum for training OMAs in low vision, including a review of subjective refraction This has been used for training 14 OMAs in the field, 3 groups of approximately 22 students - OMAs at the SADCC 1 year training course in Lilongwe, Malawi and 15 ophthalmic nurses in Kwazulu Natal, South Africa
- 3 Training manual for training of specialist teachers and CBR workers in low vision This is being merged and finalised with the draft training manual developed by Jill Keeffe and Helen Nottle and will be published by October 1997
- 4 Booklet 'Working with pre-school visually impaired children' It is printed in English and Chichewa
- 5 Booklet with examples of vision training exercises to assist children in discrimination of details in pictures and eye-hand coordination

Educators Montfort College Tutors

Mr Raphael Chigadula enrolled and successfully completed the inaugural Bachelor of Social Science with a major in Special Education, Low Vision Therapy in Sweden in 1995-1996 Mr Chigadula attended two low vision courses conducted in Kenya in 1995 and 1996 As he was in Sweden and then working on a related project until the end of 1996 he has had little opportunity to implement training courses other than for the current teachers in training at Montfort College

Mr Edward Linyanga, tutor at Montfort College, has been trained in low vision together with the specialist teachers and received additional practical exposure

Specialist Teachers

The 62 specialist teachers in the field have been trained in low vision work with (school) children. They received 2 x 3 days training in 1995 and one week in 1996. Facilitator was Karin van Dijk, and from 1996 jointly with Mr Edward Linyanga. Objectives of the training of specialist teachers are outlined in Appendix IV.

From 1996 new specialist teachers completing visual impairment training at Montfort College receive low vision as a module in the curriculum. In 1996 13 were trained for resource centres and blind schools, in 1997 9 Itinerant teachers are being trained for Blantyre district.

In 1996 training of generic specialist teachers started at the Montfort main teacher training college. Fifteen of the 45 teachers trained that year took 2.5 months in visual impairment, which included low vision.

Mr Raphael Chigadula, low vision coordinator and Mr Edward Linyanga, tutor, have been the main facilitators in 1997 and this will continue in the future.

Classroom Teachers and Headmasters

SSI sponsored seminars for headmasters and classroom teachers of schools cooperating in the ITPs. To be entered once data from Montfort College have been received.

Rehabilitation and Pre-school

Community Based Rehabilitation Workers

Two groups of 8 CBR workers, one for Machinga CBR (funded by SSI) and one for Nkhotakota CBR (funded by CBM) including their supervisors, received training in vision screening, primary eye care and low vision work. Both groups received a total of 5 - 6 days training, in two parts.

Main facilitator was Karin van Dijk. The primary eye care, vision screening for the CBR Machinga workers was done by Mr Steve Kanjoloti, OMA, while Mr Mwalija, MACOHA rehabilitation specialist, concentrated on teaching methods used with children. Objectives of the training of specialist teachers are outlined in Appendix V.

The Salima CBR programme (funded by CBM) had 6 workers trained in screening.

Pre-school

Fourteen people, working either in pre-school programmes or disability projects received a one week training in working with pre-school visually impaired children, with a 2 day follow-up 6 months later. The aim was to ensure that children with visual problems are identified and worked with in an appropriate way. Objectives of the training of specialist teachers are outlined in Appendix VI.

The booklet "Working with Visually Impaired Pre-school Children" is used as a basis. UNESCO has used it in 1997, for training trainers for pre-school projects.

Some of the physiotherapists / trainers working with MAP, Cheshire Homes and the Pre-school Association have started taking vision into account when working with their mainly multiply handicapped clients

Medical Services Health Surveillance Assistants

In 1995 a pilot project to train HSAs in vision screening was started in cooperation with IEF in Chikwawa district. IEF already had introduced primary eye care work and was interested in extending their program. The aim was to identify and refer people with visual problems early. Three HSA supervisors were trained by Karin van Dijk to become the trainers.

In 1996 a start was made in Blantyre district. Facilitators here were OMAs Mrs Olga Mtambo and Mr Steve Kanjoloti. A total of 35 HSAs were trained using the Primary eye care/ vision screening curriculum. The length of training was 2 days. Objectives of the training of specialist teachers are outlined in Appendix VII.

Due to change of country directors in IEF in 1996, the HSA training stopped and is being picked up again in 1997.

Ophthalmic Medical Assistants

Seven OMAs received a one week training course in low vision assessment and retinoscopy in September 1995. One got was appointed to other duties, the remaining six were working as mobile OMAs and in Lilongwe, covering Malawi. A 1½ day follow-up training was given 6 months later.

A second group of 7 OMAs, including 1 tutor at the SADCC ophthalmic training course received 1 week of training in 1996, with a review of subjective refraction. Retinoscopy was not taught. Main facilitators Rosemary Lowdon, optometrist and Karin van Dijk. All 14 received together 1½ day follow-up training in early 1997. Objectives of the training of specialist teachers are outlined in Appendix VII.

All resource centres, blind schools and ITPs in Malawi have now access to an OMA trained in assessing low vision children. Low vision is now part of the curriculum for training OMAs.

In 1997 the 1 week training in low vision on the SADCC course will be given by 2 Malawian OMAs, Mr Steve Kanjoloti and Mrs Olga Mtambo, using the low vision curriculum for training ophthalmic staff, to ensure continuity of the training.

Results of Vision Screening by HSAs and CBR Workers

- 1 Chikwawa district People who attended the screening had complaints about their eyes or vision Results indicated that 52% of the people screened had healthy eyes

Eye findings	0-5 years	6-16 years	>16 years	Missing	Total (%)
Conjunctivitis, red eyes	23	21	25	2	71 (13.5)
Bitots spots, night blindness	1	1	6		8 (1.5)
Corneal scars, cloudy cornea		3	5		8 (1.5)
Cataract		4	2	1	7 (1.3)
Squint		2	1		3 (0.6)
Low vision - cause not recorded	1	5	19		25 (4.7)
Believed blind	1	1	5		7 (1.3)
Miscellaneous (sores, pain, 1 eye, tears, tumour, itching, yellow eyes, etc)	6	22	59		87 (16.6)
Not recorded, unknown	1	15	19	1	36 (6.8)
Healthy eyes	82	93	89	10	274 (52.2)
TOTAL	115	167	228	14	524 (100)

Table 4 Eye findings and vision of people screened in Chikwawa District by HSAs

LP - <6/60	6/60 - <6/18	>6/18	Not recorded	TOTAL
14 (2.7%)	22 (4.2)	346 (67.5%)	130 (25.3%)	512

Table 5 Distribution of distance visual acuity results from screening in Chikwawa district by HSAs

Visual acuity could not be tested in children up to 5 years of age, n = 82

N8 - N12	N16 - N20	>N20	Not recorded	TOTAL
317 (61.9%)	34 (6.6%)	21 (4.1%)	140 (27.3)	512

Table 6 Near vision results from screening in Chikwawa district by HSAs Visual acuity could not be tested in children up to 5 years of age, n = 82

From the results, the number of 125 referrals would appear to be appropriate - VA 6/18, conjunctivitis, Bitots spots, cataract, squint and corneal scarring. The OMA confirmed the appropriateness of those referred to them. The exact number seen by the OMA are not known but have been estimated to be about 50 (40%)

In the 0 -5 year age group early identification and treatment of a 'simple' problem such as conjunctivitis, is the most important outcome

- 32/115 (27.8 %) seem to have eye and/or vision problems
- 2 (1.7 %) were found to be blind or have low vision
- the number of irrevocably low vision among the 27.8 % is not yet known

In the school age group more severe problems were found. This could be due to the fact there was no early identification when these children were younger and that visual acuity can be reliably tested

- 4 (2.4 %) were identified with cataract
- 2 (1.8 %) with corneal scars
- of the 5 recorded as having low vision, 1 has been confirmed as having low vision, results on the other 4 are not yet known

Identification of people with possible eye and vision problems by basic health workers (HSAs) is a good possibility. The number of people referred to and seen by the OMA needs to be improved, the reasons for non-attendance by people referred needs to be determined. The OMA in the area has now established fixed mornings in the week when he will be at the district hospital, in addition to his regular visits to health centres

2 Blantyre district

In 1996 a start was made through the training of 15 HSAs in vision screening and Primary Eye Care to identify people with eye or vision problems. This will be extended to 3 more areas in 1997. An attempt will be made to include HSAs who are working in areas where the Blantyre ITP will start in the second half of 1997

Data from only 11 HSAs have been received so far. Of the 6 HSAs who recorded treatment of TEO - 48/138 (34.8 %) patients they saw were treated with TEO. Their diagnosis and treatment of these has not been able to be checked. Seventy-five percent of those treated were not referred to an OMA as if no other condition was present, referral would not be necessary. Five of the 11 HSAs did not record if they had treated their patients with conjunctivitis with TEO (they have supplies of TEO)

44/186 (23.7 %) screened were referred. The number seen by the OMA is not known yet, as follow-ups have just started, due to lack of OMAs at the Central Hospital of Blantyre

Both in the 0 - 5 and the school age group conjunctivitis was the main problem identified, while 6 corneal scars and 2 cataract were reported in the over 16 years of age group. This confirms findings in Chikwawa that conjunctivitis is a concern and that there are some previously unidentified people with low vision and blindness

Eye findings	0-5 years	6-16 years	>16 years	Missing	Total (%)
Conjunctivitis, red eyes	28	21	25	2	76 (40.9)
Bitots spots, night blindness	1	1	1		3 (1.6)
Corneal scars, cloudy cornea			6		6 (3.2)
Cataract				1	1 (0.5)
Squint					
Low vision - cause not recorded		2	2		4 (2.1)
Believed blind					
Miscellaneous (sores, pain, 1 eye, tears, tumour, itching, yellow eyes, etc)	3	4	9		16 (8.6)
Not recorded, unknown	1	4	3	1	9 (4.9)
Healthy eyes	1	39	29	2	71 (38.2)
TOTAL	34	71	76	5	186 (100)

Table 7 Table 1 Eye findings and vision of people screened in a suburban area of Blantyre

3 CBR Machinga

The data available are until May 1997. Eight field workers started their screening in the summer of 1996. These are the results, given by Mr Mwalija, MACOHA rehabilitation specialist and collected by Mr Chimowa, the CBR supervisor. These data have not been independently checked.

The total number identified with possible visual problems was 567. Of those 417 (73.5%) were referred for clinical assessment by an OMA. Those not referred were regarded as irrevocably blind and/or already had hospital forms showing this.

Seen by the OMA- 229

- 58 (25.3%) received or identified for sight restoration
- 18 (7.9%) referred for special education (school children)
- 94 (41%) are receiving functional training (blind/ low vision)
- 59 (25.8%) unknown

Due to organisational problems, training work with low vision clients did not start till April/ May 1997 and no results are yet available on that area.

4 CBR Nkhotakota

Five CBR workers and 2 CBR supervisors started to identify people with disabilities, referring those with problems and started training those who were irrevocably disabled at the end of 1996

After the training in vision screening, the results concerning vision problems from 44 villages covered in the first phases of the programme have been reported by Dr Brian Savage, CBM ophthalmologist

Total number identified with possible visual problems - 646, i.e. approximately 15 people per village

Number who came for an eye check	416	(65 %)
The results from those reported on are		
Diagnosis		
Corneal scars	91	(26 0%)
Active trachoma	47	(13 4%)
Trichiasis	31	(8 9%)
Allergic conjunctivitis	33	(9 4%)
Immature cataract	64	(18 2%)
Mature cataract for surgery	10	(2 9%)
Presbyopic or aphakic glasses supplied	24	(6 9%)
Refractive errors	25	(7 1%)
Retinal or optic nerve disorders	16	(4 6%)
Referred for low vision assessment (2-16 yrs)	9	(2 6%)
Total	350	100 %

The vision screening and identification of people with possible vision problems can be considered successful considering the number of people identified and subsequently found to have avoidable or treatable vision problems. The field workers had received 2 days of training. Data on the training of those with irrevocably low vision clients is not yet available.

Use of Tetracycline Eye Ointment (TEO)

Treatment of conjunctivitis by HSAs with TEO seems an important part of control / prevention of eye problems in both programmes. IEF and the Low vision Programme did a short evaluation, through interviews and observation of HSAs of the use of TEO in Chikwawa. It was found that treatment was given for the right reasons in the majority of cases. Frequency and length of treatment was correct, except where patient lived far away from the HSA. Unless a tube was given to the patient, treatment would be done only once in these cases. A separate evaluation report is being prepared by IEF and the low vision programme.

Programmes - Clinical services

As outlined earlier 13 OMAs in areas where there are Blind schools, resource centres and ITPs are assessing children with possible low vision and prescribing glasses for distance correction and magnifying glasses. If a need for magnifiers is noted, the OMA refers to the low vision coordinator or the advisor.

A choice was made to concentrate on magnifying glasses for school age children, since OMAs were already used to prescribing glasses and found this easy to add to their services.

It was also felt that children are both able to read and write using glasses, while writing is more difficult when using a magnifier

The performance of the first group of OMAs who learned retinoscopy, was evaluated in 1996 and the complete report can be found in Appendix III. The results were overall encouraging, considering the limited training given

A second limited evaluation was done in 1997. The results of 3 OMAs trained in 1996, (16 children) who can only use subjective refraction and 2 OMAs who can use retinoscopy (23 children) were compared with the assessment results of an ophthalmologist or optometrist

Main findings

Diagnosis was correct in all but 1 case, although incomplete in 8 (Additional problems like nystagmus were omitted)

Refraction

- evaluator and OMA agreed in all cases when a refraction was judged to be impossible, due to corneal or lens opacities

Results of the 2 OMAs trained in retinoscopy and subjective refraction

- 7 out of the 11 were accurate

- 4 were not accurate. However the difference was small and in none of these cases were glasses prescribed. Therefore the result did not detract from the child's resulting visual status

Results of the 3 OMAs trained only in subjective refraction

- 7 of the 13 were accurate

- 6 were not accurate. 4 of the inaccurate refractions were children with high refractive errors. No glasses were prescribed for the other 2 inaccurate results, so nothing changed in the child's visual status

All OMAs appear to diagnose and refract children with lower refractive errors correctly. OMAs who can only do a subjective refraction seem to have difficulties in detecting high refractive errors. Retinoscopy is here a useful tool. The OMAs using retinoscopy pick these up accurately

Prescription of distance glasses

- orders were filled in correctly in all cases

Near vision/ magnification

- near vision was taken routinely and correctly in all but 3 cases. In

these 3 the OMA did not record the smallest size, but one size larger

- magnifying glasses were prescribed for 7 children. 6 correctly, while 1 child was prescribed too much magnification

There is still a tendency not to prescribe children with N 8, who can only read at a very short distance such as 4 - 5 cm, low power magnifying glasses. It is encouraging to see it is starting to happen as can be seen from table 10

Record keeping

- in all cases refraction forms were filled in correctly

Evaluation of more OMAs and their children is planned for August 1997. A more complete report will be prepared then by Rosemary Lowdon and Karin van Dijk.

Every year all OMAs involved in the low vision work will get short follow-up training, combined with time for planning assessments. Areas like prescription of low power magnification and detection of children with high refractive errors will be included.

Programmes - Education and Rehabilitation

There are currently 60 specialist teachers working in 2 blind schools, 13 primary school resource centres, 6 secondary school resource centres and in ITPs in 5 districts. As outlined under clinical services the number of low vision children in the boarding facilities is 127. The number of whom forms have been received in the ITPs is currently 86. From visits, it is estimated that there are an average of 6 low vision children per IT teacher, which would mean that there are possibly 180 low vision children in the ITPs. Some ITPs have only 4 students as some of their enrolled students have been assessed and found to have vision within the normal range.

During the evaluation 5 resource centres, 1 blind school and 5 itinerant teachers were visited. Together they had 75 low vision children under their care. An additional 25 children, mainly in the ITP had not yet been assessed. One of the 5 ITs was also visiting children who had been not clinically assessed, the others said they did not visit children until after assessment by an OMA.

Assessment of Vision by specialist teachers

Records were reviewed and many of the specialist teachers were asked to demonstrate an assessment of distance and near visual acuity and functional vision.

Distance Visual Acuity Testing

Some teachers showed that they had a good understanding of the use of the test, correct test procedures and accurate recording of the results but there were many who had not achieved these skills. Points which need to be taught or consolidated in training teachers and others to test distance visual acuity:

- teach children so that they understand the requirements of the test
- correct test distances
- sequence of steps to test acuity and correct use of charts used
- testing visual acuity to threshold or required criterion
- correct recording of results, especially if other than 6 metre test distance used
- need to test one, each or both eyes

A comparison of the VA recorded by the OMA with the one recorded by the teacher indicates the accuracy of the VA obtained by teachers (Taking into account that the OMA is not always right!)

29 forms were studied

Distance acuity	Accurate 26	Not accurate 3
Near acuity	Accurate 22	Not accurate 7*

Near Vision

As with distance visual acuity testing, many teachers were not competent to test near vision. Near vision was not tested with all students. Common incorrect procedures were

- use of 'normal' reading distance rather than find the smallest size seen at close distance
- not attempting smallest size*

When different tests were used (LH and LV Kit tests card), teachers did not understand the equivalence of sizes used in the tests

Since the fixed assessment days by OMAs of children have been introduced the likelihood of teachers working with children who have not been clinically assessed has become less. This has also reduced the time between identification of a child by the teacher and assessment by the OMA from up to 6 months in some cases in 1996 to anything from 1 week - to a maximum 3 months in 1997. Teachers also reported that they had good access to and information exchange with OMAs to discuss issues related to their students. The blind schools and resource centres were generally assured of scheduled visits by an OMA or access to a district hospital so that the time between identification and assessment was reported on average to be about 1 month.

From the forms used during the evaluation (Appendix II) and records of all 213 low vision children currently assessed (see Table 10 on next page), it emerged that teachers had obtained information from OMAs on diagnosis of the cause of impaired vision, refraction to determine if glasses would improve vision or not, the need for magnification and if had been tried. Completed forms by teachers and OMAs were evidence of the efficient exchange of information from vision screening and testing by teachers and subsequent examination by OMAs. Of the teachers visited in RCs and ITPs, most referral slips filled in by the OMA were still with the teachers. The information on the vision screening record forms showed what had been learned from the OMA (9 vision screening record forms were not found)

- information on 3 children, just assessed, had not yet been entered
- 2 children had recently arrived from other resource centres and no information had been received from the previous teachers
- no records had been kept on 4 children
- even if refraction details had not been recorded, the prescription of glasses had been noted

Information	Complete	Incomplete
Diagnosis	102 (96.2%)	4 (3.8%)
Refraction/ glasses prescribed	94 (88.7%)	12 (11.3%)
Near vision/ magnification	98 (92.4%)	8 (7.6%)

Table 8 Information exchange using forms between OMA and specialist teachers

Learning Media

	Print	Braille	Print & Braille
Boarding	46 (38.6%)	20 (16.8%)	53 (44.5%)
ITP	86 (88.7%)	9 (9.3%)	2 (2%)

Table 9 Use of braille, print, or both by students in special schools, resources centres (boarding) or itinerant programs (ITPs) No information was available on the reading medium that 13 children were using Source forms returned to the Low Vision Programme

Of the 75 children visited during the evaluation

- 40 were using braille and print, this represented children changing from braille to print
- 29 were using print only
- 4 were using braille
- 2 were pre-school children prior to a decision of braille or print

The learning medium used was correct in 73 of the 75 cases In 2 cases, the children should have been using print only instead of braille and print It is yet unknown how many of the 40 currently using both braille and print will ultimately use print only

Functional assessment

Many teachers had made use of the materials and ideas in the Low Vision Kit to conduct assessments of some of the children with low vision Some showed that they were familiar with the procedures and selected appropriate items to use to assess children Teachers had been introduced to both the short and long forms of assessment in their training but did not seem to thoughtfully apply the guidelines they had been given

Many teachers had only partially completed an assessment It was common to have administered only a few items early in the year and not to have completed the rest of the assessment There was often no evidence of the application of results or other vision related assessment or training

Of the 75 low vision children under the care of the teachers visited, the following was done

Complete functional assessment	52
Short version	7
Incomplete functional assessment	2
Not done	14

Interpretation of the results of the assessment was

Appropriate	43
Not appropriate	4
No suggestions made	12

This confirms the impression that a number of teachers needs to practice these skills with the low vision coordinator when he visits

The knowledge and skills of teachers in the assessment of functional vision and the use of results to plan training was observed in classrooms and by examination of teachers' records. Teachers had access to basic materials in the form of the Low Vision Kit. The activity books prepared by Karin van Dijk provided some additional materials for use in vision training programmes.

Vision training

As shown above, 16/59 of the teachers had not been able to appropriately interpret the results of the assessment of functional vision. There were also other instances where the training outlined was not related to the results of the functional assessment.

Notes of training activities were often very brief with little detail of the activities or notes on children's responses or needs for follow-up. The sequences did not follow the hierarchy of skills recommended for use in vision training, more difficult skills were taught before more simple pre-requisite skills. In most programmes notes observed, only one session was devoted to teaching a skill area where it is probably more appropriate or necessary to teach and consolidate skills over many sessions.

For children changing from braille to print there was no evidence of vision training activities to support the change.

Many children observed were in need of training to improve eye-hand coordination but few appeared to have had such training. Teachers had been issued with copies of the activity book prepared by Karin van Dijk but were not utilising it despite not having any other resources books in this area. The only other resource books in addition to the Low Vision Kit were the Fichtner Visual Efficiency Training Programme books.

Children assessed

The following data are taken from low vision children with complete refraction forms. Information from October 1995, when the OMAs started their low vision work until June 1997 (where available) have been used. As can be seen from the table showing number of blind, low vision and normal vision children, the total number of low vision children of whom records have been received by the low vision programme is 213. The number will rise considerably once the records of all children in the ITPs have been received. Assessment is an ongoing process, and records are sent to/ collected by the low vision programme yearly.

	Blind	Low vision	VA = 6/18	Normal vision >6/18	Not seen by OMA
Boarding	234	127	7	6	12
ITP	38	86	19	255	177
	272	213	26	261	189

Table 10 Number of children with normal or low vision or blindness 1995 - 1997

All 6 children boarding who have VA > 6/18 have left, while those with VA 6/18 have been advised to leave. The 12 children still to be clinically assessed in the resource centres, all arrived within the last months. In most cases contact has been made with the OMA in the area for assessment.

Fifty-five of the 177 children not assessed in the ITPs are on the 1996 list, but information on their assessment had not been received yet from a teacher and/or OMA

The number of children with normal vision in the ITPs can be split as follows

- 45 / 255 (17.6%) children in the ITP improved through correction, from a visual acuity below 6/18 to a VA of 6/12 or more
- there are records of 210 / 255 (82.5%) children who already had VA 6/18 or more, before clinical assessment. All these were referred by IT teachers. The number is higher, but records are not always kept of children not needing any assistance

From percentages found in 1996, it seems that these are the reasons for referral

- 1/3 are referred because one eye has a VA < 6/18
- 18% have eye problems such as conjunctivitis or early trachoma
- 9% have a refractive error

Around 40% seemed to have no eye problem or it was not recorded. This number includes those incorrectly screened by the specialist teacher

The assessment of children identified in the ITPs has improved considerably. The low vision programme, in cooperation with the OMAs concerned, has planned fixed assessment days. Each teacher can bring newly identified children to the nearest district hospital where the OMA is based, once every school term. The low vision programme pays for transport of child, parent and teacher as a trial. In 1998 financing will be included in the SSI funding of the ITPs

Glasses and magnifying devices

Spectacles

The prescription for spectacles is derived from subjective refraction or retinoscopy by an OMA or occasionally from an ophthalmologist or Mrs Lowdon (optometrist). Thirteen OMAs have been trained in subjective refraction of people with low vision, only five OMAs have been trained in retinoscopy. Dense media opacities are very common in Malawi and so preclude objective refraction in many children.

The effectiveness of refraction by OMAs has been evaluated previously (Appendix III)

An optical workshop for the manufacture of low cost spectacles and magnifiers has been funded by CBM at Nkhoma Mission Hospital. It is modeled on those operating in Kenya and Botswana. The workshop supplies the needs of many Mission Hospitals and the Low Vision Programme. CBM has recommended that Nkhoma services be extended to other consumers in Malawi in order to become self sufficient rather than rely on external funding from CBM. Assurances have been made that people who are part of the Low Vision Programme who need spectacles or magnifiers will continue to receive priority. In the workshop, lenses are surfaced from -1 to +3 and spherical lenses from -20 to +20 are kept in stock. Both second hand plastic and metal frames and new plastic frames are used.

