

**FEDERAL
REPUBLIC OF
NIGERIA**



PERFORMANCE STANDARDS

FOR PROVISION OF CHILD EYE HEALTH SERVICES IN NIGERIA

FEDERAL MINISTRY OF HEALTH, NIGERIA - 2020



Content

A. Performance Standards	
Foreword.....	i
Acknowledgement.....	ii
Introduction.....	1
Child Eye Health Assessment check list for Tertiary and Secondary Eye Units In Nigeria.....	3
Child Eye Health Proposed Assessment check list Tertiary and Secondary Eye Units In Nigeria.....	10
Paediatric Low Vision Assessment.....	14
Performance Standard for Pediatric Refraction.....	23
Performance Standards on Infection Prevention.....	30
Primary Eye Care.....	42
B. Post Training Supportive tool	
Pediatric Low Vision Service.....	47
Pediatric Refraction.....	59
Primary Eye Care Services.....	67
Infection Prevention.....	78
Structures, Utilities and Job Aides.....	89
Action Plan Development.....	93
List of contributors.....	95



Foreword

This document outlines standards, targets and goals to improve delivery of child eye care services in Nigeria. It provides health workers with specific system performance expectations and establishes success indicators for key tasks and procedures.

For child eye care services to meet desired outcomes, they must be evidence based, safe (for patient and provider), effective, efficient, patient centred and equitable.

These standards are applicable at all levels of care, to ensure consistency and uniformity, thereby reducing errors and saving costs.

Beyond offering technical expertise, it measures observable behaviours and actions which contribute to eliciting accurate responses, thereby improving patient experience and treatment outcomes at point of care.

Enclosed in the document is a post training supportive supervision tool with sections on performance observation by the use of competency based skill checklists, infection prevention protocols, infrastructural and job aid assessment; and feedback aimed at problem solving that identifies gaps, causes and interventions to ensure quality assurance.

Supportive supervision encourages health workers to improve their performance by promoting open communication and collaborative problem solving between them and their supervisors.

This is a product of extensive review of evidence based practices geared towards enhancing the capacity of all professionals and organizations engaged in the delivery of child eye care services in Nigeria.

I therefore endorse and recommend its use as a benchmark for the delivery of child eye care services in Nigeria.



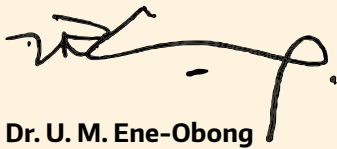
Dr. E. Osagie Ehanire, MD, FWACS
Hon. Minister of Health

Acknowledgement

The Federal Ministry of Health wishes to thank all individuals and organizations that contributed time and professional expertise to the development of the Performance Standards for the Provision of Child Eye Health Services in Nigeria.

We gratefully acknowledge the expert opinion and technical input provided by Nigerian Paediatric Ophthalmology and Strabismus Society, Ophthalmological Society of Nigeria, National Eye Centre, Nigeria Ophthalmic Nurses Association, Nigerian Optometric Association, National Primary Health Care Development Agency, Albino Foundation, Health and Development Society, Nigeria Association of the Blind.

We are grateful to the Seeing is Believing (SiB) Standard Chartered Bank Programme managed by CBM and Brien Holden Vision Institute for providing financial and technical support to the development of this document.



Dr. U. M. Ene-Obong
Director, Public Health

Introduction



This document was produced by a team of specialists and stakeholders that work in the field of child eye Health (CEH) in Nigeria. It covers key eye health thematic areas such as paediatric ophthalmology, low vision and refraction services, as well as infection prevention in CEH facilities.

The document outlines standards, criteria for measurement of standards achieved and should serve as a tool to measure performance of child eye health care providers working at primary, secondary or tertiary health facilities. It could also be adopted for conduct of post training supportive supervision to monitor trained CEH service providers / specialist including paediatric ophthalmologist and optometrists trained on low vision and refraction as they move from competency to proficiency starting four weeks after and concluded after 13 weeks.

It is expected that each trained provider would have attained proficiency after at least three rounds of post training supportive supervision within 12 weeks.

Consequently the tool will be used to monitor performance at the service delivery sites to ensure that health care workers continue to adhere to approved standards in the delivery of child eye health services. At this level, an action plan tool is used to document gaps and also develop remedial actions to ensure that identified gaps are addressed during each quarterly supportive supervision round.



Child Eye Health Assessment check list for Tertiary and Secondary Eye Units in Nigeria

These tools have been developed for the child eye care programme in Nigeria.

HISTORY TAKING, CLINICAL EXAMINATION, PRE AND POST OP ACTIONS

Name and place of Eye Unit: _____

Name of Assessor: _____

Date: _____

	RATING						COMMENTS
	3RY	2RY	GREEN	AMBER	RED	N/A	
HISTORY TAKING							
OCULAR HISTORY							
<u>Presenting ocular complaint</u> Redness, poor vision, white speck in the eye, eye discharge, eye swelling	√	√					
<u>History of presenting ocular complaint</u> Ocular history of the condition leading to this consultation is taken routinely (including type, onset and duration of symptoms; which eye(s) affected; progression; treatment used) Associated symptoms e.g. preceding trauma, pain, double vision	√	√					
<u>Previous ocular history</u> Ocular history of previous or co-existing conditions is taken routinely (eye diseases; trauma; surgeries; use of glasses and at which age the first pair of glasses were prescribed)							
GENERAL MEDICAL HISTORY							
<u>History for other medical problems is taken routinely.</u> (For example hearing and speech impairment, trauma, congenital anomalies, hospitalization,							

medication used; need for occupational, physical or speech therapy, convulsions, loss of consciousness, febrile illness, blood transfusions, non-ocular surgeries)							
PERINATAL HISTORY							
<u>Mother</u> The mother's history during pregnancy is taken routinely. (For example general health; febrile illness, rashes, duration of labour, complications of pregnancy; use of medication, drugs including herbal medications, alcohol; tobacco, trauma; surgery; CMV, AIDS, hypertension; diabetes)							
<u>Baby</u> The baby's history is taken routinely (for example: place and method of delivery, APGAR score, crying after delivery, gestational age at birth, birth weight, complications at birth; congenital anomalies)							
POSTNATAL HISTORY							
<u>Risk factors routinely assessed for</u> <ul style="list-style-type: none"> retinopathy of prematurity such as low birth weight, sepsis, transfusions, unstable course, respiratory distress, duration of oxygen therapy; jaundice, neonatal seizures cortical visual impairment: intraventricular hemorrhage (in addition to above) 							
<u>Developmental mile stones</u> History is taken routinely for key mile stones (such as age when infant achieved social smile, neck control; reaching/grasping objects, sitting, crawling and walking / talking age)							
<u>Family history</u> Taken routinely for eye conditions (such as strabismus, refractive error, cataract, other eye diseases; other non-ocular systemic diseases and congenital anomalies); interventions							
<u>Main educational milestones</u> School attendance has been asked (Such as age of entry, type of school, performance; continuity, appropriate class for age)							
CLINICAL EXAMINATION							
<u>General Observation</u> Overall physical appearance, general developmental stage, interaction with the							

environment, following objects, head posture, eye movements are observed routinely						
Visual Acuity Taking Techniques appropriate to the mental age of the child have been applied correctly and routinely. Recommended protocol, (if not available)						
Infants: birth to 18 months <ul style="list-style-type: none"> Object awareness: lighted objects, human face; optokinetic nystagmus; fixation and following Preferential looking: Teller acuity cards, LEA gratings 						
Toddlers: 18 months to 3 years <ul style="list-style-type: none"> Lea symbols, matching test Teller acuity cards 						
Preschool: 3-5 years <ul style="list-style-type: none"> Lea symbols, matching test, naming object Picture chart Lighthouse card and numbers for near E's with crowding bars, linear E's, optotypes, Landolt C chart 						
School age: 5 plus years <ul style="list-style-type: none"> Distance: Snellen chart, ETDRS/Lighthouse chart, optotypes Near: Lighthouse cards 						
Objective Refraction Indicated and performed appropriately: <ul style="list-style-type: none"> Dry retinoscopy - for rough estimate Cycloplegic refraction 						
Anterior Segment assessment Done routinely, appropriately to age. For example: <ul style="list-style-type: none"> Baby / small children: held up to slit lamp / hand held slit lamp used or penlight, indirect with 20D lens, or loupes Older children: Slit lamp						
Intra-ocular pressure Measurement <ul style="list-style-type: none"> Indication and technique appropriate to age Babies / small infants: for example Tonopen®, Icare tonometer, Perkins applanation devices; Older children: any device 						

<p>Assessment for Strabismus / Binocular Vision This is done appropriately using / applying</p> <ul style="list-style-type: none"> • Polarized stereo test • LANG Test • Frisby test • Observation, Hirschberg test • Krimsky test • Cover tests (cover - uncover) • Alternate cover test • Prism cover test 							
<p>Visual Field Testing This is indicated and performed appropriately and according to age</p> <ul style="list-style-type: none"> • Young children: confrontation fields, paediatric perimeter • Older child: Goldmann perimetry, automated visual field analyser 							
<p>Colour Vision Testing This is indicated, performed and interpreted appropriately.</p> <ul style="list-style-type: none"> • Ishihara chart • D 15 panel 							
<p>Contrast Testing Indicated, performed and interpreted appropriately</p> <ul style="list-style-type: none"> • Hiding Heidi for young children 							
<p>Posterior Segment Examination Indicated, performed and interpreted appropriately:</p> <ul style="list-style-type: none"> • Performed through dilated pupils with binocular indirect ophthalmoscope • Indirect non-contact fundus lenses with slit lamp • Direct ophthalmoscope 							
PRE- AND POST-OPERATIVE ACTIONS							
Preoperative laboratory evaluation done according to hospital guidelines							
In case of CRS Congenital rubella syndrome: Complete Rubella work up done (hospital guidelines)							
Informed Consent signed (hospital standard)							
Preoperative anesthetic assessment done and medication given (general / topical) hospital protocol							

Any other existing protocol observed and implemented							
For Cataract Surgeries: Biometry and IOL selection done before or during operation according to protocol or attached guidelines							
Postoperative Medications: as per hospital protocol or attached guidelines							
Postoperative follow-up protocol observed and examination done routinely. If no protocol available, follow for example schedule below: <ul style="list-style-type: none"> • 1 week after discharge • 1 month (3-5 weeks after surgery) 							
<ul style="list-style-type: none"> • 3 months (every 3 months after surgery till age of 6 years) • At least twice yearly after the age of 6 years Postoperative examination elements: <ul style="list-style-type: none"> • Visual acuity both eyes • Motility and alignment • Intraocular pressure • Ophthalmoscopy • Refraction / retinoscopy (1-2 per year) 							
<u>Refractive Management</u> Protocol followed routinely. If not available consider schedule below: Refract as early as possible post-operatively <ul style="list-style-type: none"> • Aphakic children and younger pseudophakic children: to receive optical correction within the first 1 to 2/52 post-operatively. • Older pseudophakic children: 4 to 6 weeks postoperatively. Bifocals versus single-vision correction Young children, particularly those less than 2 years of age, <ul style="list-style-type: none"> • do not generally require a bifocal and do well with single-vision correction • use either spectacles or contact lens(es) • Target to overcorrect by +2.00 to +3.00 diopters so that the far point is 50 to 33 cm. Older children (> 2 years of age) have greater visual demands and benefit from <ul style="list-style-type: none"> • Bifocal 							

<ul style="list-style-type: none"> Upper segment: distance correction for emmetropia Lower segment: near correction with a +2.50 to +3.00 add <p>Flat-topped lower segments (D-shaped or executive style) are easier for children to use and have larger optical zones with minimal distortion.</p>						
<p>Management of posterior capsule opacity Implemented routinely according to protocol. If no protocol available:</p> <ul style="list-style-type: none"> Children less than 5 years of age in virtually all: primary surgical posterior capsulotomy and anterior vitrectomy be performed at the time of initial cataract surgery recommended; Children 5-8 years of age: Primary surgical capsulotomy and anterior vitrectomy is optional. A reasonable alternative would be a 						
<p>primary surgical capsulotomy alone, without anterior vitrectomy (when Nd-YAG laser is not readily available)</p> <ul style="list-style-type: none"> Children older than 8 years of age can generally be managed as adults with the posterior capsule left intact at the time of cataract surgery. Very dense opacifications: surgery with a pars plana vitrectomy. 						
<p>References for Management of childhood Cataract including surgery</p> <p>CHILDHOOD CATARACT , KCCO (full document available)</p>						

1st VISIT

Total of standards	23
Total observed	
Total Achieved	

2nd VISIT

Total of standards	23
Total observed	
Total Achieved	

3rd VISIT

Total of standards	23
Total observed	
Total Achieved	

Recommendations

Persons who Conducted the Visit

NO OF VISITS	NAME	SIGNATURE	DATE
1st Visit			
2nd Visit			
3rd Visit			

Child Eye Health Proposed Assessment check list for Tertiary and Secondary Eye Units in Nigeria

These tools have been developed for the child eye care programme in Nigeria.

