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SUPPORTING VISION 2020: THE RIGHT TO SIGHT

THE RIGHTS OF BLIND PEOPLE

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I am now aged 72. In my lifetime, the attitude of the general public in the United Kingdom towards disabled people, and their rights, has undergone a radical change. This has meant that it has been possible for lawmakers to confer a large collection of 'rights' on blind (and other disabled) people.

At the age of eight, I joined the disability movement when glaucoma finally resulted in my becoming totally blind. I moved easily from a sighted elementary school into a residential special school for the blind. From there, my transition to Oxford University was far from easy – a major and challenging culture shock. I previously had little contact with my sighted fellows. Academic demands and the need to acquire social graces made life hard. But I survived; took my degree safely; and became a solicitor. I got a well-paid job; married; have four sons; was widowed; and was appointed a deputy Chancery Master (the first blind person in modern times to be appointed to judicial office). By courtesy of my work colleagues, all the while I had spent some of my time and energy working for various blind charities on a voluntary basis. That is where I come from.

Blind pupils in Uganda listen to their blind teacher
Photo: Sue Stevens

The Rights of Blind People

The rights of blind people? It is tempting to reply, no different from those of the sighted. We want a happy childhood; a good education (but should we be set apart or in the mainstream?); a satisfying job; a fulfilling family life; enjoyable leisure and social activities, and the chance to take a full part in public life. We want respect; esteem; affection (if we deserve it); but above all recognition that we are citizens with full civil and human rights.

Prejudice

Prejudice (intolerance or discrimination against a person or group) leads people to think that a blind person will always be less effective than his sighted counterpart. In those circumstances, a blind person must have 'luck' (not rights) to find an employer who will decide that they 'will take a chance'. 'Prejudice, not being founded on reason, cannot be removed by argument' (Dr Samuel Johnson).

We must, of course, accept that there are certain activities that we cannot undertake – those for which sight is essential. We cannot carry out surgical operations; or drive a car!

Change During My Lifetime

The 1948 Universal Declaration of Human Rights mentions disability only once (Article 25). There was what one might call

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'institutionalised prejudice' against blind people in the workplace. But, in the United Kingdom, things are different now.

There have been two interrelated factors which have led to blind peoples' rights becoming both recognised and enforceable in some countries.

- social legislation
- technology

The Blind, Discrimination and the Law

Consider legislation in the United Kingdom. We have the Disability Discrimination Act, 1995. Discrimination on the ground of disability is not acceptable in law, in certain fields of activity. Discrimination is defined as treating a person less favourably because of his or her disability.

Since 1997, in the fifteen member states of the European Union, we have Article 13 of the consolidated treaty. This directs European Union institutions to introduce measures against discrimination based on disability. Last year saw the introduction of a directive on discrimination in employment.

The United Nations is planning 'a comprehensive and integral international convention on the protection and promotion of the rights and dignity of persons with disabilities'. This is likely to be slow-moving. However, since 1993, we have had the (not legally binding) United Nations standard rules for the equalisation of opportunities for persons with disabilities, which have had some effect on state legislation.

In 1992, disability living allowance was introduced, reflecting the fact that blind people need compensation to enable them to meet the cost of increased daily living expenses. Other forms of statutory support have given blind people rights to a decent standard of living.

The Blind and Technology

The second half of the twentieth century saw dramatic advances in many areas of technology. First, the tape recorder; then the extraordinary progress of television. And finally, computers, with information and communication technology.

Tape recorders made it much easier for blind workers to carry out clerical and administrative tasks. If they proved they could do a job as speedily and efficiently as 'the next man', they had a right to be employed.

Access to television, as a leisure interest, enabled blind people to enjoy a mainstream activity.

We have established the need for audio description of television programmes – a commentary using the natural gaps in speech to explain what is happening on the screen. The Broadcasting Act, 1996, recognised this need, and it lays down targets which broadcasters must meet – thus, giving a right to blind persons. But we are, just now, in the frustrating situation that, although we have that right, we cannot exercise it because the necessary receiving equipment is not available.

Above all, computers were made accessible to blind people who quickly became programmers, analysts and trainers. But even more, a blind professional could use a computer with voice synthesis or a Braille display to access all the information available to a sighted colleague.

All this sounds miraculous, and compared with twenty-five years ago, it is. But nothing moves faster than technology, and we have to run in order to stand still. For example, we have achieved an agreement that websites should be accessible to blind people, by always having text as an alternative to graphics. But these rights are not easy to enforce. We must always be watching.

☆ ☆ ☆

Helping the Blind and Visually Impaired

The individual articles in this Issue of the *Journal of Community Eye Health* reflect a wide variety of personal experience and support for the blind and visually impaired. Sir John Wall writes of his own experience in a European country (UK) and the changes for good, with frustrations also, that he has experienced. Solomon Mekonnen movingly recounts his early years in a developing country (Ethiopia) and, with the support he received in his childhood, achieving so much both personally and in his academic life. From his experience in Tanzania, Geert Vanneste brings to us the practical needs and means of providing support and help for the newly blind, while Sue Stevens shares the essential courtesies and assistance for blind and visually impaired people.

This spectrum of experience, needs, support and care will surely encourage those who have the privilege of sight (and those who do not), to realise the huge potential that exists in each boy, girl, man and woman, who is blind or visually impaired – to enjoy and be blessed with a real sense of worth, respect and fulfilment in every aspect of life.

D D Murray McGavin
Editor

Help for the Blind or Visually Impaired Person: The Blind Person's Perspective

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Dr Solomon Mekonnen serves on the Board of **Christian Blind Mission International USA**.

The current chairman, Dr Van Joffrion, treated the author in the seventies when he was in Ethiopia. Dr Mekonnen now serves with Dr Van Joffrion to organise help for the blind and facilitate the 'Vision 2020' global effort.

Dr Mekonnen lost his sight due to a domestic accident in which boiling water spilled over his face at the age of eighteen months.

The author holds graduate degrees from Columbia University in Law, Political Science, and Philosophy.

Dr Mekonnen and his wife, Taddelech Nigussie, have five children.

Arguably, *help* is essential in the human experience. It is expressed through giving and receiving. These expressions are exercised within the framework of either a real or a perceived attitude of mind. Such attitudes are not necessarily created both by the social, cultural, religious, economic, and political environments in which individuals are raised or the particular inclinations that develop through the different stages of human growth and development. There are, however, some common factors shared by most of those who receive *help*, and a more realistic perspective is observed from the personal experiences of such individuals, especially in the absence of any documented study that surveys the outlook of most, if not all, those who benefit on the issue of *help*.

Roped pathways – an aid for pupils at a school for the blind in Africa

Photo: Sue Stevens

A Blind Orphan: Realisation

As a blind orphan growing up in an institutional setting, my childhood perspective on life was narrowly defined. The school grounds of my childhood home were the entire world and everyone within the fences accounted for the inhabitants of what I then thought was the whole earth. I had no complaints. Provisions were plentiful and I wanted nothing more. My uninformed perception always assured me that my blindness was not an after effect. Nor did I need or receive *help*. Everything at the school was all that there was. Everything was normal and nothing was out of place.