Data on all children in the low vision program who have been prescribed spectacles have been analysed to compare the unaided visual acuity, the visual acuity obtained with the subjective or objective refraction and the final visual acuity with the spectacles prescribed.

During the evaluation teachers were asked about the efficiency of the provision of glasses in terms of time for delivery and accuracy of fit of the glasses received
 Correctly filled in records of 203 of the 215 low vision children and 14 children who improved to 6/18 have been used for the following table

Presenting visual acuity	Refraction	Awaiting surgery	No improvement after refraction	Improved to <3/60		Improved to 3/60 - <6/60		Improved to 6/60 - <6/18		Improved to 6/18	Total	
				NC	C	NC	C	NC	C			
LP - <3/60	28	3	7	3	4	-	3	2	5	-	-	55
3/60 - <6/60	17	5	13	-	-	-	2	3	8	-	-	48
6/60 - <6/18	28	4	43	-	-	-	-	14	11	7	7	114
Total	73	12	63	3	4	-	5	19	24	7	7	217

Table 11 Distance vision and prescription of glasses (NC = VA with the actual glasses not checked yet, C = checked)

Fifty-five (27%) of the 203 low vision children were prescribed glasses, while another 14 improved to a VA of 6/18. Of the 96 pairs prescribed, there is evidence that

- 23 children have an improved VA with their glasses
- of the 6 children who have the same VA, 3 like wearing the glasses and report it helps vision, the other 3 are not wearing them
- of 40 children information on the resulting VA with the prescribed glasses is yet unknown

The power of the lenses prescribed are summarised in Table 12

A total of 30.3% (25.7% + 4.6%) falls within the +3.00 D to -3.00 D range which are available from various sources in normal circumstances. An additional 30.3% are aphakic glasses which are normally available through different hospitals. The other 40% are special prescriptions.

After diagnosing astigmatic refractive errors twice as many spherical equivalents were prescribed as actual cylinders. This is important to note, since cylinders have to be ordered especially from South Africa, take 3 or more months to arrive and are expensive.

Lenses prescribed	Number	Best spherical equivalent	Total N	Total %
Sph 0 00 to -3 00	13	4	17	25 7
Sph 0 00 to +3 00	3	-	3	4 6
Sph >-3 00	11	4	15	22 7
Sph >+3 00	6	-	6	9 1
Aphakic +10 00 to +13 00	18	2	20	36 3
Cylinders	5	-	5	7 6
Total	56	10	66	100

Table 12 Glasses prescribed

Note Information was omitted on 3 children who were prescribed glasses as the forms were not able to be interpreted

All refraction forms with an order for glasses and/or magnifying glasses are sent to the optical workshop of Nkhoma Mission Hospital After initial problems, there is now a range of lenses from - 19 00 to + 20 00, and + 28 00 in stock The time from order to the receipt of glasses by the child (sent by post to the teacher from Nkhoma, since OMA and child are often far apart) is on average less than a month None of the glasses sent by post has been broken during transport

	N8 - N12 6/19 to 6/7 5	N16 - N20 6/24, 6/30	>N20 6/38	Total
Total no unaided	123	29	41	193
<u>Not assessed for magnification</u>	81			81
a Not needed				
b Waiting for surgery	7	6	3	16
c Need to be assessed	11	2	12	25
<u>Assessed for magnification</u>	7	6	11	24
a Tried, not prescribed				
b Distance prescription improved near	2	2	1	5
c Prescribed, near VA improved	N8 - N12 15	N8 - N12 12	N8-N12 N16-N20 >N20 2 9 2	40
Trying stand magnifier		1	1	2

Table 13 Near vision and magnification

Note In some cases the size print did not get smaller with magnification, but the distance improved

Near vision and magnification

- The N16 - N20 category is the size print used in schoolbooks in standard 1 and 2 (large print)
- N24 and N32 are in the majority in the category > N20
- Twenty of the 213 either had such poor near vision, such as HM, or magnification could not be assessed due to learning difficulties or other problems that their records have not been used in the above table
- The N8 - N12 category is predominant in the ITPs
- Half of the 40 pairs of magnifying glasses have been checked on the children, all gave an improvement, either in size or in distance

To summarise the results of the 213 low vision children

- 9.4% (20) of children's near vision could not be assessed for the reasons outlined above, while 7.5% is awaiting an operation, before magnification is tried
- 19.7% was prescribed magnification, while 2.3%'s near vision improved with the distance prescription
- 11.7% still needs to be assessed for magnification
- 11.4% did not benefit from magnification, mainly because of corneal problems
- 38% did not need magnification in the first place, this number will be higher after the children needing an operation and those who have not been assessed yet, are looked at

In Malawi children who are unable to have near vision corrected or improved with magnification to N20 or less are unlikely to be print readers. Beyond Standard 3, the print in books is generally N8 which, in the absence of large print, means that braille is necessary. From Table 11, from the 41 with near vision of >N20, there are 26 children (less 3 awaiting surgery and 12 still to be assessed) who would be expected to need braille as their learning medium. The number currently on braille alone is 29 (Table 9). The results of near vision testing and assessment for magnification confirms the appropriateness of that number of braille readers.

Surgery

Low vision children identified for an operation have to wait a considerable time before being operated. Firstly it takes time to obtain permission from parent or guardian. It is usual to take up to 3 months for children boarding as parents are at the most met once a term, whereas it is less than a month in the ITPs where teachers live near the parent / guardian. Secondly it takes time for the teachers to inform the OMA and/or low vision programme that permission has been obtained. This could be speeded up, if the OMA was being contacted by post directly after permission is obtained. Thirdly the time between permission and the actual operation is at best between 2 and 3 months (which is normal, since school holidays are the best time for operations), but commonly between 3 months and a year. There are several reasons for this:

- there are very few ophthalmologists in Malawi
- transport has to be arranged for children from all over Malawi to either Blantyre or Lilongwe. In 1995 and most of 1996, Lilongwe and Nkhoma, which are near each

other, were the only places where children could be referred to. The situation has improved, now Blantyre has its own ophthalmologist
- teachers are sometimes late in informing the OMA about permission

After low vision children started to be identified for operations from October 1995 onwards, unto date, the situation is now as follows

Identified for operations/ further investigation	60
Operated/ received further investigation	23
Dates fixed for an operation	2
Permission obtained, but not yet operated	10
Permission unknown	8
Permission refused	10
Left school / transferred to unknown location	7

The above information was gained from sending all teachers who have children identified for operations an extensive questionnaire. From 60 Questionnaires sent out this picture emerges (Questionnaire can be found in Appendix 9)

- specialist teachers often get the same answer, yes or no, as an OMA when talking to parents / guardians. The OMA apparently does not carry more weight

Reasons for not giving permission are noted down as follows

- a previous eye operation on child or other family member was not regarded as successful
- religious reasons
- fear of child becoming blind or dying

All parents/guardians interviewed mentioned that they could not afford to stay near the hospital when their child was being operated but there is no evidence that this has prevented children being operated so far. Transport of the children to the hospital is being paid for by the low vision programme, once the OMAs have organised dates.

A more detailed report on surgery of low vision children will be published shortly by Paul Courtright and Karin van Dijk

At the moment 10 children are waiting for an operation for whom permission is being received. The OMAs are trying to arrange for their operations in August. Teachers of children where the status of permission is unknown have been urged to find out what the parent/ guardian wants.

The low vision programme has started to update the numbers for operations and permission every term and sends the OMAs concerned the information.

Orientation and Mobility (O&M)

Few teachers are teaching O & M to children with low vision or not teaching skills specific to low vision. There may be a number of reasons for this. Reasons given or observed were

- children develop independence and protective skills in early years, they are not overprotected so learn some basic and safe mobility
- decisions were not based on functional assessment but purely on visual acuity which does not indicate the need for O&M training
- seminars in low vision introduced use of vision in O & M but this was not seen as high a priority (given time and skills needed) as other areas in the seminars

- a lack of understanding of concepts and language needed for training O&M to people with impaired vision in general and low vision specifically
- the courses at Montfort do not provide specific training in O & M for people with low vision but concentrate O&M for people who are blind
- some teachers use the same methods as for people who are blind
- some only teach routes within the school and not skills to generalise to unfamiliar situations

Record keeping

Records on all but 4 of the assessed children were kept. On 54 children, complete records were kept, while on the others vision screening record forms and/or referral slips could be found, but functional assessment and/or progress record forms were missing. If records were updated depended often on the fact if the child had been (re) assessed lately. Activities done with the children, be it vision training or practising print were not regularly recorded.

Resources

Visual Acuity Charts

All teachers have the following

- Snellen E chart
- Snellen letter chart
- small E-chart
- near vision charts- words in English, Chichewa and numbers

All primary school resource centres and the 2 blind schools in addition have

- LH single symbol book
- LH near vision chart (symbols)

All ITP teachers in charge also have a LH distance and near set, as do an additional 15 ITP teachers

Non-optical Reading and Writing Devices

Reading Stands

Simple wooden reading stands similar to that illustrated on page 51 of the Low Vision Kit have been made by the carpenter at Montfort College. The stands have been designed to sit on a desk or the floor. There are no or few desks for students in many classrooms in Malawi. It has been decided that an alternative stand will be made which can be rested on the student's legs while sitting on the floor. This will be a useful alternative to the current stand.

All schools for the vision impaired, RCs and ITPs had at least one reading stand. Whilst the stands are designed for both reading and writing, many students made no or limited use of the stands using them only for reading or writing and not necessarily when indicated by a short working distance resulting in poor posture. Often reading stands were used only in the RC and not in classrooms. This situation may improve with the introduction of the new stand designed for use in classrooms with no desks.

Writing Guides

A modified locally made writing guide can be used to assist in early stages of writing before regular or bold lined books are used. These were available for use by students in some RCs but often not in ITPs or in the school for the VI. Very little use was made of the guides but could be used in early writing programs for some students beginning writing.

Typoscope

A typoscope or reading slit is put over a page to reduce glare and helps to keep the place while reading. They have these been supplied by Karin van Dijk to all schools, RC and ITP. Most teachers or centres did not use typoscopes with students. Some teachers were aware of the advantages of a typoscope.

Bold-lined Exercise Books

Sight Savers made available books with dark green or black lines to assist students to align their writing. The whole stock of books have been distributed mainly to ITP with some to schools for the VI and RCS. Some teachers had assessed students' writing in regular books and noted the need for darker lined books. Others made the choice based on the knowledge that lines of a greater contrast would be better for students with low vision. The books were often chosen because of the spacing between the lines is larger (only slightly) than in the books issued to all students. Some resistance to use of the books was noted by students who want an exercise book the same size as the other students use.

Karin van Dijk has opted for the use of writing guides instead of bold-lined books as an aid to beginning writing which can be used with any paper or books.

The Ministry of Education now provides exercise books to children with low vision as they do for sighted students throughout the country. Schools for the VI can place orders with DEOs to receive the necessary books.

Pens

Thick 'felt pens' and black ball point pens have been distributed to all schools and centres. Usually the felt pens are used by RC or class teachers to prepare material for students' use. Very few students use the felt pens but most use the ball point pens. It is standard practice for students in Standards 1 and 2 to use pencils. Some low vision students at the lower levels have been allowed to change to using pens which give greater contrast, teachers need to be encouraged to allow all students with low vision to use a darker pen if indicated.

Large Print

The Ministry of Education aims to supply text books so that there is at least one book for each two students. Ideally there should be one book for each child with low vision. Text books in the early grades have print which is suitable for most children with low vision.

The Ministry provides examination papers in large print when requested for students. There is a choice of two enlarged sizes. There was no evidence of guidelines for assessment of students to determine the most appropriate size for each student.

It has been decided not to commence production of large print at this stage. The aim has been to assess near vision and needs for magnification. The demand for large print is not yet known. There is envisaged to be many obstacles to the production and distribution of large print, one of which is cost. Priority has been given to refraction, assessment of near vision and magnification needs.

Low Vision Task Force

The Low Vision Task Force was established under the auspices of the National Prevention of Blindness Committee. It has met three times a year since its first meeting in May 1995. The Low Vision Advisor, Karin van Dijk acted as chairperson of the Task Force. The members

of the Committee represent MACOHA, Ministry of Education, OMA training at Lilongwe School of Health Sciences, Montfort College, the International Eye Foundation (IEF) and the Malawi Union of the Blind. Individuals working in areas related to low vision also attend the meeting - Mr Steve Kanjoloti (OMA, Chikwawa), Mrs Rosemary Lowdon (optometrist), Dr Batumba (ophthalmologist). The Chairperson, Montfort, IEF representatives and the ophthalmologist who attend the Task Force also sit on the National Prevention of Blindness Committee.

One of the important functions of the Task Force has been to facilitate communication between the different professionals and organisations which have interest in the Low Vision Programme. It has reviewed and had input into policy documents such as the guidelines for admission of students into schools for the VI, RCs and ITPs which has officially been approved by the Ministry of Education. The Task Force has reviewed the objectives of the Low Vision Programme and coordinated activities in different areas of eye care, education and rehabilitation especially in training and resources.

The formation of national groups which bring together the medical, education and rehabilitation professions under the umbrella of a National Prevention Blindness Committee such as this Task Force is to be encouraged. The preventive, curative and rehabilitation aspects of low vision should be an integral part of public eye health planning.

The Low Vision Programme

During the evaluation, teachers, students and others were asked what the Low Vision Programme meant to them. Comments are reported as told to the evaluators.

Students exposed to words and newspaper, magazines. Read other books, more available in print than in braille. Can read every day signs, able to communicate with friends.

Reading print now and "joining the world"

"There are pictures in print books but none in braille"

"I might be able to go beyond Standard 8 if I can read print"

"Now the same as others students because I can read print"

Standard 8 can write exams

Progress is not easily seen in the early stages of LV programmes but after vision training, students have progressed more quickly.

Some students are still sharing print text books.

Transport is a problem, I would like also to follow up children at home.

Seminars needed for class teachers to share ideas.

Occasional concern of teachers that they need to keep students on braille in case vision deteriorates.

Low vision programmes entail planning a lot of activities for the students which takes a lot of time.

No problems with parents in changing children from braille to print - can communicate with their children.

Children were previously 'neglected' as no one knew they had low vision.

Introduced both braille and print but have changed to print.

Teacher needs to assess pre-school children but not able to do so when he can't use VA cards.

With print, students are enjoying life reading newspapers, using vision at home and reading signs such as bus numbers.

No resistance from parents in changing from braille to print as they are happy that they can communicate with their children

Now know how to assess size of print needed by students with low vision

Possible new students referred from headmasters in surrounding area - informed through DEO of ITP

Class teachers can read children's work and monitor progress which is not possible when children use braille

The role and work of the RC teacher has changed with less braille to transcribe now many children have changed to print. In some RC teachers have to spend a great deal of their time transcribing students notes so that they can be returned to class teachers to mark students' work. This greatly reduces the amount of time to teach VI students. Is it possible to consider the use of non-teacher trained braille transcribers in RCS where there are high enrollments with many braille using students? This would make more of the teachers' time available for the specialist teaching of VI students

Braille is sometimes used by students with low vision for examinations even though they are described as print users

Teachers have to learn new language to assess and understand use of vision, e.g. scanning

Children are motivated to use their vision and take pride in the work they are doing. They are excited about using print

Print tests and exercise books are now needed in schools for the blind and in RCs. Application can be made to DEOs to obtain materials for students with low vision. Materials and reference books are needed for vision training programmes

One teacher requested that he would like large print books for four of his students. (When we investigated the needs of these students, two of them may benefit from large print, the others able to use regular print effectively.)

Children can learn without the presence of the specialist teacher in the classroom unlike the blind children

General comments

Students observed in class rooms were seated in an appropriate area of the classroom to optimise light available and distance from teacher/ board. In many of the classrooms, text books were not available or used, teachers presented good oral lessons and included vision impaired students in discussion. Copying from boards present problems, telescopes are unlikely to alleviate the problems as the contrast on the board is poor and there is low light levels in most rooms. Student next to vision impaired student read notes, some teachers read notes as they are written on the board and for younger students some teachers write notes on black felt pen for student to copy. Teachers observed in classrooms appeared to have a basic understanding of the needs of students with low vision

A telescope had been issued to one RC but teachers did not know how to use it so it had been locked in a cupboard. The future use of telescopes in schools need to be considered. The CBM 2x telescope may have some benefit. Many teachers are still not good though at teaching use of near magnification

Teachers feel that there is more work teaching low vision than blind students as individual assessment and planning is needed but they also acknowledge that it is easier to teach print than braille, especially for those with little or no special training

There appears to be a need for prescriptive training of teachers in methods of working with students as they have not been able to modify or build on ideas given to them. They also need additional resource books such as the activity book of ideas for vision training prepared by Karin van Dijk. Teachers in training could prepare books which could be shared and thus build up a collection of activities for teaching their students with low vision. They also need to make more use of the activities outlined in Book 2 of the Low Vision Kit.

There were some requests for refresher courses on low vision for specialist teachers. It is felt that there is more need for practical assistance in their schools or centres to work with their own students. Any further courses should not be scheduled until there is supervision and "hands on" training in each teacher's centre to improve practical knowledge and skills. It is not envisaged that additional courses would be conducted in the next year or so.

There were requests for large print books, particularly for Standards 5 - 8. The print in lower Standards, certainly 1 and 2 and some in 3 contain very good clear large print. Tables 9 and 13 indicate that most students at this stage can use the print available with or without low vision devices. This should be the priority - to assess students for their ability to use regular print books and if necessary to supply magnification devices.

During the evaluation we met some Montfort students who were on a teaching practice period - knowledge and skills with low vision students were not well developed yet.

RECOMMENDATIONS

Existing procedures to collect records, both by the Low Vision Programme and Montfort College, should be streamlined in order to build up accurate information on numbers of children and their needs. For example, the data collected by the Low Vision Programme on numbers and needs of children with low vision in the ITPs should be used for further planning in the areas of identification and assessment of new children with low vision and resources needed. The data should be maintained so that it can be used in ongoing research and evaluation.

Assessment of each child should include determination of the appropriate frequency of assistance needed to achieve optimum functioning. Some children need intensive assistance at some stages during their education whilst many children require less frequent visits. The need for services is not determined by the extent of vision loss but from individual assessment of needs. The number of visits and type of assistance for each child should be regularly reviewed (at least every two years, if not annually).

Braille books were not available for the new school syllabus. Teachers spend much of their time preparing braille for their blind students. The computer braille production facility at Montfort has not been able to operate for some months but is expected to re-commence production later in 1997. The use of teacher aids as braille transcribers should be considered so that teachers with many blind students can be freed to teach their students who are blind and have low vision. This may be a means to increase the number of students in schools for the blind, RCs and ITPs.

The training of teachers at Montfort College should reflect the skills needed in the schools and programmes where they will work. As most of the children in programmes have low vision, this should be a substantial part of the courses for preparation of teachers.

Low vision should be taught as a separate subject only in those areas that are specific to low vision such as assessment of vision, vision training. In other areas, low vision should be an integral and important part of subject areas such as orientation and mobility, activities of daily living.

Use of the term vision impairment to embrace blind and low vision will assist in integrating low vision into the total programs and provision of services. The implementation of a Low Vision Programme has been necessary to initiate programmes and train specialists.

The tutors at Montfort College with responsibility for Low Vision and the ITP should collaborate to visit to train and support teachers in schools and services for vision impaired children. At this stage teachers need practical training in the management of children. This can best be done by the tutors working with teachers and children in each programme. The conduct of more formal (theoretical) group seminars should be delayed until practical skills have been enhanced and teachers have developed assessment and programming skills with their students.

In addition, supervision of the low vision work of specialist teachers should be strengthened, both through regular visits by the Montfort College tutors trained in low vision, and through the use of school inspectors who could assess areas such as the numbers of children assessed and receiving vision training and the understanding of the needs of children with low vision by classroom teachers.

The teachers who have been appointed to Itinerant Teaching Programmes "Teacher in Charge" positions should be supported so that they can coordinate local aspects of services. They can support the work of the Montfort tutors in the training of individual teachers "on-the-job".

After the "handing over" of the implementation and coordination of the Low Vision Programme from the CBM Advisor to the Montfort coordinator, plans should be put in place for ongoing support to Montfort and evaluation of the programme.

Future training in low vision should be considered at an institution in Africa for those who will provide training, initiate and manage low vision services. An investigation should be held to select an institution which has the range of disciplines necessary, e.g. special education, low vision and orientation and mobility. Courses should be offered at certificate, diploma and degree level and eventually at postgraduate level.

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APPENDIX 1

EVALUATION LOW VISION PROGRAMME JUNE 9 - JUNE 20 SCHEDULE

DATE	DESTINATION
Monday June 9	Montfort College Montfort Demonstration School Blantyre Secondary School with O M A Mrs Mtambo
Tuesday June 10	Lulwe school for the blind -with Ophthalmologist
Wednesday June 11	Makande Resource Centre Meet Mr Kanjoloti, O M A
Thursday June 12	Nsiyaludzu Resource Centre Nkhoma Optical Workshop - Dr Blignaut
Friday June 13	Salima ITP (Mr Chiwanda) Salima Resource Centre
Saturday June 14	Meet Rosemary Lowdon - optometrist Report writing
Sunday June 15	to Liwonde
Monday June 16	to Mangochi Report writing
Tuesday June 17	Nkope Hill R C (Mr Maluwa) Machinga CBR - Mr Sande
Wednesday June 18	Zomba ITP - Mr Nyaleye Zomba - Mrs Uta
Thursday June 19	Zomba ITP - Mrs Kaphwiyo, Mr Douglas to Blantyre & report writing
Friday June 20	Montfort College - report on preliminary findings Report writing

* Dr M C Chirambo was out of the country on the dates the evaluation team was in Lilongwe

2/2

APPENDIX II

FORM 1:

INTERIM EVALUATION OF MALAWI LOW VISION PROGRAMME

JUNE 9 - 20, 1997

Form to be filled in per teacher

Clinical services

1 How effective are referral of children and information exchange between O M A 's and specialist teachers?

- Date of identification by teacher and date of clinical assessment of an individual low vision child (*Not possible from record forms + mainly relevant for ITPs*)

- Clinical information on vision screening form, including

+ Diagnosis

+ Refraction / glasses prescribed

+ Near vision / Magnifying glasses
prescribed

Yes

No

Comments

2 How effective is the provision of glasses to individual low vision children through Nkhoma's optical workshop?

Comments

3 How effective is the route from identification for a possible operation to the actual operation?

No of children identified for operation

No with permission %

No operated %

No no permission %

No left school %

- Time between identification, obtaining of permission and operation

4 How many children who might benefit from magnifying devices have been assessed for it and provided with the device?

No with magnifying devices, using it successfully

Improves near vision Yes No

Used in the correct way Yes No

Comments

FORM 2

**INTERIM EVALUATION OF MALAWI LOW VISION PROGRAMME
JUNE 9 - 20, 1997**

Form to be filled in per teacher visited

Clinical services

1 How effective are referral of children and information exchange between O M A 's and specialist teachers?

No of LV children identified	No assessed	-	%
No of low vision children in teachers care			

- Date of identification by teacher and date of clinical assessment of an individual low vision child *(Not possible from record forms + mainly relevant for ITPs)*

Difference in dates ITP	1 month or less
	2 - 3 months
	> 3 months
Difference in dates Boarding	1 month or less
	2 - 3 months
	> 3 months

- Number of filled in referral forms

Total no of LV children	Referral slips filled in
-------------------------	--------------------------

- Clinical information on vision screening form, including

Total no of vision screening forms			
+	Diagnosis	Yes	No
+	Refraction / glasses prescribed	Yes	No
+	Near vision / Magnifying glasses prescribed	Yes	No

3 How effective is the route from identification for a possible operation to the actual operation?

- Number of children identified for an operation and with permission from parent / guardian against number of children operated

No of children identified for operation	
No with permission	%
No operated	%
No no permission	%
No left school	%

- Time between identification, obtaining of permission and operation

Stock of Non-optical devices

Stands	No needed (perceived)
Writing guides	No needed (perceived)
Bold lines	No needed (perceived)
Typoscopes	No needed (perceived)
Black felt pens	No needed (perceived)

Comments

Low vision skills and educational issues

7 How accurate are the following skills of individual teachers trained in low vision *Comparing results of O M A with teachers findings*

a Taking distance visual acuity Accurate Not accurate
Comments

b Taking near visual acuity Accurate Not accurate
Comments

c Functional assessment
Comments

d Correct interpretation appropriate visual training suggested Yes No
Comments

e Record keeping
Records on all children Yes No

Complete? (screening, referral, functional + progress) Yes No

Records updated Yes No

Comments

APPENDIX 111

AN EVALUATION OF THE TRAINING OF OPHTHALMIC MEDICAL ASSISTANTS IN LOW VISION AND REFRACTION

Held in Malawi in October 1995, February 1996

For: **Low Vision Programme Malawi**

International Eye Foundation

* Introduction

In 1995 and 1996 IEF funded the training of seven Ophthalmic Medical Assistants (O M A 's) in low vision. This training extended their skills in the examination of low vision children, with particular emphasis on objective refraction and the provision of glasses where necessary. The total training time was 7 days and the objectives of the training can be found in Appendix A.