OPHTHALMIC OPERATING THEATRE PRACTICE

Name and place of Eye Unit: _____

Name of Assessor: _____

Date: _____

	RATING			COMMENTS / OBSERVATIONS
	GREEN	AMBER	RED	
<p>Ophthalmic Operating Theatre Practice</p> <p>For detailed description of each position below please refer to: Ophthalmic Operating Theatre Practice: A manual for lower-resource settings; p. 81 - 92 Editor: Heather Machine</p>				
<p>Dress Code(theatre scrubs, face mask, theatre caps, theatre foot wears), Personal Protective Equipment (PPE) (wide brim eye wears, plastic apron, gloves, rubber boots) and Personal Hygiene (staff should have well-kept short nails)</p>				
<p>Cleaning the OT</p> <ul style="list-style-type: none"> • Cleaning theatre before surgery with detergent or antiseptic, removing cob webs, cleaning the tiles as well as drip stand • Cleaning in between surgery- empty the trash can, cleaning the bed after each case and when necessary the floor as well • Cleaning after surgery-empty the trash can, clean the floor and mop, re-arrange the theatre and send soiled materials to the laundry • Fumigation once in three months • Cleaning air-conditioner filter once in three months 				

<p>Surgical Hand Washing</p> <ul style="list-style-type: none"> Adherence to standard guidelines/procedure for hand washing Having liquid soap and antiseptics to use Having running water to use 				
<p>Gloving</p> <ul style="list-style-type: none"> Standard gloving should be observed Outer part should not be touched Preferably powder free gloves 				
<p>Handling Drapes, Patient Preparation and the Sterile Field</p> <ul style="list-style-type: none"> Drapes sterilized Handled by circulating nurse to the scrub nurse 				
<p>Preparation of the OT Trolley</p> <ul style="list-style-type: none"> Is the trolley properly carbolised Cover trolley with a sterile drape Use of Cheatle's forceps to pick drapes, gowns, sterile gauze and other instruments Cover the sterile field with a sterile drape until surgery time 				
<p>Preparing the patient</p> <ul style="list-style-type: none"> Use spirit to clean the periorcular skin twice, dry with gauze, paint with 10% povidone iodine then instil 5% into the conjunctival sac for 3-5 minutes Cover with sterile drapes Insert lid speculum 				
<p>Aseptic (non-touch) technique</p> <ul style="list-style-type: none"> Cleaning of the operating microscope with methylated spirit and covering of knobs with sterile plastic covers Unsterile person should avoid contact with the sterile fields The gloved surgeon should avoid touching unsterile surface Both gloved surgeon and scrub nurse should avoid touching tips of instrument Observe non touch technique when handling the cautery, giving set, vitrector, etc 				
<p>Universal precautions</p> <ul style="list-style-type: none"> Culture theatre once in three months Fumigate theatre once in three months Avoid crossing the red line without adhering to dress code 				
<p>Techniques for Passing Items to the Surgeon</p> <ul style="list-style-type: none"> Avoid touching the tip of the instrument 				

<ul style="list-style-type: none"> • Pass instrument using the handle • Ensure surgeon has handled the instrument before letting go 				
<p>Examination of Both Eyes Under Anesthesia</p> <ul style="list-style-type: none"> • Dilate the eyes • Clean with povidone • Cover with drape • Insert lid speculum • Check corneal diameter • Intraocular pressure with Perkin's • Direct and indirect funduscopy • Refraction • Gonioscopy • Biometry (for cataract surgery) • Hand held slit lamp examination of anterior segment 				
<p>Intraocular Lens Calculations</p> <ul style="list-style-type: none"> • Hand held keratometric reading • Axial length measurement 				
CATARACT SURGERY TECHNIQUES				
Cataract Surgery performed without IOL in children less than 2 years of age or corneal diameter less than 10.5mm				
Preferred surgical procedure for pediatric cataracts consists of lensectomy, posterior capsulectomy and anterior vitrectomy which may be performed via an anterior or posterior approach, IOL is mandatory for children up to 7 years with IOL implantation using hydrophobic acrylic foldable.				
Cataract surgery in children older than 7 years , perform manual small incision cataract surgery with posterior continuous curvilinear capsulorrhexis (PCCC), anterior vitrectomy may be required in some cases. In adolescents Nd-YAG laser capsulotomy may be used to treat posterior capsular opacification.				
Pediatric cataract surgical outcome forms should be filled and analysed after each surgery				

1st VISIT

Total of standards	23
Total observed	
Total Achieved	

2nd VISIT

Total of standards	23
Total observed	
Total Achieved	

3rd VISIT

Total of standards	23
Total observed	
Total Achieved	

Recommendations

Persons who Conducted the Visit

NO OF VISITS	NAME	SIGNATURE	DATE
1st Visit			
2nd Visit			
3rd Visit			

Paediatric Low Vision Assessment

ASSESSMENT CHECK LIST FOR TERTIARY AND SECONDARY EYE UNIT

These tools have been developed for the child eye care programme in Nigeria.

Name and place of Eye Unit: _____

Name of Assessor: _____

Date: _____

		RATING						
		3RY	2RY	GREEN	AMBER	RED	N/A	COMMENTS
1. The low vision specialist receives the child	A. Welcomes the child with a smile and in a friendly manner	√	√					
	B. Rooms are well lighted and wall colorfully designed and painted							
	C. Floor is well carpeted and clean							
	D. Have child-friendly toys in the room							
	E. Presents procedures as a game with the child							
	F. Explains procedures to the child and make procedure less threatening							
	G. Constantly reassures the child that everything will be okay							
2. The low vision specialist performs case history	A. Asks question on onset of visual impairment. <ul style="list-style-type: none"> • What kind of visual problems? • How is the vision affected during the day/night? • Ask about illumination, mobility and activities of daily living 	√	√					

	<p>B. Asks question on previous eye examination</p> <ul style="list-style-type: none"> • Has the diagnosis been confirmed? • Has standard refractive, medical and surgical treatment been given to the patient? • Has visual prognosis been confirmed? 							
	C. Asks question on previous low vision assessment							
	D. Asks question on uptake of low vision (device).							
	<p>E. Asks question on educational history.</p> <ul style="list-style-type: none"> • Asks question on mode of learning (if patient is in school) 							
	F. Asks question on family oculovisual history							
	G. Asks question on expectation/ goal of low vision assessment							
	H. Guide patient on setting goal of low vision assessment							
	Use of structured history questions inventory to ascertain visual function							
	Parent reported history questions inventory is used to identify specific abnormal visual functions and visual perceptual disorders							
3. The low vision specialist performs visual acuity (VA) assessment	A. Instructs patient on the procedure to be performed							
	B. Instructs patient to occlude the unexamined eye.							
	C. Uses appropriate charts to test distance VA							
	D. Uses age-appropriate technique to test vision.							
	E. Tests vision at appropriate test distance							
	F. Tests vision with previous glasses/LVDs where available							

	G. Records VA for each eye							
	H. Notes any special consideration when testing VA (e.g. eccentric fixation, head movement etc)							
4. The low vision specialist performs visual field assessment	Communicates effectively with the patient on procedure							
	Performs confrontation test.							
	Hand held disc Perimetry:							
	Places disc appropriately							
	Uses targets suitable for people with low vision.							
	Tests each eye separately							
	Tests both eyes together							
	Records result correctly.							
	Bjerrum Tangent Screen:	√	√					
	Performs test at specified distance.							
	Uses targets suitable for people with low vision.							
	Occludes the unexamined eye.							
	Charts the patient's visual field							
	Records patient's visual field on recording sheet.							
	Repeats for fellow eye.							
	Automated visual field analyzer:	√	√					
	Give appropriate instruction to patient.							
	Positions the patient comfortably on the VFA.							
	Enters patient's information in the computer and select the appropriate test strategy.							
	Dims room illumination.							
Performs automated perimetry.								
Prints report								
Interprets results								

5. The low vision specialist performs colour vision	If using Panel D 15 effectively with the patient on the test to be performed:	√	(√)					
	A. Instructs patient on what to do							
	B. Displays the discs in random order.							
	C. Continues to instruct patient on what to do.							
	D. Records the order on the record sheet							
	F. Determines the type of colour vision defect based on the result on the record sheet.							
	If using Ishihara plate	√	√					
	Instructs patient on what to do							
	Uses appropriate plates to determine colour vision.							
	Records score.							
	If using coloured sticks/discs:	√	√					
	Instructs patient on what to do.							
	Presents coloured sticks/discs of appropriate sizes in the primary colours.							
	Randomizes order of presenting colours							
	Records coloured sticks/discs seen by patient.							
6. The low vision specialist performs contrast sensitivity (CS) test.	Uses age-appropriate charts for CS test.	√	(√)					
	Instructs patient on the procedure.							
	Measures CS.							
	Records score for each eye							
7. Test for visual function and visual perceptual disorders	Assessment with Lea mailbox	√	√					
	Assessment with Lea rectangles	√	√					
	Assessment with Lea puzzle black/white and colored.	√	√					
8. Performs ocular health examination	Performs ophthalmoscopy under dim illumination.	√	√					

	Measures IOP where applicable.	√	√					
	Carries out a detailed eye examination using the slit lamp biomicroscope.	√	√					
Performs objective refraction (Cycloplegic refraction)	Instructs patient on the procedure to be performed.	√	√					
	Educates care giver and obtains verbal consent to instill cycloplegic agent.	√	√					
	Instills prescribed cycloplegic agent in appropriate dosage.	√	√					
	Digitally occludes punctum while instilling cycloplegic agent.	√	√					
	Wait out the time required for cycloplegic agent to take action.	√	√					
	Dims room illumination to perform retinoscopy.	√	√					
	Determines objective refraction in both principle meridians of the eye (radical retinoscopy where applicable).	√	√					
	Repeats procedure for the fellow eye.	√	√					
	Records results correctly in minus cylinder.	√	√					
9. Performs subjective refraction	Uses appropriate pediatric trial frame and full aperture trial lenses	√	√					
	Determines subjective refraction starting from the objective finding OR	√	√					
	Determines subjective refraction using bracketing technique.	√	√					
	Employs maximum plus to best VA rule.	√	√					
	Records subjective refraction for each eye.	√	√					
10. Determines best corrected visual acuity.	Communicate effectively with the patient on the procedure to be performed.	√	√					
	Patient is wearing the best lens correction obtained from subjective refraction.	√	√					