It was not long before I realised that there was something different about me. Two unpleasant factors affected my thoughts with the harsh realities of my situation. First, I realised that those around me – including some students – had sight. They had something I did not have. Second, as far as I could tell, I was the only orphan in the school. Hence, the truth about me was that I was a blind orphan unlike anyone else in the school. Why?

Although not voiced at the time, the truth deeply hurt my feelings and completely undermined my stability. Suddenly, I was lonely even though nothing around me had changed. It hurt to know that the two sockets beneath my brow had contained a once vital organ damaged by a domestic accident. Could this have been prevented? What is a blind orphan good for? Am I now twenty percent less of a human being simply because I lost the use of one of the five sensory faculties? There was no answer. I felt that the world was deliberately quiet, cruel, and condescending. I became suspicious of everyone around me.

Instead of resigning to a fatal acceptance of my perceived fate, I resolved within myself not to surrender to a condition that I did not bring upon myself. Nor would I look beyond myself to anyone for anything at all. Armed with the vow I made to myself and with the determination to back it, I began my lone journey in life and thrust myself onward, at all costs and by all means, achieving for myself. I 'charmed the naïve, impressed the gullible, outwitted the witless, disarmed the condescending and complimented the fearsome'. I was convinced that, wherever and whenever, everyone around me was there simply doing what one did and it was up to me to make it work for myself. I began a life without appreciation. I did not know any better because I did not understand anything at all.

A Spiritual Experience

In 1973, the course of my journey was completely altered by a profound spiritual experience. The narrow childhood perspec-

tive that directed my life was completely reconstituted. Compelled by the need to recapture what I had missed during my growing years, I forced myself to relive the past by recalling my experiences and re-examining each aspect with a much broader, more enlightened, and more mature perspective.

I asked one simple question that guided me through my journey back in time. What would it have been like if I did not have the *help* I had as I grew up? We may never find out the 'might-have-beens' of the past. Nevertheless, observing the lives of those who were less fortunate confirmed that my circumstances would have been hopeless, if not fatal. Awakened from an enduring numbness (lack of feeling), I suddenly realised that I am not only alive, but also better off than most of my blind compatriots.

One single and essential constant provided the core building blocks for my life, i.e., *help*—what others did for me. Indeed, goodness and kindness cradled me in the loving care of those who offered *help*. My life was deeply influenced by each caring individual who selflessly offered the *help* that made a difference. My aunt helped in pleading my case to the late Emperor Haile Sellassie when she recognised her limitations to care for me. The Emperor helped when he took me into his care and placed me under the stewardship of a missionary couple. Simply put, my success and good fortune undoubtedly were the direct and the immediate fruit of the *help* I have been receiving from so many individuals and institutions.

Help and the Blind Person

My thoughts showed me that *help* does not bring anyone to a lower situation of permanent dependency (relying on others). Rather, it is an interdependent society responsible for securing meaning and significance for its members. Because of *help*, mankind enriches itself through the potential of each individual by extending the benefits of its resources to others. Society's resources are mobilised through giving and receiving.

A companion effort in orientation and education must be integrated into all eye care programmes, to facilitate these aims. Both those who give and those who receive must be aware of the great significance of their participation in this most noble and most required of all causes.

In some areas, setting blind children on fire to rid communities of evil spirits has been reported. I remember a ten-year-old blind boy who did not know how to walk because his parents kept him secluded in a little room, out of embarrassment. On the other hand, there are some individuals of enormous wealth and others with incredible skill who fail to recognise the rewarding significance of their participation in fulfilling the good purposes of *help* in the lives of others, through organised and individual efforts.

Help and Need: Testimony and Professional Care

The good purpose of providing support and professional help must be clearly presented to all benefactors (those who give) so that they may find their places in this cause and fill it effectively and enthusiastically. Also, the personal experiences of those who receive must be strategically included within the overall eye care effort so that their testimony can help in penetrating the formidable barrier between *help* and need. *Help* is necessary, indispensable, and good. But, meaningful, effective, and efficient *help* is even better. I commend the efforts of eye care centres as well as those who are organising *help*. Certainly, a concerted effort of all involved parties will most assuredly realise the most excellent and finest aspects of *help*. We should no longer watch quietly, as indifference and despair deny us the wonderful rewards of a fulfilling experience. ❑

How Eye Workers Can Help Newly Blind People

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8 a.m. The hospital day begins. Eighty people are queuing at the eye clinic. Eye workers, Mary and Gerard, know they'll be busy until late afternoon. First they must see the post-operative patients. Two older cataract patients have a very good outcome after surgery. A 9-year-old child operated on for congenital cataract has a doubtful result, and cannot see any hand movement. With outpatients beginning to knock at the door, Mary has to find something to say to this child's mother.

The woman asks whether she has to come back to the hospital, and when. What can Mary say? It is unlikely that the child will have any functional vision, even after some months. Mary has a few private words with Gerard. '*What should I do?'* she asks. '*Tell the mother to go to a school for the blind'*, Gerard advises. Mary doubts if the child could get into that school. The mother looks very poor and the school has very few places. She decides to tell the mother to come back within a month for review. Mary now begins to see the outpatients.

11 a.m. The work goes well, it's a routine day. Two cataract patients arrive, who are booked for surgery next week. Gerard has a special case: a 35 year old man who became blind after falling on his head. The head wound itself isn't too bad, but probably brain damage has led to the blindness, which can't be cured. Now Gerard is unsure, and consults Mary. '*Do you know that man's village?'* he asks. '*Can you tell these people that there is a big problem, and that there is nothing we can do*?' But Mary feels that Gerard should explain the situation himself. The man is *his* patient!

These are all too familiar situations in eye units in developing countries. Confronted with newly blind people, many eye workers are uneasy and have little or no useful information to communicate. They feel that if surgery has not been successful, there is not much hope left.

This article explains the task and potential contribution of eye workers faced with newly blind persons. For several reasons, eye workers can have an important impact on further rehabilitation. They are the people from whom families initially try to get help in terms of eye care. They may also be the first to assess objectively irreversible blindness. They are considered specialists, and they are at hand when families face this crisis. The eye workers' own attitudes to the crisis, and their well- or poorly-informed responses, may set people on the right or the wrong road. Families and newly blind persons may quickly sense whether eye workers are trying to avoid them, or are giving well informed and considered advice about the next steps to take.

Eye Workers, Referrals and Transfers

Eye workers will rarely be involved in formal rehabilitation or education itself. Their role will be to refer or transfer the blind child or adult to a unit where services can be provided to improve their life and their self care skills. It is important to distinguish between referral and transfer. A **referral** means that the eye worker says, '*you could go to a school for the blind, they may be able to help you there*'. A **transfer** means that the eye worker has accurate information about the school (or other service), about conditions of admission, and will even make an appointment. Transfers are more likely to lead to services being provided later on, so eye units should be encouraged to aim for **well-informed transfers** rather than referrals.