Between October 1995 and April 1996, the O M A 's examined 128 blind and 221 low vision children across Malawi. All these children are under Education for the Blind either in a School for the Blind, attached to a Resource Centre or in an Itinerant Teaching Program (ITP).

The number of 221 relates to children who are low vision, as defined by visual acuity below 6/18 (WHO definition).

The O M A 's examined many more children than the number of 221, but these proved to have normal vision or had normal vision, after being prescribed glasses. This last group was excluded from the evaluation, since the emphasis lies on low vision.

Mrs Lowdon, the optometrist, did the clinical evaluation of all the children in July and August 1996, and wrote the results in a preliminary report. Ms van Dijk, the low vision advisor, selected children and helped interpret the results into this final evaluation report.

* Scope of the evaluation

The optometrist looked at the skills outlined below, because these are considered essential in the assessment of a low vision child and because these skills were relatively new to the O M A 's. Skills looked at were:

- 1 Objective refraction correct or not? What differences were found?
- 2 Subjective refraction correct or not? What differences were found?
- 3 Prescription of distance glasses Does the visual acuity improve?
Do the glasses fit?
Are they used for the right activities?
- 4 Filling in of the refraction form (see Appendix B), used as a record and for ordering glasses

Although the O M A 's also learned to prescribe magnifying glasses, there is insufficient data to comment on that skill. The low vision advisor is now checking prescriptions of magnifying glasses, when found. In 1997 a thorough evaluation of this part is planned. Other areas, such as use of LH chart for visual acuity, were already checked and found satisfactory during supervision visits of the low vision advisor.

For the purpose of this evaluation most of the children were chosen by the low vision advisor based on the following criteria

- children who had been prescribed glasses by the O M A
- children who had/or were likely to have a refractive error, but for whom no glasses were prescribed by the O M A

The choice of children is not random on purpose, since a large number of children have severe corneal scarring and refraction is often not possible

The work of four of the seven O M A 's was reviewed Mr Divala (Kasungu), Mr Chisambo (Karonga), Mr Godia (Salima) and Mrs Mtambo (Blantyre)

The remaining three O M A 's were supervised by Mrs Lowdon when carrying out their examinations and were not included in this evaluation

Visits were made to children from the following centres

- Chilanga School for the Blind, Kasungu
- Ekwendeni Resource Centre, near Mzuzu
- Nsiyaludzu Resource Centre, Balaka
- Mkope Hill Resource Centre, Monkey Bay
- Zomba Itinerant Teaching Program

At the two smallest centres, Ekwendeni and Nsiyaludzu, all the low vision children were examined At the other three larger centres a selection of children were examined, based on the criteria outlined above

* Findings

Incidence of refractive errors

28 children were examined (12.7 % of the 221)

- 21 (75%) of these children had significant refractive error, defined as a spherical error of +/-5.00 Diopters (D) or greater, and/or astigmatism of 2.00 D or greater
- 2 (7%) had low ametropia, +/-2.50 D or less
- 5 (18%) had no refractive error

An analysis of the refractive errors of the 23 children is as follows

Aphakia	21.5 %	(5)
Spherical hypermetropia	13 %	(3)
Hypermetropia + significant astigmatism	4.5 %	(1)
Low myopia	4.5 %	(1)
Spherical high myopia	17.5 %	(4)
High myopia + significant astigmatism	21.5 %	(5)
Significant astigmatism only	17.5 %	(4)
	<hr/>	
	100 %	23

Of the 10 children with significant astigmatism 6 were prescribed glasses to correct the astigmatism The 4 others were prescribed spherical lenses, because it improved the visual acuity Astigmatic correction was not needed

Analysis of eye diseases/disorders

The 28 children had the following eye diseases and disorders

Albinism	32.1 %	(9)
Aphakia	17.8 %	(5)
Corneal scars	21.4 %	(6)
Glaucoma	3.6 %	(1)
Nystagmus only	3.6 %	(1)
Refractive error only	3.6 %	(1)
Other	17.8 %	(5)
	<hr/>	
	99.9 %	28

In addition 18 children had nystagmus as well

Comparing this to the percentages found among the low vision children assessed in 1995, such as corneal problems 35 %, aphakia/cataract 16.4 %, albinism 8.2 %, glaucoma 1.6 %, it shows the emphasis in this evaluation on choosing children with (possible) refractive errors, and not on choosing a representative sample according to eye diseases/disorders

Retinoscopy

Objective retinoscopy

Objective refraction (retinoscopy) was found to be impossible in one quarter of the children due to corneal scars and cataracts. It was possible in 21 of the children. Subjective refraction was found to be impossible in just under a quarter of the children because they were too young to respond. It was possible in 22 children.

Where retinoscopy was possible (21 cases) the O M A 's were found to be

- Accurate in 9 (43%) of the cases,
- Fairly good approximation 9 (43%), to the accurate refraction
- Inaccurate 3 (14%)

Subjective

Subjectively their results were

- Good in 18 (81.8 %) of the cases
- Inaccurate 4 (18.2 %)

However the accuracy rate in these subjective results may be artificially high since in all cases the subjective result was obtained by modifying the objective result, instead of beginning with plano. It must also be noted that it is impossible for the O M A 's to detect and prescribe for astigmatism without carrying out retinoscopy, since the children are not capable of responding sufficiently well to any subjective tests for astigmatism.

Prescription of glasses

- The O M A 's prescribed spectacles for 14 (50%) of the children
- The optometrist prescribed another 4 (14%), giving a total dispensing rate of 64% (Since a biased sample of children was used, this is by no means a general dispensing rate among low vision children)
The additional four reflect a greater experience and confidence in prescribing for

particularly difficult cases on the part of the optometrist

- The remaining 3 children (11%) with significant refractive errors were not prescribed glasses because there would be no visual improvement due to the presence of other pathology

Improvement in visual acuity

- Out of the 14 pairs of spectacles ordered by the O M A 's
 - 9 (64%) give a significant visual improvement,
 - 3 (21%) possibly improve vision (this refers to children where it was difficult to get a subjective response),
 - 2 (14%) made the vision worse than without glasses

There was no significant difference in accuracy between any of the four O M A 's reviewed.

Fitting and size of frames

From the side of the O M A 's

- The correct size of frame was ordered in 60% of the cases
- In 40% too small an eye size and bridge size was ordered
- The length of the sides and the interpupillary distance was accurate in 100% of the cases

From the side of the optical workshop supplying the glasses

It was found that there were also errors in the frames supplied by the Optical Workshop at Nkhoma

- The power of lenses supplied by the workshop were accurate in 100% of the spectacles
- 60% were supplied with smaller eye and bridge sizes than ordered
- 40% were supplied with sides shorter than ordered

The compounded errors of the O M A 's and the workshop has led to 20% of the spectacles needing to be reordered with larger frames

Filling in of forms

- Accurately filled in . 20 (71%) of the cases
- In 8 (29%) there were mainly minor errors
 - Primarily in leaving sections of the forms blank, in stead of writing "not applicable" or "not possible",
 - There was one copying error where the sign of the prescription was incorrect (*i e* a hypermetropic prescription was shown for a myopic child)
 - In several cases the prescription was not recorded to two digits decimal point (In stead of for example - 5 00, -5 was filled in)

*** Conclusions and Recommendations**

Out of 18 children who could be helped with glasses, the O M A 's prescribed

- helpful glasses to 12 children (67%),
- incorrect glasses to 2 children (11%),
- and missed prescribing for 4 children (22%)

In view of the complicated nature of many of the prescriptions, and the shortness of the training as compared to those who work in low vision in the developed world, these results are fairly good

- The present system for obtaining spectacles is working well, although the problems in obtaining the correct size of frames need to be addressed

The low vision programme already has hired Mrs Lowdon to work with the technicians at Nkhoma Mission Hospital in September, to ensure they send out the correct sizes of frames

The prescription of correct sizes frames has already been emphasized during the training of the second group of 8 O M A 's in the beginning of September 1996

- Any further supervision of the O M A 's would help build their confidence and would improve the accuracy of their results
- Future training in low vision should continue to include practical experience of working with low vision patients, since little experience is gained in the day-o-day duties of most O M A 's

The September training of the second group of O M A 's has included 2 days of practicals on low vision children

- It is also recommended that subsequent training should include objective refraction

This is important for several reasons

Firstly a significant proportion of the children are too young for a subjective examination at all,

Secondly where a subjective examination is possible the results are sometimes unreliable in children and so prescribing errors are more likely,

Thirdly there seems to be a significant incidence of astigmatism which will be missed with only a subjective examination

There are though several problems with objective refraction

- The cost of the equipment
- The (considerable) training needed to be able to do objective refraction At the moment this is not being taught to O M A 's during the 1 year training
- The provision of glasses to correct astigmatism These have to be ordered from South Africa and are very expensive Certainly outside the means of most Malawians

The second group of O M A 's trained in low vision was only trained in subjective refraction In the first half of 1997 the results of their assessments of low vision children will be evaluated and compared to the results of the O M A 's trained in objective refraction

September 1996

R E Lowdon (Mrs) BSc MCOptom
Optometrist

Ms K van Dijk
Advisor on low vision and blindness

APPENDIX IV

MAIN OBJECTIVES LOW VISION TRAINING SPECIALIST TEACHERS

* **General**

- To illustrate the use and importance of a low vision programme
- To illustrate the role of different professionals and family members in eye care, education and rehabilitation
- To define low vision, blindness and normal vision
- To illustrate social and emotional consequences of low vision for an individual
- Keep records of data on vision, use of vision and progress of each child

* **Eye, disorders and diseases**

- Describe the parts of the eye and their functions
- Illustrate how a person sees
- Use visual development milestones from birth to 7 years, for referral purposes
- List the major eye diseases/disorders and the visual implications of each
- Describe the meaning of refractive errors
- Illustrate why regular eye checks and refraction are important
- List measures for prevention of low vision and blindness

* **Assessment**

- Identify and refer children with low vision
- Screen children, assessing distance and near visual acuity, and interpret the results
- Assess vision of a child functionally, using different activities and interpret the results

* **Working with a low vision child, teachers and parents**

- Start implementing an intervention programme, using visual training and other non-optical methods
- Choose the right learning medium for an individual child (braille or print or both)
- Use and make training materials and non-optical devices
- Advise regular teachers and family members about the needs of an individual low vision child, including use and stimulation of vision

* **Optical low vision devices**

- Describe the meaning of magnification
- Use different types of magnifiers, and magnifying glasses
- Train Low Vision children in their use

APPENDIX V

OBJECTIVES TRAINING OF CBR WORKERS

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
- 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 Keefe E-chart
- Interpret results of visual acuity testing in terms of sighted, low vision, blind
- State in which cases referral is needed and to whom (medical/pre- school/education)
- Record the results

Low Vision

Objectives

- * Define Low vision and Blindness, using WHO functional definition
- * Describe 2 problems people with Low Vision are facing
- * Discriminate between 3 myths and facts concerning use of vision
- * Illustrate how a visually impaired young child learns differently from a sighted child
- * Illustrate normal visual development from 0 - 7 yrs
- * Illustrate signs of visual problems in pre-school children
- * List ways of assessing vision in a young child
- * Describe the way to perform a short functional assessment
- * List basic activities to encourage use of vision in a young child
- * List ways of training young Low Vision children in using basic visual skills
- * Illustrate non-optical ways of enhancing use of vision
- * Use step-by-step teaching methods
- * Give examples of advice that can be given to parents/guardians regarding use of vision, movement, and ADL skills of a young visually impaired child

APPENDIX VI

OBJECTIVES TRAINING OF PRE-SCHOOL AND DISABILITY WORKERS

* Aim of the training

To train key people in assessment of and (visual) development programmes for pre-school children with a visual impairment, with emphasis on low vision

Objectives

- Discuss eye diseases and eye problems common in children in Malawi
- Illustrate importance of referral for ophthalmic examination
- To illustrate how children with no or little sight learn differently from sighted children
- To assess a low vision child what she sees and does not see
- To start using appropriate working and teaching methods to be used with a visually impaired child
- To identify appropriate toys and games, both for totally blind and for low vision children
- To list ideas and develop a programme to stimulate a child to use her/his vision
- To describe practical methods for developing good body movement and body image
- To list measures to be taken for including a visually impaired child in a pre-school play group
- Illustrate guidelines when working with a multi handicapped child

APPENDIX VII : OBJECTIVES HSA TRAINING

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 ointment and 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 Keefe 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

APPENDIX VIII : OBJECTIVES O.M.A. TRAINING

General

- * Define Low Vision (WHO + functional) and list WHO categories
- * Outline the part O M A 's play in a Low vision programme, including the use of referral and refraction forms and the co-operation with other professionals
- * Refer uncorrectable low vision children to the appropriate professionals (medical /education/rehabilitation)
- * Keep records, using refraction and referral forms
- * Fill in an information form for parents/ local teachers (if no specialist teacher is available)

Eye diseases and disorders

- * List common causes for low vision in SADCC countries
- * Describe what different people with low vision might see/have difficulty seeing and relate this to common eye diseases
- * Discuss the Low Vision management for the most common eye diseases / disorders

Assessment and related terms

- * Correctly take a low vision history, including the measuring of distance and near vision, using E-chart, simplified E-chart, LH, or other symbol charts
- * Describe the role of teachers in screening and functionally assessing a low vision child

Refraction and prescription of spectacles

- * Subjectively refract a low vision child, using the simplified optical assessment
- * Centre spectacle lenses correctly (measuring pupil distance)
- * Fit spectacles comfortably, using eye size, bridge size and length to bend
- * Describe the route from prescription of spectacles to provision, to an individual low vision child (if applicable)

(Optical) low vision devices

- * Use a hand- and a stand magnifier, and magnifying glasses
Illustrate for which specific tasks each can be used
- * Prescribe correct magnifying glasses (or magnifying devices, if applicable) to a low vision child
- * Describe the role of teachers/others in prescription, distribution and training and in the use of non-optical devices

APPENDIX IX
QUESTIONNAIRE - SURGERY LOW VISION CHILDREN

Name _____ Age _____ Sex Male Female

Name of Blind School/Resource Centre/ITP/Secondary School _____

In Standard/Form _____

Number of brothers/sisters _____ Birth order (No 1,2,3,) _____

Father/ Male guardian	<input type="checkbox"/> Literate	Mother/ Female guardian	<input type="checkbox"/> Literate
	<input type="checkbox"/> Illiterate		<input type="checkbox"/> Illiterate
	<input type="checkbox"/> Died		<input type="checkbox"/> Died
	<input type="checkbox"/> Not at house		<input type="checkbox"/> Not at house
	<input type="checkbox"/> Farmer		<input type="checkbox"/> Farmer
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____

1 Distance to nearest main (paved) road _____ Km

2 Distance to nearest health centre _____ Km

3 Distance to nearest hospital (O M A) _____ Km

PLEASE ASK THE FOLLOWING QUESTIONS OF THE PARENT/GUARDIAN:

Person responding Father Mother Both Other _____

4 What do you think is the cause of your child's problems in seeing?

- Disease
- Accident
- Use of traditional medicine
- Witchcraft
- Other _____

5 Surgery might be possible for your child. If so, are you willing to let your child have surgery?

Yes No

If NO why? _____

6 Do you think surgery would help your child

- See better
- See the same

See worse

7 What would you want your child to be able to do after surgery?

In school _____

For work _____

8 Has the O M A talked to you about surgery? Yes No

9 Has the specialist teacher talked to you about surgery? Yes No

10 Who could go with the child to the hospital?

Mother Father Other _____

11 Your child would need to spend time in hospital How long can you reasonably stay away from your family to be with your child during surgery?

12 How long do you think you would need to be away? _____

13 What times of the year is it easy to leave home for the operation

for the child _____

for you _____

14 If you went to the hospital with your child can you pay for your stay?
(Child's operation will be free)

Yes No

CLINICAL INFORMATION

Best corrected
Visual acuity

Cause of blindness/Low vision

Cornea

Cataract

Other _____

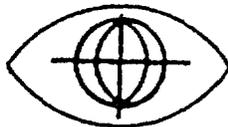
Attachment Q: Vision Screening and Primary Eye Care, Karen van Dijk

CURRICULUM

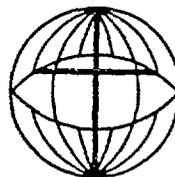
VISION SCREENING AND PRIMARY EYE CARE

FOR TRAINING

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



International Eye Foundation



**CHRISTOFFEL-
BLINDENMISSION**

**DEVELOPED FOR USE IN MALAWI
BY KARIN VAN DIJK**

MALAWI LOW VISION PROGRAMME
JANUARY 1996, REVISED MAY 1997

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 Kanjoluti, 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

All materials in this curriculum can be freely photocopied, if the source is mentioned

CONTENT

<u>Introduction</u>	4
<u>Objectives for training.</u>	
Health surveillance Assistants .	5
2 day programme	6
Primary school teachers	7
1 day programme .	8

The training curriculum, lesson notes and handouts

Introduction session	9
1. Primary eye care - review	10
2. Primary Eye Care: prevention, referral	12
3. Vision screening importance; What is low vision	14
4. Vision screening: Use of E-chart, distance acuity	16
5. Near vision screening	19
6. Use of forms and referral	21
7. Myths and facts concerning use of vision	23
8. Visual problems in a (pre) school child	25
9. Practical tips for use of low vision	27
10. Practice on clients; Review screening procedure	29
Evaluation and closing	30

And at the end of the curriculum

- * Evaluation form
- * Supervision checklist
- * Screening form
- * Screening form - version when using pinhole
- * Form for patient (referral)

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 ointment and 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

**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 Keefe 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 <ul style="list-style-type: none">- 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: <ul style="list-style-type: none">- 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	<ul style="list-style-type: none">- Continued practice distance vision- Practice near vision + recording of results- Referral- Summary of screening procedure- Recording + referral
3.30 - 4 30	<ul style="list-style-type: none">- Myths and facts concerning use of vision- Practical tips for stimulating use of limited vision- What to do back at work
4 30	<ul style="list-style-type: none">- Evaluation- Closing

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

THE TRAINING CURRICULUM, LESSON NOTES AND HANDOUTS

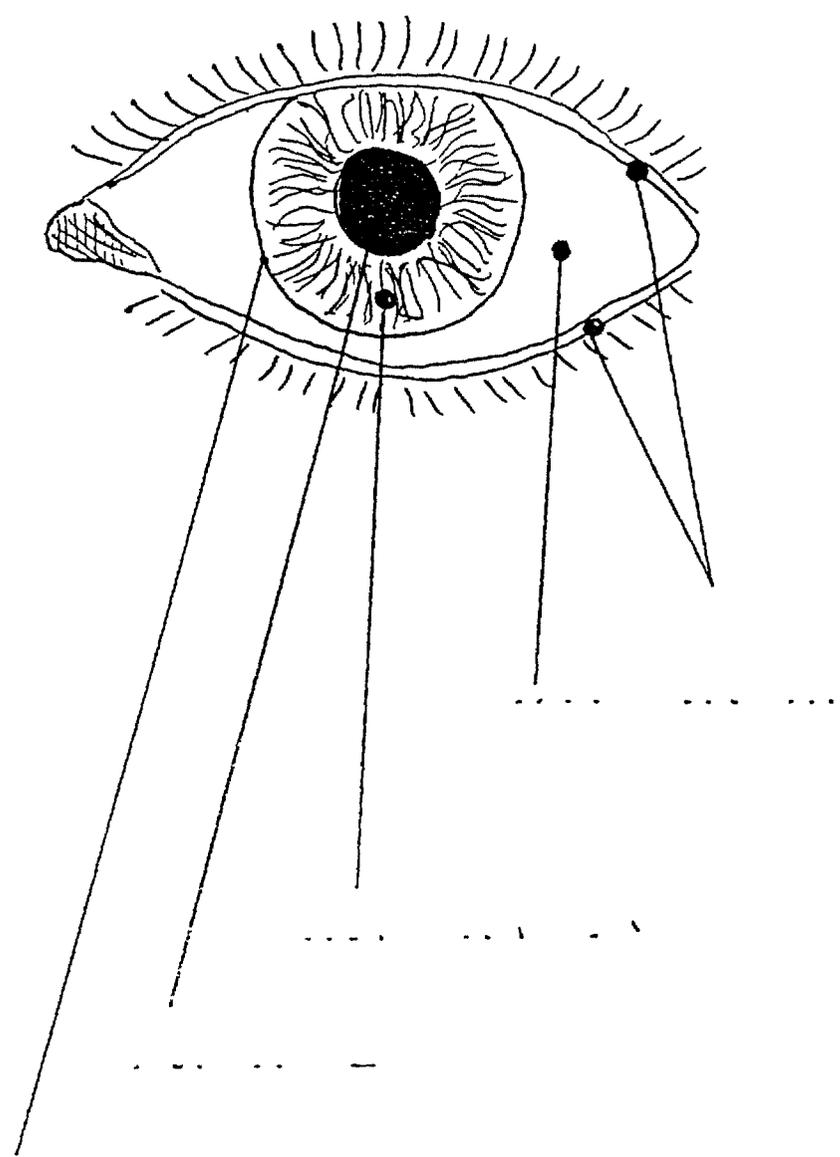
INTRODUCTION SESSION

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

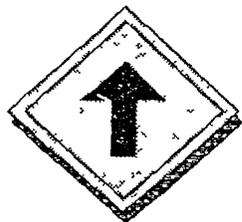
- * **Introduction** What is PEC/ importance of healthy eyes
- * **Structure of eye** let participants look into each others eye and note down the parts they see on the diagram/picture provided.
Ask (or explain)
 - what these parts are used for
 - 6 signs of a healthy eye
- Only explain eye parts from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



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
<u>Primary Eye Care Prevention and referral</u>	
Objectives:	
<i>By the end of the session the student will be able to</i>	
* 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
* <i>Introduction</i> What is session about (objectives)	3
* <i>Small group exercise</i> 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"	
* <i>Feedback</i>	
Put all 3 flipcharts on wall in front + ask for comments	
Discuss common eye problems	
Repeat 6 healthy signs of an eye	25
* <i>Question/answer</i>	15 min
Ask: 'How can people get eye problems'	
List them on flipchart	<u>Flip with how you get eye problems</u>
* <i>Brainstorm</i>	10
Ways of prevention	
(Or alternatively.	
* <i>Drawing exercise</i>	
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))
* <i>Question exercise</i>	
List of examples of eye problems on flipchart (ready)	
e.g. Red eye and no other problems	Ask Do you refer or not?
	<u>Flip with eye problems</u>
Write correct answer after each example	
Trainer gives explanation (per example)	10 -15
<u>Optional:</u>	
* <i>Demonstration</i>	20
Treatment of conjunctivitis	
+ discussion	

Handouts	Materials
How you can get eye problems	Tetracycline eye ointment
Conjunctivitis	Pictures of different eye problems

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
 Cannot read/see properly *Complaints by patient*

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) See Handout

* **Prevention** See handout

* **Treatment of conjunctivitis** 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)

	<i>Complaint</i>	<i>Referral yes/no</i>
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 unless HSA has vit A

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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 enough 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

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

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

Comments: Use of pinhole is particularly useful when screening schoolchildren

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 ACUTY	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*

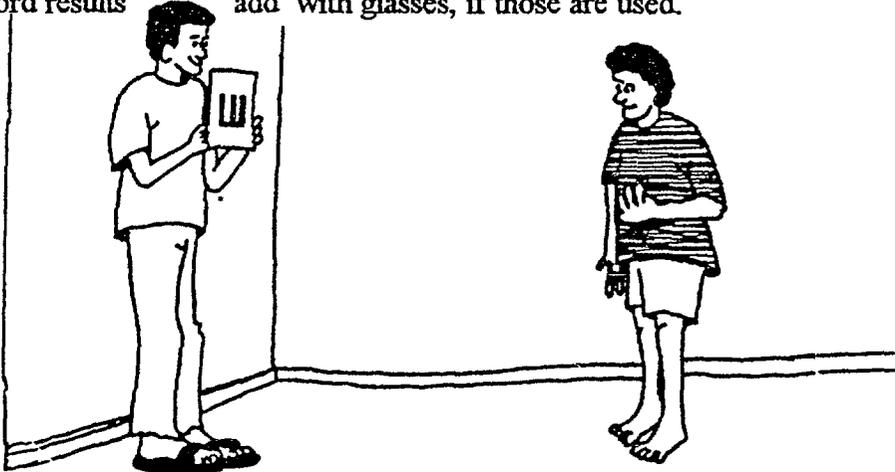
- For example: One person with 6/60 might be able to walk around easily, another with the same visual acuity of 6/60 might have problems

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

- * 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 = $\frac{6}{18}$. 3 out of 4 correct. Testing finished
Low vision = $< \frac{6}{18}$ Not 3 out of 4 correct, now try:
2. Largest E = $\frac{6}{60}$ (if 3 out of 4 are seen) at 6 m
If not seen:
3. Largest E at 3 metres = $\frac{3}{60}$ If not 3 out of 4 seen:
4. $< \frac{3}{60}$

* 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!