	Instructs patient to occlude the unexamined eye.	√	√					
	Uses age-appropriate charts to test distance VA	√	√					
	Uses age-appropriate technique to test vision	√	√					
	Tests vision at appropriate test distance (both distance and near VA).	√	√					
	Records VA for each eye	√	√					
	Records VA for both eyes							
11. The low vision specialist determines telescopic magnification for distance	Observe if he/she A. Uses best corrected distance VA to calculate telescopic magnification requirement to achieve goal acuity.	√	√					
	B. Modifies telescopic magnification based on visual acuity goal and task	√	√					
12. The low vision specialist determines magnification for near distance.	A. Uses best correct near VA to determine magnification requirement for: • Spectacle magnifier • Hand held magnifier. • Stand magnifier. • Electronic devices							
	B. Modifies near magnification based on performance							
13. The low vision specialist determines achieved visual acuity with LVDs	A. Instructs patient on the procedure to be performed. (with patient using telescope for distance VA and magnifiers for near VA)	√	√					
	B. Instructs patient to occlude the unexamined eye.	√	√					
	C. Uses appropriate charts to test distance VA.	√	√					
	D. Uses age-appropriate technique to test vision.	√	√					
	E. Tests vision at appropriate test distance (distance, intermediate and near VA and tasks (where applicable).							
	F. Record VA for each eye							

14. The low vision specialist selects appropriate LVDs	A. Selects appropriate LVDs for distance, intermediate and near vision tasks.	√	√					
15. The low vision specialist trains patient on use of selected LVDs	A. Provides training in use of telescope							
	B. Provides training in use of selected LVDs for near vision							
16. The low vision specialist counsels patient/care-giver on available options for improving vision.	A. Counsels patient/care-giver on cause and implication of visual impairment.	√	√					
	B. Counsels patient/care-giver on available options for visual enhancement.	√	√					
	C. Counsels patient/care-giver on care and use of LVDs.	√	√					
	D. Counsels patient/care-giver on limitations of LVDs	√	√					
17. The low vision specialist/teachers of children with visual (TVCI) impairment perform functional vision assessment.	A. Demonstrates the eight domains of functional vision	√	√					
18. The low vision specialist facilitates access to prescribed LVDs.	A. Orders LVDs with the specified magnification and other specifications.	√	√					
	B. Communicates next appointment date and purpose to patient/care giver	√	√					
19. The low vision specialist verifies	A. Verifies the ordered LVDs when received.	√	√					
	B. Documents patient has received LVDs.	√	√					
20. The low vision specialist evaluates patient's use of LVDS	A. Evaluates patient feedback on use of LVDs.	√	√					
	B. Addresses patients concerns (when reported) on the use of LVDs.	√	√					
21. The low vision specialist dispenses LVDs	A. Instructs patient on use and care of the LVDs.	√	√					
	B. Dispenses LVDs.	√	√					
	C. Provides written instruction on care and use of LVDs.	√	√					

	D. Documents patient has received LVDs	√	√					
	E. Gives instruction on follow-up visit	√	√					
22. Determination of non-optical devices	A. Identification of visual function domain that requires support.							
	B. Selection of non-optical device							
	C. Counselling on use of non-optical device							
23. Identification of tailored visual support strategies based on specific questions identified from the visual function inventory	A. Parental selection of appropriate tailored visual support strategies							
	B. Discussion on implementation of visual support strategies							
	C. Follow up on implementation and increasing the number of strategies.							

FOLLOW UP VISIT

22. The low vision specialist receives feedback from patient on use of LVDs	A. Asks questions on success/challenges/failure in use of LVDs on specified tasks.	√	√					
	B. Assesses LVDs to determine whether they are intact.	√	√					
	C. Records VA (distance and near) with LVDs.	√	√					
	D. Notes any defect in LVDs.	√	√					
23. The low vision specialist receives feedback from patient on use of non-optical aids	A. Notes on challenges with non-optical aids							
24. The low vision specialist receives feedback from patient on implementation of visual support strategies	A. Notes on challenges implementing visual support strategies							
25. The low vision specialist address any challenge reported	A. Determines cause for failure (if reported).	√	√					
	B. Addresses the cause of failure.	√	√					
	C. Reinforce use of LVDs.	√	√					

	D. Reinforce instruction on use and care of LVDs.	√	√					
	E. Reinforce counseling on limitations of LVDs.	√	√					
	F. Reinforce counseling on the use of non-optical devices.							
	G. Reinforce counseling on implementation of visual support strategies							
Follow up	Trace and ensure child is in an early intervention program, a special school or a main stream school							
	Home visits are performed at least yearly.							

1st VISIT

Total of standards	23
Total observed	
Total Achieved	

2nd VISIT

Total of standards	23
Total observed	
Total Achieved	

3rd VISIT

Total of standards	23
Total observed	
Total Achieved	

Recommendations

Persons who Conducted the Visit

NO OF VISITS	NAME	SIGNATURE	DATE
1st Visit			
2nd Visit			
3rd Visit			

Performance Standard for Pediatric Refraction

Instructions: Mark was 'C' if the procedure is performed correctly and N if procedure was not performed correctly
Observe for the following:

ENTRANCE EXAMINATION AND PRELIMINARY EXAMINATION

1. Performs • Age-appropriate case history. • Determines visual acuity.	Observe if he/she	√	√											
	A. Asks question relating to birth history													
	B. Asks question about age-appropriate milestone													
	C. Asks question on presenting complaints													
	D. Asks question on onset of visual symptom													
	E. Ask questions on duration													
	F. Ask questions on allergies (ocular, systemic and drugs) taken													
	G. Ask questions on previous action													
	H. Ask question on previous eye examination and actions recommended and taken	√	√											
	I. Ask questions on use of herbs and other unorthodox practices													
	J. Ask question on family history of ocular and systemic disease													
	Evaluation													
	BIRTH – 6 MONTHS													
A. Checks for presence of cornea (blink) reflex														
B. Checks for pupillary response														
C. Checks for defensive blink														
6 MONTHS – 2.5 YEARS														

	A. Performs preferential looking tests (Lea grating paddles, optokinetic nystagmus)									
	2.5 – 5 YEARS									
	A. Measures VA using age- and developmental appropriate techniques and charts (symbols, direction, matching tests).									
	B. Present single symbols of logMAR charts									
	C. Notes the preferred response of the child (pointing matching, showing direction or saying it loud)									
	D. Tests both eyes before individual eye									
	E. Tests near VA using appropriate techniques and charts.									
	F. Notes age-appropriate VA standard									
	G. Notes inter-ocular VA difference									
	H. Tests VA at age- and chart-appropriate distance									
	I. Test performed under appropriate illumination									
	J. Does not use mirror reflection									
	K. Identifies asymmetry in VA and uses single optotypes for VA assessment									
2. Performs binocular vision assessment	Observe if he/she									
	A. Performs Hirschberg test									
	B. Performs Krimsky test									
	C. Performs Bruckner's test.									
	D. Estimates magnitude of ocular deviation									
	E. Performs unilateral cover test									
	F. Performs alternate cover test									
G. Notes the presence and magnitude or absence of ocular deviation										

3. Measures glare sensitivity	<p>Observe if he/she</p> <p>A. Determines glare sensitivity test using brightness acuity test (BAT)</p>									
4. Performs ocular health examination	<p>Observe if he/she</p> <p>A. Performs ophthalmoscopy under dim illumination</p>									
	B. Measures IOP where applicable.									
	C. Carries out a detailed eye examination using the slit lamp biomicroscope									
5. Performs color vision assessment	If using panel D 15									
	A. Communicates effectively with the patient on the test to be performed.									
	B. Instructs patient on what to do									
	C. Displays the discs in random order									
	D. Continues to instruct patient on what to do									
	E. Records the order on the record sheet.									
	F. Determines the type of colour vision defect based on the result on the record sheet.									
	If using Ishihara plate									
	A. Instructs patient on what to do									
	B. Uses appropriate plates to determine colour vision									
	C. Records score									
	If using coloured sticks/discs									
	A. Instructs patient on what to do									
	B. Presents coloured sticks/discs of appropriate sizes in the primary colours.									
	C. Randomizes order of presenting colours.									
	D. Records coloured sticks/discs seen by patient									
Paper coloring/matching game										
Assesses colour vision using colour matching or paper colouring										

6. Performs visual field assessment	Observe if he/she Communicates effectively with the patient on procedure																					
	Amsler grid																					
	Uses Amsler chart to test central visual field																					
	Hand held disc perimetry																					
	Places disc appropriately.																					
	Uses targets suitable for people with low vision																					
	Tests each eye separately																					
	Records result correctly																					
	Bjerrum Tangent Screen																					
	Performs test at specified distance																					
	Uses targets suitable for people with low vision																					
	Occludes the unexamined eye.																					
	Charts the patient's visual field																					
	Records patient's visual field on recording sheet.																					
	Repeats for fellow eye																					
	Automated visual field analyzer																					
	Give appropriate instruction to patient.																					
	Positions the patient comfortably on the VFA																					
	Enters patient's information in the computer and select the appropriate test strategy																					
	Dims room illumination																					
Performs automated perimetry																						
Prints report																						
Interprets results																						
7. Performs contrast sensitivity (CS) test	Observe if he/she:																					
	A. Uses age-appropriate charts for CS test.																					
	B. Instructs patient on the procedure																					

	C. Measures CS.																		
	D. Records score for each eye.																		

PEDIATRIC REFRACTION

1. Performs objective refraction (Cycloplegic refraction)	Observe if he/she:																		
	A. Instructs patient on the procedure to be performed.																		
	B. Educates care giver and obtains verbal consent to instill cycloplegic agent.																		
	C. Considers hypersensitivity risk and takes appropriate/alternative action.																		
	D. Considers duration of action of cycloplegia and recovery from cycloplegia.																		
	E. Instills local anaesthetic agent																		
	F. Instills prescribed cycloplegic agent in appropriate dosage and timing.																		
	G. Digitally occludes punctum while instilling cycloplegic agent.																		
	H. Wait out the time required for cycloplegic agent to take action.																		
	I. Determines the cycloplegia is complete as determined by pupil dilation and inability to read prints																		
	J. Appropriate room illumination to keep the child at ease.																		
	K. Use appropriate fixation target																		
	L. Uses appropriate fixation distance for the technique employed.																		
	M. Determines objective refraction in both principle meridians of the eye.																		
	N. Uses appropriate pediatric trial frame and full aperture trial lenses.																		
	O. Repeats procedure for the fellow eye.																		
P. Records results correctly																			

2. Performs subjective refraction	Observe if he/she											
	A. Uses appropriate pediatric trial frame and full aperture trial lenses.											
	B. Modifies cylindrical component of the wet refraction.											
3. Prescribes spectacle correction	C. Records subjective refraction for each eye.											
	Observe if he/she											
	A. Considers family history of refractive error.											
	B. Considers symptoms (VA and near stereopsis).											
	C. Considers accommodative and learning problems.											
4. Ensure appropriate spectacles are delivered and patient and family counselled on use	D. Considers age.											
	E. Uses the table for age and symptom guideline for prescribing spectacle correction.											
	A. On receipt, trial of new spectacles											
	B. Counselling on lens cleaning and spectacle use as prescribed											
	5. Criteria for referral to a tertiary facility	A. Best corrected VA of <math><6/9</math> in an eye										
		B. Any identified or suspected ocular or systemic pathology										
C. Any history/presentation of ocular trauma												
D. Moderate - High refractive errors												
E. Uncooperative children												
F. Children with neuro developmental disorders												

1st VISIT

Total of standards	23
Total observed	
Total Achieved	

2nd VISIT

Total of standards	23
Total observed	
Total Achieved	

3rd VISIT

Total of standards	23
Total observed	
Total Achieved	

Recommendations

Persons who Conducted the Visit

NO OF VISITS	NAME	SIGNATURE	DATE
1st Visit			
2nd Visit			
3rd Visit			

Performance Standards on Infection Prevention

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	1ST VISIT			2ND VISIT			3RD VISIT		
		C	N	CONTENT	C	N	CONTENT	C	N	CONTENT

Instructions: Mark was 'C' if the procedure is performed correctly and 'N' if procedure was not performed correctly