When There is No Treatment: Can Low Vision Work Help?

If the visual impairment cannot be improved through any kind of treatment, the first question to ask should always be: '*Will low vision therapy and consequently the provision of optical and/or non-optical low vision devices improve the use of a patient's vision and, therefore, assist the patient to perform visual tasks more independently*?'. It is essential for each eye unit to work together with a qualified low vision specialist, e.g., Vision Therapist/ Vision Support Teacher. Of all people with visual impairments (blind and low vision), only one third (30%) are totally blind. Without effective provision of low vision services, three quarters of them (75%) would be considered as functionally blind. It is, therefore, very important to transfer a patient to a low vision specialist whenever the best possible visual acuity is less than 6/18 (less than 0.3) in the better eye, and/or the visual field is less than 20˚ wide measured from the point of fixation. If low vision services cannot improve the situation sufficiently, we have to consider additional systems of rehabilitation.

Medical students experience blindness simulation through supervised role play
Photo: Sue Stevens

Which Services Can be Provided to Newly Blind Persons?

1. Psychological care

Even though eye units cannot usually provide formal psychological care, they can at least avoid reinforcing the new blind person's doubts and fears. The aim should be to ensure that blind people are transferred speedily to one of the following specialist services (see 2 to 5 below), with an explanation of what support is available. The information, the transfer, and the services that may follow, will offer a positive perspective, which is psychologically very helpful at this stage.

2. Early childhood intervention

Children with congenital visual impairments need special training to support their physical development. As 80% of learning in a normally sighted child is acquired through vision (i.e., by imitation of seen behaviours/activities) the learning process in a visually impaired child has to be adapted. The child needs encouragement to learn body-movements while using other senses. In low vision, the child needs to gain awareness of visual stimuli and to learn how to respond to them. Find out whether there are community based rehabilitation programmes (CBR) or other programmes that would provide appropriate help if blind and low vision children are transferred to them.

Helping the Newly Blind

3. Education in special schools or integrated systems

Most developing countries have one or more special schools for the blind, or annexes attached to regular primary schools, or an itinerant teacher programme supporting integrated education. Integrated systems assist the 'normalising' of life and opportunity for blind children, but the quality of education is often weak. Whatever the system, the aim will be to provide primary school education. Having completed primary school education, some children continue integrated education in a secondary school, but most children will return home and may then need one of the following services.

4. Functional rehabilitation by community based rehabilitation (CBR) programmes

Functional rehabilitation is provided at home and in the community by CBR programmes or by associations of the blind. They aim at increasing the activities blind people can do at their homes and in the neighbourhood, focusing on what matters in that specific community, and at that specific stage of life.

5. Vocational rehabilitation by CBR programmes or by vocational training programmes

Vocational rehabilitation services aim at providing a livelihood to the blind person. It consists of skill training, possibly provision of a small loan, and often additional training in basic marketing skills.

Hospital staff must set a good example and be aware of the needs of the visually impaired

Name of Eye Unit
Address
Telephone Number

Dear Director,

Our eye unit, at ……., often comes across blind people. We are collecting information on rehabilitation and education services in this area, so that we can transfer people to an appropriate source of help. Kindly complete this questionnaire, and return it to us, or attach your information leaflet.

1. What type of services does your programme provide for blind people? ……
2. Which people are you able to help? ……
   Criteria for admission? ……
   – sex ……
   – age ……
   – vision (VA) ……
3. How long do the services take? ……
4. Is there an admission form? ……
5. At which time of the year does your programme take new entrants? ……
6. What should people bring with them when they come to your service provision? ……
7. What is the cost of your services that has to be paid by the family (total)? ……
8. How many people can you enlist per year? ……
9. Whom should we contact for admissions? ……
   Telephone number? ……
   Email? ……

Many thanks for returning this form to the Eye Unit (address above).

Feedback Form

Please return to: [Name of Eye Unit, Person Responsible, Address, Phone number]

Dear Director (of a Centre/School for the Blind),

We are sending …….. who was a patient at our eye clinic. We have no further services that might improve the vision of this patient, so would like to transfer him/her to you. Please fill in this form, and return it to us.

We appreciate your efforts.

Yours, Signed [the Responsible Person for the Newly Blind].

1. Name of person transferred and assessed: ……
2. Are you able to assist this person? ……
3. Why (not)? ……
4. What type of services can you provide? ……
5. In case there are no services that your programme can provide, is there any other programme that could help this person? ……
6. Your name: ……
   Telephone number? ……
   Email? ……

Which Services are Available? How are they Accessible?

It is important for each eye unit to know which services are available in the region/country, and to have **accurate and sufficient information** about them. To obtain this information, the questionnaire (left) can be used.

Make Appointments and Ask for Feedback

Once the eye unit has collected this information about special schools, education and rehabilitation programmes that are available for blind people, a nurse or administrative person should be appointed as blind people's counsellor. Clinicians should transfer all newly blind patients to the counsellor. The counsellor would also cooperate with the different transfer service units. He/she should visit all these units regularly, and update the information gathered by the questionnaire. In caring for each newly blind person, the counsellor should contact the respective unit (if possible) by phone, make an appointment for the patient and ask for feedback after the visit.

A sample Feedback Form, which is shown on this page, can be sent along with the patient.

Further Reading

Vanneste G. *Breaking Down Barriers. How to Increase the Cataract Surgical Rate*. A Practical Guide for Eye Units in Developing Countries. Christoffel Blindenmission, 2001. Available from CBM in English, French, Spanish and Kiswahili.

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Assisting the Blind and Visually Impaired: Guidelines for Eye Health Workers and Other Helpers

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Introduction

As eye health workers, we give much attention to learning and teaching the importance of health education and the prevention and treatment of eye disease. Despite our gained knowledge, sadly, our efforts are not always successful and we are presented with the responsibility and challenge of caring for people who have to cope with visual impairment, perhaps for the rest of their lives. We have to understand their difficulties, recognise their abilities and learn how to cooperate and communicate with them in a social as well as hospital environment. It is often within the eye hospital itself that the lack in education of health workers and their understanding of the assistance needs of blind and visually impaired patients is all too evident.

Visually impaired and blind people come from all kinds of backgrounds. Many are elderly, some are young. They may be sportsmen and women, gardeners, farmers, chess players, teachers, typists, musicians, lawyers, housewives, computer programmers, physiotherapists, social workers, telephonists, parents……

Such people have many abilities and can achieve many things despite visual impairment or blindness, but there are times when they will appreciate and welcome practical assistance.