- * 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!
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4.	$< \frac{3}{60}$

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

Pinhole

- Use it for anyone with visual acuity $< \frac{6}{18}$
- 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 $\frac{3}{60}$ - with $\frac{6}{60}$ or $\frac{6}{18}$
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- 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!

- * **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: 50 - 60 min
<u>Screening procedure. eyes and acuity combined</u>	
<u>Forms and referral (+ forms)</u>	
Objectives:	
<i>By the end of the session the student will be able to</i>	
* 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
* <i>Introduction</i> What is session about (objectives)	3
* <i>Short talk/asking questions</i>	
Sequence of testing	10
(1 history, 2 visual acuity, 3 eye check list on <u>flipchart</u>)	
* <i>Case study</i> Individual exercise:	10
'Who to refer from the 3 case studies' Tick the yes or no box	
* <i>Feedback</i>	
Check in front of group if they referred the right people + discuss who (not) to refer for each case study	
Review referral in general	10
* <i>Individual exercise</i> Fill in referral slips based on 3 case studies	10
* <i>Feedback</i>	
Check slips + participants can check each others slips	15
Demonstrate on flipchart	<u>Flipch with referral form</u>

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

Comments.

It is important to review at this stage who needs to be referred and who does not need referral (yet).

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

- Those with conjunctivitis can be treated first. If there is no improvement after the period of treatment, referral is needed

*** Filling in of referral slips**

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

SCREENING FORM

Name Simplex Khembo
Address/area
Tested by

Age 6
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
Address/area
Tested by

Age 16
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
Address/area
Tested by

Age 40
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 eye lids very Red, tearing, discharge of pus. Complains of pain

Referred: Yes No

LESSONPLAN 7

Aim/Title: <u>Myths and facts concerning use of vision</u>	Time. 40 - 50 min
Objectives: <i>By the end of the session the student will be able to</i>	
* 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
* <i>Statement game</i> 'Myths and facts'	<u>Paper with statements for trainer</u>
* <i>Feedback and discussion</i> on most common myths in Malawi	25
* <i>Discussion.</i> 'Vision is learned'. importance of early use	10

Handouts
- Myths and facts

Comments:

If a discussion on beliefs about blindness is added, the session will be 20 - 30 minutes longer

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 after each statement

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
- *Add any beliefs common in the work area and make them into a statement*

* **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!!!**

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. <i>Glasses improve vision for those who need them</i>
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
<u>Detecting visual problems in a pre-school and a school age child</u>	
Objectives:	
<i>By the end of the session the student will be able to</i>	
* 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
* <i>Introduction</i> objectives of session	5
* <i>Small group exercise</i> 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
* <i>Feedback + discussion</i> Use recommendations list	20
<u>Flipchart with list visual problems</u>	
What to fill in on screening form + referral slip	10
Location of specialist teachers	

Handouts	Materials
- Recommendations list on a card	Plastic folder for chart and E-chart

Comments

* **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 x 2 groups, each gets different age group

For example 1 0 - 5 yr old 2 Primary school age

* *Give each group a flipchart to write.*

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

OBSERVATION LIST AND LIST OF RECOMMENDATIONS

HANDOUT

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 follow 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
- * Complains 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 an 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*

OBSERVATION LIST AND LIST OF RECOMMENDATIONS

Handwritten: **native HANDOUT**
(when pinhole is used)

DISTANCE VISUAL ACUITY

- Vision is 6/18 or better - no further action
- Vision is worse than 6/18 but improves with pmhole 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/
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- 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
* <i>Introduction</i> objectives of session	5
* <i>2 groups exercise</i> 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!	15
	<u>Flipchart with a, c, d, h, l, r, s.</u>
	<u>Flipchart with b, h, k, p, r, s, t</u>
* <i>Feedback</i>	<u>Flipch with ideas</u> 15
* <i>Discussion</i> Advice to give to parents Combine with facts learned about use of vision	15 min

Handouts
 - ~~Notes~~ for 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, hight
- 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

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:

LESSON NOTES 10

- * Possible feedback
 - Difference between a corneal scar and cataract
Importance of early referral of cataract in young children
 - Effect of some traditional medicine
 - Correct filling in of forms
Important to write if patient was treated with TEO or not
 - Who to screen in the community who is at risk
 - Who to refer and who not
 - Importance of follow-up on a patient treated / referred
-

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 form
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 Done in good light?
(Use of E-chart) 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

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: Dr. Sargent's Report on his Visit to Honduras and Guatemala

Robert A Sargent, MD
6152 East Princeton Circle
Englewood, Colorado 80111

Saturday, March 21, 1997

Victoria M Sheffield, Exec Dir
Ellen M Parietti, Program Officer
International Eye Foundation
7801 Norfolk Avenue, Suite 200
Bethesda, Maryland 20814

Post-it® Fax Note	7671	Date	7-17	# of pages	3
To	LMK	From	AMS		
Co /Dept		Co	IEF		
Phone #		Phone #			
Fax #	301-365-5417	Fax #			

Dear Victoria and Ellen

Sorry for the enormous delay in getting a letter off to you. If it's not one thing, it's another that seems to tie up time. I see why they use a merry-go-round as a metaphor of life's activities, from which we should step off once in a while. Now how do I say that in Spanish?

Thank you once again for taking a chance on me going to two of our countries of the world. I certainly prepared for the trip with slides and lectures. The Spanish got easier day by day. It was partly a crutch having Maynard with me in Guatemala (he's more fluent than I), but found the give and take with him made our effectiveness greater. I am so sorry to have heard about Cynthia's death (don Rolando Figueroa's daughter, and wife of Gerardo who ran the hostel).

In general the physicians of both Guatemala and Honduras are moderately well educated and aware of current ophthalmologic literature. They seem to have attended the Amer Academy's meetings over the years. Each person has an area of interest in which the knowledge is quite good. Maria Eugenia did a beautiful cataract operation on a baby, better than most of us could perform in the US. Mind you, she did not have the suction and cutting devices we all use here (costs a fortune, but makes the operation easier and safer). Her technique, learned in India, was what I initially used when Mike Lemp and I were residents at Georgetown, and at Children's with John O'Neill. Perhaps that is a better approach in the world, in that each new physician coming into practice in these countries probably won't have the money or access to obtain such equipment for the hinterland. On the other hand, one good machine in a large city hospital could be used by all the MDs, so that training of its use could be passed on to the new MDs.

Residents do not have exposure to the organized lectures that we require in our US residency programs. I was struck by the need for Raul Gomez to get the slide projector from his FIO office and bring it to the San Felipe Hospital, rather than the hospital having that educational equipment on hand. That is, it reflects the reality of their having nominal didactic education. Both Guatemala hospitals had more in this regard.

It is the lack of ophthalmologic equipment that diminishes the delivery of cutting edge care. They seem to know that, but are restricted by their limited finances. All three hospitals (two in Guat. City, and San Fel. in Teguc.) need sutures for all types of surgery. Luckily, we brought what we needed in both countries, and gave them the left over stuff. Being a pediatric ophthal. I am readily cognizant of what is needed in an examining lane. They need toys and gadgets that attract the attention of children and babies, so that measurements can be made of strabismus deviations. They have the prisms to do the measuring, but need these more technical items (technical in the sense that they are wired to the electrical outlets, and controlled by foot pedals that turn them on).

I asked Dr. Edgardo Navarrete of the San Felipe Hospital in Tegucigalpa to write up a list of the most important items his clinic and hospital need for the care of patients, making sure it is not a huge laundry list of 'everything'. I would agree with the list here:

- Surgical instruments for cataract, retina, and strabismus
- An autoclave to sterilize surgical equipment
- Contact lenses, particularly those for aphakia (when cataracts are removed) that have unusual and high powers
- Sutures for strabismus
- Complete general anesthesia machine, with accessories for babies and children

I could not tell what was needed at the Roosevelt Hosp. in Guat. City, because they just had a terrible intraocular infection (endophthalmitis) and shut the eye operating room down when we were there. The Robles Hosp. and the one in Honduras needs better overhead lighting. We had to trip around bulky light stands and couldn't really sit comfortably to do surgery. In fact, in Teguc. the heavy stand fell over (!) and partially broke the anesthesia machine (!). They had to replace the anes. machine for us to complete the operation. Luckily, it did not fall into the eye we were operating on (!). So, I would add overhead lights to that list above (for ALL the hospitals' eye operating rooms).

Because the Guat. City programs were combined during our lecturing time in the evening, we had at least 40-50 doctors that first night. Thereafter, about 20-30 each night. In the operating rooms everybody gathered and crowded about the patient to observe. So, the numbers totalled 8-10, five or so watching Maynard in his room, the same in my suite---you just can't show more during an operation without a camera and TV system. In Honduras there were about 15-20 doctors most evenings.

In the clinics we would call the other MDs over to see a lesion or strabismus condition. It was just a matter of luck what patient or condition happened to come in that day. I mention this because the teaching could have been more fruitful had the visited clinic culled out interesting or problem cases in advance of our coming. I am not suggesting a Grand Rounds type approach, but that a large number of patients be asked to return on those days we are there. This is easier said than done, because many of the patients just don't have the transportation to stop back, or come from far away. Nonetheless, a better effort should be made regarding the booking of surgery. They certainly know in advance that a vertical muscle, or a re-operation case will be needing surgery. Interestingly, even what I consider a routine case is of

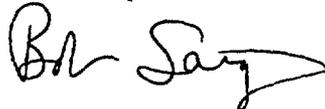
educational benefit to the doctors, because the techniques are new and different even for the 'straight forward' operations. Claudia Silva made a comment from Teguc that there could have been better organization of my time, she was referring to this issue.

For pediatric ophthalmology the majority surgery is for strabismus, and to a lesser extent blocked tear ducts and ptosis. Next time I would like to coordinate in advance with the involved parties. Oddly, cataracts were what they served up, and *our* operations involve the use of expensive equipment none of the places possessed. The overall scheduling of time was excellent. Some free time was needed by mid-late afternoon both to rest and to prepare the slides for the evenings' lectures.

I appreciated your sending me a copy of Raul Gomez' survey. Most the comments were positive, which should be known by the other agencies that might be considering assistance for the IEF program(s). I just got an invitation from Juan Baitle, MD from Dominican Republic to return to Santo Domingo. One has to spread this out over the year. The people in both Guat and Honduras said to avoid the summer months of sweat and rain. I guess our (IEF) best time is in the mid-late winter(?).

Please let me know if there were topics I did not cover in this letter. I would be happy to assist on any committees or in any decisions where you might want my input. I thank you again for having me participate with IEF.

Sincerely,



Robert A. Sargent, MD

Attachment S: Dr. Raul Gomez's Report on Dr. Robert Sargent's
Visit to Honduras

Dr. Robert Sargent's visit to Honduras Report January 18-24, 1997

As part of the Matching Grant Project, and under the Child Sight component, there is an overall objective to have trainings for ophthalmologists so that they can improve their knowledge and skills in order for them to give a better service to the patients.

In order to achieve this objective, Dr. Robert Sargent an Ophthalmologist from The Colorado Children's Hospital in Denver Colorado, was identify by IEF headquarters in Bethesda and sponsored his trip to Honduras. Dr Sargent visited Honduras to share experiences and knowledge and to train Ophthalmologist and residents of ophthalmology of the Hospital General San Felipe (A public Hospital of Honduras In the Capital City, Tegucigalpa ,which has an Ophthalmology Service and where the residency program of the Honduran National University is functioning)

Dr Sargent arrived to Honduras on January 18th at 9 a m.
On January 19th met with Dr Raúl Gómez, National Director of International Eye Foundation in Honduras and plan the work of the week.
The scope of work was developed in such a way that Dr. Robert Sargent would be doing surgery in the mornings, then after surgery he would be seen and examined patients and then at 7 p.m. he would be giving conferences to the group of Ophthalmologists invited.

Prior Dr. Sargent's coming to Honduras, Dr Edgardo Navarrete, Head of the Ophthalmology Service at the Hospital San Felipe, as well as Dr Alberto Ehrler, were identifying children among the patients to have them come and ready for Dr Sargent visit Also Dr Sergio Zuniga contacted the drug and medicine Distributors in Tegucigalpa, so that they could pay for the coffee break during the conferences at night

An invitation was sent to the Honduran ophthalmology society, so that they could attend the conferences

Dr Sargent's work during that week is detailed as follows

January 20, 1997.

At 7:30 a.m he was taken to Hospital San Felipe, and introduced to all the ophthalmologists and residents working there He was then taken to a visit of all the clinics there and the operating room, as well as the optic Luz y Amor and the room where the patients are hospitalized

Then he examined the children that were waiting for the surgery and began doing two surgeries One of it was a ptosis correction and the other an Strabismus

At night gave a conference on Amblyopia and Strabismus as well as visual screening among children.

The following Doctors attended:

1. Dra. Laura Nuñez
2. Dra. Claudia Silva
3. Dra. Maura Chavarria
4. Dra. Xiomara Garay
5. Dra. Belinda Rivera
6. Dra. Daniela Salinas
7. Dra. Geraldina Amador.
8. Dr. Alberto Ehrler
9. Dr. Edgardo Navarrete
10. Dr. Juan C. Boquin
11. Dr. Sergio Zuniga
12. Dr. Roberto Matamoros
13. Dr. Raul Gomez

January 21, 1997

At 7:30 he began doing surgery, he one surgery (estrabisms) and then he also was seen out patients with the residents. This day also at 11 30 a.m he gave a conference on Nistagms

At night he gave a conference on Blocked Tear Ducts and Palsy of the eye muscles

The Following Doctors attended

1. Dr. Elias Handal (President of the Sociedad Hondureña de Oftalmologia)
2. Dr. Alberto Ehrler
3. Dr. Edgardo Navarrete
4. Dr. Mario Leon Gomez
5. Dra. Doris Alvarado
6. Dra. Belinda Rivera
7. Dr. Dennis Espinal
8. Dr. Sergio Zuniga
9. Dra. Maura Chavarria
10. Dr. Roberto Matamoros
11. Dra. Daniela salinas
12. Dra. Claudia Silva
13. Dra. Elisa de Corrales
14. Dra. Karla Aguilar
15. Dr. Jorge Mendoza
16. Dra. Geraldina Amador
17. Dr. Juan Carlos Boquin
18. Dra. Deborah Wildt
19. Dr. Raúl Gomez

January 22, 1997

During the morning he did surgery on two children with estrabism, these children had four muscle correction that according to Dr. Sargent is not common, usually is only two muscle correction, so that was if he had done 4 surgeries.

In the afternoon he was taken to lunch, then he visited a private clinic, called Clínica Santa Lucía, and the National university of Honduras.

At night he talked about A and V patterns.

The following Doctors attended:

- 1 Dr Edgardo Navarrete
- 2 Dr Doris Alvarado
- 3 Dr Alberto Ehrler
- 4 Dr Mario Leon Gomez
- 5 Dr Roberto Matamoros
- 6 Dra Elisa de Corrales
- 7. Dra. Geraldina Amador
- 8. Dra Daniela Salinas
- 9 Dra Deborah Wildt
- 10 Dra Claudia Silva
- 11, Dr. Juan Carlos Boquin
- 12 Dr. Sergio Zuniga
- 13 Dr Raul Gomez

January 23, 1997

Due to the magnitude was able to perform two operations (cataracts) then he

The following Doctors attended:

- 1 Dra Doris Alvarado
- 2. Dr Mario Leon Gomez
- 3 Dra Elisa de Corrales
- 4 Dra Geraldina Amador
- 5 Dr Jorge Mendoza
- 6 Dr Roberto Matamoros
- 7 Dra Maura Chavarria
- 8 Dr Alberto Ehrler

- 9. Dra Deborah Wildt
- 10 Dra. Belinda Rivera
- 11 Dra Claudia Silva
- 12 Dr Edgardo Navarrete
- 13 Dra Daniela Salinas
- 14 Dr Raul Gomez

Dr. Sargent also had time to have a city tour of Tegucigalpa on Monday, January 20, by Dr. Raul Gomez.

On January 23, 1997 he visited also Valle de Angeles in the company of Dra Claudia Silva.

At the end of his last conference, the International Eye Foundation and the Hospital San Felipe awarded him with a Diploma of Recognition . All the Doctors bought a gift and gave it to him as appreciation for all the experiences he shared among them. FIO also gave him a souvenir from Honduras

An evaluation was passed among the Doctors during the last conference to evaluate Dr. Sargent performance. These are the results

Question N 1.

Do you feel that you have more knowledge after the conferences of dr Sargent?

100% of the doctors answered yes.

Question N. 2

Did you understand Dr. Sargent's presentations?

100% answered yes.

Question N. 3

Did you understand Dr Sargent 's Technical Language?

100% answered yes

Question N 4

Did you understand Dr Sargent's Spanish?

100% answered yes

Question N 5

Did he clarify concepts? Did he answered your questions?

100% answered yes

Question N.6

Regarding the level of the conference do you think it was appropriated or very high for you?

100% answered appropriated.

Question 7

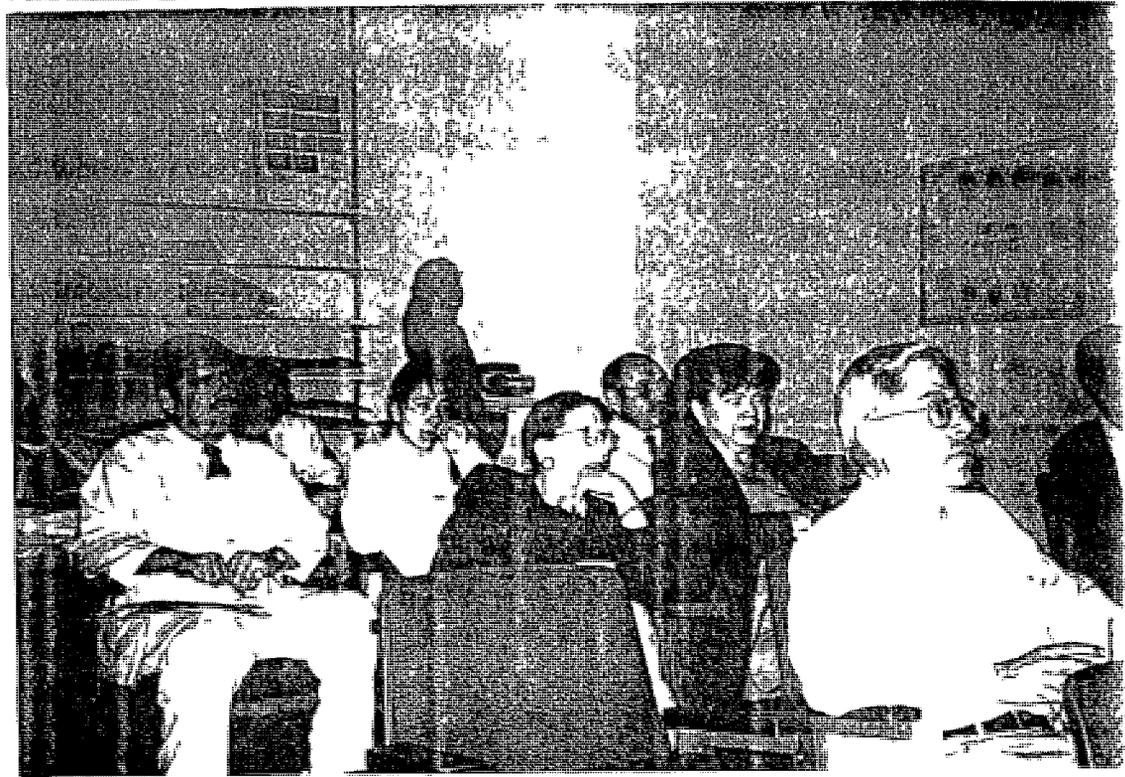
Please write comments and suggestions:

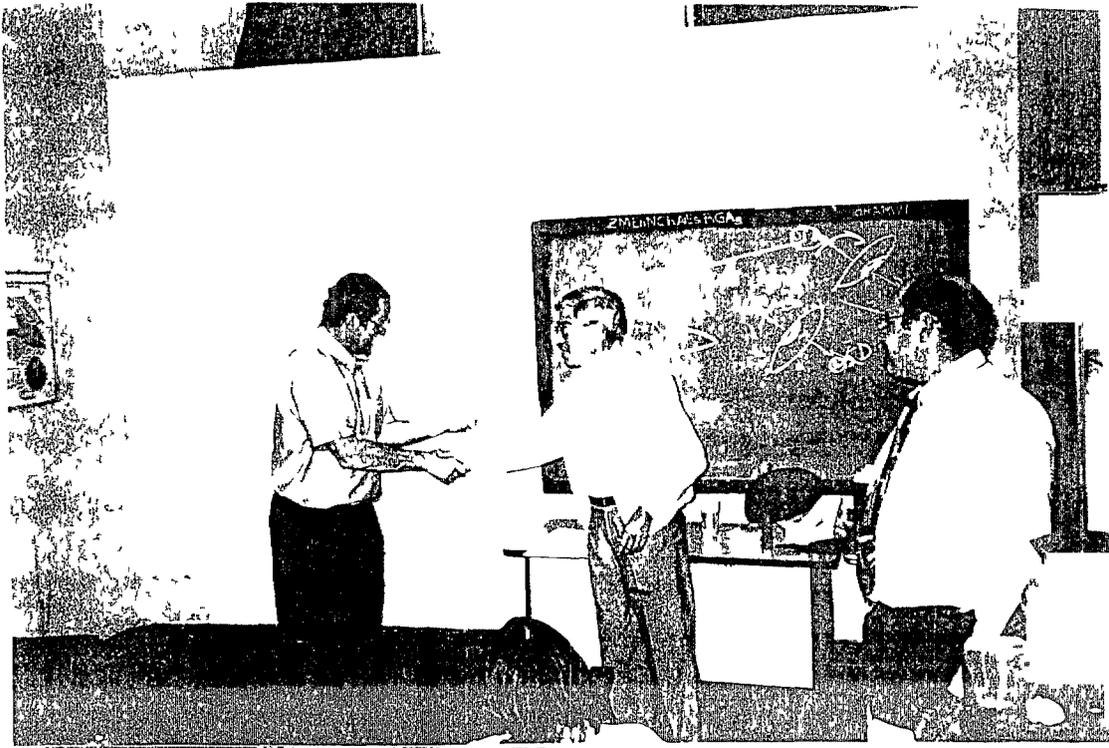
- a) He was very didactic. He always kept the attention of the doctors. His conferences were of high quality (Doris Alvarado)
- b) It was a good choice to bring Dr. Sargent to Honduras. He was excellent (Daniela Salinas)
- c) It was a good experience to have him here because he was really concerned if we were learning and also he was interested in teaching us and that we could learn (Belinda Rivera)
- d) He was a gentleman, easy to work with and communicate with and willing to teach and share his knowledge. I hope he will come back again. (Maura Chavarria)
- e) It was a good experience to have him here, specially for us the residents, he is very patient and likes to teach, and with a lot of experience (Geraldina Amador)
- f) Very good conferences. I hope they will continue. (Mario León Gómez)
- g) I think that the experience he left among us is excellent because he thought us and help us to develop professional operations. (Deborah Wildt)
- h) He is a gentleman, very sincere and with a lot of knowledge. (Elisa de Corrales)
- k) He is excellent as a human being, also likes to teach and has love for the patients. I hope he will return. (Sergio Zuniga)
- l) His visit was beneficial for all of us, he is very capable. I hope he will return. (Alberto Ehrler)
- m) I think a better organization prior his coming should have come up with better use of his time. It was an excellent experience. (Claudia Silva)

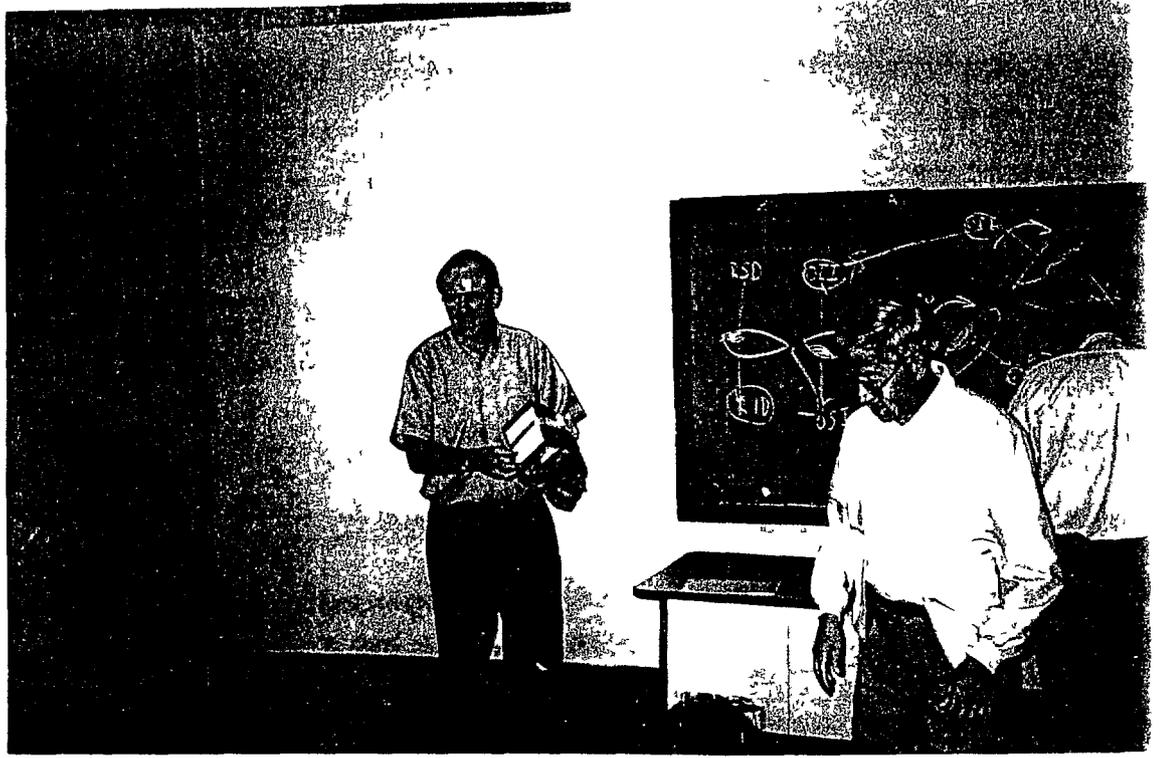
January 24, 1997.

