

APPENDIX E

Methods for Determining Prevailing Traditional Eye Practices by Healers

There are some simple, yet important, steps to undertake in order to determine the prevailing traditional eye medicine practices by healers.

- Contact the National Prevention of Blindness Committee to determine if studies have been undertaken in your country or a surrounding country.
- If there is no locally appropriate information that can assist you, prepare a list of issues and questions such as those included below. Use these questions to help create a “picture” of traditional eye practices in your area.
 - Be sure to sensitize the healers regarding the reasons for your questions
 - Be sure to define your area of study (make it reasonable)
 - The person who carries out the questionnaire needs to be accepted and respected by healers and eye care personnel
 - Put the answers in a form that can be easily summarized
- Suggested recording form for assessing traditional eye practices of healers

DATE: VILLAGE:

DISTRICT:

NAME of HEALER:

TREATS EYE DISEASES: YES / NO

TREATS EYE DISEASE IN:

- CHILDREN
- ADULTS

TREATMENT METHODS (EYE DISEASES):

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	DRINKING OF MIXTURES
<input type="checkbox"/>	<input type="checkbox"/>	FACE WASHING
<input type="checkbox"/>	<input type="checkbox"/>	WEARING OF AMULETS
<input type="checkbox"/>	<input type="checkbox"/>	SMOKE/POWDER BLOWING
<input type="checkbox"/>	<input type="checkbox"/>	DIET/FASTING
<input type="checkbox"/>	<input type="checkbox"/>	LICKING
<input type="checkbox"/>	<input type="checkbox"/>	INCANTATIONS
<input type="checkbox"/>	<input type="checkbox"/>	SCARIFICATION
<input type="checkbox"/>	<input type="checkbox"/>	POULTICING/CUPPING
<input type="checkbox"/>	<input type="checkbox"/>	TOPICAL INSTILLATIONS
<input type="checkbox"/>	<input type="checkbox"/>	FUME BATHS

SURGERY (FOR EYE DISEASES)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	EPILATION
<input type="checkbox"/>	<input type="checkbox"/>	EYELID SURGERY
<input type="checkbox"/>	<input type="checkbox"/>	COUCHING
<input type="checkbox"/>	<input type="checkbox"/>	OTHERS _____

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	AWARENESS OF EYE CARE FACILITIES
<input type="checkbox"/>	<input type="checkbox"/>	DO YOU REFER TO EYE CARE FACILITIES?
<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WANT COLLABORATION WITH EYE CARE SERVICES/HOSPITAL?