Meeting and Greeting (Fig. 1)

There are some general points to remember, which are really common sense and a matter of courtesy:

- Always ask first before offering any help and do not be offended if it is refused. Some people have had very bad experiences of what a sighted person thinks is being helpful!
- Be precise if giving instructions – giving directions by pointing and saying, 'it is down there on the right', is not much help and very thoughtless
- The use of a white cane does not necessarily mean that a person is totally blind
- In some countries a person is accompanied by a guide dog but the animal must never be distracted. Often it is the animal who receives attention and the owner ignored! Together they usually make a good working team and rarely need extra help
- Once into a conversation, never leave without saying you are doing so. Do not allow the blind person the embarrassment of talking into the air!

Fig. 1

Approach and Attitude

- Always treat a blind person normally; speak first and introduce yourself
- Shake hands but only if a hand is offered
- It is also politeness to look at him/her during conversation and adopt the same level of position, e.g., sit or stand
- Do not be afraid of using normal language and include words like 'look', 'see', 'read', remembering that blind and visually impaired people have exactly the same vocabulary as sighted people
- Explain noises and silences and do not shout
- Do not expect or invite others to speak for blind people. Do not be afraid to 'touch' but be sensitive to cultural differences.

Guiding (Fig. 2)

- Always consider a person's age and any other disabilities
- Never presume where the person wants to go. Ask for details of where and how he/she would like to be guided. It is not uncommon to see a person being propelled or steered, and at great speed! Go at their pace and, if there is space, walk side by side and always 'hand to arm'
- If there is a guide dog, but extra help is needed, approach and walk on the other side. The animal has been trained to understand that he is still in charge and responsible!
- Give adequate room around obstacles and hazards and plenty of time for response if you need to say, "bend your head low to avoid this tree branch!"
- Describe any sudden changes in the environment. It is also very important to explain changes in ground surfaces and especially when moving into wide open spaces, e.g., fields.

Trying to be helpful – but the patient would have felt more supported if the helper had walked alongside him

Photo: Sue Stevens

Fig. 2

Assisting the Blind

Walking in Single File or in Narrow Spaces (e.g., in shops, offices and busy crowded areas) **(Fig. 3)**

- Tell your partner of the change in surroundings and then move your own guiding arm towards the middle of your own back

Fig. 3

- Your partner should automatically step in behind you, still holding your arm, and together you will be able to negotiate a narrow space.

Doorways **(Fig. 4)**

- It is important to take this manoeuvre (movement) very slowly; it is not an easy one to master
- Tell your partner if the door opens towards you or away from you
- Go through the door with your partner on the hinge side

Fig. 4

- Open the door with your guiding arm; your partner should place his/her hand against the door to feel the handle
- He/she should then follow you through and close the door behind both of you.

Steps, Stairs and Slopes **(Fig. 5)**

- Tell your partner whether the steps, stairs or slope go up or down. Going down is more difficult.
- Allow your partner plenty of time to hold the handrail securely and judge the first step carefully

Fig. 5

- Go one step ahead and take a slightly longer stride on the last step to allow your partner space.

Kerbs and Roads **(Fig. 6)**

- Never take risks!
- Tell your partner if you are approaching a 'kerb up' or 'kerb down' (the step onto or off a pavement/sidewalk) and pause slightly before taking the step

Fig. 6

- Make sure you approach the kerb together – both facing, and at an equal distance from the kerb – taking extra care with rounded kerbs
- Cross the road using the shortest distance and go straight across
- Tell your partner if you are parting company after crossing the road and ensure they know which way they are facing.

Seating **(Fig. 7)**

- Never propel or steer a blind or visually impaired person backwards into a seat!

Fig. 7

- Guide your partner to the seat and explain what type it is – e.g., upright chair, low sofa, armchair, stool
- Ask them to let go of your arm and place their hand on the back or the seat of the chair
- This is sufficient help as your partner will now be able to judge the height of the seat and will be able to sit safely and at his/her own pace.

Travelling **(Fig. 8)**

- Tell your partner if he/she is getting into the back or the front seat of a car and whether it is facing left or right
- Place your guiding hand on the door handle and allow him/her to slide his/her grip hand down your arm to the door handle

Fig. 8

- With his/her other hand, the car roof can be noted and your partner will lower his/her head appropriately
- At the end of the journey, get out of the car before yourpartner and help them out
- Tell them if there are wider than average gaps to cross – this is particularly important when travelling by train!
- Always lead your partner on and off public transport.
- In rural areas, extra help may be needed when you and your partner have to negotiate getting on and off unstable modes of transport, e.g., carts, boats, etc.

In the Eye Hospital

- The patient will expect eye health workers to know how to help them
- Always apply all the principles mentioned above; be extra gentle and take time
- Remember your patient is at the hospital because they cannot see well – sadly, an often seemingly forgotten point, even by the more senior or so-called experienced staff members!
- Never be afraid to ask the patient's opinion about a situation specific to them and how they would like to be assisted

- In the treatment room, always explain what you are going to do – and to which eye!
- When providing written information, make sure it is in a readable size and font and pass it to an attending sighted carer for future reference
- An unaccompanied patient who may be unable to hear, as well as having sight problems, may benefit from taped information to take away and share with family at home.

Eye health workers have a responsibility, and an important position, for teaching others about assistance to the visually impaired. But we must be seen to be practising what we teach. A community-based rehabilitation project in Uganda, some years ago, used a very appropriate and challenging means of raising awareness.

Fig. 9: 'Don't pull me!'

They provided T shirts for the project team members with illustrations and slogans which read, '*Don't pull me*' (front – see Fig. 9) and '*Walk with me*' (back – see Fig. 10). Can you think of similar activities, perhaps?

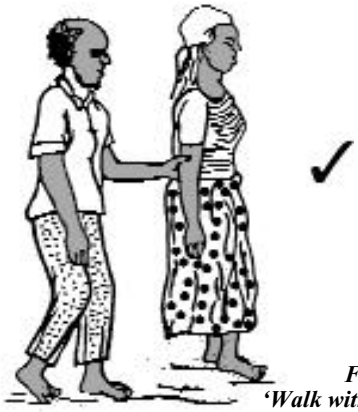

Fig. 10: 'Walk with me!'

Acknowledgements

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- Illustrations (Figs. 1–8) by Teresa Robertson.
- My thanks are also due to the many visually impaired patients who have helped me to understand their needs and taught me how to help them. ❑

Technology for Vision 2020

Purchasing and Stock Control for Eye Care Units

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This article aims to provide guidelines in support of the Infrastructure and Technology component of VISION 2020.

Purchasing and stock control play an important part in effective project management and coordination. All efforts are wasted if necessary supplies are unavailable.

- Patients willingly travel to a hospital that is reliable and has a well-established reputation, but will not attend an eye unit that cannotdispense their medication on discharge or will cancel their operation because a replacement microscope bulb cannot be found
- Staff will soon become demoralised seeing 'out of stock' written in order books or on store shelves and, more importantly, patients will suffer
- The effect will not only be felt by the hospital staff and the individual patient but will have far-reaching consequences, outside of the hospital, for the community it is aiming to serve.