Dr Sargent went in the morning to Hospital San Felipe, did a surgery and left at 11 a.m. to the airport for his departure to the USA

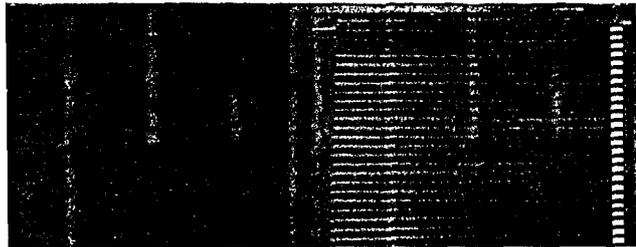
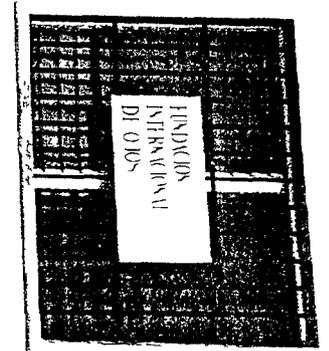
The International Eye Foundation in Honduras wants to give our deepest appreciation to Dr Robert Sargent, a devoted person that even when he was sponsored by IEF to come to Honduras, gave also his time, he could have been seen his patients at his clinic and earning money but instead he came to Honduras to help us and to teach us that if you have a heart then you must have "solidaridad" with the ones in need. His great spirit of sharing and teaching made of him a true gentleman and an excellent resource for the world







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Attachment T: Dr. Wheeler's Report on his visit to Guatemala

The International Eye Foundation
7801 Norfolk Ave
Bethesda, MD 20814

COPY

TRIP REPORT

January 12 - 17, 1997

Maynard B Wheeler, MD

Guatemala City

Personnel Maynard B Wheeler, MD, Hartford, Ct & Robert Sargent, MD, Denver CO

Purpose Evaluate and stimulate program in subspecialty of Pediatric Ophthalmology in Guatemala

Location Roosevelt Hospital and Hospital de Ojos & Oidos, Dr Rodolfo Robles and their Out-Patient Clinics in Guatemala City

Format Drs Wheeler and Robert Sargent attended different hospitals in the morning and gave lectures to combined staffs in the evenings

Primary Contacts

Roosevelt	Dra Lisette Aguilar, just returned from maternity leave Dra Anna Raquel Hernandez, about to leave for a pediatric ophthalmology fellowship with Dr Pillar de Castro in Cali, Columbia
Robles	Dra Ana Maria Illescas, head of Pediatric Ophthalmology Dra Maria Eugenia Sanchez de Oliva, recently finished 6 months at Aravind Hospital in India

Other Significant Contacts

Dr Roberto Quevedo, Chief of Ophthalmology at Roosevelt

Dr Roberto Curley, senior strabismus surgeon with former appointments at both hospitals

Dr Orlando Oliva, anterior segment surgeon at Roosevelt and administrator for IEF

Report

The level of ophthalmologic training and skill appeared to be relatively high, but the facilities were limited. The chiefs of Ophthalmology at the two hospitals speak excellent English and appear to have insisted upon the same from their staffs. Because of the insistence of the two

visiting Americans to speak in Spanish, the English-speaking ability of the local Ophthalmologists was not evaluated but seemed more than adequate when clarification was needed. Texts from the USA are used almost entirely (whereas, in South America, Spanish texts are used). Equipment in the examining areas is functional and very basic. In the operating rooms, basic instruments appear to be adequate but tables, lighting seating and anesthesia are either barely adequate or limited.

At Roosevelt, a large percentage of cases in children are traumatic. Accidents involving loss of vision in one or both eyes were caused by fireworks, pointed objects, or lye burns. Robles had patients with strabismus and developmental cataracts. Because the age of patients with cataract tended to be over the age of 4 years when intraocular lenses instead of contact lenses are used to rehabilitate vision, Drs Sargent and Wheeler were of little use with these patients because of their limited experience in this area. Both hospitals lacked areas conducive to examining children without distractions and with adequate control of fixation for accurate measurement of visual function and strabismus.

During the period of this visit, the operating rooms at Roosevelt were closed due to infectious contamination so no surgery was observed or done there. At Robles, Dr Sargent was able to observe intraocular surgery including a cataract with intraocular lens done very skillfully by Dr Sanchez de Oliva. On the last day 8 strabismus cases were scheduled in two rooms so that both visiting doctors could teach and demonstrate. They felt that there was room for more information and additional skills in the area of strabismus surgery. Interestingly, medical staff from both hospitals were present. Ethicon generously supplied special sutures for use in strabismus and pediatric cataract surgery.

The evening lectures from 7 to 9 PM were held in the conference room at the office of Alkane and were attended by all the training staff from both institutions as well as the physicians assigned to running the pediatric ophthalmology clinics. Dr Quevedo and Curley also attended all lectures. *APPROXIMATELY 35-40 ATTENDEES*

Future Interaction

As a result of this initial visit, the local ophthalmologists may request more focused visits in the future. Clearly, special expertise in pediatric cataracts age 4 and over in whom intraocular lenses can be used would be an area particularly pertinent to the local needs.

Short of such focused visits, there is probably a beneficial role in having Pediatric Ophthalmologists visit periodically to raise awareness of this most recently evolved of all the ophthalmological subspecialties.

Respectfully submitted,



Maynard B. Wheeler, MD

Attachment U: Dr. Orlando Oliva's Report on the
Pediatric Ophthalmology Visits

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VISITA DE LOS OFTALMOLOGOS PEDIATRAS A GUATEMALA

DR. MAYNARD WHEELER Y DR. ROBERT SARGENT

GUATEMALA, 13 - 17 DE ENERO DE 1997

COORDINADO POR DR. EDGAR ORLANDO OLIVA

Este taller se desarrolló para cumplir con el objetivo 3 del componente Childsight del programa Sightreach de IEF:

Aumentar la capacidad de oftalmólogos pediatras para evaluar pacientes y hacer cirugía en dos centros de atención terciaria a través de la provisión de entrenamiento, equipo e insumos.

IEF patrocinó la venida a Guatemala de dos Oftalmólogos Pediatras, los doctores: Maynard Wheeler y Robert Sargent quienes brindaron apoyo a los dos postgrados de Oftalmología existentes en Guatemala en el Hospital Rodolfo Robles V. y Hospital Roosevelt.

Las actividades se desarrollaron del 13 al 17 de Enero de 1997 y fueron las siguientes:

a. Evaluación de Pacientes:

Por las mañanas ambos médicos brindaron ayuda en la evaluación de pacientes en los dos hospitales mencionados, se evaluaron en esta manera aproximadamente 15 pacientes diarios en cada hospital. El Dr. Wheeler asistió al hospital Roosevelt Lunes y Martes y al Rodolfo Robles Miercoles y Jueves; el Dr. Sargent asistió a ambos hospitales en forma contraria al Dr. Wheeler.

Se estima que la cantidad de pacientes evaluados en total fué de 120.

b. Cirugía:

El Dr. Wheeler participó en una cirugía en el Hospital Roosevelt el día Lunes 13 y el Dr. Sargent estuvo en una el día Martes 14 en el Hospital Rodolfo Robles.

Ambos Oftalmólogos participaron en 10 cirugías el día Viernes 17 en el Hospital Rodolfo Robles, en esta ocasión se contó con la asistencia de dos médicos del hospital Roosevelt a dos cirugías.

En total participaron en 12 cirugías en su estadía en Guatemala.

En el Hospital Roosevelt no pudo haber participación en más cirugías ya que los procedimientos se cancelaron durante esta semana debido a contaminación de la sala de operaciones

c. Docencia:

Ambos médicos impartieron docencia durante la evaluación de pacientes discutiendo con los médicos locales el diagnóstico y tratamiento de los pacientes evaluados

Se desarrollaron sesiones científicas todos los días de Lunes a Jueves de 19:00 a 21:00 horas durante las cuales los doctores Sargent y Wheeler impartieron varias conferencias (ver programa adjunto), durante estas sesiones se contó diariamente con la presencia de 40 oftalmólogos de ambos hospitales.

Además el Dr. Sargent impartió clases a los residentes del postgrado de oftalmología del hospital Roosevelt los días Miércoles 15 y Jueves 16 por la mañana.

d. Donaciones:

El Dr. Wheeler donó al hospital Rodolfo Robles 12 instrumentos usados y dos cajas de sutura para cirugía de estrabismo.

En el Hospital Roosevelt no pudo haber participación en más cirugías ya que los procedimientos se cancelaron durante esta semana debido a contaminación de la sala de operaciones

c. Docencia.

Ambos médicos impartieron docencia durante la evaluación de pacientes discutiendo con los médicos locales el diagnóstico y tratamiento de los pacientes evaluados.

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d. Donaciones:

El Dr. Wheeler donó al hospital Rodolfo Robles 12 instrumentos usados y dos cajas de sutura para cirugía de estrabismo.

Attachment V: Ana Raquel Hernandez, Pediatric Ophthalmology Fellow,
Reports of Activities

Date January 19 1988
To: Ellen Parietti, IEF Program Officer
Fax (301) 886-1878

From: Ana Raquel Hernández, MD
Fax: 011-572-5520898

Miss Parietti:

I am sending you the report on my activities realized during the months of November, December and January. I am going back to Guatemala on January 21st because my visa expires on that date so that is why this report goes a little sooner than expected.

Our outpatient consultation has continued to grow, we have about 80 to 100 patients per week and the amount of surgery has increased. The screening program was interrupted because of the Holidays in December but will be re-started in March.

The surgeries I performed during these months are a total of 49, divided as follows: 21 strabismus surgeries, 8 lacrimal system probings, 8 cataracts (2 of them with IOL), 3 corneal wound closures, 2 ptosis correction procedures, 2 trabeculectomies with Mytomicyn, 1 enucleation due to Retinoblastoma, 1 palpebral wound repair, 1 epiblepharon and entropion correction and 1 chalazion drainage.

Some of the themes revised include special strabismus considerations in surgical techniques, theories about amblyopia, refraction, tumors, corneal pathologies in children, retinopathy of prematurity, retinal degenerative diseases, surgery for congenital glaucoma, neurological examination of toddlers, ocular manifestations of dermatological diseases.

I am including a copy of the abstract of the report on Intraocular Lenses in Children that I performed during this year. I hope to hear from you soon, I would like to thank you for the help you have given me for my training and you will be hearing from me when I get back home.

Sincerely,

Ana Raquel Hernández
Ana Raquel Hernández, MD

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INTRAOCULAR LENSES IN CHILDREN

Pilar Echeverri de Castro, MD
Ana Raquel Hernández C, MD

OBJECTIVE: To evaluate retrospectively the results of IOL implantation in patients from 0 to 16 years of age at the Hospital Universitario del Valle and the Clínica de Oftalmología de Cali from July 1993 to October 1997

METHODS: We reviewed the medical records of 34 patients that had undergone cataract surgery with implantation of IOL during that period of time. The collected data included the following: pre-operative and post-operative visual acuities, type of cataract, postoperative refraction, uni or bilateral cataracts, presence of amblyopia, type of IOL used and complications. Comparisons were made with chi-square methods.

RESULTS: The study included 42 eyes of 34 patients with an average age of 7.69 years of which 28 of them were boys and 34 were girls. Congenital cataracts comprised 47.60% of the cases, 21.4% were developmental cataracts and 31% were traumatic cataracts. No correlation was found between the type of cataract and the age of the patients at the time of surgery, age and bilaterality of cataracts, age and amblyopia, type of cataracts and gender or type of cataracts and development of amblyopia. The lowest preoperative visual acuities were recorded in patients with traumatic cataracts and the best ones in patients with developmental cataracts which turned out to be statistically significant. The post-operative visual acuities showed improvement in 91% of the cases. The preoperative visual acuity does not have a predictive value for surgical outcome. The final refractive values in most of the patients were ± 1.98 D from emetropia. The follow-up period of the patients had an average of 40.76 weeks. The complications reported were similar to those reported for cataract surgery in adults.

CONCLUSION: The use of IOL is a safe and effective method for visual rehabilitation of the child with cataract if the surgeon adequately selects the patient, the surgical technique and the type of lens that will be implanted. He should also provide a careful follow-up with aggressive management of amblyopia and any other complications that may arise.

Date: October 31 1997
To Ellen Panetti, Program Officer
Fax (301) 986-1876

From: Ana Raquel Hernández, MD
Fax: 011-572-5520896

Miss Panetti:

I am sending you the report on my activities realized during the months of August, September and October.

I continue the outpatient consultation and examination of patients in the four places I mentioned in my previous report but the only difference is that the number of patients examined has increased to approximately 90 per week. This can be explained because we are performing a screening program for children from 9 to 18 years of age in all the peripheral Health facilities that the Colombian government has. This program basically serves to identify children with refractive problems and we are capable of providing them with the optical correction they need (we provide the glasses). If we identify children with other problems such as cataracts, strabismus, glaucoma, trauma, etc, we refer them to the Hospitals or the Foundation so they can receive proper care.

Even though the number of patients we have been examining has increased, the number of surgeries during these three months has diminished. The explanation of this, we believe, is the economical situation that we are living and the people just can't afford the surgeries even when they are performed at the lowest possible cost. The elective surgeries that I realized or assisted to during these three months are a total of 34, divided as follows: 12 strabismus corrections, 4 trabeculectomies, 3 cataract plus anterior vitrectomy (one of them with intraocular lens implantation), 2 lacrimal system probings, 2 corneal sutures removals, 2 dermoid cyst removals, 2 drainages of palpebral hematomas due to capillary hemangioma (same patient), 1 congenital ptosis correction, 1 pupiloplasty, 1 granuloma excision, 1 papilloma resection, 1 enucleation due to retinoblastoma, 1 dacryocystorhinostomy, 1 conjunctival nevus resection

Some of the themes revised during this period of time are: Penetrating Keratoplasty in Children, Double Elevator Palsy, Neuroophthalmology themes, Physiology of Amblyopia, Refraction in Children, Surgical results of Strabismus Surgery for Infantile Esotropias, Uveitis in Children, VI th nerve paralysis, Ocular Motility Disorders with neurological importance, IOL Implantation in children, Nystagmus, Current Management of Lacrimal Obstruction, Inferior Rectus Agenesis, Preservation of the Crystalline lens during Vitreoretinal surgery in Children, Amblyopia and Strabismus, Special cases of Strabismus, Progressive Chronic Ophthalmoplegia, Tonometry in children, Use of Fresnel prisms prior to strabismus surgery, Low Tension Glaucoma, Optic Atrophy, Vascular Orbital tumors

On September 27 I presented the results of my study on IOL implantation in children, all of them cases operated here at the State Hospital and the Clinic. I will send a copy of the abstract when I have the final report ready

I hope that this report fills your expectations

Waiting to hear from you, sincerely,

Ana Raquel Hernández
Ana Raquel Hernández MD

Attachment W: Trip Report, Albania November 1996, Dr. Edward Parelhoff

Report to Health for Humanity
Albania Trip (Vlora) 11/2-10/96
Edward Parelhoff, M.D.

I arrived in Tirana on 11/3/96. There was no problem with my luggage or the items I was bringing into the country for donation. These included surgical instruments, sutures, textbooks, and a CD-ROM disc containing the entire Duane Series of Ophthalmology. The only bag checked by customs was one containing clothes and shoes. I was met at the airport by Garth Pollack and taken back to Tirana for the night.

The next morning, we left before dawn for Vlora, four hours away. Upon arriving, we secured hotel accommodations and I was introduced to various hospital administrators. I also met the Eye Clinic staff of physicians and nurses. The physicians were Elvira Dervishi, Dilaver Haskaj, and Arben Demiraj.

I spent five days in the Eye Clinic. The daily routine consisted of patient examination from 8-12, surgery from 12-2, lunch together at a restaurant in town, then a lecture (by me) back at the clinic and post-op rounds. I was treated with great respect at all times and developed lasting friendships with all the doctors during the week that I was there.

The clinic sees a great number of people on a daily basis. The physicians are dedicated and hard-working. For the most part, they do good work despite primitive conditions and numerous constant frustrations. There is little attention paid to hygiene by the hospital workers. Trash is everywhere, including medical waste and human waste. There is no organized system for its collection or removal. The water only ran for about two hours per day, usually in the late afternoon. This made hand washing impossible most of the time. I got the impression that the water was dirty as everyone seemed to avoid it when it was running. Surgical scrubs were with soap and water stored in an open bucket, followed by an alcohol rinse.

The other frustration was the lack of organization of the hospital in general. There is no system of appointments at the present time. In the morning, throngs of patients and their families congregate at the main entrance of the hospital and constantly push to get into the hospital. They are controlled by a policeman. Once they are admitted, the same scene is repeated in the hall outside the eye clinic. This leads to a lot of noise and a lot of short tempers as people try to get in more quickly by cutting in line. Once the door to the clinic opens to allow a patient to exit, ten people rush the door and must be restrained by one of the doctors. There is no waiting room and no system (that I could detect) for "appointments." A number system, like in a bakery, would be simple and make for a more peaceful day.

We saw a wide variety of disorders in children and adults. The clinic population was slanted toward Pediatrics because of my presence that week. There is a rudimentary system of medical records, using a form developed by Garth Pollack, but not all patients have a chart, and the filing is haphazard. Elvira seems the most interested in record keeping and most of her patients had charts. The majority of the surgical patients also had charts, but most patients were recalled from memory. The use of physician's assistants or trained nurses to aid in record keeping would be very

useful. One of the women who translated for me expressed interest in this type of job. She was in nursing school in Vlorë and had asked to be assigned to the Eye Clinic upon completion of her training.

Another problem is the lack of organization of equipment and supplies. The physicians seemed to have little knowledge of the supplies they had on hand and no lists of surgical and office equipment on hand. This would be helpful so that supplies could be ordered or requested in a timely fashion, before they ran out. There were few eye drops in the clinic for therapy or examination and these could have been brought from Tirana if Garth had known.

The approach to patients remains problem oriented. Few complete, systematic eye exams were performed. The doctors are good at diagnosing visible pathology, but knowledge of etiologies, differential diagnoses was lacking in some cases. This leads to a triage type of medicine where only patients that have a problem amenable to treatment with the supplies or equipment on hand were "accepted." Cataract patients were a good example. Few retinal exams were done pre-op in these patients to ascertain the health of the retina. I also witnessed a patient approved for cataract surgery who had a 4+ afferent pupil. I understand that a SOAP approach to examination was introduced, and Garth assured me that there has been progress over the last two years.

I assisted on several cataract extractions with the attendings. As a rule, they went smoothly and the quality of the surgeons was good. The equipment needs maintenance, though. The microscope controls were not working well and had been in this state for about a year. There is no phaco or IA equipment as yet, but the doctors are eager to get them.

We also performed four strabismus cases towards the latter part of the week. The anesthesia was not optimal. There is no monitoring equipment and the use of ether precludes any cautery in the OR. Overall, I was somewhat nervous during the surgery because of concerns for the health and well being of the children under anesthesia. The hospital will hopefully upgrade its anesthesia equipment in the near future. I don't think that pediatric surgery will be viable on a large scale until this occurs. Happily, all our cases turned out well with smiling children post-op with straight eyes and very appreciative parents. These cases represented the first strabismus surgeries on children in the history of Vlorë.

The only problem I encountered that was bothersome was a lack of consistent translating. I had Garth for one day which was great, but then he had to return to Tirana and this caused a problem. For the rest of the week, students were used to translate. They had good conversational skills, but little medical knowledge and this made communicating with both patients difficult and wasted a lot of time.

In summary, my experience was wonderful. I'll return next year willingly and look forward to seeing my friends and witnessing the progress made from our suggestions and help. I was treated with great friendship and respect. I was made to feel very wanted and needed and felt that HFH's help there is greatly appreciated. I left a list of my suggestions with the doctors and hope that they begin implementing some of them.

My suggestions can be summarized as follows. 1. Better system of record keeping to inc efficiency 335

allow for the development of some outcome analysis.

2. Better appointment system to allow for less confusion, noise and disharmony.

3. More attention paid to inventory and supplies.

4. Use of nurses or assistants to assist in patient care, education, record keeping, and inventory. The physicians are overextended clinically and don't have time to do everything.

5. Better maintenance of equipment in the clinic and OR. No one seems to know what to do when a bulb burns out or a fuse blows.

6. More access to books and journals, there are few available.

7. Continued emphasis on comprehensive exams and algorithms for clinical decision making

8. Work with the hospital to stress hygiene and public health concerns.

9. Improve system of providing visitors with better translators.

Respectfully submitted,

Edward Parelhoff, M.D.

Attachment X: Trip Report, Bulgaria February 1997, Victoria Sheffield

TRIP REPORT

BULGARIA Matching Grant - ChildSight Seeing 2000

22 February - 3 March 1997
Victoria M. Sheffield, Executive Director

A. PURPOSE

1. Participate in the "IV ChildSight Workshop" for ophthalmologists, pediatricians, and micro-pediatricians (neo-natologists) from around the country.
2. Observe the "Seeing 2000" Pediatric Ophthalmology course for ophthalmologists held at the "Pashev Center for Sight".
3. Visit field site in southern Bulgaria for the new "Seeing 2000" project.
4. Management visit to discuss progress of ChildSight activities and budget.

B. CHILDSIGHT WORKSHOP AND "SEEING 2000" COURSE

From Monday, 24 February to Friday, 28 February 1997, the IEF cosponsored with the Bulgarian Eye Foundation, two workshops on pediatric ophthalmology. Prof. Marilyn Miller, a distinguished pediatric ophthalmologist from the University of Illinois Eye Center/Chicago, participated in both workshops. Prof. Miller has visited Bulgaria for the IEF before having conducted the first pediatric ophthalmology conference at the University Eye Center in Plovdiv with Dr. Susan Day of San Francisco in August 1995.

1. IV ChildSight Workshop

The first workshop of the week was held at the Institute of Biology from Monday, 24 February to Wednesday, 26 February for ophthalmologists, pediatricians, and micro-pediatricians focusing on retinopathy of prematurity (ROP), a serious condition affecting premature infants and which leads to total blindness if not recognized and treated early. Out of town participants were housed at the Hotel Pliska within walking distance of the Institute.