		C	N	CONTENT	C	N	CONTENT	C	N	CONTENT
1. The Child Eye Clinic is clean	Check during the visit for the absence of dust, blood, trash, used needles and syringes and cobwebs in the following areas									
	A. Records/registration room/ nurses room									
	B. Visual acuity room/ refraction room									
	C. Procedure room									
	D. Consulting room/ child friendly area/space/waiting area									
	E. Areas for cleaning the instruments (central supply and sterilization department [CSSD])									
	F. Toilets in the Eye Clinic									
2. The Eye Clinic has sharps containers	Observe in each of the following areas:									
	A. Child eye health procedure room									
	i. Whether the sharps containers are appropriate: cardboard box, hard plastic containers, cans that are closed, with only a small opening for disposing of syringes with needles									
	ii. The sharps containers are located at "point of use"									

	iii. Syringes with needles are disposed of immediately after use, following decontamination with a 0.5% chlorine solution, without being recapped and without being taken apart																		
	iv. Containers are closed and collected when three-quarters full																		
	v. Each sharps container is used only once and is discarded when three-quarters full																		
3. Antiseptics and disinfectants available	Verify in the storeroom and/or central stockroom, by comparison with usage during the previous month as indicated on the stock control form, the existence and amounts of the following:																		
	A. Consumable materials																		
	B. Antiseptics: - Chlorhexidine (solution)																		
	C. Alcohol, 60–90% (methylated spirit):																		
4. The concentration and use of antiseptics for skin.	D. Disinfectants: Sodium hypochlorite (bleach)																		
	Observe the Eye health Clinic:																		
	A. Eye health procedure room																		
	B. Operating Theater																		
	C. The antiseptic concentration is labeled with the name and concentration of the antiseptic as follows: Whether:																		
D. Ethyl, isopropyl alcohol (60%–90%), or																			
E. Cetrime and chlorhexidine gluconate (2%–4%) (e.g., Savlon®), or - Chlorhexidine gluconate (2%–4%) (e.g., Hibiclens®)																			

	F. The reusable containers are thoroughly washed with soap and water, rinsed with clean water, and dried before refilling.																		
	G. Reusable containers are labelled with date each time they are refilled.																		
	H. Gauze or cotton wool is stored in dry containers without an antiseptic																		
	I. Instruments and other items are stored in dry containers without antiseptics																		
	K. Pick-up forceps are stored in dry containers without antiseptics																		
5. The decontamination of instruments	Observe in each Eye clinic/ operating theatre, if the person cleaning the instruments complies with the following steps and recommendations: The concentration of chlorine solution is 0.5%: Liquid chlorine: - If using a concentration of 3.5%, uses 1 part bleach for 6 parts water, OR - If using a concentration of 5%, uses 1 part bleach to 9 parts water																		
	A new chlorine solution is prepared at the beginning of each day or sooner if needed																		
	Plastic containers are used for decontamination																		
	Instruments and other items are soaked in the 0.5% chlorine solution for 10 minutes																		
	After 10 minutes, instruments and other items are removed from the chlorine solution and cleaned immediately																		
	Formalin tablets can also be used																		

6. There is an area designated for processing instruments	Observe in the following services: a. Eye Clinic/procedure room b. Operating Theatre If: A. This area is separated from the procedure areas																		
	B. Dirty and clean items do not have contact																		
	C. There is a receiving counter for dirty items																		
	D. There is at least one sink with running water for washing instruments																		
	E. There is a counter for instruments to dry If instruments are wrapped/ packed in this area:																		
	F. There is a clean work area for wrapping/packing instruments with: - A work table - Shelves for holding clean packages - Office desk for record keeping																		
7. The process of cleaning instruments	Observe in each of the following areas if the person cleaning the instruments complies with the following steps and recommendations: A. Child eye health procedure room b. Operating Theater																		
	Wears: - Utility gloves - Mask and eyewear protection or face shield - Plastic apron - Rubber boots or enclosed shoes(for theatre)																		
	Utilizes: - Soft brush - Detergent (liquid or powder)																		
	Scrubs instruments and other items under the surface of water, completely removing all blood and other foreign matter																		

	Disassembles instruments and other items with multiple parts, and cleans in the grooves, teeth, and joints with a brush																		
	Rinses the instruments and other items thoroughly with clean water																		
	Allows instruments and other items to air-dry, or dries with a clean towel																		
	Applies lubricating oil before storage																		
	Cleans and reesterilizes again before use																		
	Washes hands after removing gloves and other personal protective equipment: -																		
	Washes hands with running water and soap for 10–15 seconds and dries with an individual clean towel, paper towel or allows hands to air-dry, OR - Rubs hands with 3–5 ml of an alcohol-based solution until the hands are dry (if hands are not visibly soiled)																		
8. The High Level Disinfection (HLD) process	Observe during the HLD cycle if the standard conditions listed below are followed:																		
	If boiling: All cleaned, disassembled instruments are totally immersed in water before lid is closed																		
	The lid is closed																		
	Instruments are boiled for 20 minutes starting from the time a rolling boil begins																		
	After 20 minutes, instruments are removed with HLD or sterile forceps or gloves, dried, and stored in HLD containers																		

	AND/OR If chemical: Glutaraldehyde (2–4%), formaldehyde (8%), or 0.1% chlorine solution (prepared with boiled or sterile water): -												
	All cleaned, disassembled instruments are immersed in solution for 20 minutes in a container with a lid -												
	There is a label on the container indicating the starting time of HLD - There is a label on the container indicating the date of reconstitution, and it is within 14 days if using glutaraldehyde, 28 days if using formaldehyde or within 24 hours, if using chlorine solution												
	After 20 minutes, instruments are removed with HLD or sterile forceps or gloves, rinsed with sterile or boiled water, dried, and stored in HLD containers												
9. The process of packaging of instruments to be sterilized	Observe during the packaging process if:												
	<ul style="list-style-type: none"> ■ The instruments are clean and dry If packaged items to be sterilized through steam sterilization (autoclave): 												
	<ul style="list-style-type: none"> ■ Cloth items have been laundered, dried, and are intact (have no holes) 												
	<ul style="list-style-type: none"> ■ All jointed instruments are opened or in unlocked position 												
	<ul style="list-style-type: none"> ■ All instruments are disassembled 												
	The types of materials used for wrapping are: Cloth wraps, muslin, or cotton: double wrapping - Paper (Kraft or other paper): double wrapping												

	<ul style="list-style-type: none"> ■ If using paper, it is used only once and discarded (it is not reused) 																		
	<ul style="list-style-type: none"> ■ Canvas or other waterproof material is never used for wrapping AND/OR If packaging items to be sterilized through dry-heat: 																		
	<ul style="list-style-type: none"> ■ The types of materials used are: - Cloth wraps, muslin: double wrapping OR Metal containers with lids 																		
	<ul style="list-style-type: none"> ■ Wrapped/packed instruments are sent for sterilization 																		
10. The collection of soiled linen	<p>Observe in Children Eye Clinic if:</p> <p>A. Eye clinic/procedure room B. Operating Theatre</p>																		
	<ul style="list-style-type: none"> ■ Soiled linen is collected in leak-proof containers without being presoaked or washed in the ward 																		
	<ul style="list-style-type: none"> ■ Workers wear utility gloves when collecting soiled linen 																		
	<ul style="list-style-type: none"> ■ Linen is sent to the laundry in closed containers (buckets, plastic bags or carts) for sorting, washing, and drying 																		
11. The collection of medical waste	<p>Observe in each of the following areas if:</p> <p>A. Child eye health procedure room b. Operating Theatre Medical waste (e.g., cotton wool, gauze, etc):</p>																		
	<ul style="list-style-type: none"> ■ Medical waste is placed in a washable container with a leak-proof plastic bag 																		
	<ul style="list-style-type: none"> ■ Containers are closed and collected when three quarters full 																		
12. The disinfectant cleaning solution	<p>Verify if the disinfectant cleaning solution is prepared</p>																		

	<p>properly in each of the following areas:</p> <p>A. Eye clinic procedure room B. Operating Theatre</p> <ul style="list-style-type: none"> • 0.5% chlorine solution is prepared • Detergent that does not contain an acid, ammonia, or ammonium is added to the 0.5% chlorine solution until a mild soapy cleaning solution is made 																		
13. The cleaning equipment is decontaminated, cleaned, and dried before reuse or storage	<p>A. Eye health procedure room. B. Operating Theatre</p>																		
	<p>Observe in the following areas if the mops, buckets, brushes and cleaning cloths are:</p> <p>Decontaminated by soaking for at least 10 minutes in 0.5% chlorine solution or other approved disinfectant after use</p>																		
	<p>Washed in detergent and water after use</p>																		
	<p>Rinsed in clean water</p>																		
	<p>Dried completely before reuse or storage</p>																		
14. There is a written plan for waste management	<p>Verify with the person responsible for the waste management if:</p> <ul style="list-style-type: none"> ■ There is a written plan for waste management including: <ul style="list-style-type: none"> • Segregation at point of use • Transportation • Interim storage • Final disposal 																		
15. Waste management and disposal.	<p>Observe if:</p> <ul style="list-style-type: none"> ■ There are sufficient dustbins outside the health 																		

	<p>facility (in the grounds) for general waste to avoid littering</p>									
	<ul style="list-style-type: none"> ■ The grounds (outside the health facility) are clean 									
16. Use of personal protective equipment when handling waste	<p>Observe during the visit, if:</p> <p>Housekeeping personnel wear personal protective equipment when handling medical waste:</p> <ul style="list-style-type: none"> · Utility gloves · Rubber boots · Plastic apron · Masks covering nose and mouth 									
	<ul style="list-style-type: none"> ■ Disposable personal protective equipment (examination gloves, surgical masks) are decontaminated in 0.5% chlorine solution (if applicable) and disposed in a leak-proof container after use 									
	<ul style="list-style-type: none"> ■ Re-usable personal protective equipment (e.g., utility gloves, gumboots, plastic apron, face shield) are reprocessed after use: Decontaminated in 0.5% chlorine solution <ul style="list-style-type: none"> · Washed with soap and water · Dried and stored 									
17. The staff washes hands after handling waste and removing gloves	<p>Observe if housekeeping staff performs hand hygiene after handling waste and removing gloves:</p> <ul style="list-style-type: none"> ■ Wash hands with running water and soap for 10–15 seconds and dry with an individual clean towel, paper towel or allow hands to air dry, or 									
	<ul style="list-style-type: none"> ■ Rub hands with 3–5 ml of an alcohol-based solution until the hands are dry (if hands are not visibly soiled) 									

18. There is a system for interim storage of waste.	Observe if:																		
	<ul style="list-style-type: none"> ■ The traffic in the interim storage area is controlled (accessible only to the in-charge personnel) 																		
	<ul style="list-style-type: none"> ■ Containers are leak-proof and closed with tight lids 																		
	<ul style="list-style-type: none"> ■ All waste is inside of the containers 																		
	<ul style="list-style-type: none"> ■ The interim storage area is free of waste on the grounds 																		
	Verify with the manager if:																		
	<ul style="list-style-type: none"> ■ There is a written plan for a short term storage: maximum two days, and cleaning of storage area and containers 																		
	<ul style="list-style-type: none"> ■ Waste is transported in vehicles or containers used only to transport waste 																		
	<ul style="list-style-type: none"> ■ Vehicles transporting waste have a cover or tarp/tarpaulin to prevent waste from littering during transport. 																		
19. Disposal of contaminated waste	Verify if:																		
	<ul style="list-style-type: none"> ■ Contaminated waste is disposed of on-site through: <ul style="list-style-type: none"> · incinerating, or · burying, or · burning in a closed pit 																		
20. Disposal of non-contaminated waste	Verify if:																		
	<ul style="list-style-type: none"> ■ Non-contaminated waste is disposed of on-site through: <ul style="list-style-type: none"> · incinerating, or · burying, or · burning in a closed pit or 																		
	<ul style="list-style-type: none"> Non-contaminated waste is sent offsite (municipal waste or sanitary landfill) 																		
21. The waste disposal process	Verify: If the waste is incinerated:																		
	<ul style="list-style-type: none"> ■ The traffic in this area is controlled and accessible only to the in-charge personnel 																		