Deciding What is Needed

Each department needs to decide what supplies are required. The following list will help to identify which supplies are already held and which extra items may need to be ordered and kept available in the store.

- **Routine consumables:** e.g., syringes, needles, gloves, IOLs, eye drops, other medications
- **Specialist items** : e.g., vitrectomy tubing, paper for A-scan biometry, Schirmer's test strips, intra-vitreal antibiotics, sutures for plastic and retinal surgery, anti-fungal pellets, instruments for specific surgical training
- **Bulbs** for routine equipment: e.g., slit lamps, direct and indirect ophthalmoscopes, lasers, lensometers, operating lights
- **Spare parts** for routine equipment needing regular and frequent maintenance: e.g., fibre optic cables for microscopes, spare keys for lasers, foot pedals for microscopes, A-scan probes.

Needs should be discussed with staff members who know their department well and clear explanations given regarding what they hope to achieve through good stock control practice. When supply needs are decided the information can be collated and a stock control policy devised.

Establishing a Stock Control System

A person of integrity should be appointed as the store keeper. The system should be clearly explained and the importance and responsibility of their role emphasised. Supervised practice is necessary in the early days following the appointment.

Stock Cards

Each item in store, e.g., medical drug, spare part, stationery item, should be entered on a dedicated stock card. These cards:

- Can be either hand-written or be stored in a computer; the important factor is accuracy
- Show a running balance of the quantity of the specific item
- Can be maintained by the store keeper who is responsible for entering the quantity issued and the requesting department on the card
- Should be checked each month by someone in authority to ensure accuracy and also to enable monitoring of the general usage in each department.

Noting the monthly usage is useful when considering the annual budget and requirements for the year ahead. An end-of-year stocktaking exercise is required for correct auditing procedures.

Minimum Stock Levels

The heads of department will indicate the minimum stock levels required for each item based on the quantities required for

maintaining a service. This figure is entered on the stock card. It needs to be taken into consideration whether an item is a local or overseas purchase. Orders need to be placed well in advance of the minimum stock level being reached. At least two months working supply for local purchases and 6 months for overseas purchases is recommended. Forward planning is important as holiday times will affect the processing of orders from the suppliers. If the Unit has students in (surgical skills) training, allowance should be made for extra use of certain items, e.g., sutures and visco-elastic.

Identifying and Accessing Stock

Storage Suggestions

- Storage conditions are a vitally important consideration in hot humid climates. Air conditioning may be necessary as most drugs need optimum storage conditions. Medications and other consumables can be stored alphabetically for ease of access
- Frequently used items, e.g., bulbs, spare parts and surgical instruments are best kept in a central place within the department where staff who are familiar with them and understand their functions can quickly access them and order as stock levels demand
- Specialist equipment and expensive materials should be stored in a secure place in the store where access is limited
- Anaesthetic equipment should be stored in a designated area
- Displayed lists and colour-coding of shelves will provide easier access
- Food, stationery and cleaning materials must always be stored separately and away from medical equipment.

Developing a Purchasing Policy

It is the responsibility of the management team to devise and establish a purchasing policy based on the priority needs for consumable and non-consumable items as identified by the departmental staff.

Depending on individual and local practices the policy will vary but basic principles of accounting and auditing should be followed.

Purchasing Procedure Suggestions

- Maintain a register with up-to-date names and contact details of all suppliers used. List what each supplier provides and the costs
- Request an updated price list and catalogue each year. Copies of these may be kept in the finance department and stores for reference
- Try to keep the number of suppliers to a minimum. This may be difficult especially regarding specialist items ordered from overseas
- Purchase local items on a monthly or weekly basis. If possible, organise group bulk purchasing with other eye units to reduce costs. A 30-day credit facility is useful when using local suppliers
- When the orders have been prepared they should be passed to the person responsible for estimating the cost, e.g., the department finance manager. With available funds and no outstanding debts with suppliers confirmed, the order can be presented with the relevant stock card showing the current balance for approval by management and the order placed with the supplier.

Receiving Purchased Items into the Store

The purchases will arrive with an invoice or a delivery note and should be checked into the store by the store keeper or other responsible person appointed to this particular task. A 'goods received note' (GRN) should be completed and the date and quantities received entered on the stock card to give a running balance. This entry should be signed by the person receiving the goods. All invoices, delivery notes and GRNs should be sent for final checking by the finance manager before cheque payment is made.

Pharmacy store – labelling and displayed lists assist easy access

Photo: Sue Stevens

Considerable financial investment is necessary when stocking an eye unit and this is an important reason for creating an efficient and effective purchasing and stock control system. Unnecessary ordering, especially items that will become out-of-date is wasting money. Emergency orders and delays in service delivery will eventually increase the cost of surgery. Items purchased locally will help to maintain the low cost of cataract surgery. Consistently good quality materials are important to both the surgeon and the patient.

Health care budgets are already stretched. We have a responsibility to manage donors' and patients' money carefully. Well-maintained stores and effective purchasing policies will enable the provision of affordable eye care for the community as a whole.

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NEW APPOINTMENT

Professor Allen Foster OBE FRCS FRCOphth

Allen Foster

Allen Foster has been appointed **Professor of International Eye Health** at the **London School of Hygiene and Tropical Medicine (LSHTM).**

Professor Foster is Director, International Centre of Eye Health (ICEH), now situated at the LSHTM.

For many years, Allen Foster has been Medical Director, CBM International, following ten years of service in Tanzania. He is Senior Vice-President of the International Agency for the Prevention of Blindness.

ICEH staff and serving committee members of the *Journal of Community Eye Health* are delighted to report this academic recognition of Allen Foster's many contributions to the prevention of world blindness and Vision 2020: The Right to Sight.

Editor

Gender and Blindness: Eye Disease and the Use of Eye Care Services

Summary and Recommendations from a meeting at the Kilimanjaro Centre for Community Ophthalmology, Moshi, Tanzania, June 17–21, 2002

Blindness is an increasing global health problem that afflicts approximately 50 million people, two-thirds of whom are women, and ninety per cent of whom live in poorer countries. Much world blindness is due to cataract, routinely curable through surgery, or due to chronic trachoma infection, preventable through clean water and improved sanitation. The Vision 2020 initiative of the World Health Organization is addressing this problem through advocacy, planning and programming.

In poorer countries, women of all ages utilise eye care services much less than men. As a result, more women than men are blind or visually impaired from cataract, trachomatous trichiasis and angle closure glaucoma. To date, however, Vision 2020 programmes have not incorporated gender issues into evaluation, planning, or treatment efforts. Little applied research is available to help guide decisions in service provision.