The prevalence of ROP is rising in Bulgaria as technology improves in saving the lives of premies. Unfortunately, this technology, which includes incubators with increased levels of oxygen, contributes to ROP in the infant. These babies are not routinely examined by an ophthalmologist and it is up to the pediatricians and micro-pediatricians to consider ROP as a risk and call in the ophthalmologist to examine any premature infant, especially if they are in an incubator. Training is also required as to the appropriate levels of oxygen in the incubators.

Approximately 200 physicians from university eye and pediatric centers from around the country participated. Senior lecturers in all three disciplines made presentations and presented cases of interest. Ms. Sheffield presented a lecture on the "Role of NGOs" in eye care around the world and specifically the IEF's programs in Bulgaria. She presented the results from the Blindness Prevalence Survey conducted by the IEF and Johns Hopkins University in 1993. A hard copy of her transparencies (reduced) is attached - **Appendix I**.

Prof. Marilyn Miller arrived in Sofia in the evening of Tuesday, 25 February and presented lectures with slides and videos on a number of topics relating to ROP and congenital anomalies. There was a lot of time for discussion.

On Monday, 24 February, a press conference was scheduled at the Press Center in Sofia for Ms. Sheffield and Prof. Vassileva to discuss ROP and the new "Seeing 2000" project of the Bulgarian Eye Foundation which will focus on training pediatric ophthalmologists in order to enhance services for children with ocular conditions, especially those needing surgery.

Prof. Petja I. Vassileva, MD, PhD, DSc, MPH, IEF's Country Director, and Yordanka Koleva, IEF's Project Manager, are to be commended for the excellent organization of this workshop and the gathering of key individuals in the three disciplines from around Bulgaria.

2. Pediatric Ophthalmology Course sponsored by "Seeing 2000"

On Thursday and Friday, 25 and 26 February, Prof. Miller presented lectures with slides on a number of topics on pediatric ophthalmology at the "Pashev Center for Sight" at the St. Anna Hospital. Approximately 40 ophthalmologists from Sofia and other areas of the country participated. Prof. Miller examined patients at the Center for Sight who had been asked to come in specifically during the training course. The course focused ROP, strabismus and congenital anomalies with emphasis on examination techniques, differential diagnosis, and complications.

The course was well attended and there was lively discussion and sharing of experiences within the group. Ms. Sheffield provided slide/script sets and training videos on ROP, management of strabismus, and other pediatric ophthalmic conditions available from the American Academy of Ophthalmology (AAO). These were purchased from the AAO by the project.

C. VISIT TO "SEEING 2000" FIELD SITE

On Saturday and Sunday, 1-2 March, Ms. Sheffield joined Prof. Vassileva, Ms. Koleva, and Dr. Petrov, a young ophthalmologist from the Center for Sight, to Bansko in the Pirin Mountains in southern Bulgaria. We visited two primarily ethnic Muslim villages where the "Seeing 2000" project is focusing activities. Children have been screened for vision problems and referred for treatment and surgery as necessary. Also, health workers in the area have been trained to measure vision and recognize common eye conditions needing further examination.

These villages are very primitive with stove heaters, outdoor toilets, and the use of horse carts for much of the transportation. People wear traditional Turkish dress and tend to have large families. Tobacco is grown in the area and people who do have money put it into building modern homes even though they still live very simply in those homes. The health workers are general technicians who are very dedicated and attentive. They keep good records and know the families in the villages. However, they have little equipment and medications. Patients have to travel to Bansko or larger cities for hospital care and medicines. The "Seeing 2000" project has been welcomed and supported locally by the health workers and townspeople who are rarely visited by senior ophthalmologists from Sofia. On Saturday evening, we were hosted for dinner at a local restaurant by the Mayor of Bansko who expressed his appreciation for the project.

D. MANAGEMENT VISIT

Ms. Sheffield reviewed the budget for the ChildSight project, discussed closeout and reviewed the plan for the "Seeing 2000" project. The IEF office at the "Pashev Center for Sight" also supports the activities of the Bulgarian Eye Foundation and serves as a resource center for NGOs and other interested parties working in public health eye care

On Thursday, 27 February, Ms Sheffield and Ms. Koleva met with Dr. Nikolov, Assistant Director of the St. Anna Hospital, who has resisted providing maintenance for the ophthalmic equipment in the Eye Department. The state hospital does not have funds to maintain equipment and he insists that the IEF should maintain it. The IEF, recognizing that the equipment has benefited the hospital's patients and fairly large income derived by the hospital from those patients, feels that the hospital should maintain the equipment. A contract is being negotiated relating to control of the equipment and is still not yet finalized. Negotiations are ongoing.

E. MEETINGS

A number of key meetings were held during the week:

Wednesday, 26 February 1997

8:30 a.m. St. Anna Hospital: Dr. Chikarov, Director
Prof. Vassileva
Ms Sheffield

Courtesy visit.

11:00 a.m. US Embassy: US Ambassador Avis T. Bohlen
Prof. Vassileva
Prof. Miller
Ms Sheffield

Courtesy visit to the US Embassy to update the ambassador on the IEF's activities and to thank her for her support. Ambassador Bohlen informed us about the efforts in the area of health reform and to develop a national health insurance scheme which may be established within two years. The present financial collapse and high inflation in Bulgaria has caused a crisis among the old, children, and very poor due to lack of money to buy food and heating fuel. The ambassador is working with USAID to bring in relief food and medicines. The IEF and sister organizations have brought in ophthalmic medications which are being distributed to colleagues from the Pashev Center for Sight.

2:30 p.m. Sofia Eye Bank, Queen JoAnna Hospital: Prof Vassileva
Ms Koleva
Ms Sheffield

The IEF helped facilitate the establishment of the Sofia Eye Bank which was built and is monitored by the Baltimore-based International Federation of Eye Banks (IFEB). Prof. Vassileva is director and Ms. Koleva is manager of the Eye Bank. The Sofia Eye Bank is now functioning well and providing corneal tissue at international standards to ophthalmologists in Sofia and around the country.

4:00 p.m. USAID/Sofia: John Babylon, First Secretary, Int'l Development
John Tennant, Deputy First Secretary
Ljudmila Mincheva, Project Officer - Social Sector
Prof. Vassileva
Prof. Miller
Ms. Sheffield

We updated Messrs. Babylon and Tennant on the activities of the project. They reiterated the ambassador's current concerns for ameliorating the food and medicine shortages in the country. We informed them of the IEF's "in-kind" pharmaceutical donation program which provides ophthalmic medications not only to the Center for Sight but also to other Bulgarian colleagues, especially at the university centers in Plovdiv and Stara Zagora. We again discussed the process of health care reform and learned about the technical assistance being supported by USAID to the MOH in developing a national health insurance scheme. It is expected that such a scheme will be available in approximately two years.

5:30 p.m. Ministry of Health: Dr. Boygiev, Acting Minister of Health
Prof. Vassileva
Prof. Miller
Ms. Sheffield

We updated Dr. Boygiev on the IEF's activities in Sofia and on the outcomes of the pediatric ophthalmology workshops. He was pleased with the IEF's progress in Bulgaria and especially with the new "Seeing 2000" project in the south. He allowed that there is tremendous pressure for reform at that moment due to the dissolution of Parliament and the demand for health care reform. Dr. Boygiev is expected to be appointed Minister of Health in the new government after elections and we hope that Prof. Vassileva will continue to serve as Consultant Ophthalmologist to the MOH.

F. CONTACTS

International Eye Foundation

Prof. Petja I. Vassileva, MD, PhD, DSc, MPH Ms. Yordanka Koleva	Country Director Projects Manager
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Sofia Eye Bank

Prof. Petja I. Vassileva, MD, PhD, DSc, MPH Ms. Yordanka Koleva	Director Manager
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St. Anna Hospital, Sofia

Dr. Chikarov Dr. Nikolov	Director Deputy Director
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Ministry of Health

Dr. Boygiev Prof. Petja I. Vassileva, MD, PhD, DSc, MPH	Acting Minister of Health Consultant Ophthalmologist
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US EMBASSY

The Honorable Avis T. Bohlen	Ambassador
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USAID

John Babylon John Tennant Ljudmila Mincheva	First Secretary, Int'l Development Deputy First Secretary Project Officer - Social Sector
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CONSULTANT

Prof Marilyn Miller, MD	Univ. of Illinois Eye Center/Chicago
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**The Role of NGOs
in the Prevention of Blindness**

- **Advocates for public health approaches to the provision of eye care.**
 - **Support operational research to gather blindness prevalence data for the purposes of planning programs and targeting resources.**
 - **Support the World Health Organization Programme for Prevention of Blindness' strategy to establish and/or support National Blindness Prevention Committees, Plans and Programs.**
-
- **Mobilize internal and external resources from donors and bilateral agencies for blindness prevention programs. This includes advocating with the Ministry of Health to make blindness prevention a priority and to commit resources to programs.**
 - **Assist national governments to establish public health ophthalmology programs which address the leading causes of blindness in the country.**
 - **Collaborate with clinical/surgical ophthalmologists and affiliated sectors to maximize efforts.**
-

**BULGARIA
Public Health Eye Care Program
1991-1995**

1991: IEF commits funds to assist with the development of a public health eye care program in Bulgaria.

1992: "Pashev" Center for Sight established.

1992: Clinical and surgical equipment provided to the Center for Sight in support of public health activities.

1993: "Sofia Eye Study", an epidemiologic random sample survey conducted in Sofia District and Sofia City by Johns Hopkins University, Dana Center for Preventive Ophthalmology, Baltimore, USA. Data published 1994. Used by WHO.

1994: Bulgarian Eye Foundation established.

1991-1995:

18 US and European sub-specialists in ophthalmology visited Bulgaria under the sponsorship of the IEF program and "Pashev Center for Sight".

1995: IEF facilitates the establishment of the IFEB "Sofia Eye Bank" opened in September.

BULGARIA
SightReach/ChildSight
1994-1998

Bulgaria is one of 6 countries benefitting from the IEF's ChildSight Program. ChildSight is one initiative in support of the WHO's 1990 strategy to reduce childhood blindness. Objectives:

1995: Survey of the Blind Schools at Sofia and Varna completed. Data entered at Moorfield's Eye Hospital, London, and WHO data bank. ROP seen as major cause of childhood blindness.

1995-1997:

Four regional workshops held in Plovdiv, Pleven, Varna, and Sofia to create awareness about leading causes of childhood blindness in Bulgaria, projections for future disease burden, and to mobilize other sectors such as pediatricians and neo-natologists to reduce these diseases.

1995-1997:

Support visits of pediatric ophthalmic specialists Dr. Marilyn Miller and Dr. Susan Day to provide training and consult in clinics and surgery (Plovdiv, Stara-Zagora, Sofia.)

BULGARIA
Lions SightFirst International
1996-1998

1996: Bulgarian Eye Foundation mobilizes Bulgarian Lions and Expert Committee of Ophthalmologists to design a program to address unoperated cataract, the leading cause of blindness in the Sofia Eye Study.

1997: Ophthalmic equipment distributed to 6 centers.

Cataract surgery to be increased for poor people in the 6 centers.

BULGARIA
"SEEING 2000"
1997

1996: Bulgarian Eye Foundation submits successful competitive proposal to expand ChildSight activities to include training for young pediatric ophthalmologists.

1997: "Seeing 2000" program will identify 6 young ophthalmologists to be trained in pediatric ophthalmology.

WHO Programme
for the Prevention of Blindness

Data 1994

- **38 million blind worldwide - vision $\leq 3/60$ (0.05) in the best corrected eye**
 - **110 million visually impaired - vision $> 3/60$ (0.05) but $\leq 6/18$ (0.3) in the best corrected eye**
 - **Total of 148 blind and visually impaired worldwide**
-

- **Worldwide blindness prevalence rates:**

0.3% Established Market Economies and Former Socialist Economies of Europe

0.6% China

1.0% India

1.4% Sub-Saharan Africa

SOFIA EYE STUDY - 1993

EUROPE (WHO and World Bank Region) BULGARIA

Population estimate (millions)	Date of data	Type of data	Definition of blindness	Population area covered	Prevalence of blindness (%)	Prevalence of low vision (%)	Main causes of blindness	Source of data
8.823	1993	S	<3/60	Sofia district (urban and rural): 6,000 examined	0.5	-	Cataract 42 Diabetic retinopathy 15 Optic atrophy 14 Macular degeneration 12 Glaucoma 4	BGR.1

S = survey (or special study)

Conducted by: Dana Center for Preventive Ophthalmology, Johns Hopkins University, Baltimore, USA
International Eye Foundation, Bethesda, USA and Sofia, Bulgaria

2/10

Attachment Y: Lists of Patients Receiving Donated Cataract Materials

Recibi de la FUNDACION INTERNACIONAL DEL OJO (I E F) lo siguiente en calidad de donación para uso en pacientes de mi clinica Respack ubicada en Huehuetenango.

2 IOL CP Poder +19 00
 6 IOL CP Poder +19 50
 4 IOL CP Poder +20.00
 1 IOL CP Poder +20.50
 3 IOL CP Poder +21.00
 1 IOL CP Poder +21 50
 4 IOL CP Poder +22.50

1 IOL CA Poder +13.00
 2 IOL CA Poder +25.00

10 Viscoelásticos Rafi x 3 cc
 10 Ampollas de Pilocarpina Intraocular Rafi
 2 Caja de Sutura Nylon 10-0

PACIENTES

1.	Miguel Bartolomé 75 a Catarata AO	San Sebastián Coatán
2.	Domingo Gerónimo Pablo 56a Catarata AO	Ixcán Grande
3.	Eustaquio Matías 89 a Catarata AO	La Democracia
4.	Pedro Méndez Agustín 91a Catarata OS	Aguacatán
5.	Isidoro Gómez 81a Catarata AO	La Libertad
6.	Alonzo Bernabé Alonzo 80a Catarata OS	Soloma
7.	Aurelio Vazquez 70a Catarata OD	Huehuetenango
8.	Andrés Pérez 61a Catarata AO	Ixtahuacán
9.	Octavio Villatoro 66a Catarata OS, Ojo Unico	Palmira
10.	Andrea Cardona Jiménez 68a Catarata OS	Santa Bárbara
11.	Serapia Ambrosio 78a Catarata OD	San Antonio Huista

12. Francisca Rivas San Pedro Necta
69a Catarata AO
13. Glendy Mérida Méndez .. Sacapulas, Quiché
20a Cataratas Congénitas AO
14. Eugenia Pérez Barillas
59a Catarata OD, Ojo Unico
15. María Encarnación Miguel Soloma
78a Catarata AO
16. Isabel Martínez La Libertad
64a Catarata AO
17. María Celestina Sick Barillas
75a Catarata OS, Ojo Unico

Estos artículos serán utilizados exclusivamente para cirugías de los pacientes mencionados y que son de escasos recursos, de esta manera se contribuirá a disminuir el costo de las cirugías.

Firma: 

Nombre: Dr. Gonzalo Cruz

Guatemala, 16 de Septiembre de 1997

Recibí de la FUNDACION INTERNACIONAL DEL OJO (I.E.F) lo siguiente en calidad de donación para uso en pacientes de mi clínica Respack ubicada en Barberena, Santa Rosa

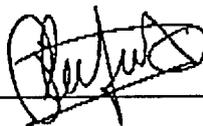
2 IOL CP Poder +19.00
2 IOL CP Poder +19.50
2 IOL CP Poder +20.00
1 IOL CP Poder +21.00
7 Viscoelásticos Rafi x 3 cc
5 Ampollas de Pilocarpina Intraocular Rafi
1 Caja de Sutura Nylon 10-0

Pacientes:

María del Rosario Mérida	Cuilapa
Everarda de la Rosa	Barberena
Victor Vicente	Mataquescuintla
María Piche	Nueva Santa Rosa
Gerardo Domínguez	Pueblo Nuevo Viñas
Elsi Calderón	Nueva Santa Rosa
Matilde Alvarado	Nueva Santa Rosa

Estos artículos serán utilizados exclusivamente para cirugías de los pacientes mencionados y que son de escasos recursos, de esta manera se contribuirá a disminuir el costo de las cirugías.

Firma: _____



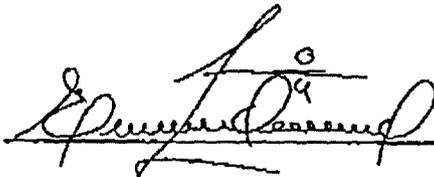
Nombre: Dr. Paul Cifuentes

Guatemala, 16 de Sept. de 1997

Recibí de la FUNDACION INTERNACIONAL DEL OJO (I.E.F) lo siguiente en calidad de donación para uso en las clínicas Respack ubicadas en Zacapa y Sanarate.

- 2 Pares de Anteojos para Afaco Bifocales
- 1 Caja de Beaver Blades 374531 x 3
- 1 Caja de Beaver Blades 374721 x 3
- 1 Caja de Beaver Blades 374532 x 3
- 1 Caja de Beaver Mini Blades 378700 x 24
- 1 Caja de Beaver Mini Blades 378400 x 24
- 3 Beaver Keratome Knife 374851
- 2 Beaver MicroUnitome Knife 377516
- 6 MSP 558320UCDK
- 1 Mango para Beaver Blades
- 1 Caja de Jeringas de 5 ml x 100
- 4 Bolsas de Merocel Surgical Spears x 10
- 12 Parches Oculares
- 12 Gazas Estériles
- 10 Conchas Protectoras
- 8 Rollos de Transpore
- 5 Cyclogyí Colirio 1% x 2 ml
- 6 Phenylephrine Colirio 10% x 5 ml
- 30 OcuFén Colirio x 2.5 ml
- 12 Betagan 0.5% x 5 ml
- 3 Isopto Carpina 4% x 15 ml

Estos artículos serán utilizados exclusivamente para pacientes de escasos recursos y no habrá ningún tipo de intercambio monetario por los mismos.

Firma: 

Nombre: Dr. Edgar Orlando Oliva De L.

Guatemala, 9 de septiembre de 1997

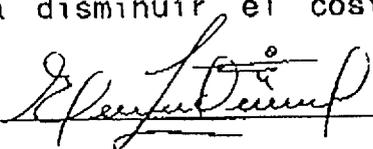
Recibí de la FUNDACION INTERNACIONAL DEL OJO (I.E.O.) lo siguiente en calidad de donacion para uso en pacientes de mi clínica Respack ubicada en Huehuetenango

4 IOL CP Poder +19.00
 4 IOL CP Poder +19.50
 2 IOL CP Poder +20.00
 2 IOL CP Poder +20.50
 8 Viscoelásticos Rafi x 3 cc
 8 Ampollas de Pilocarpina Intraocular Rafi
 1 Caja de Sutura Nylon 10-0

PACIENTES

1	Luz Mendez 56a	Catarata OD	Rio Hondo, Zacapa
2	Mardoqueo Castañeda 75a	Catarata OS	Rio Hondo, Zacapa
3.	Miguel Guevara 37a	Catarata OS	Zacapa
4	Julia Aragón 87a	Catarata OS	Zacapa
5	Hilda Salguero 61a	Catarata AO	Quezaltepeque, Chiquimula
6	Blanca Loyo 72a	Catarata OD	La Fragua, Zacapa
7.	Maria Estrada 74a	Catarata AO	Estanzuela, Zacapa
8.	Irma Villela 61a	Catarata OD	La Fragua, Zacapa
9.	Maria Elena Estrada 59a	Cataratas AO	Zacapa
10.	Elsa Cordón 70a	Catarata OS	Gualán, Zacapa

Estos artículos serán utilizados exclusivamente para cirugías de los pacientes mencionados y que son de escasos recursos, de esta manera se contribuirá a disminuir el costo de las cirugías.

Firma: 

Nombre: Dr. Edgar Orlando Oliva

Guatemala, 14 de Octubre de 1997

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Ciudad de Cataratas
Dr. Sidney Morales Cero

1. Sebastian Cueul.
2. Elisa Oliva
3. Osea de Caceros
4. Roberto Cueul.
5. Isabel Rosa Aguilar.
6. Antonio Pop
7. Tomas Garza.
8. Lucia Camnal.
9. Manuel Paña
10. Juan Lopez Vega.
11. Lorenzo Alvarez.
12. Gloria Eraso
13. Eusebia Gregorio.
14. Clementina Alvarado
15. Otilia Martinez.
16. Guillermo Benitez
17. Pablo Cordon.
18. Reyes Martinez Morales.
19. Solin

10 33

- 22. Dominga Pelf.
- 23. Juana Cristiana Gomez.
- 24. Santos Susa
- 25. Roberto Pineda.
- 26. Santos Falda.
- 27. Jesus Racinos.
- 28. Antonia de Jesus Osorio.
- 29. Maria Agustina Garcia.
- 30. Marta Gonzales.
- 31. Eulalia Sudeite.
- 32. Guacolda Agustin.
- 33. Juana de Petillo.
- 34. Jose Fidel Canales.
- 35. Abel Salguero.
- 36. Eugenia Amador.
- 37. Jose Gilberto Ramirez.
- 38. Rosalina Oliva Parz.
- 39. Rosalia Cruz.
- 40. Olbin Lopez.

Nota: Pcederente entregar mater
 - Sidney Morales.

Attachment Z: Trip Report, I Pan American Congress on Prevention of
Blindness, Brazil September 1996, Ellen Parietti

TRIP REPORT
I Pan- American Congress on the Prevention of Blindness
Sao Paulo, Brazil Sept 4-7, 1997

Ellen M. Parietti, MPH, Orlando Oliva, MD, & Juan Batlle, MD

Objectives:

- A. Attend the I Pan-american Congress on the Prevention of Blindness
- B. Present the Manejo Gerencial Workshop to Participants
- C. Meet with Dr. Francisco Martinez Castro & committee to plan for the III Congresso Latinoamericano de Prevención de la Ceguera in Cancún May 1, 1997
- D. Meet with Dr. Francisco Martinez to discuss institutionalization of ResPack-modeled program in the PAAO.
- E. Meet with Dr. Batlle on the Syllabus for the Manejo Gerencial Course

A. I PAN-AMERICAN CONGRESS ON THE PREVENTION OF BLINDNESS:

Leaders in Blindness Prevention throughout Latin America were invited to present their work and discuss solutions to common problems. Practically every speaker stated that the main obstacle in the prevention of blindness was the concentration of ophthalmologists in the capital cities.

Newton Kara Jose, MD, Brazil

Has organized a cataract campaign throughout Brazil in which 12,000 operations have been performed. Individual doctors in different regions take responsibility for outreach work and are, in effect, regional directors of the cataract campaigns. A display at the Congress presented each region head and their work. The Ministry of Health gave money for the disposable supplies necessary in the operations. The doctors gave their labor for free. When asked why he did not make use of the support available from the Lion's club, Dr. Kara Jose responded that he no longer wanted anything to do with the Lions club. The reason for this lay in the fact that the Lions demand all the credit for work accomplished in the campaigns. This may not be a problem when only one doctor is involved in the project, but when many doctors are involved, things get complicated. The medical director (in this case, Dr. Newton Kara Jose) is responsible for keeping Lions happy, sometimes at the expense of the supporting doctors happiness. Now Dr. Kara Jose understands that to truly cultivate a feeling of commitment in the area of prevention of blindness, each doctor needs to receive recognition and must have autonomy; each project must be their own. To this end, he has been able to assure assistance from the MOS in order to end their reliance upon the Lions Club. The Brazilian Cataract Campaign has become more sustainable as a result.

Dr. Juan Batlle has confronted similar problems in being the liaison between the

Lions Club and participating doctors. He has been unable to solicit assistance from his Ministry of Health in the area of disposable materials. The key to independence from Lions would be help from the "casas comerciales" such as Alcon, Ethicon. Could the MOS pressure them into providing materials as a requirement for operating in country?

Rainald Duerksen, MD Paraguay

He is a former resident of Juan Batlle's in the Dominican Republic. He is beginning a residency program right now in Asunción, Paraguay. It is an innovative program where the graduates go out and become "medical directors" of their own project. There is a great feeling of ownership for the program. The doctors feel truly attached to their projects and their communities.

Javier Cardoba Umaña, MD Costa Rica

He reports he is the only ophthalmologist in Costa Rica displaying a willingness to work in the prevention of blindness. When he first started working, he was assigned to the general hospital in San Isidro de General, Perez Zeledón. Ophthalmologists and ancillary personnel were coming from Vision Health International (calif.). The previous ophthalmologist would not work with them, and would leave town when they came. Dr. Cardoba made friends with them and invited them to work at the hospital. After giving them a lot of support, the VHI people left him microscope to work with. They also sent him donations of IOLs, suture, etc. As soon as he got the microscope, the MOH transferred him to San Juan de Dios in San José. It's the largest referral center in San Jose. They do have a microscope, but lack basic diagnostic equipment. They are without tools to do refractions. They do not even have a full trial lens set. He says that the other doctors do not make a big fuss, that way the patients will need to go to the private clinics. He wants to obtain basic diagnostic equipment to attend his patients in San Juan de Dios or he will leave the public hospital for his private clinic. He reports feeling demoralized.