	<ul style="list-style-type: none"> ■ During incineration, there are flames 									
	<ul style="list-style-type: none"> ■ Ash from incinerated material is disposed of as non-contaminated waste 									
	<ul style="list-style-type: none"> ■ There is no waste lying around the grounds 									
	<p>Or If the waste is buried in a pit</p> <ul style="list-style-type: none"> ■ The area is not accessible to other staff, the community, and domestic animals 									
	<ul style="list-style-type: none"> ■ The burial site is lined with a material of low permeability (e.g., The burial site is at least 50 meters away from any water source, and it is located in an area free of floods clay) 									
	<ul style="list-style-type: none"> ■ The pit is about 1 meter square and 2 meters deep 									
	<ul style="list-style-type: none"> ■ The disposed waste is covered with 10–15 cm of soil each day 									
	<ul style="list-style-type: none"> ■ The final layer of soil is 50–60 cm 									
	<ul style="list-style-type: none"> ■ The burial pit last 30–60 days maximum 									
	<ul style="list-style-type: none"> ■ There is no waste lying around the grounds <p>or If the waste is burned</p> <p>The area is not accessible to other staff, the community, and domestic animals</p>									
	<ul style="list-style-type: none"> ■ The waste is burned in a small designated area 									
	<ul style="list-style-type: none"> ■ The waste is transported to the area just before burning 									
	<ul style="list-style-type: none"> ■ During burning, there are flames 									
	<ul style="list-style-type: none"> ■ Person in charge remains with the fire until it is out 									

	<ul style="list-style-type: none"> ▪ A layer of soil is used to cover the burned waste 																		
	<ul style="list-style-type: none"> ▪ The grounds around this area are free of waste 																		

1st VISIT

Total of standards	23
Total observed	
Total Achieved	

2nd VISIT

Total of standards	23
Total observed	
Total Achieved	

3rd VISIT

Total of standards	23
Total observed	
Total Achieved	

Recommendations

Persons who Conducted the Visit

NO OF VISITS	NAME	SIGNATURE	DATE
1st Visit			
2nd Visit			
3rd Visit			

Primary Eye Care

Date: _____

Name and place of Eye Unit: _____

Name and designation of Assessor: _____

Name and designation of person assessed: _____

	RATING				
	GREEN	AMBER	RED	N/A	COMMENTS
ANATOMY OF THE NORMAL EYE					
Primary eye care giver should be able to describe anatomy of the normal eye using schematic eye					
SIMPLE EYE CONDITIONS					
Know a list of simple conditions such as <ul style="list-style-type: none"> • Conjunctivitis • Keratitis/corneal ulcer • Causes of red eye • Trauma to the eye • Refractive error • Complications of traditional eye medicines 					
HISTORY TAKING					
OCULAR HISTORY					
What is the problem?					
Presenting ocular complaint Redness, poor vision, white speck in the eye, eye discharge, eye swelling					
<u>History of presenting ocular complaint</u> When did it occur? Which eye is affected? How did it occur? What treatment has been given? Ask about pain, redness, loss of vision, eye injury, swelling or lump on the eye lids or any abnormality affecting the eye					
<u>Previous ocular history</u> Ocular history of previous or co-existing conditions (eye diseases; trauma; surgeries; use of glasses and at which age the first pair of glasses were prescribed)					

GENERAL MEDICAL HISTORY					
History of other medical problems and what has been done <ul style="list-style-type: none"> (For example hearing and speech impairment, trauma, congenital anomalies, hospitalization, medication used; convulsions, loss of consciousness, febrile illness, blood transfusions, non-ocular surgeries) Immunization history					
NEONATAL HISTORY					
Was baby admitted at birth? Was there any jaundice or medical condition at birth?					
POSTNATAL HISTORY					
<u>Developmental mile stones</u> History is taken routinely for key mile stones (such as age when infant achieved social smile, neck control; reaching/grasping objects, sits, crawling and walking / talking age)					
<u>Family history</u> Taken routinely for eye conditions i.e. any family history of eye problems, specifically eye surgery and blindness					
<u>Main educational milestones</u> School attendance -age of entry, type of school, performance (reason for poor performance should be documented); continuity, appropriate class for age Why not in school if not or if dropped out from school					
CLINICAL EXAMINATION					
<u>General examination</u> Overall physical appearance, pallor, icterus, febrile					
<u>Visual Acuity Taking</u> Techniques appropriate to the mental age of the child have been applied correctly and routinely. Recommended protocol- use a single cut off level of optotypes at 6/12 for unioocular and binocular assessment					
<u>Infants: birth to 18 months</u> <ul style="list-style-type: none"> Object awareness: lighted objects, fixation and following, movement of the eyes while looking at the human face; 					
<u>Toddlers: 18 months to 3 years</u> <ul style="list-style-type: none"> Tumbling E chart 					
<u>Preschool: 3-5 years</u> <ul style="list-style-type: none"> Tumbling E chart 					
<u>School age: 5 plus years</u> <ul style="list-style-type: none"> Distance: Snellens chart, Lea chart 					

<p><u>External eye examination (with pen torch)</u></p> <ul style="list-style-type: none"> • The eye look straight • Eyelids open and close • The white is white • The black circle is black • The transparent part is clear 					
<p><u>Retinal red reflex test (using the Arclight screener)</u></p> <ul style="list-style-type: none"> • Presence or absence of red reflex • Absent red reflex- white reflex or black reflex? 					
PRIMARY LEVEL INVESTIGATION					
<ul style="list-style-type: none"> • Laboratory evaluation done according to hospital guidelines 					
COMMUNICATION					
<ul style="list-style-type: none"> • Across all levels of care (community, primary, secondary, tertiary)- referral book • Availability and able to explain their eye ICE material (prevention and health education of visually impairing conditions) 					
HEALTH INFORMATION MANAGEMENT SYSTEM					
<ul style="list-style-type: none"> • The primary health report form should have filled the number of children with visual problems. This report is sent to their Primary Health Development Agency (PHDA) • The number of COMPLETED referrals per month should be documented • In the record of attendance, there should be age, gender, diagnosis and referral facility 					
LIST OF PROCEDURES					
<ul style="list-style-type: none"> • Eye irrigation • Eversion of the lids • Instillation of eye drops and or ointment • Making of eye pad 					

1st VISIT

Total of standards	23
Total observed	
Total Achieved	

2nd VISIT

Total of standards	23
Total observed	
Total Achieved	

3rd VISIT

Total of standards	23
Total observed	
Total Achieved	

Recommendations

Persons who Conducted the Visit

NO OF VISITS	NAME	SIGNATURE	DATE
1st Visit			
2nd Visit			
3rd Visit			



Post Training Supportive Supervision Tool

SECTION 2A

Pediatric Low Vision Service

Name of participant _____

Designation of participant _____

Name of Assessor _____

Designation of Assessor _____

Name of health facility _____

Ward the health facility is located _____

Primary, secondary, tertiary facility _____

LGA _____

State _____

Instructions: S/he observe the participant performs the various procedures and allot scores as follows:

- ✓ If did this step well
- ✗ If did not do or only partly did this step

	1ST VISIT			2ND VISIT			3RD VISIT		
	✓	✗	COMMENTS	✓	✗	COMMENTS	✓	✗	COMMENTS

Observe if performs the following:
 Entrance examination and preliminary examination:
 Child friendliness

	✓	✗	COMMENTS	✓	✗	COMMENTS	✓	✗	COMMENTS
1. CASE HISTORY									
A. Asks question on onset of visual impairment.									
B. Asks question on previous eye examination									
C. Asks question on previous low vision assessment									

D. Asks question on uptake of low vision devices								
E. Asks question on educational history. Asks question on mode of learning (if patient is in school)								
F. Asks question on mobility, illumination, activities of daily living								
G. Asks question on family oculovisual history.								
H. Asks question on expectation/goal of low vision assessment.								
2. USE OF STRUCTURED HISTORY QUESTIONS TO ASCERTAIN VISUAL FUNCTION								
A. Using a history questions inventory (parent reported) parents identify areas of visual dysfunction								
3. VISUAL ACUITY (VA) ASSESSMENT								
A. Instructs patient on the procedure to be performed.								
B. Instructs patient to occlude the unexamined eye.								
C. Uses age (chronological/mental) appropriate charts to test distance VA								
D. Uses age-appropriate technique to test vision.								
E. Tests vision for distance and near								
F. Tests vision with previous glasses/ LVDs where available								
G. Records VA for each eye. Records distance at which VA was taken								
H. Notes any special consideration when testing VA (e.g. eccentric fixation, head movement etc)								
4. VISUAL FIELD ASSESSMENT.								
Communicates effectively with the patient on procedure								

Performs confrontation test.									
Hand held disc Perimetry:									
Places disc appropriately									
Uses targets suitable for people with low vision.									
Tests each eye separately									
Records result correctly.									
Bjerrum Tangent Screen:									
Performs test at specified distance.									
Uses targets suitable for people with low vision.									
Occludes the unexamined eye.									
Charts the patient's visual field									
Records patient's visual field on recording sheet.									
Repeats for fellow eye.									
Performs the procedure in both eyes									
Automated visual field analyzer:									
Give appropriate instruction to patient.									
Positions the patient comfortably on the VFA.									
Enters patient's information in the computer and select the appropriate test strategy.									
Prints report									
Interprets results									
5. COLOUR VISION ASSESSMENT.									
If using Panel D 15 effectively with the patient on the test to be performed:									
A. Instructs patient on what to do									
B. Displays the discs in random order.									
C. Continues to instruct patient on what to do.									

D. Records the order on the record sheet									
F. Determines the type of colour vision defect based on the result on the record sheet.									
If using Ishihara plate:									
A. Instructs patient on what to do									
B. Uses appropriate plates to determine colour vision.									
C. Records score.									
If using coloured sticks/discs:									
A. Instructs patient on what to do.									
B. Presents coloured sticks/discs of appropriate sizes in the primary colours.									
C. Randomizes order of presenting colours									
D. Records coloured sticks/discs seen by patient.									
5. CONTRAST SENSITIVITY (CS) TEST.									
A. Uses age-appropriate charts for CS test.									
B. Instructs patient on the procedure.									
C. Measures CS.									
B. Records score for each eye.									
6. ASSESSMENT FOR VISUAL PERCEPTUAL DISORDERS									
A. Assessment with the lea mailbox									
B. Assessment with lea rectangles									
C. Assessment with lea puzzle(black/white and coloured)									
7. OCULAR HEALTH EXAMINATION									
A. Carries out a detailed eye examination using the slit lamp biomicroscope									
B. Performs ophthalmoscopy under dim illumination.									