Ophthalmic and women's health researchers, policy makers and programme staff held a meeting in Moshi, Tanzania from 17–21 June, 2002 to discuss gender and blindness. The Kilimanjaro Centre for Community Ophthalmology (KCCO) at KCMC (Tumaini University) and the British Columbia Centre for Epidemiologic & International Ophthalmology (University of British Columbia) organised the conference, while a consortium of Canadian public health agencies sponsored the meeting. The participants identified key research, policy, and programme priorities listed below. A full report is available.

The participants agreed upon the following recommendations:

Policy Issues

1. Programme managers in all national and local blindness prevention programmes need to assess gender equity of service utilisation. This means separately assessing the potential barriers to use of services by men and women, throughout the life span.
2. Eye care agencies should follow WHO policy and critically evaluate gender roles within their own organisations, developing strategies to improve gender equity in the work environment.
3. Programme monitors need to incorporate sex specific indicators used for all eye care programme activities (e.g., cataract surgical rate, trichiasis surgical coverage). Leprosy control programmes should also monitor lagophthalmos and cataract surgical rates by sex.
4. Eye care service providers should encourage collaboration with non-health care programmes (e.g., water and sanitation) to improve environmental factors influencing women's health.

Programme Issues

1. Eye care programme planners should direct most attention to the community level in order to gain long term trust and to involve community members in planning and providing prevention and treatment strategies. Programme planners should especially encourage women's representation. This is a difficult and sensitive process requiring an understanding of local social, political and economic issues in their historical context.
2. Programme planners need to be aware that women often do not have decision-making power within communities. Programmes designed to increase utilisation of services by women, therefore, must include the people (often husbands or male community elders) who have decision-making authority. The goal is to empower communities to meet their eye care needs, not to achieve gender equity in the decision making process.
3. All cataract surgery facilities should have designated personnel (preferably, maleandfemale)toprovidegoodquality education for cataract surgery patients.
4. Eye care programme planners need to be aware of many different approaches to promote health education in a gender sensitive fashion within communities (e.g., school child health programmes, collaboration with traditional healers, women's groups, local service groups).
5. Trachoma control activities need to emphasise facial cleanliness and environmental hygiene improvements (known as the 'F and E' components of the SAFE strategy), because these will be the most effective in long-term control of this disease, which affects primarily women.

Research Issues

General

1. In each context (society/culture/religion) researchers need to:

- Clarify decision-making roles for accessing eye care
- Identify existing or potential social networks which support women needing eye care
- Define barriers and enabling factors to increase the use of eye care services by women and men
- Determine effective gender-sensitive methods to provide health information (regarding existing perceptions of surgery, primarily fatalistic attitudes and fear of surgery).

2. Researchers need to determine if the excess burden of blindness rates for women found in Africa, Asia and in industrialised countries is also found in Latin America and Eastern Europe/ Russia. In addition, researchers need to determine the specific causes of this excess blindness. Do these causes vary between the industrialised and non-industrialised countries?

Cataract

1. Epidemiologists and anthropologists need to clarify the factors that influence acceptance of cataract surgery by women. For example, do women accept cataract surgery more readily if counselled by female health workers, by other women who have had surgery, or by other community based groups?
2. Health services researchers need to determine how health sector reform and cost recovery affects service utilisation by men and women. What is the effect of marital status, education, family size, or other factors? What mechanisms can be put into place to ensure equity in utilisation?
3. Basic science researchers needed to understand better why women have a higher risk of developing cataract than men of a similar age.

Trachoma

1. Researchers need to clarify what the impacts of F and E will be on the roles and activities (e.g., use of time) of women?

2. Researchers need to determine if girls are re-infected more readily than boys following antibiotic distribution.
3. Researchers must determine which local community-based approaches best improve uptake (and equity in uptake by men and women) of trichiasis surgical services before vision loss occurs. Researchers must also examine whether women have a higher rate of recurrence of trichiasis following surgery and what can be done to reduce recurrence.

Childhood eye diseases

1. In each context, researchers need to determine what prompts parents to bring their children for surgery and when. Do mothers and fathers have different perceptions of the need of eye care for children and does this depend on the household structure or economic status? How do these perceptions affect utilisation of services?
2. Researchers need to explore why, in most settings, parents bring more boys for juvenile (non-traumatic) cataract surgery than girls. They must also study long-term follow up of children receiving surgery to assess utilisation and benefit of low vision services.

Other conditions

1. For glaucoma and other major causes of blindness, researchers need to clarify the utilisation of services and outcomes of service by men and women. Very little information exists to date on screening, medical and surgical services. In many settings there are more men than women receiving surgery.
2. For leprosy, researchers need to determine if the burden is similar for men and women and if more cosmetically appealing lagophthalmos surgery (compared to tarsorrhaphy) can improve socio-economic status or quality of life. Lagophthalmos is a significant cause of vision loss and disability in leprosy patients and is a burden on quality of life because of its stigmatising qualities.

For more information, please contact:

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Report

Training Principles for Ophthalmic Care in Developing Countries

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Introduction

Over the past few decades the authors have visited a number of developing countries in Africa, Asia and the Americas, providing both general ophthalmology care and specialised consultation, teaching and service. The programmes initially were largely oriented towards cataract surgery and glaucoma care in more rural areas, then towards teaching in the field of paediatric ophthalmology and strabismus in large city hospitals. There seems to be a never-ending amount of service needed in these countries, although, over time, the ability of colleagues to provide service to their own people has increased. However, as the cataract backlog is reduced, there develops an interest in learning specialised ophthalmic concepts and surgery techniques.

Volunteers visiting a developing country should not make assumptions based on previous visits because perceptions and conditions in the country vary. It is essential to have good communications with colleagues in the country visited.

The recognition and application of three major principles should be observed on medical mission trips:

1. **Appropriate technology** based on the existing infrastructure and the needs determined at both local and national level.
2. **'Empowerment' of the physicians** and **paramedical personnel** in the country. This should include informal teaching in the clinic, working together with colleagues in the operating room, as well as formal lectures and courses at centres of medical education.
3. **Project sustainability**. Equipment should be donated to local organisations, such as Lions Clubs or Rotary Clubs with support organisations placed in those Clubs so that return trips can be organised more effectively. There is a need, also, for colleagues in these countries to come for further training in more developed countries. This provides the greatest amount of 'multiplier effect', as then a person can return to his or her own country and devote his or her career to service in ophthalmology – particularly paediatric ophthalmology and strabismus, the specialty interest of the authors.

Appropriate Technology

Supporting the improvement in technology in a developing country should be 'step by step', rather than by introducing the latest technology, which may remain unused. For example, phakoemulsifiers at small hospitals in the poorly served periphery (e.g., rural areas) may be used by the visiting specialist, after which it may be placed under a dust cover for years. In countries where the water supply is not clean, sediment in the water supply typically contaminates the lenses of lasers, reducing effectiveness and ultimately the use of the laser. It is best to work with colleagues in these countries to select what is appropriate. Surgical instruments are most commonly needed.