Juan Batlle, MD Dominican Republic

Presented the nationwide survey conducted on Blindness & Diabetes. He also presented the Lions Club Mega Project in which they completed 1000 cataract surgeries throughout the country. Lesson learned: they need to ask for more money to cover the cost of pediatric surgeries. The anesthesiology is more complicated.

B. PRESENTATION OF THE MANEJO GERENCIAL COURSE

Dr. Juan Batlle presented the course as a guide to young ophthalmologist who were attending the concurrent Brazilian Congress on Prevention of Blindness and Visual Rehabilitation. (This is the second largest ophthalmology meeting in the world, after the AAO.)

Attached is an agenda and a summary of information presented. The entire presentation was conducted in Spanish, and although all participants but one spoke Portuguese, there were no apparent language problems. A total of 20 ophthalmologists attended, including 2 heads of residency programs.

Manejo Gerencial para Programas de Prevención de Ceguera
Sao Paulo, Brazil September 6, 1996
Juan Batlle, MD
Orlando Oliva, MD
Ellen Parietti, MPH

Introducción - Ellen Parietti

- I. Estadísticas Actuales - Juan Batlle
- II. Encuesta Nacional De Ceguera de la Republica Dominicana - Juan Batlle
- III. Filosofia de Prevención de Ceguera - Ellen Parietti
- IV. Plan Nacional de Prevención de Ceguera - Juan Batlle
- V. Mercadeo y Financiamiento de Programas de Prevención- Juan Batlle
- VI. Programa ResPack de la Fundación Internacional de Ojos - Orlando Oliva
- VII. Como Evitar Tropiezas al Empezar - Juan Batlle
- VIII. Relaciones Profesionales - Juan Batlle
- IX. Relaciones Institucionales- Juan Batlle
- X. Organización Administrativa del Consultorio - Juan Batlle
- XI Closing Remarks - Ellen Parietti

C. MEET WITH DR. FRANCISCO MARTINEZ CASTRO & COMMITTEE TO PLAN FOR THE III CONGRESSO LATINOAMERICANO DE PREVENCIÓN DE LA CEGUERA IN CANCUN MAY 1, 1997

The III Congreso Latinoamericano de Prevencion de la Ceguera will be held May 1-2, 1997 (Thursday- Friday). Some members of the planning committee are worried that this, along with the Pan American Association of Ophthalmology Conference, to be held May 3-8, 1997, will prove to be too long for people to take off for.

A debate regarding the participants was raised. César Vicenio of Chile argued that by linking the Prevention of Blindness meetings with Clinically - Focused meetings, they were inviting distractions to the planned work. People would be lured to the other clinical meetings. He proposes that they be held separately. Those who truly wanted to work in the prevention of blindness would still attend.

Dr. Francisco Martinez Castro has planned the meeting in Cancún in such a way that every clinical meeting will open with 5 minutes of Prevention of Blindness information.

The IEF will be responsible for a worktable on Friday, May 2, 1997 from 9am-1:30pm "Cómo Crear y Mantener Servicios." Dr. Martinez Castro is very interested in seeing Victoria and John attend, so they understand the importance the ResPack model has in the future of Prevention of Blindness programming.

D. MEETING WITH DR. MARTINEZ CASTRO TO DISCUSS INSTITUTIONALIZATION OF RESPACK - MODELED PROGRAM WITH THE PAN-AMERICAN ASSOCIATION OF OPHTHALMOLOGY

Thursday morning upon Dr. Martinez's arrival we met about the feasibility of institutionalizing a Respack- type program with the PAAO. He understands fully the limitations of the AID agreement, and wants to find a way to extend the opportunity to other Latin American countries. We discussed a variety of alternatives, such as state-sponsored arrangements, alternate donors, etc, but none in any detail. I will send him a copy of the ResPack section of the latest AID report so as he is appraised of the accomplishments and limitations the ResPack program to date.

E. MEETING WITH DR. JUAN BATLLE ON THE SYLLABUS FOR THE MANEJO GERENCIAL COURSE

We have right now an outline with all of his slides written out. The lecture is composed in great part by the slides. (We have copies of these slides in HQ.) They are self-explanatory and can be easily followed. (See attached sheets.) These slides cover the topics of : **Philosophy** (Culture of Service, quality of service, professional & institutional relations, how to avoid pitfalls) and **Office Administration** (Administration of the clinic, Fixed costs, variable costs, Charging the Patient, Pegboard System, Low Cost Cataract Operations.) The

manual drawn up by David Green includes more **hard accounting** such as calculations on fixed costs, variable costs, equipment acquisition & depreciation costs, and projections. The problem with this manual is that it is intimidating to ophthalmologists, especially at the level of our ResPack participants. **No one** is actually putting into practice the methodology illustrated in the instructive booklet. Our goal should be to either re-format it or put it into some way where the ResPack participants want to use it or would not be intimidated by it.

One area not covered in course work is a **Self-Evaluation**. During conversation regarding our Res-Pack participants we decided that it was vital to the survival & supuration of the ResPack program that there be a more accurate way to evaluate participant's progress. The Self-Evaluation would include: an audit, objective assessment & subjective assessment. In this way we could better screen our participants, and perhaps have some scaled approach to the type of support that we offer.

Right now, the way the ResPack program is run is somewhat of a record club. Pay up front and you get a good deal with basically no obligation to continue. IEF is sort of powerless to force you to continue with the plan. For the program to work better, the admission needs to be tighter. (Garbage in, garbage out.) IEF could either try to base admission through a local NCPB (National Committee for the Prevention of Blindness), or have an interview process where there would be 3 people. A rigorous interview where the candidate would really be screened on their motivation for joining the program and their plans.

After the candidate is accepted and working, incentives need to be offered based on tangible results, (objective & subjective evaluation.) This incentive could be support in terms of donations, equipment, or training.

The manual should be presented in a Prevention of Blindness spirit. Dr. Battle has big ideas for making this manual a book. I emphasized that we needed a manual immediately. One which would liberate us from having to send around Dr. Battle, and enable us to have our ResPack people get involved in the instruction. We broke the ideas into a manual and a book which would ideally be included together. See attached.

FILOSOFIA DE LA PREVENCIÓN DE CEGUERA
ELLEN M. PARIETTI, MPH
SEPTEMBER 6, 1996
I CONGRESSO PANAMERICANO DE PREVENCAO DA CEGUERA
SAO PAULO, BRAZIL

Yo empecé a trabajar con la Fundación Internacional de Ojos hace un año. Fui a conocer las clínicas de Respack, y a los doctores. Aunque muchos estaban bien, y se han ido mejorando aún, siempre habían problemas en cuanto al trabajo comunitario. Que la gente no puede pagar, que no hay dinero, la gente no llega, que los materiales están carísimos. Yo sentí que no era camino fácil, que era un reto.

Poco después conocí al Dr. Juan Batle. Me habló de sus clínicas en la República Dominicana. "Tiene que ir a verlas," me decía, y me platicaba del gran número de gente que llegaba todos los días. Me costó entender cómo lo estaban haciendo, y fui a verlas. Estando en la RD el Dr. me dio más detalles sobre el servicio que proveen allí. La verdad, me sentí un poco confundida, con dudas, desconfiada, y deprimida que nosotros no pudieramos hacer lo mismo con tal facilidad. Como es que todo les sale tan bien en la R.D., me pensé. ¿Que secreto guardaba la R.D.? Eran sus instalaciones? Su gente? ¿Que era??

Me dí cuenta poco tiempo después de que lo que tiene la DR es gente como Juan Batle, o más preciso, es lo que Juan tiene por dentro. Su actitud, su motivación, su espíritu. Ese espíritu no se da por vencido ni se desanima por la adversidad. Siempre busca una solución al problema, sin dejar de mirar hacia la meta. Hay algo muy poderoso por dentro que mantiene encendido. Es el hecho de decir "si puedo" en lugar de darse por vencido y decir simplemente "no se puede." Es tan fácil decir "no se puede."

Tal vez usted conoce a alguien a quien realmente puede hacer que funcionen las cosas a pesar de la adversidad y los problemas. Gente de muchos campos de vida. Desde que empecé a trabajar para la Fundación, he tenido la suerte de conocer oftalmólogos muy trabajadores, trabajando en situaciones sumamente difíciles. Pero también he conocido maestros que trabajan diligentemente para motivar a los demás, y sacerdotes que hacen posibles cambios para el mejoramiento de sus comunidades. Me hace pensar... ¿Cómo fue que se hicieron así? ¿Cómo obtuvieron toda esa energía e el deseo de ayudar? Existe una clave en el proceso de ayuda comunitaria. El cambio que viene a través de uno mismo cuando UNO se pone al servicio de los demás, cuando UNO comparte y da de sí mismo a los demás. Es así que uno llega a conocer las vidas de otras personas, a través de una verdadera interacción.

Es muy fácil llenar nuestros días con nuestros asuntos y nuestras cosas en nuestro propio mundo. Todo el día está lleno con nuestro trabajo, nuestra familia, etc. Ocupa todo nuestro tiempo. Y nunca nos tomamos el tiempo de mirar más allá de ese mundo. Es tan fácil decir "Estoy muy cansados y preocupados como para enfrentar los problemas de otros." Pero

aceptamos que los obstaculos son insuperables. Nuestro mundo es tan cerrado y tan oscuro que no podemos crecer. Lo mejor que podemos esperar es que tal vez uno diría, "ojalá que yo pudiera hacer algo."

Lo que nos puede hacer salir de este hoyo en que nos encontramos es el ver la luz que existe en el ser humano, en la sonrisa d un niño, en la alegría del anciano. Al realmente senir y apreciar a las demas personas, su alegría y su suframiento es cuando podemos dar de nosotros mismos y solo asi podremos CRECER.

No tenemos que empezar ayudandoen cosas grandes y titanicas. Podemos llegar a tener un impacto real tan pronto que salimos de nuestros propios mundos y hacernos disponible para trabajar con las demas personas. Cuando uno se pone al servicio de la comunidad, nuestra personalidad cambia. Cuando uno demuestra cariño, aceptación y deseo de trabajar hacia una meta común, uno sale de ese micromundo y todas las limitaciones implícitas del mundo. Es transferir el centro de atención de uno mismo a los demás que tanto lo necesitan. Cómo consecuencia y beneficio de nosotros mismos, nuestro mundo se empieza a simplificar porque nuestros problemas que antes parecían tan grandes se hacen chiquitos porque tenemos otras cosas en que pensar. Un mundo de posibilidades se abren a nuestro paso. Nos sentimos llenos al experimentar la confianza que otros tienen en nosotros y como comparten sus vidas con nosotros. Todo ese sentimiento se vuelve algo contagioso. Al trabajar para la comunidad tu inspiras a otros y otros lo hacen lo mismo te inspiran a ti a seguir adelante.

I. Tenemos que tomar el primer paso y mirar más allá de nuestros problemas, nuestros munditos.

II. Luego tenomos que ver que es lo que ocurre allá afuera, cuales son las necesidades.

III. Brindar un servicio. DAR. Ponerse al servicio de alguien, sin pensar en si mismo.

IV. Siempre mantenga su visión sobre la meta. No se de por vencido...Diga "SI PUEDO" en vez de decir "ojalá que yo pudiera."

Cuando empezamos de actuar en tal manera, los demás van a ver el cambio, y van a aceptar que esa es la manera de ser. Nuestros colegas, y hijos tambien van a aceptar que asi se hace las cosas. En cambio, cuando nosotros nos quedamos en nuestros hoyos oscuras, nuestros colegas, y hijos tambien aceptan que asi se hace las cosas.

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Attachment AA: Trip Report, III Latin American Congress on the
Prevention of Blindness, Mexico May 1997,
Ellen Parietti

III Congreso Latinoamericano de Prevención de la Ceguera
May 1 & 2, 1997 Cancún, Mexico
Trip Report
Ellen Parietti, MPH & Raúl Gomez, MD

Objectives:

1. Facilitate round table on "Prevención de Ceguera y Desarrollo Profesional: ¿Como Conseguirlo?"
2. Hold meetings with members of the prevention of blindness community to solicit opinion on future IEF programming.
3. Followup on the following Honduran issues: Eye Bank, National Committee for the Prevention of Blindness, and ResPack participants.

I had planned on meeting with several leaders in blindness prevention activities in small groups to discuss what they feel to be the main barriers to the access of ocular care, and the best ways of dealing with these obstacles. Unfortunately, this was difficult as only one of the invited confirmed, and later was forced to cancel. I had a meeting Friday, spoke with most of the others privately. I shall follow-up by phone and fax to get additional information.

1. Prevención de Ceguera y Desarrollo Profesional ¿Como Conseguirlo?

I gave my presentation from Brazil on the Philosophy of the Prevention of Blindness, Dr Juan Batlle gave his presentation on the National Survey on Diabetes & Blindness. Following the presentations, we had a real round table. The people who attended were: 3 people from the residency program in Nicaragua including Dr. Julio Quezada Toruño, 2 residents from Mexico, Tuli & Claudia Silva Solomon.

We drafted conclusions from the draft on how Prevención de Ceguera should be integrated into Professional Formation.

1. Prevention of Blindness should be included in the curriculum at all schools of medicine and ophthalmology residency programs.
2. Ophthalmology residency programs should include community service projects and campaigns that will serve to stimulate the interest of residents in social service and prevention of blindness.
3. It is recommended that the health codes include Prevention of Blindness as a priority in primary health campaigns.
4. The visual health professional should recognize his/her responsibility to all of the surrounding communities. His/her efforts should go beyond those patients who seek consultation, since there are patients who cannot come to a regular consultation due to distance or a lack of economic resources.

Prior to the presentation, I met with Juan Battle- discussed how to go about our presentation of professional development & the incorporation of prevention of blindness He gave me a publication of his national survey on Diabetes & Blindness. It contains not only the results of the survey, but how they went about getting the support & cooperation of institutions to conduct the survey. It will serve in a way as a manual on how to get go about such a survey. He hopes that a manual on blindness prevention will do the same thing. The following are outlines of two manuals we had discussed.

PREVENTION OF BLINDNESS

- i. Preface: VICTORIA - recognitions & agradecimientos
- ii. Introduction- Francisco Contreras
- I. Worldwide Statistics- Juan Carlos Silva
- II. Prevention of Blindness Philosophy - Allen Foster
- III. Blindness in Children - Rainald Duerdsen
- IV. Blindness in Adults- Dr. Juan Battle
- V. The Cataract Problem - Carl Kupfer
- VI. The Glaucoma Problem - Remo Santana, Diggern Berges, Paul Palmberg
- VII. Vitamin A
- VIII. Diabetic Retinopathy
- IX. Macular Degeneration
- X. Trachoma
- XI. Onchocerciasis
- XII. Ophthalmia Neonatorum
- XIII. Prevention of Blindness Programs in Brazil - Newton Kara Jose
- XIV. Prevention of Blindness Programs in Peru - Francisco Contreras
- XV. Prevention of Blindness Programs in Colombia - Virglio Galvis
- XVI. Prevention of Blindness Programs in Guatemala - Fernando Beltranena

CLINIC ADMINISTRATION FOR PREVENTION OF BLINDNESS CLINICS

1. National Plans & Committees for Blindness Prevention
2. National Surveys of Blindness
3. Regional Maldistribution of Eye Services
4. Training of Ancillary Personnel; the Multiplication Factor
5. Creation of Satellite Clinics
6. Successful Establishment of Satellite Clinics
7. Supplies of Equipment and Disposable Materials
8. Management of the Private Office
 - a. Fixed Costs
 - b. Variable Costs
 - c. Equipment Costs
 - d. Projections
 - e. Personnel
 - f. Accounting
 - g. Insurance
 - h. Ethics in Ophthalmology
9. Appropriate Technology
10. Why do you Give ?
11. Sustainability & Self-assessment
 - a. Objective & Subjective Evaluation
 - b. Incentives & Obstacles
 - c. Who Pays? Why Not for free?
 - d. Who gets the credit?
 - e. Long Term Goals in the Prevention of Blindness
12. The International Eye Foundation
13. NGOs dedicated to the Prevention of Blindness

Bibliography

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Include : "how to submit a proposal."

2. Hold meetings with members of the prevention of blindness community to solicit opinion on future IEF programming.

Breakfast meeting of Friday, May 2nd:

Attendees:

Rosa Amalia Gutierrez de Vasquez- Directora del Programa de Prevención de Ceguera del Comité pro Sordos y Ciegos (Robles Hospital)

Dr. Ortiz- Comité Pro Sordos y Ciegos (Robles) In charge of all cases of Low Vision.

Dr. Proaño-Representative of SightReach program in Ecuador. Works only with his private practice.

Carlos Beltranena Instituto Ecuatoriano de Seguro Social. Half time. His institution only covers people who are working & covered. Only over 18yrs old. Has private practice in Quito.

1. Do you consider there to be a problem with the access to eye care in your country? problems with access? All said yes

2. What do you consider to be the main barriers? (rank)

Dr. Proaño - Ecuador:

1. Costo- Lack of Economic Resources on both the part of the doctors/gov't to take care of people, & lack of resources for the people to deal with it.
2. Lack of knowledge where they can access care.
3. Lack of services available outside of the capitals.

Rosa Amalia: in Guatemala, the distribution of the population. It is very dispersed, very remote. Phone service is very difficult. The roads are dangerous; in very poor condition, and subject to assaults.

1. GEOGRAPHY- sparsely distributed population-shortage of real population centers. very time intensive to access populations.
2. INFRASTRUCTURE-lack of reliable phone lines and safe highways for communication and transport
3. SEASONAL MIGRATIONS - lack of static population
The population is also migratory - they go to pick coffee at the harvest season; the rest of the time they are working in the sugar cane plantations.

In Ecuador, the population doesn't migrate as much; it is more uniform throughout the year.

Guate: cultural reasons in general. Not specifically Illiteracy. They are not as in need of 20/20 vision. If you are blind, or cannot function, then you will look for help. Not necessarily a question of literacy.

PERCEPTION OF A LOWER STANDARD OF CARE

equipment in the hospitals: they don't have the technology & the people know that.

THE PRECEDENT OF FREE SERVICE BY THE GOV'T. Now, the governments have less money for the health care.

3. How do you think we can best reach the segment of the population that is not currently being served?

Rosa Amalia- ophthalmologists aren't motivated to go there

Dr. Proaño:

1. Find some way to consistently offer access to care at **LOW PRICES**
2. Publicity for where services are available.
3. Increased availability of services outside of the capital.

IEF should equip a clinic within a private charity hospital. The low price could be insure with the larger volume, & publicity is already taken care of for you. People perceive the private clinics to be expensive.

Rosa Amalia- Community participation. There is little participation, the people don't go. Promotion is very important. Communities have been changing too. In Guatemala, some rural areas have seguro medico campesino. They pay 3 quetzales per month. They have access to exams by a general practitioner when needed. If they need an ophthalmologist, they pay 10 quetzales.

Ways to motivate them to work out in the surrounding areas:

1. Send them to participate in regional congresses & present the work they do.
2. Give them a salary???????
3. Recognition of their work

They need a team to work with. Ellen: use volunteers to make their time better organized?

Dra. Maria Jose Cordova- Nicaragua

Dra. Cordova and three other doctors have applied for sites surrounding Managua. One of them is only 10km away from Managua. I have not yet given her a decision regarding these sites. We got feed-back from a friend of Orlando Oliva's saying that these areas are truly very in need of services. Still, I would like to confirm that these areas are appropriate for a SightReach clinic.

The Centro Nacional de Oftalmologia has a total of 12 ophthalmologists. Maria Jose is director of the residency program and they do have fee for service. With Nicaragua having 70% unemployment, there are many that pay very very little. A mere pittance. But they bring together everything they can, and it does add up. They are able to get suture, etc at very low prices through Alcon for some things. They also get many donations of IOLs, but they run out. For example, right now they have none, and they tell the people that cannot afford to buy one that they need to wait for donations to come in. The government provides roughly 25% of their budget. Currently, they have permission to charge for surgery, but at any moment, the government could change and they can be prohibited to charge anything. Another way they recover cost is by renting out the use of their equipment for doctors to treat their private patients. Sometimes they come at off hours, others don't care and come in while all the public patients are there. There are a total of 10 ophthalmologists that have come together to form a group called "Brigadas Ayudemos A Ver." Those outside the group didn't like it at first, but now, more and more they want to join the group because they see it as a positive thing. They do campaigns into rural areas to refract children, etc. They do not have access to a microscope, and would like to be able to offer surgery as well.

Dra. Brigitte Hudicourt-Haiti

There are a total of 10 ophthalmologists for Haiti. There are 2 in Cape Haitien. Dr. Clark and 1 Haitian doctor. In La Cayes, there are 3 doctors. I believe the other 5 are in Port au Prince. There are microscopes in Port de Paix & Jeremie, but no one can use them for some reason rooted in politics. Dr. Hudicourt used to go to a clinic in Mirebalias to do social work, but since the problems Haiti has been through she no longer goes.

I asked her some of the questions intended for use during the breakfast meetings. In her opinion, the biggest single barrier to the access to eye care in Haiti is communication. She says she is eager to work with other ophthalmologists in blindness prevention projects, yet she cannot even communicate with them by telephone because the service is so poor. Ophthalmologists cannot organize themselves. Second, she cites economic reasons. Third, a poorly developed infrastructure, as poor roads and lack of buildings. I gave her Dr. John Cheatham's name & I advised her to get in touch with him there.

Dr. Marcelo Arce-Bolivia- Dr. Arce is the director of the residency program at the Instituto Nacional de Ojos (INO) in Bolivia. He has been working with several NGOs. He says that in Bolivia, the NGOs work together in a very coordinated manner. Among them are Desaret, (a Mormon group that gets donations of medicines and surgical equipment) Lions Club, and Help the World See (Wayne Cannon) & Orbis. With the Orbis & Wayne Cannon's group, they conducted an Amblyopia Project. Orbis provided the money to train teachers and pay an ophthalmologist. 10,000 children were screened. 20% of the children really needed glasses. They already had the optica in the works with Help the World See.

The optica has been in existence 6-8 months yet has not broken even yet because the eyeglass volume isn't high enough. They are trying to institute a national plan for the screening of children in schools but they have come up against a barrier: MANPOWER. There is no longer any funding available from Orbis to pay the ophthalmologist who was seeing those children that really needed eye glasses & misc. other people that needed follow-up. They estimate that of the 200,000 school children that would be screened, approximately 75,000 would need to be seen by an ophthalmologist. They would like to see if they can get money for an automatic refractor, because that would lighten the load on the ophthalmologist.

cost recovery: At the INO, they do charge most of the people for services provided. A social worker sees all of the patients and assesses their ability to pay. Roughly 15% of patients don't pay anything. 85% do pay something- just about cost, which for cataract surgery is \$65. Thirty five percent are patients who have money and could go anywhere, but choose to go to the INO because of its good reputation. They are charged up to \$800. All of these people receive EXACTLY the same care. There is absolutely nothing different about the surgeon, the surgery, the materials, or the accommodations received. They don't think that would be fair to the poorer patients & would leave a bad taste in their mouth. This system of fee for service could change at any moment, as it is at the whim of the government. The government has just declared that all Bolivians over the age of 65 are to be provided health care free of charge. (All of their cataract patients.)

There is also a part of the hospital that is rented out to ophthalmologists so they can attend their private patients there. They charge them; the doctors are happy to have somewhere to operate.

Dr. Arce doesn't think it is possible for his state-run institute to become self-sufficient. They currently recover about 50% of their operating costs. He believes he is recovering all the money that he can from patient fees. They are dependent upon the government for their salaries.

When I told him about our SightReach program, he said that it was very interesting, but that for him to really believe that the person be dedicated to serving an outerlying community, they should be from &/or have family in that area. He has one of his residents in that situation; working in an indigenous area. His family is from there and he has no doubt that he will stay. (This is the same doctor who has been working with the catholic priests in Camiri.) He said that is the only person he would give his

guarantee on. There are just too many pressures to stay in the main cities of La Paz, Cochibamba, & Sta. Cruz. We discussed the possibility of working with institutions who might be reaching the populations in need. He said that Pro-Salud is working in the main strip of those 3 principal cities. They are looking to expand and include ophthalmic service in those clinics. Dr. Arze feels that those Pro-Salud clinics have not yet reached self-sustainability yet, but can not be quite sure since it is run by AID and they don't really let people know. This could be a very opportune time to get involved in the expansion of those clinics.