C. Measures IOP where applicable.									
8. OBJECTIVE REFRACTION (CYCLOPLEGIC REFRACTION)									
A. Instructs patient on the procedure to be performed.									
B. Educates care giver and obtains verbal consent to instill cycloplegic agent.									
C. Instills prescribed cycloplegic agent in appropriate dosage.									
D. Digitally occludes punctum while instilling cycloplegic agent.									
E. Wait out the time required for cycloplegic agent to take action.									
F. Dims room illumination to perform retinoscopy.									
G. Determines objective refraction in both principle meridians of the eye (radical retinoscopy where applicable).									
H. Repeats procedure for the fellow eye.									
I. Performs the procedure in both eyes									
J. Records results correctly									
9. SUBJECTIVE REFRACTION									
A. Allows effect of cycloplegia to wear off before attempting subjective refraction.									
B. Uses appropriate pediatric trial frame and full aperture trial lenses.									
C. Determines subjective refraction starting from the objective finding OR									
D. Determines subjective refraction using bracketing technique.									
E. Employs maximum plus to best VA rule.									
F. Records subjective refraction for each eye.									
G. Performs subjective refraction for both eyes									

10. DETERMINES BEST CORRECTED VISUAL ACUITY.									
A. Communicate effectively with the patient on the procedure to be performed.									
B. Patient is wearing the best lens correction obtained from subjective refraction.									
C. Instructs patient to occlude the unexamined eye.									
D. Uses age (chronological/mental)-appropriate charts to test distance VA									
E. Uses age -appropriate techniques to test vision									
F. Tests vision at appropriate test distance (both distance and near VA).									
G. Records VA for each eye and records working distance for near									
H. Records VA for both eyes at distance and near and records working distance for near.									
Determination of magnification requirements.									
11. DETERMINES TELESCOPIC MAGNIFICATION FOR DISTANCE									
A. Uses best corrected distance VA to calculate telescopic magnification requirement to achieve goal acuity.									
12. DETERMINES MAGNIFICATION FOR NEAR DISTANCE.									
A. Uses best correct near VA to determine magnification requirement for: <ul style="list-style-type: none"> • Spectacle magnifier • Hand held magnifier. • Stand magnifier. 									
13. DETERMINES ACHIEVED VISUAL ACUITY WITH LVDS									
A. Instructs patient on the procedure to be performed. (with patient using telescope for distance VA and magnifiers for near VA)									

B. Instructs patient to occlude the unexamined eye.								
D. Uses appropriate charts to test distance VA.								
D. Uses age-appropriate technique to test vision.								
E. Tests vision at appropriate test distance (distance, intermediate and near VA and tasks (where applicable).								
F. Modifies telescopic/near magnification based on visual acuity goal and task								
G. Records VA for both eyes								
14. PRESCRIBING & DISPENSING LVDS								
A. Prescribes appropriate LVDs for distance, intermediate and near vision tasks.								
15. TRAIN PATIENT ON USE OF SELECTED LVDS								
A. Provides training in use of telescope								
B. Provides training in use of selected LVDs for near vision								
16. DETERMINATION OF APPRIOPRIATE NON-OPTICAL AIDS								
A. Prescribes appropriate non optical devices for distance, intermediate and near vision tasks.								
17. IDENTIFICATION OF APPRIOPRIATE VISUAL SUPPORT STRATGEIS IN RESPONSE TO STRUCTURED HISTORY QUESTIONS INVENTORY FOR VISUAL PERCEPTION PROBLEMS								
A. Selection of appropriate visual support strategies by care givers and implementation								

18. COUNSELLING OF CHILD/ CARE-GIVER								
A. Counsels patient/care-giver on cause and implication of visual impairment.								
B. Counsels patient/care-giver on available options for visual enhancement.								
C. Counsels patient/care-giver on care and use of LVDs.								
D. Counsels patient/care-giver on limitations of LVDs								
E. Counsels care-givers on implementing visual support strategies for visual perceptual disorders								
19. REFERRAL								
A. Refers child for rehabilitation Yes/No. If Yes,why?								
20. FACILITATES ACCESS TO PRESCRIBED LVDS								
A. Orders LVDs with the specified magnification and other specifications								
B. Communicates next appointment date and purpose to patient/care giver								
21. VERIFIES ORDERS WHEN RECEIVED								
Observe if optometrist / dispensing optician:								
A. Verifies the ordered LVDs when received.								
B. Instructs patient on use and care of LVDs								
C. Dispenses LVDs								
D. Provides written instruction on the care and use of LVDs								
E. Documents patient has received LVDs.								
F. Gives instruction on follow up visit								

22. USE OF NON-OPTICAL ADDS									
A. Encourage the provision and use of non-optical aids									
23. FOLLOW UP VISIT									
A. Evaluates patient feedback on use of LVDs.									
B. Addresses patients concerns (when reported) on the use of LVDs.									
C. Asks questions on success/ challenges/failure in use of LVDs.									
D. Assesses LVDs to determine whether they are intact.									
E. Records VA (distance and near) with LVDs.									
F. Notes any defect in LVDs.									
G. Determines cause for failure (if reported).									
H. Addresses cause of failure.									
I. Reinforce use of LVDs.									
J. Reinforce instruction on use and care of LVDs.									
K. Reinforce counseling on limitations of LVDs.									
L. Reasses visual function and expands on choices of non-optical aids									
M. Encourage the application of new visual support stratgeis and reinforcement of old ones.									
24.INTEGRATION INTO EDUCATION									
A. Trace and ensure child is in an early intervention programme, a speical scool or a main stream school									
B. Follow up assessment in health facility is performed at least yearly									
C. Home visits are performed at least yearly.									

25. CHILD FRIENDLINESS								
A. Welcomes the child with a smile and in a friendly manner.								
B. Rooms are well lighted and wall colorfully designed and painted								
C. Floor is well carpeted and clean								
D. Have child-friendly toys in the room.								
E. Presents procedures as a game with the child.								
F. Explains procedure to the child and make procedure less threatening								
G. Constantly reassures the child that everything will be okay.								

VISIT NUMBER (1ST, 2ND, 3RD ETC.)

Total of standards	
Total observed	
Total Achieved	

Based on the scores, work with the health care provider to develop a remedial plan using the action plan table.

NAME _____

DESIGNATION _____

SIGNATURE _____

DATES _____

KEY ISSUES RAISED _____

VISIT NUMBER (1ST, 2ND, 3RD ETC.)

Total of standards	
Total observed	
Total Achieved	

Based on the scores, work with the health care provider to develop a remedial plan using the action plan table.

NAME _____

DESIGNATION _____

SIGNATURE _____

DATES _____

KEY ISSUES RAISED _____

VISIT NUMBER (1ST, 2ND, 3RD ETC.)

Total of standards	
Total observed	
Total Achieved	

Based on the scores, work with the health care provider to develop a remedial plan using the action plan table.

NAME _____

DESIGNATION _____

SIGNATURE _____

DATES _____

KEY ISSUES RAISED _____

After the third visit, the provider should be certified as competent. Those certified should be handed over to the supervision team to be provided with quarterly supportive supervision. During this process, the provider attains proficiency. If after the third visit the provider is still unable to perform procedures correctly, then the provider should not be certified.

SECTION 2B

Pediatric Refraction

Name of participant _____

Designation of participant _____

Name of Assessor _____

Designation of Assessor _____

Name of health facility _____

Ward the health facility is located _____

Primary, secondary, tertiary facility _____

LGA _____

State _____

Instructions: S/he observe the participant performs the various procedures and allot scores as follows:

- ✓ If did this step well
- ✗ If did not do or only partly did this step

STEPS/ PROCESS	1ST VISIT			2ND VISIT			3RD VISIT		
	✓	✗	COMMENTS	✓	✗	COMMENTS	✓	✗	COMMENTS
	✓	✗	COMMENTS	✓	✗	COMMENTS	✓	✗	COMMENTS
1. PERFORMS AGE-APPROPRIATE CASE HISTORY & DETERMINES VISUAL ACUITY									
A. Ask question relating to birth history.									
B. Ask question about age-appropriate milestones									
C. Ask question on presenting complaints									
D. Ask question on onset of visual symptom.									
E. Ask questions on duration									
F. Ask questions on allergies (ocular, systemic and drugs taken).									

G. Ask questions on previous action taken									
H. Ask question on previous eye examination and actions recommended and taken.									
I. Ask questions on use of herbs and other unorthodox practices.									
J. Ask question on family history of ocular and systemic disease.									
" Evaluation of vision Birth–6 months"									
A. Checks presence of cornea (blink) reflex									
B. Checks for pupillary response.									
C. Checks for defensive blink									
6 months – 2.5 years									
A. Performs preferential looking tests (Lea grating paddles, optokinetic nystagmus).									
2.5 – 5 years									
A. Measures VA using age- and developmental appropriate techniques and charts (symbols, direction, matching tests).									
B. Present single symbols of logMAR charts									
C. Notes the preferred response of the child (pointing, matching, showing direction or saying it loud).									
D. Tests both eyes before individual eye.									
E. Tests near VA using appropriate techniques and charts.									
F. Notes age-appropriate VA standard.									
G. Tests VA at age- and chart-appropriate distance									
I. Test performed under appropriate illumination									
J. Does not use mirror reflection									

2. PERFORMS EXTRAOCULAR MUSCLES ASSESSMENT									
A. Performs Hirschberg test									
B. Performs Krimsky test.									
C. Performs Bruckner's test.									
D. Estimates magnitude of ocular deviation.									
E. Performs unilateral cover test.									
F. Performs alternate cover test									
G. Notes the presence and magnitude or absence of ocular deviation									
3. MEASURES GLARE SENSITIVITY									
A. Determines glare sensitivity test using brightness acuity test (BAT).									
4. PERFORMS OCULAR HEALTH EXAMINATION									
A. Performs ophthalmoscopy under dim illumination									
B. Measures IOP where applicable.									
C. Carries out a detailed eye examination using the slit lamp biomicroscope.									
5. PERFORMS COLOUR VISION ASSESSMENT									
If using Panel D 15									
A. Instructs patient on what to do									
B. Displays the discs in random order.									
C. Continues to instruct patient on what to do.									
D. Records the order on the record sheet									
E. Determines the type of colour vision defect based on the result on the record sheet.									
If using Ishihara plate:									
A. Instructs patient on what to do									

B. Uses appropriate plates to determine colour vision.									
C. Records score.									
If using coloured sticks/discs:									
A. Instructs patient on what to do.									
B. Presents coloured sticks/discs of appropriate sizes in the primary colours.									
C. Randomizes order of presenting colours									
D. Records coloured sticks/discs seen by patient.									
Paper coloring/matching game									
Assesses colour vision using colour matching or paper colouring									
6. VISUAL FIELD ASSESSMENT									
A. Communicates effectively with the patient on procedure									
B. Performs confrontation test.									
"Amsler grid									
A. Uses Amsler chart to test central visual field"									
Hand held disc perimetry									
A. Places disc appropriately.									
B. Uses targets suitable for people with low vision									
C. Tests each eye separately									
D. Records result correctly									
Bjerrum Tangent Screen									
A. Performs test at specified distance									
B. Uses targets suitable for people with low vision									
C. Occludes the unexamined eye.									
D. Charts the patient's visual field									
E. Records patient's visual field on recording sheet.									

F. Repeats for fellow eye									
Automated visual field analyzer									
A. Give appropriate instruction to patient.									
B. Positions the patient comfortably on the VFA									
C. Enters patient's information in the computer and select the appropriate test strategy									
D. Dims room illumination									
E. Performs automated perimetry									
F. Prints report									
G. Interprets results									
7. PERFORMS CONTRAST SENSITIVITY (CS) TEST									
A. Uses age-appropriate charts for CS test.									
B. Instructs patient on the procedure									
C. Measures CS.									
D. Records score for each eye.									
8. ASSESSMENT FOR STEREOPSIS									
A. Instructs patient on the procedure									
B. Measures stereopsis.									
9. PERFORMS OBJECTIVE REFRACTION (CYCLOPLEGIC REFRACTION)									
A. Instructs patient on the procedure to be performed.									
B. Educates care giver and obtains verbal consent to instill cycloplegic agent.									
C. Considers hypersensitivity risk and takes appropriate/ alternative action.									
B. Considers duration of action of cycloplegia and recovery from cycloplegia.									
E. Instills local anaesthetic.									

F. Instills prescribed cycloplegic agent in appropriate dosage and timing.									
G. Digitally occludes punctum while instilling cycloplegic agent.									
H. Wait out the time required for cycloplegic agent to take action.									
I. Determines the cycloplegia is complete as determined by pupil dilation and inability to read prints.									
J. Appropriate room illumination to keep the child at ease.									
K. Use appropriate fixation target									
L. Uses appropriate fixation distance for the technique employed.									
M. Determines objective refraction in both principle meridians of the eye.									
N. Uses appropriate pediatric trial frame and full aperture trial lenses.									
O. Repeats procedure for the fellow eye.									
P. Records results correctly.									
10. PERFORMS SUBJECTIVE REFRACTION									
A. Uses appropriate pediatric trial frame and full aperture trial lenses.									
B. Modifies cylindrical component of the wet refraction.									
C. Records subjective refraction for each eye.									
11. PRESCRIBES SPECTACLE CORRECTION									
A. Considers age.									
B. Considers symptoms (VA and near stereopsis).									
C. Considers accommodative and learning problems.									
D. Considers family history of refractive error.									