Empowerment of Physicians and Paramedical Personnel

Most people in the developing world, including physicians, are so used to diminishing resources and an unresponsive government that they may have given up trying to establish new programmes. It is, therefore, important to empower the physicians and other personnel to improve this situation. Service programmes can bring in visiting specialists with expensive equipment and highly trained technicians to do a large number of operations or procedures in a short period of time. These programmes leave a clear and inappropriate message that visiting doctors can carry out various procedures and the local doctors cannot. Should this type of visit continue as the developing country progresses, the

service organisations can easily run into more and more problems, formally and informally.

The inability of getting goods through customs, for instance, tends to occur where local organisations have not been asked to participate and cooperate with mission service trips. Some countries, such as Mexico, restrict the type of volunteer organisations allowed by requiring letters of support from local Mexican physicians or local medical societies – before any organisation is allowed to work within that country. It is important to ask questions constantly of those participating in medical service visits – is it appropriate and will it provide empowerment?

Programme Format

A typical programme format that we have evolved over the years is to provide first consultation, second lectures, and third demonstration surgery. Lectures are done both formally as well as informally. Demonstration surgery is done together with colleagues of the country, working with them on patients within their own practice. The policy of coming in with inexperienced visiting surgeons is entirely inappropriate, suggesting that they have come simply to practice their surgical techniques.

Another common mistake is to allow very important people from the local villages and cities to come in and receive care from the visiting 'experts'. These typically are those who could afford to pay for private care locally. Providing care to these people provides a direct loss of revenue to the local physicians. This should be avoided whenever possible, and patients referred to the local ophthalmologist should be seen in consultation, with the local ophthalmologist providing a bill for services. An important rule in making any decisions in developing countries is to include not only the local ophthalmologists in these decisions, but actually adopt their preferences whenever possible.

Project Sustainability

One of the other important concepts to share is that of the 'spirit of volunteerism'. In many countries, the ability to help people beyond the local family or village unit has not been developed. This can be addressed by suggesting the formation of volunteer organisations by the local ophthalmologists.

In Nicaragua, following the formation of an organisation called Fundacion Ayudemos Aver, local ophthalmologists provide volunteer services for screening and surgery on the last Friday of every month. Their transportation and supplies are organised through either the local Lions or the Rotary Clubs. Also, organisations like Fundacion Ayudemos Aver, working with local Lions and Rotary Clubs, are a great source of support in the organisation and planning of future visits as well as fundraising for equipment and supplies purchase. Basic surgical instruments are most often needed. Commonly, local service clubs will provide funds (~£2000) for the purchase of a set of instruments. These can be donated and procured with the help of a local club in the host country.

CPR and Developing Countries

Sadly, many developing countries can be recovering from war and, in the early stages of recovery, have three phases (called 'CPR') through which the country progresses in restoring health care for the people.

The **first phase** is that of **crisis and chaos ('C')**. At times like this any help will be useful and does not have to be coordinated with local doctors as much as in the later stages. However, help at this time can be dangerous to volunteers as the country may still be effectively a war zone. Eye care may largely be related to trauma.

The **second phase** of recovery would be characterised by **peace with poverty ('P')**. Government resources have largely been devoted to providing the most efficient aid for indigenous diseases and epidemics. Unfortunately, many governments provide very small amounts of their countries resources to the health care of their people. In this stage of recovery, public health measures are most needed with basic health training and distribution of health resources. Health funding from outside sources is still most appropriate.

The **third phase** is that of **recovery and resourcefulness ('R')**. Medical schools are typically started or revived at this stage, and then ophthalmology training is re-established. The training model may include educating ophthalmology technicians along with ophthalmic surgeons. Specialty care is then taught at teaching hospitals, usually in large cities. Until this phase is reached, children's needs are usually ignored. Well-documented childhood starvation at times of drought or political crisis illustrates this. As concerns paediatric ophthalmology, these conditions are manifest as a lack of childhood screening programmes in cataract camps, lack of general anaesthesia services, lack of equipment in hospitals, and in the lack of paediatric ophthalmology and strabismus management skills by general ophthalmologists.

Once in the recovery phase, ophthalmologists have begun to address the backlog of war injuries, industrial trauma and cataracts, and are more able to help in paediatric care. This phase is the most appropriate for teaching paediatric ophthalmology and strabismus surgery.

Acknowledgements

The authors wish to thank Smith-Kettlewell Eye Research Institute, California Pacific Medical Center, University of California San Francisco, and the Pacific Vision Foundation for their support of fellows in their training, and are delighted to report that all of them have returned to their countries for service to their own citizens. Many thanks to the Mission Support programme of Alcon Laboratories for their repeated donations of sutures and medications. Lastly, a special note of thanks is given to the members of the San Francisco Rotary Club for their generous funding of the purchase of many sets of surgical instruments.

Further Reading

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Abstracts

Helping Blind and Partially Sighted People to Read: the Effectiveness of Low Vision Aids

Tom H Margrain

Aims: To substantiate the claim that low vision aids reduce the degree of disability associated with visual impairment.

Methods: An observational study of vision, ocular pathology, age, sex, and reading ability in new referrals to a low vision clinic. Reading ability was assessed both with the patients' own spectacles and with an appropriate low vision aid.

Results: The reading performance and biographical characteristics of new referrals to a low vision clinic were recorded. Data were collected for 168 people over a 6 month period. Upon arrival at the clinic the mean functional visual acuity equated to 6/36 and 77% of patients were unable to read newsprint (N8). After a low vision assessment and provision of a suitable low vision aid, 88% of new patients were able to read N8 or smaller text.

Conclusions: The degree of visual impairment observed in new referrals to a low vision clinic is sufficient to prevent the majority from performing many daily tasks. Low vision aids are an effective means of providing visual rehabilitation, helping almost nine out of 10 patients with impaired vision to read.

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Planning Low Vision Services in India
A Population-based Perspective

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Objective: To access the prevalence and causes of low vision in a population in southern India for planning low vision services.

Design: Population-based, cross-sectional study.

Participants: A total of 10,293 persons of all ages from 94 clusters representative of the population of the Indian state of Andhra Pradesh.

Methods: The participants underwent a detailed eye examination, including measurement of visual acuity with logarithm of the minimum angle of resolution charts, refraction, slit-lamp biomicroscopy, applanation tonometry, gonioscopy, and stereoscopic dilated fundus evaluation. Automated threshold visual fields and slit-lamp and fundus photography were done when indicated using predefined criteria.

Main Outcome Measures: Low vision was defined as permanent visual impairment that was not correctable with refractive error correction or surgical intervention. The participants with best-corrected distance visual acuity <6/18 to perception of light or central visual field <10° because of an untreatable cause in both eyes were considered as having low vision.