Dr. Francisco Contreras I had the chance to speak briefly with Dr. Contreras. He was very interested to know how the SightReach program was going and why Peru had never been included. He said that he knows some of the people trained under him people would be interested as they are very blindness prevention oriented. I told him of our interest in broadening the program to include new initiatives & that I wanted his input. He said he would be very happy to communicate with me via fax regarding these matters.

CONCLUSIONS REGARDING INFORMATION GATHERED:

1. It is potentially problematic to work with govt institutions on cost recovery projects b/c of periodic changes in policy limiting ability to charge patients.
2. There is still a lot of interest in current Respack program; people wanting to participate
3. Commonly voiced issues regard infrastructure (roads & communications) as barriers to serving the underserved.
4. Many believe that by working with an established private not for profit hospital or clinic, we could reach people who wouldn't go to a private clinic. reasons: people are afraid to go to private clinics b/c of cost, and established hospitals already have their clientele established.
5. Most people are open to charging & most are doing so currently, by use of social workers. The question is are they recovering as much as they could be??
6. Keeping costs down is very necessary for people to be able to access services. This becomes difficult with an emphasis on cost recovery or self-sufficiency.

3. Followup on the following Honduran issues: Eye Bank, National Committee for the Prevention of Blindness, and ResPack participants.

Eye Bank:

APABO - Met Dr. Farge & Anna Maria Torres- discussed briefly their role with the Asociación Panamericana de Bancos de Ojos (APABO). She cited how she worked well with Dr. Carlos Gonzalez of Honduras, and how they would be meeting together. We both expressed a desire to sit down and discuss the Honduras project. (I believe she thought my main concern to be the reputation of their project.)

Raúl Gomez-expressed to me the fact that the NCPB didn't trust the people who were working with the formation of the APABO eye bank. He thought that most of the issues had to do with pride and recognition. He feels that Maura Chavarria did do a lot of early, very difficult work towards the establishment of an eye bank (getting the law passed, getting the personaria juridica, etc) and she resents the fact that she will have no power within the new group. The comite also has a fear that the corneas from the eye bank will be reserved for their private patients and the indigent patients will not have any access to them. With Claudia Silva, we discussed the above-mentioned fears held by the people from the Comite Nacional for the Prevención de la Ceguera. Claudia is friends with Carlos Gonzalez and said that she truly hoped that the Comite would join with those of Sta. Lucia and let them use the Personaria Juridica because Claudia feels that they will go ahead and get the Personaria Juridica on their own and exclude those from the Comite. The people from the Comite would then feel humiliated and would not access &/or not have access to the corneas produced by the eye bank. Carlos Gonzalez is a very dynamic man and will not stop until this eye bank is established; with or without the support of the Comite.

Raul cited Dr. Gonzalez's plan of a governing board which would not include any ophthalmologist, therefore insuring a just distribution of the corneas. They both felt the plan was very ingenious and clever, but Raúl is not sure he can trust Carlos because Dr. Gonzalez once accepted an IEF scholarship to specialize. In exchange, he was supposed to work two years in the Clinica Magi. He did not fulfill this obligation and went to work in the Clínica Sta. Lucia.

Raúl said that if Carlos Gutierrez were to fulfill his promises, he thinks it would work out great; he just can't be sure that he will. He doesn't trust him. The last two meetings that the groups have had have ended in fighting. It is a shame that with so much for each to gain that they cannot come to an understanding.

Conclusions regarding Eye Bank: Claudia suggested that a conflict resolution meeting be held with a mediator. I suggested Juan Batlle, who will be in Honduras this month (in El Progreso). Juan Batlle is an executive officer of APABO, yet is very supportive of the efforts of the Comite for the Prevention of Blindness. I think he would be a person who would not only help each side to understand the importance of working together, but also would help insure that the eye bank be there for the public patients of San Felipe. Raul said that he would fax Juan Batlle for his support, as will I. It was decided not to try to approach Ana Maria Torres about the conflict, as she has already

established a close relationship with Dr. Gonzalez, and we did not want to seem as we were gossiping. We will simply let Dr. Battle know the fears that Hondurans have related to the eye bank.

Dr. Hector Membreño-Honduras--I was unable to locate Dr. Membreño for the first 2 days of the Congress. Raúl finally found him and introduced us. I was with Claudia Silva at the time, whom I presented as well. He interrogated Claudia as to her activities in Siguatepeque to date. He said he had "heard of a lot of new ophthalmologists in that area. Did she know who they were?" He was referring to an ophthalmologist she hosted from Volunteer Eye Surgeons to perform surgeries in the Hospital Evangelico where she is working. He said that he would like to speak with her so he could "find out exactly who these people are." He practically attacked Claudia at their first meeting. Subsequently, I spoke to Raúl and he said that although he had not had the opportunity to speak with Dr. Membreño about the Clínica Magi & the possibility for any specific future collaboration, he was able to get on better personal terms with him. Raúl said that any past misunderstandings had been just that, and he simply had wanted to help support the Clínica Magi, and would like to do so in the future. Dr. Membreño was very open to that.

Meeting with Doris Alvarado I met with Dra. Doris Alvarado to discuss the circumstances around the change in her ResPack activities. (I had been told that she & Sergio Zuñiga had moved their clinic to a new location in Colonia Florencia (a wealthy neighborhood.) Her husband was also present. She said that the truth of the matter was that very few patients coming to her clinic in the "Centro Medico." The location was thought to be a bad choice. As Doris put it, the surrounding population took the fact that they were charging 80 Lempira (very cheap, in her mind) for a consultation to mean that the quality of the care was not good. For this reason, she said, they didn't have many clients. They did advertising & publicity, but no one came. She said that it didn't make sense for her to sit there all day waiting on patients when no one came. She had another set of equipment which she put in the new site. Therefore, she would attend patients in her new clinic and when patients would show up in the old clinic, they would beep her. [Raúl Gomez visited her old clinic in Colonia Kennedy & this was not what he found. The receptionist told him that if he wanted Doris Alvarado, he would need to go to her new clinic in Colonia Florencia.] She says that she maintains the clinic in Colonia Kennedy in order to fulfill her obligation to the Respack program. Sergio Zuñiga does not help her with this; while he had his equipment there, he did, but now since he entered into the other clinic with Ehrler & Doris, he is not part of the upkeep of that clinic.

I told her that if she was having problems with the viability of the clinic in Colonia Kennedy, she should have let us know that and then seek solutions to the problem. Simply establishing a new clinic was not the step to take. The submission of monthly reports would also have helped with communication in this matter. She should have let us know she was having problems and if she definitely wanted to move, propose a new site.

Meeting with Claudia Silva, participant of the SightReach program in :

Claudia is concerned that the actions of current "participants" are putting the program in a bad light and perhaps jeopardizing its existence. Sergio Zuñiga is saying he is outraged at my attitude towards him, yet Claudia herself is aware that he has been dishonest with me regarding use of his equipment. She recommends that only people who are truly working within the program be focused on and supported.

Conclusions regarding Respack: Respack in Honduras needs to be restructured. Problems originated when Zuñiga was approved in Guatemala for Colonia 21. That set a precedent for others to be in peri-urban areas. Based on our experience in Honduras, this was a negative step. There were no strict lines set as to which specific areas were eligible for SightReach clinic establishment. Grey areas exist where participants felt they could argue for a need, generating conflict. Of eight sets of equipment in country, the only 2 or 3 that are functioning as intended are that of Jorge Cisneros, Claudia Silva, (& Denis Espinal.) The Honduran program is in a crisis. I feel that it needs to be restructured. We need to clearly identify eligible ResPack sites. Make the application process more rigorous. Change the convenio to include repayment of an established amount of money. Show clearly how they can be in compliance: by submitting monthly reports, etc. What they can expect from us, and decide who is really dedicated to the program. Support those. Those who do not, cut our losses and let them go.

375

Attachment AB: Invoice of Albanian Shipment of
Donated Ophthalmic Equipment

SHIPPERS EXPORT DECLARATION AND COMMERCIAL INVOICE

SHIPPED FROM
The International Eye Foundation
7801 Norfolk Avenue,
Bethesda, MD 20814

SHIPPED TO
Att Dr. Sulejman Zhugli
University Hospital Center
Dibra St # 370
Tirana
ALBANIA
TEL 355-42-26750

DATE 12/19/96

Shipping Method Air Sea American carrier desired Yes Not necessary Insured for \$56,000

- 1 Zeiss OPMI 6S microscope
- 1 Zeiss OPMI 6 microscope
- 1 Mentor Slit Lamp
- 1 Zeiss 30SL Slit lamp with Applanation Tonometer
- 2 manual slit lamp tables
- 2 Bausch & Lomb keratometers
- 3 Keeler All Pupil Indirect Ophthalmoscopes kit #2
- 3 Teaching mirrors
- 3 Shin Nippon Trial Frames
- 3 Khosla Trial Lens sets
- 1 Ocular Instruments 3 mirror lens
- 2 Ocular Instruments laser coated 3 mirror lenses
- 3 Welch Allyn Streak Retinoscopes w/ handles
- 1 Alcon Phaco-Emulsifier Aspirator
- 1 Coherent Yag Laser
- 4 sterilization trays
- 1 instrument sterilization box
- 14 Phaco I/A paks
- 2 Forceps
- 1 pair curved needle holders
- 2 dozen black sutures
- 3 AU-15s
- various used ophthalmic journals
- various used ophthalmic texts
- used hospital linens

DONATIONS WILL NOT BE SOLD

The items listed above are a donation to the University Eye Clinic from the International Eye Foundation They are for charity use only and will not be sold

Ellen M Parietti, Program Officer

Date

SHIPPERS EXPORT DECLARATION AND COMMERCIAL INVOICE

SHIPPED FROM
The International Eye Foundation
7801 Norfolk Avenue,
Bethesda, MD 20814

SHIPPED TO:
Att: Dr. Sulejman Zhugli
University Hospital Center
Dibra St # 370
Tirana
ALBANIA
TEL. 355-42-26750

DATE 02/16/97

Shipping Method Air Sea American carrier desired Yes Not necessary Insured for \$500

3 Trial lens sets with frames
3 20D lenses
3 90D lenses
72 Isopto Cetapred 15ml

DONATIONS WILL NOT BE SOLD

The items listed above are a donation to the University Eye Clinic from the International Eye Foundation They are for charity use only and will not be sold

Ellen M Parietti, Program Officer

Date

Attachment AC: Summary Document, Traditional Healer Symposium,
Malawi September 1997

**TRADITIONAL HEALER SYMPOSIUM
BLANTYRE, MALAWI
September 10-12, 1997
Summary Document**

Statement of consensus and recommendations on the need for collaboration between African traditional healers and biomedical eye care workers in eye care.

Prepared by participants at the:

International Symposium on Collaboration with Traditional Healers for Prevention of Blindness in Africa

Traditional healers are an integral and important part of most cultures and will remain so. They are respected members of their communities and live and work in the most rural areas. They are the most commonly consulted and most accessible health care providers in all African communities.

Eye care programmes have been effective at the district hospital level in many countries. There has, however, been limited success in expanding activities beyond this level and in overcoming many of the barriers precluding cataract surgery uptake by rural communities.

Collaboration with traditional healers in Zimbabwe and Malawi has been successful with an increase in the cataract surgery uptake and a decrease in the incidence of blinding corneal ulcers due to harmful traditional eye medicines.

Eye care programmes could increase accessibility of services to rural communities by collaborating with traditional healers. Traditional healers are interested in collaborating with eye care workers. There is now a clear imperative for collaboration. This should be based on mutual trust and respect with the two disciplines as both should complement each other to the benefit of the patient.

Recommendations

1. Collaboration should focus on improving the capacity of traditional healers to assist their patients, on referral, on counseling patients and their families, and on decreasing harmful traditional practices.
2. There is tremendous variation in traditional healer practice; approaches to collaborative blindness prevention programmes, therefore, must reflect local conditions.
3. A clear understanding of traditional eye care practices is necessary prior to development of collaborative activities and training.

4. Such collaborative activities should be consistent with Ministry of Health policy and guidelines.
5. Ministries of Health are encouraged to set policy and guidelines, and establish and regulate traditional healer associations. To protect the public, regulations concerning advertisements and service outcome should apply to all health providers be they traditional healers, couchers or biomedical personnel.
6. If Ministry of Health allows the use of pharmaceuticals by traditional healers consideration should be given to sustainability and possible adverse effects of combining pharmaceuticals and traditional eye medicines.
7. Collaborative activities should be patient focused, community based, culturally appropriate, and sustainable.
8. Training programmes for healers should be participatory in nature, reflecting the unique role healers have in their communities; the proposed manual should be adapted as necessary.
9. Collaborating eye care programmes should only be established where there are adequate training, support, referral, and feedback capacities.
10. Couching remains a significant cause of visual loss and blindness; the provision of affordable, accessible high quality modern cataract surgery with good visual outcome would reduce this practice.
11. Operational research is needed to clarify the best approaches to collaborative interventions.

Organizing institutions:

**BC Centre for Epidemiologic & International Ophthalmology
University of British Columbia, Vancouver, CANADA**

&

**Lilongwe Central Hospital WHO Collaborating Centre for the Prevention of
Blindness**

Lilongwe Central Hospital, Lilongwe, Malawi

The International Symposium on Collaboration with Traditional Healers for the Prevention of Blindness, held in Blantyre, Malawi from September 10-12, 1997 was supported by the Task Force of the Partnership Committee of Non-Governmental Organizations Collaborating with the W.H.O. Programme for the Prevention of Blindness. Symposium participants included eye care professionals from Africa, North America, Europe, and Asia as well as traditional healers from Zimbabwe and Malawi. The organizers and participants would like to thank the NGO Task Force and W.H.O. as well as the International Eye Foundation /Malawi for their support of the symposium.

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Attachment AD: Pipeline Analysis for this Reporting Period

TABLE C: Headquarters & Countries Budget INTERNATIONAL EYE FOUNDATION

Matching Grant
 FY 93 DIP Guidelines

Expenses through 12/31/97

383

	<u>BUDGET</u>		<u>ACTUALS</u>		<u>BALANCE</u>		<u>TOTAL</u>
	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	
<u>I. PROGRAM MGMT</u>							
a) Salaries	106	11	164.5	46.5	-58.5	-35.5	-94
b) Fringe Benefits	18	3	46	15	-28	-12	-40
c.) Travel, Transportation & Per Diem	108.5	18	117.5	17	-9	1	-8
d) Subcontracts	0	0	0	0	0	0	0
e) Other Direct Costs	212.5	12	57.5	21.5	155	-9.5	145.5
SUBTOTAL	445	44	385.5	100	59.5	-56	3.5
<u>II. PROCUREMENT</u>							
a.) Consultations	144	50	64	0	80	50	130
b) Supplies	4	1721	9	230	-5	1491	1486
SUBTOTAL	148	1771	73	230	75	1541	1616
<u>III. INDIRECT COSTS</u>							
SUBTOTAL	107	335	69	7.5	38	327.5	365.5
TOTAL HEADQUARTERS/COUNTRY COSTS	700	2150	527.5	337.5	172.5	1812.5	1985

TABLE C: Headquarters (Regional) Budget

INTERNATIONAL EYE FOUNDATION

Matching Grant

Expenses through 12/31/97

FY 93 DIP Guidelines

185

	<u>BUDGET</u>		<u>ACTUALS</u>		<u>BALANCE</u>		<u>TOTAL</u>
	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	
<u>I PROGRAM MGMT</u>							
a.) Salaries	67	11	134	44	-67	-33	-100
b.) Fringe Benefits	18	3	45.5	14	-27.5	-11	-38.5
c.) Travel, Transportation & Per Diem	34.5	18	48	13	-13.5	5	-8.5
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	22.5	12	7.5	17	15	-5	10
SUBTOTAL	142	44	235	88	-93	-44	-137
<u>II PROCUREMENT</u>							
a.) Consultations	23	2	6.5	0	16.5	2	18.5
b.) Supplies	4	1	1.5	52	2.5	-51	-48.5
SUBTOTAL	27	3	8	52	19	-49	-30
<u>III. INDIRECT COSTS</u>							
SUBTOTAL	31	9	35	5	-4	4	0
<u>TOTAL HEADQUARTERS COSTS</u>							
	200	56	278	145	-78	-89	-167

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 12/31/97

	<u>BUDGET</u>		<u>ACTUALS</u>		<u>BALANCE</u>		<u>TOTAL</u>
	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	
<u>I. PROGRAM ELEMENTS</u>							
a) Salaries	39	0	30.5	2.5	8.5	-2.5	6
b) Fringe Benefits	0	0	0.5	1	-0.5	-1	-1.5
c.) Travel, Transportation & Per Diem	74	0	69.5	4	4.5	-4	0.5
d) Subcontracts	0	0	0	0	0	0	0
e) Other Direct Costs	190	0	50	4.5	140	-4.5	135.5
SUBTOTAL	303	0	150.5	12	152.5	-12	140.5
<u>II. PROCUREMENT</u>							
a) Consultations	121	48	57.5	0	63.5	48	111.5
b) Supplies	0	1720	7.5	178	-7.5	1542	1534.5
SUBTOTAL	121	1768	65	178	56	1590	1646
<u>III. INDIRECT COSTS</u>							
SUBTOTAL	76	326	34	2.5	42	323.5	365.5
<u>TOTAL PROGRAM COSTS</u>	500	2094	249.5	192.5	250.5	1901.5	2152

SUPPORT WITH BUDGET NARRATIVE - CASH \$ IN THOUSANDS

SFB

TABLE B: Country Budget For GUATEMALA INTERNATIONAL EYE FOUNDATION

Matching Grant

Expenses through 12/31/97

FY 93 DIP Guidelines

386

	<u>BUDGET</u>		<u>ACTUALS</u>		<u>BALANCE</u>		<u>TOTAL</u>
	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	
<u>I. PROGRAM ELEMENTS</u>							
a.) Salaries	10	0	18	0	-8	0	11
b.) Fringe Benefits	0	0	0	0	0	0	0
c.) Travel, Transportation & Per Diem	18	0	26	1	-8	-1	18
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	40	0	14	1	26	-1	60
SUBTOTAL	68	0	58	2	10	-2	89
<u>II. PROCUREMENT</u>							
a.) Consultations	20	6	12	0	8	6	38
b.) Supplies	0	275	2	82	-2	193	0
SUBTOTAL	20	281	14	82	6	199	38
<u>III. INDIRECT COSTS</u>							
SUBTOTAL	16	52	10	0.5	6	51.5	24
<u>TOTAL PROGRAM COSTS</u>	104	333	82	84.5	22	248.5	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 12/31/97

	<u>BUDGET</u>		<u>ACTUALS</u>		<u>BALANCE</u>		<u>TOTAL</u>
	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	
<u>I. PROGRAM ELEMENTS</u>							
a) Salaries	6	0	3	0	3	0	11
b) Fringe Benefits	0	0	0	0	0	0	0
c.) Travel, Transportation & Per Diem	15	0	19	0.5	-4	-0.5	18
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	30	0	11	0	19	0	60
SUBTOTAL	51	0	33	0.5	18	-0.5	89

II. PROCUREMENT

a) Consultations	20	6	10	0	10	6	38
b.) Supplies	0	275	1.5	24.5	-1.5	250.5	0
SUBTOTAL	20	281	11.5	24.5	8.5	256.5	38

III. INDIRECT COSTS

SUBTOTAL	13	52	7.5	0	5.5	52	24
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TOTAL
PROGRAM
COSTS

84	333	52	25	32	308	151
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SUPPORT WITH BUDGET NARRATIVE - CASH \$ IN THOUSANDS

387

TABLE B: Country Budget For ECUADOR

INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 12/31/97

282

	<u>BUDGET</u>		<u>ACTUALS</u>		<u>BALANCE</u>		<u>TOTAL</u>
	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	
<u>I. PROGRAM ELEMENTS</u>							
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	0.5	0	9.5	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	3.5	0.5	31.5	-0.5	89

II. PROCUREMENT

a.) Consultations	15	6	2.5	0	12.5	6	38
b.) Supplies	0	275	0	29	0	246	0
SUBTOTAL	15	281	2.5	29	12.5	252	38

III. INDIRECT COSTS

SUBTOTAL	9	52	1	1	8	51	24
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TOTAL
PROGRAM
COSTS

59	333	7	30.5	52	302.5	151
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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 12/31/97

389

	<u>BUDGET</u>		<u>ACTUALS</u>		<u>BALANCE</u>		<u>TOTAL</u>
	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	
<u>I. PROGRAM ELEMENTS</u>							
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
<u>II. PROCUREMENT</u>							
a) Consultations	20	6	0	0	20	6	38
b.) Supplies	0	275	0	3	0	272	0
SUBTOTAL	20	281	0	3	20	278	38
<u>III. INDIRECT COSTS</u>							
SUBTOTAL	8	52	0	0	8	52	24
TOTAL PROGRAM COSTS	56	333	0	3	56	330	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 12/31/97

0/2

	<u>BUDGET</u>		<u>ACTUALS</u>		<u>BALANCE</u>		<u>TOTAL</u>
	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	
<u>I. PROGRAM ELEMENTS</u>							
a) Salaries	3	0	0	2.5	3	-2.5	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	12	0.5	11	-0.5	60
SUBTOTAL	33	0	21.5	4	11.5	-4	89

II. PROCUREMENT

a.) Consultations	9	6	11	0	-2	6	38
b.) Supplies	0	155	1	35	-1	120	0
SUBTOTAL	9	161	12	35	-3	126	38

III. INDIRECT COSTS

SUBTOTAL	7	31	6	0	1	31	24
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TOTAL
PROGRAM
COSTS

49	192	39.5	39	9.5	153	151
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SUPPORT WITH BUDGET NARRATIVE - CASH \$ IN THOUSANDS

TABLE B: Country Budget For BULGARIA

INTERNATIONAL EYE FOUNDATION

163

Matching Grant

Expenses through 12/31/97

FY 93 DIP Guidelines

	<u>BUDGET</u>		<u>ACTUALS</u>		<u>BALANCE</u>		<u>TOTAL</u>
	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	
<u>I. PROGRAM ELEMENTS</u>							
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	10	0	-4	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	19	0	9	0	89

II. PROCUREMENT

a.) Consultations	11	6	6	0	5	6	38
b) Supplies	0	155	2	0	-2	155	0
SUBTOTAL	11	161	8	0	3	161	38

III. INDIRECT COSTS

SUBTOTAL	7	28	4.5	0	2.5	28	24
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TOTAL
PROGRAM
COSTS

46	189	31.5	0	14.5	189	151
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SUPPORT WITH BUDGET NARRATIVE - CASH \$ IN THOUSANDS

TABLE B: Country Budget For ERITREA

INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 12/31/97

	<u>BUDGET</u>		<u>ACTUALS</u>		<u>BALANCE</u>		<u>TOTAL</u>
	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	
<u>I. PROGRAM ELEMENTS</u>							
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
<u>II. PROCUREMENT</u>							
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
<u>III. INDIRECT COSTS</u>							
SUBTOTAL	7	31	1	0.5	6	30.5	24
<u>TOTAL PROGRAM COSTS</u>	47	192	7	2	40	190	151

SUPPORT WITH BUDGET NARRATIVE - CASH \$ IN THOUSANDS

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TABLE B: Country Budget For MALAWI

INTERNATIONAL EYE FOUNDATION

Matching Grant
FY 93 DIP Guidelines

Expenses through 12/31/97

	<u>BUDGET</u>		<u>ACTUALS</u>		<u>BALANCE</u>		<u>TOTAL</u>
	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	<u>AID</u>	<u>PVO</u>	
I. PROGRAM ELEMENTS							
a) Salaries	6	0	7.5	0	-1.5	0	11
b) Fringe Benefits	0	0	0.5	0	-0.5	0	0
c.) Travel, Transportation & Per Diem	6	0	4	2.5	2	-2.5	18
d.) Subcontracts	0	0	0	0	0	0	0
e.) Other Direct Costs	19	0	2.5	2.5	16.5	-2.5	60
SUBTOTAL	31	0	14.5	5	16.5	-5	89

II. PROCUREMENT

a.) Consultations	15	6	11	0	4	6	38
b.) Supplies	0	155	1	3	-1	152	0
SUBTOTAL	15	161	12	3	3	158	38

III. INDIRECT COSTS

SUBTOTAL	9	28	4	0.5	5	27.5	24
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**TOTAL
PROGRAM
COSTS**

55	189	30.5	8.5	24.5	180.5	151
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SUPPORT WITH BUDGET NARRATIVE - CASH \$ IN THOUSANDS

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