E. Uses the table for age and symptom guideline for prescribing spectacle correction									
12.REFER TO OPHTHALMOLOGIST BASED ON CRITERIA FOR REFERRALS									

VISIT NUMBER (1ST, 2ND, 3RD ETC.)

Total of standards	
Total observed	
Total Achieved	

Based on the scores, work with the health care provider to develop a remedial plan using the action plan table.

NAME _____

DESIGNATION _____

SIGNATURE _____

DATES _____

KEY ISSUES RAISED _____

VISIT NUMBER (1ST, 2ND, 3RD ETC.)

Total of standards	
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Total Achieved	

Based on the scores, work with the health care provider to develop a remedial plan using the action plan table.

NAME _____

DESIGNATION _____

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DATES _____

KEY ISSUES RAISED _____

VISIT NUMBER (1ST, 2ND, 3RD ETC.)

Total of standards	
Total observed	
Total Achieved	

Based on the scores, work with the health care provider to develop a remedial plan using the action plan table.

NAME _____

DESIGNATION _____

SIGNATURE _____

DATES _____

KEY ISSUES RAISED _____

After the third visit, the provider should be certified as competent. Those certified should be handed over to the supervision team to be provided with quarterly supportive supervision. During this process, the provider attains proficiency. If after the third visit the provider is still unable to perform procedures correctly, then the provider should not be certified.

SECTION 3

Primary Eye Care Services

Name of participant _____

Designation of participant _____

Name of Assessor _____

Designation of Assessor _____

Name of health facility _____

Ward health facility is located _____

Primary, secondary, tertiary facility _____

LGA _____

State _____

Instructions: S/he observe the participant performs the various procedures and allot scores as follows:

- ✓ If did this step well
- ✗ If did not do or only partly did this step

Observe if the Primary Health Care (PHC) Worker performs the following:

STEPS/ PROCESS	1ST VISIT			2ND VISIT			3RD VISIT		
	✓	✗	COMMENTS	✓	✗	COMMENTS	✓	✗	COMMENTS
	✓	✗	COMMENTS	✓	✗	COMMENTS	✓	✗	COMMENTS
1. ASSESSING WHETHER A PATIENT HAS AN EYE PROBLEM									
"Finds a space that is properly lit Seats the child comfortably Explains to the child and parents that they are going to examine their eyes Looks at each eye."									
A. The white should be white (with a few red veins)									
B. The black should be black									
C. The eyes should be the same size									
D. The eyes should look straight ahead									

E. Asks the person to close their eyes								
F. The lids should open and close normally (lashes should face outwards, not inwards, lids should be smooth)								
G. Record what you see in the patient's eyes								
2. MANAGING A PERSON WITH AN EYE PROBLEM (CHOOSING THE CORRECT ALGORITHM)								
Seats the child comfortably in a space with good light								
Greets the child warmly and records name, age, sex and date								
Asks the parent/care giver "Why did you come and see me?"								
Whether the patient reports any pain, redness, loss of vision, eye injury, swellings or lumps on their lids or any other complaints								
Explains to the person that they are going to examine their eyes								
Checks whether the patient is a child aged less than 5 If YES, uses algorithm 5 and examines as outlined below								
Determines whether the patient reports an injury (blow, foreign body, burn) If YES uses algorithm 4 Examination protocol for all patients 1. Tests and record distance vision (except for small children) If abnormal uses algorithm 1								
Tests and record vision, If abnormal uses algorithm 1								
Checks and records if the white of the eye is white (with a few red veins) If NOT then uses algorithm 2								
Checks and records if the black of the eye is black If NOT then uses algorithm 1 or 2								
Checks and records if the eyes are the same size If NOT uses algorithm 3								

Checks and records if both eyes look straight ahead If NOT uses algorithm 3								
Checks and records if the lids open and close normally (the lashes should face outwards, not inwards, lids should be smooth with no swelling and the eyelashes clean) If NOT uses algorithm 3								
Selects the correct algorithm option for this patient and goes through it until a management decision is reached								
Carries out the management plan indicated by the algorithm (e.g. immediate treatment or referral)								
3. MEASURING DISTANCE VISION								
Stands next to the patient and gives clear and concise instructions								
Checks that the patient understands the principle of the Es in the Tumbling E chart								
If the person has spectacles for distant viewing they should be wearing them								
Stands at the correct distance (3m away)								
Tests the right eye.								
Tells the patient: -"Cover your left eye and show me the direction of the arms of this letter E" A. Makes sure the other eye is properly covered								
B. Points to the 6/60 E without obscuring it								
C. If the person cannot see the 6/60 E, records "R cannot see 6/60"								
D. If the person can see the 6/60 E, tests with the 6/12 E								
E. If the person cannot see at least 4 of 6/12 Es, records "R can see 6/60, cannot see 6/12"								
F. If the person can see at least 4 of 6/12 Es, records "R can see 6/12"								

G. Now tests the left eye. Tells the patient: "Cover your right eye and show me the direction of the arms of this letter E"								
H. Records vision accurately for each eye								
I. Interprets distance vision measurement correctly as either normal (can see 6/12 with both R and L eye) or abnormal (cannot see 6/12 or 6/60 with R or L or both eyes)								
4. INSTILLING EYE MEDICATION (DROPS AND OINTMENT)								
Seats the child comfortably								
The trainee washes his or her hands before doing anything else								
Checks that the medication is correct and has not expired								
Explains to the patient what they are going to do: asks the patient to tilt their head backwards and look up								
Gently pulls down the patient's bottom eyelid with the index finger								
Puts drops in right eye and ointment in left eye without touching the eye or lids								
Asks the person to close their eyes (and press gently with one finger over the corner of the eye next to the nose for few moments if drops have been instilled)								
Wipes away excess drops or ointment								
Records information about the eye medication administered								
Asks the patient to rate their degree of gentleness (1 to 10) (1 "too rough!" to 10 "almost didn't feel it")								
5. APPLYING EYE PAD								
Seats the child comfortably								
The trainee washes his or her hands before doing anything else Making and securing an eye pad Places the cotton wool between the two pieces of gauze								

Cuts the cotton wool and gauze into an oval shape measuring approximately 5 × 6 cm									
Applies a piece of adhesive tape, about 15cm long, to the eye pad									
Asks the patient to close both eyes									
Positions the eye pad diagonally over the closed lids, secures the tape to the forehead and cheek									
Applies a second and third piece of tape Making and securing an eye shield Makes a circle with a single cut towards the center, i.e. half the diameter of the circle, and uses adhesive tape to make a cone									
Applies the shield by attaching two pieces of tape to the cone									
Asks the patient to rate their degree of gentleness (1 to 10) (1 "too rough!" to 10 "almost didn't feel it")									
6. APPLYING A WARM COMPRESS									
Seats the person comfortably									
The trainee washes his or her hands before doing anything else									
Rinses a clean cloth with hot water									
Avoids excessively hot compresses (in order to avoid scalding, particularly in children)									
Holds it to the affected eye for 5–10 minutes									
Asks the patient to repeat the procedure three to four times daily until the lump is gone									
Asks the patient to rate the hotness of the compress (1 to 10) (1 "too hot" to 10 "too cold")									
7. EVERTING AN EYELID									
Asks the patient to look down With one hand, holds the eyelashes of the upper eyelid between thumb and index finger With the other hand, places a cotton bud or paper clip or other small blunt object midway from the eyelid margin.									

Turns up the eyelid against steady and gentle pressure on the upper eyelid								
On completion of the examination and removal of the foreign body, asks the patient to look up so that the eyelid can return to its normal position								
8. IRRIGATING AN EYE								
Instils local anaesthetic eye drops if available								
With the patient sitting or lying down, protects the patient's neck and shoulders with the waterproof sheet or towel								
If a chemical burn affects one eye only, tilts the patient's head so that the irrigation water does not flow into the other eye								
Spreads open the eyelids. Pours the fluid slowly and steadily, from a distance of no more than 5cm · onto the front surface of the eye · inside the lower eyelid · under the upper eyelid (everts the upper eyelid)								
Asks the patient to move the eye continuously in all directions Irrigates for at least 15 minutes, 30 minutes is better								
Checks and records visual acuity when the procedure is finished								
9. REMOVING A FOREIGN BODY								
Explains the procedure, advising the patient that they may experience a brief increase in discomfort but that it is important to relax and keep still								
Reassures and encourages the patient by stressing that relief should be felt immediately once the FB is removed								
Instils a drop of local anaesthetic if available								
Examines the eye to establish whether there is a foreign body on the white of the eye. Uses the moistened tip of cloth or cotton bud to remove the foreign body								

If nothing can be seen, everts the eyelid to check where there is a foreign body on the inside of the lid. With a gentle upward movement, removes the foreign body using a moistened cotton bud								
Shows the foreign body to the patient in order to reassure them that it has been removed, and asks them to return if they are still in discomfort the next day								
Refers the patient If the foreign body cannot be removed or is on the black of the eye								
10. COUNSELLING								
Creates a trusting relationship during the first part of the consultation:								
Greets the child and the parents/ caregiver								
Uses a polite form of address								
Listens without interrupting when the parent/ care giver recounts the history, appears unhurried								
Uses language the parent/ care giver understands								
Determines what the parent/care giver expect from the consultation								
Clearly explains to the parent/care giver what he or she intends to do (i.e. management)								
Describes the plan for managing the current problem and mentions health promotion and lifestyle issues if relevant								
Tries to link his or her management plan to the expectations of the parents/ care giver								
Asks the parent/ care giver for their views or questions about the child's management plan								
Allows the parent/care giver to have the final word about the management plan								
Comes to a joint agreement on the decision made								

Records the agreement clearly on the patient's chart and notes what the parent/care giver has agreed to do and what he or she intends to do								
Explains how to use the medication if provided, making the instructions easy to remember								
Explains when to return for follow-up or how to attend a referral appointment								
11. GOOD REFERRAL PROCESS								
Referral note Enters patient details: patient name, age, sex and address, and date of referral								
Enters referral facility details: name, telephone number of referral clinic and name of referral person								
Provides information about the eye condition: patient's complaint, details of eye assessment and vision, details of what was done or prescribed, or not done. Explanation: Tells the patient why they need to be seen by a specialist eye care provider								
Insists firmly but gently on the seriousness of the condition								
States whether the referral is urgent, requiring immediate medical attention or whether it can be undertaken at their convenience								
Mentions the benefits of attending and risks of not attending the referral appointment								
Specifies where and when the specialist eye care provider is available and the approximate cost								
Explains if a treatment has been started that it is not definitive								
Asks directly "Which questions do you have?" and provides the information required								

Requests feedback about the referral, so that follow-up care can be provided, and confirms that management and referral were correct. (If referral was inappropriate the trainee can learn from this experience, improving assessment and management next time.)								
12. PREPARING A GOOD HEALTH TALK								
Building a good relationship Introduces her or himself								
Uses appropriate forms of address when speaking to group members								
Is friendly and polite								
Is familiar with and sympathetic to group members' situation and problems								
Respects and tries to understand group members' beliefs								
Doesn't blame or condemn group members								
Doesn't appear to be in a hurry								
Praises enterprising effects by group members								
Listens without interrupting when group members are speaking								
Is honest about her or his opinions Making the message clear First finds out what other group members know								
Presents just enough facts and detail ("must knows") to make the message clear								
Presents facts in a logical way								
Uses familiar words and avoids jargon								
Uses short, simple sentences								
Gives the impression of knowing what he or she is talking about								
Seeks questions, interacts with group members, encourages their participation								

Uses two-way communication to make sure the messages are understood								
Uses relevant visual aids in an appropriate way								
Admits to not knowing when appropriate, and promises to rectify areas of ignorance								
Ensures that all group members have understood the talk								
Ensures that the concluding message is accepted by all group members								
13. CHILD-FRIENDLINESS								
Welcomes the child with a smile and in a friendly manner.								
Explains procedure to the child and make procedure less threatening								
Constantly reassures the child that everything will be okay.								