Results: Low vision was present in 144 participants, an age, gender, and urban-rural distribution adjusted prevalence of 1.05% (95% confidence interval, 0.82%-1.28%). The most frequent causes of low vision included retinal diseases (35.2%), amblyopia (25.7%), optic atrophy (14.3%), glaucoma (11.4%), and corneal diseases (8.6%). Multivariate analysis showed that the prevalence of low vision was significantly higher with increasing age, and there was a trend for higher prevalence with decreasing socioeconomic status. Extrapolating these data to the estimated 1014 million population of India in the year 2000, 10.6 (95% confidence interval, 8.4–12.8) million people would have low vision.

Conclusions: These data imply that there is a significant burden of low vision in this population, suggesting the need for low vision services.

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Survey of Visual Impairment in an Indian Tertiary Eye Hospital

Peter Herse PhD FAAO
Vijaya K Gothwal BOpt

A retrospective survey of 4,122 consecutive patient records was performed in a tertiary care eye hospital in Hyderabad, India. Data collected included age, gender, visual acuity after completion of treatment and diagnosis. 62.8% of the patients were male. After completion of treatment, 10.8% had low vision (best corrected visual acuity <6/18 to 3/60 in the better eye) and 2.6% were blind (best corrected visual acuity <3/60 in the better eye). Most cases of low vision were found in the 50 to 70 year age group (42.9%). The most common visual acuity range after treatment amongst patients with vision loss was <6/18 to 6/60 (71%). The 4 main causes of low vision were cataract (21.4% of low vision group), glaucoma (14.0%), diabetic retinopathy (13.0%), and retinitis pigmentosa (10.7%). The 4 main causes of blindness were glaucoma (16.3% of blind group), diabetic retinopathy (13.2%), corneal opacities (11.6%) and retinitis pigmentosa (11.6%). It is suggested that patients with low vision at the conclusion of treatment be referred to a vision rehabilitation centre. Referral should be made in cases with a best corrected visual acuity <6/18 to 3/60 or with visual field loss to within 15° of fixation. Patients aged under 50 years of age are expected to achieve maximal rehabilitation success. Motivation and vocational requirements should be assessed in older or more complex cases before referral. The data of this study show that about 10% of patients seen at a tertiary care eye hospital in India could benefit from low vision rehabilitation.

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Aetiology of Suppurative Corneal Ulcers in Ghana and South India, and Epidemiology of Fungal Keratitis

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M Hagan **J Kaliamurthy**
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V Essuman **C A N Jesudasan**
G J Johnson

Background: A multicentre study was carried out in Ghana and southern India to determine the aetiology of suppurative keratitis in two regions located at similar tropical latitudes. Studies of fungal keratitis from the literature were reviewed.

Methods: Patients presenting at rural and urban eye units with suspected microbial keratitis were recruited to the study. Corneal ulceration was defined as loss of corneal epithelium with clinical evidence of infection with or without hypopyon. Microscopy and culture were performed on all corneal specimens obtained.

Results: 1090 patients were recruited with suspected microbial keratitis between June 1999 and May 2001. Overall the principal causative micro-organisms in both regions were filamentous fungi (42%): *Fusarium* species and *Aspergillus* species were the commonest fungal isolates. *Pseudomonas* species were most frequently isolated from cases of bacterial keratitis in Ghana but in India the commonest bacterial isolates were streptococci.

Conclusion: Infections of the cornea due to filamentous fungi are a frequent cause of corneal damage in developing countries in the tropics and are difficult to treat. Microscopy is an essential tool in the diagnosis of these infections. A knowledge of the 'local' aetiology within a region is of value in the management of suppurative keratitis in the event that microscopy cannot be performed.

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Journal of Community Eye Health Web Site

The Journal, including recent back-issues, is available online at
http://www.jceh.co.uk

Articles are available as both HTML and PDF documents.
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esub@jceh.co.uk

Community Ophthalmology Information Programme & Trachoma Information Service for Eastern Africa

The **Ophthalmic Resource Centre for East Africa (ORCEA)**, under the direction of the **Kilimanjaro Centre for Community Ophthalmology (KCCO)**, has started an email based ***Community Ophthalmology Information Programme (COIP)***. This will soon be set up to reach those without email by post. Current information, primarily from the published scientific literature and from Vision 2020 initiatives in the region will be summarised and distributed on a periodic basis to those interested. The programme's primary coverage area includes eastern Africa (Egypt south to South Africa). Eye care providers and others in the area are invited to send their contact information (via email, if possible; via post, if no email). Others in Africa, interested in being included in the emailing list, are also encouraged to send their contact information.

Separately, but along the same lines, with generous support provided by Helen Keller International and start up support from Al Noor, International Eye Foundation, International Trachoma Initiative, and Seva (Canada & US), the KCCO has initiated a ***Trachoma Information Service (TIS)***. The goal of the TIS is to provide findings and interpretation of current research on trachoma and its control in Africa to those interested in trachoma control.

To sign up for either (or both) the COIP and TIS service, please send an email to riso@kcmc.ac.tz with your name, postal address, phone, fax, and email address.
If you do not have access to email, send your name, postal address, phone and fax to **ORCEA, c/o KCCO, PO Box 2254, Moshi, Tanzania**.
For further information contact **Dr Paul Courtright** at **kcco@kcmc.ac.tz**

SOURCE

International Information Support Centre

SOURCE is an international information support centre formed from the merger of the resource centres of the **Centre for International Child Health (CICH)** and **Healthlink Worldwide**, in partnership with **Handicap International** and with support from **Teaching Aids At Low Cost (TALC)**.

Source has a unique collection of over 20,000 health and disability information resources, many from developing countries and includes both published and unpublished literature. Source is located at the Institute of Child Health and the collection is fully referenced on the Source database available on the web at http://asksource.info

Contact: **Kerstin Schaefer, Disability Information Officer, SOURCE, The Friends of the Children of Great Ormond Street, Institute of Child Health, 30 Guilford Street, London, WC1N 1EH.**

Tel: 00 44 (0) 20 7242 9789 (ext. 8698) Email: source@ich.ucl.ac.uk

Photographic Competition

VISION 2020 PHOTOGRAPHIC COMPETITION

VISION 2020: The Right to Sight launches 'Visions of Children' International Photographic Competition

'Visions of Children' International Photography Competition gives you the chance to have your photograph exhibited around the world, visit a VISION 2020 project, see your photograph included in a book and have it exhibited alongside photographers such as Mary McCartney. The competition is open to both amateur and professional photographers.

The competition is divided into two categories:

'Images of children who are affected by conditions of blindness' and
'Images of others who are affected by conditions of blindness, where there is a direct impact on children'

Entries can be submitted as digital images, however a printed copy of the photo must be sent to the address below by 4 July 2003. Photographs must measure between 210mm x 148mm and 420mm x 594mm and must have the entrants name and address written in block capitals on the back of their photographs.

For further details of **'Visions of Children'** and **VISION 2020's work** please visit **www.v2020.org** or contact:

International Agency for the Prevention of Blindness/
VISION 2020: The Right to Sight
London School of Hygiene and Tropical Medicine,
Keppel Street, London, WC1E 7HT, United Kingdom
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