VISIT NUMBER (1ST, 2ND, 3RD ETC.)

Total of standards	
Total observed	
Total Achieved	

Based on the scores, work with the health care provider to develop a remedial plan using the action plan table.

NAME _____

DESIGNATION _____

SIGNATURE _____

DATES _____

KEY ISSUES RAISED _____

VISIT NUMBER (1ST, 2ND, 3RD ETC.)

Total of standards	
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Based on the scores, work with the health care provider to develop a remedial plan using the action plan table.

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DATES _____

KEY ISSUES RAISED _____

VISIT NUMBER (1ST, 2ND, 3RD ETC.)

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KEY ISSUES RAISED _____

After the third visit, the provider should be certified as competent. Those certified should be handed over to the supervision team to be provided with quarterly supportive supervision. During this process, the provider attains proficiency. If after the third visit the provider is still unable to perform procedures correctly, then the provider should not be certified.

SECTION 4

Infection Prevention

Name of health facility _____

Ward health facility is located _____

Primary, secondary, tertiary facility _____

LGA _____

State _____

Instructions: S/he observe the participant performs the various procedures and allot scores as follows:

- ✓ If did this step well
- ✗ If did not do or only partly did this step

STEPS/ PROCESS	1ST VISIT			2ND VISIT			3RD VISIT		
	✓	✗	COMMENTS	✓	✗	COMMENTS	✓	✗	COMMENTS

Observe the following areas:

Child eye health procedure room

Operating Theatre

Areas for cleaning the instruments (central supply and sterilization department [CSSD])

Toilets in the relevant area of the clinic

Toilets in the Theatre

Observe the following in these areas:

	✓	✗	COMMENTS	✓	✗	COMMENTS	✓	✗	COMMENTS
Syringes with needles are disposed of immediately after use, following decontamination with a 0.5% chlorine solution, without being recapped and without being taken apart									
Containers are closed and collected when three-quarters full									
Each sharps container is used only once and is discarded when three-quarters full									
The concentration and use of antiseptics (for skin and/or mucous membrane preparation) are correct.									

Consumable materials available:									
A. Antiseptics: - Chlorhexidine (solution)									
B. Alcohol, 60–90% (methylated spirit)									
C. Disinfectants: Sodium hypochlorite (bleach)									
D. Ethyl alcohol or isopropyl alcohol (60%–90%), or									
E. Cetrimide and chlorhexidine gluconate (2%–4%) (e.g., Savlon®), or - Chlorhexidine gluconate (2%–4%) (e.g., Hibiclens®,									
The reusable containers are thoroughly washed with soap and water, rinsed with clean water, and dried before refilling.									
Reusable containers are labelled with date each time they are refilled.									
Gauze or cotton wool is stored in dry containers without an antiseptic									
Instruments and other items are stored in dry containers without antiseptics									
Pick-up forceps are stored in dry containers without antiseptics									
The concentration of chlorine solution is 0.5%: Liquid chlorine: - If using a concentration of 3.5%, uses 1 part bleach for 6 parts water, OR - If using a concentration of 5%, uses 1 part bleach to 9 parts water									
A new chlorine solution is prepared at the beginning of each day or sooner if needed									
Plastic containers are used for decontamination									
Instruments and other items are soaked in the 0.5% chlorine solution for 10 minutes									
After 10 minutes, instruments and other items are removed from the chlorine solution and cleaned immediately									

There is an area designated for processing instruments with proper traffic flow to avoid cross - contamination									
A. This area is separated from the procedure areas									
B. Dirty and clean items do not have contact									
C. There is a receiving counter for dirty items									
D. There is at least one sink with running water for washing instruments									
E. There is a counter for instruments to dry If instruments are wrapped/packed in this area:									
F. There is a clean work area for wrapping/packing instruments with: <ul style="list-style-type: none"> • A work table • Shelves for holding clean packages • Office desk for record keeping 									
Observe whether staff:									
A. Wears: - Utility gloves - Mask and eyewear protection or face shield <ul style="list-style-type: none"> • Plastic apron • Rubber boots or enclosed shoes (for theatre) 									
B. Utilizes: <ul style="list-style-type: none"> • Soft brush • Detergent (liquid or powder) 									
C. Scrubs instruments and other items under the surface of water, completely removing all blood and other foreign matter									
D. Disassembles instruments and other items with multiple parts, and cleans in the grooves, teeth, and joints with a brush									
E. Rinses the instruments and other items thoroughly with clean water									
F. Allows instruments and other items to air-dry, or dries with a clean towel									

G. Washes hands after removing gloves and other personal protective equipment: -								
H. Washes hands with running water and soap for 10–15 seconds and dries with an individual clean towel, paper towel or allows hands to air-dry, OR Rubs hands with 3–5 ml of an alcohol-based solution until the hands are dry (if hands are not visibly soiled)								
I. Rubs hand with antiseptic hand sanitizers after screening a child or performing procedures.								
Observe during the HLD cycle if the standard conditions listed below are followed: If boiling: A. All cleaned, disassembled instruments are totally immersed in water before lid is closed								
B. The lid is closed								
C. Instruments are boiled for 20 minutes starting from the time a rolling boil begins								
D. After 20 minutes, instruments are removed with HLD or sterile forceps or gloves, dried, and stored in HLD containers AND/OR If chemical:								
E. Glutaraldehyde (2–4%), formaldehyde (8%), or 0.1% chlorine solution (prepared with boiled or sterile water): -								
F. All cleaned, disassembled instruments are immersed in solution for 20 minutes in a container with a lid -								
G. There is a label on the container indicating the starting time of HLD - There is a label on the container indicating the date of reconstitution, and it is within 14 days if using glutaraldehyde, 28 days if using formaldehyde or within 24 hours,								

H. If using chlorine solution - After 20 minutes, instruments are removed with								
HLD or sterile forceps or gloves, rinsed with sterile or boiled water, dried, and stored in HLD containers								
Observe during the packaging process if:								
A. The instruments are clean and dry If packaging items to be sterilized through steam sterilization (autoclave):								
B. Cloth items have been laundered, dried, and are intact (have no holes)								
C. All jointed instruments are opened or in unlocked position								
D. All instruments are disassembled								
E. The types of materials used for wrapping are: <ul style="list-style-type: none"> • Cloth wraps, muslin, or cotton: double wrapping • Paper (Kraft or other Paper): double wrapping 								
F. If using paper, it is used only once and discarded (it is not reused)								
G. Canvas or other waterproof material is never used for wrapping AND/OR If packaging items to be sterilized through dry-heat:								
H. The types of materials used are: - Cloth wraps, muslin: double wrapping OR Metal containers with lids <ul style="list-style-type: none"> • Wrapped/packed instruments are sent for sterilization 								
Observe whether:								
A. Soiled linen is collected in leak-proof containers without being presoaked or washed in the ward								

B. Workers wear utility gloves when collecting soiled linen								
C. Linen is sent to the laundry in closed containers (buckets, plastic bags or carts) for sorting, washing, and drying								
Medical waste (e.g., cotton wool, gauze, etc):								
A. Medical waste is placed in a washable container with a leak-proof plastic bag								
B. Containers are closed and collected when three quarters full								
Verify if the disinfectant cleaning solution is prepared properly in each of the following areas:								
A. Eye clinic procedure room b. Operating Theatre								
B. 0.5% chlorine solution is prepared								
C. Detergent that does not contain an acid, ammonia, or ammonium is added to the 0.5% chlorine solution until a mild soapy cleaning solution is made								
D. Observe in the following areas if the mops, buckets, brushes and cleaning cloths are: <ul style="list-style-type: none"> • Eye health procedure room. • Operating Theatre 								
E. Decontaminated by soaking for at least 10 minutes in 0.5% chlorine solution or other approved disinfectant after use								
F. Washed in detergent and water after use								
G. Rinsed in clean water								
H. Dried completely before reuse or storage								
Verify with the person responsible for the waste management if:								
A. There is a written plan for waste management including: - Segregation at point of use - Transportation - Interim storage - Final disposal								
Observe if:								
A. There are sufficient dustbins outside the health facility (in the grounds) for general waste to avoid littering								

B. The grounds (outside the health facility) are clean									
Observe during the visit, if:									
A. Housekeeping personnel wear personal protective equipment when handling medical waste: <ul style="list-style-type: none"> • Utility gloves • Rubber boots • Plastic apron • Masks covering nose and mouth 									
B. Disposable personal protective equipment (examination gloves, surgical masks) are decontaminated in 0.5% chlorine solution (if applicable) and disposed in a leak-proof container after use									
C. Re-usable personal protective equipment (e.g., utility gloves, gumboots, plastic apron, face shield) are reprocessed after use: <ul style="list-style-type: none"> • Decontaminated in 0.5% chlorine solution • Washed with soap and water • Dried and stored 									
Observe if housekeeping staff performs hand hygiene after handling waste and removing gloves:									
A. Wash hands with running water and soap for 10–15 seconds and dry with an individual clean towel, paper towel or allow hands to air dry, or									
B. Rub hands with 3–5 ml of an alcohol-based solution until the hands are dry (if hands are not visibly soiled)									
Observe if:									
A. The traffic in the interim storage area is controlled (accessible only to the in-charge personnel)									
B. Containers are leak-proof and closed with tight lids									
C. The interim storage area is free of waste on the ground									
D. All waste is inside of the containers									

<p>Verify with the manager if:</p> <p>A. There is a written plan for a short term storage: maximum two days, and cleaning of storage area and containers</p>									
<p>B. Waste is transported in vehicles or containers used only to transport waste</p>									
<p>C. Vehicles transporting waste have a cover or tarp/tarpaulin to prevent waste from littering during transport.</p>									
<p>Verify if:</p> <p>A. Contaminated waste is disposed of on-site through: - incinerating, or - burying, or - burning in a closed pit</p>									
<p>Verify if:</p> <p>A. Non-contaminated waste is disposed of on-site through:</p> <ul style="list-style-type: none"> • incinerating, • burying, • burning in a closed pit <p>OR</p> <p>Non-contaminated waste is sent offsite (municipal waste or sanitary landfill)</p>									
<p>Verify, if the waste is incinerated, whether:</p> <p>A. The traffic in this area is controlled and accessible only to the in-charge personnel</p>									
<p>B. During incineration, there are flames</p>									
<p>C. Ash from incinerated material is disposed of as non-contaminated waste</p>									
<p>D. There is no waste lying around the grounds Or If the waste is buried in a pit</p>									
<p>E. The area is not accessible to other staff, the community, and domestic animals</p>									
<p>F. The burial site is lined with a material of low permeability</p>									
<p>G. The burial site is at least 50 meters away from any water source, and it is located in an area free of floods clay)</p>									
<p>H. The pit is about 1 meter square and 2 meters deep</p>									

I. The disposed waste is covered with 10–15 cm of soil each day								
J. The final layer of soil is 50–60 cm								
K. The burial pit last 30–60 days maximum								
L. There is no waste lying around the grounds								
OR								
If the waste is burned:								
A. During incineration, there are flames								
B. Ash from incinerated material is disposed of as non-contaminated waste								
C. There is no waste lying around the grounds Or If the waste is buried in a pit: a								
D. The area is not accessible to other staff, the community, and domestic animals								
E. The burial site is lined with material of low permeability (e.g., clay)								
F. The burial site is at least 50 meters away from any water source, and it is located in an area free of floods								
G. The pit is about 1 meter square and 2 meters deep								
H. The disposed waste is covered with 10–15 cm of soil each day								
I. The final layer of soil is 50–60 cm								
J. The burial pit last 30–60 days maximum:								
K. There is no waste lying around the grounds								
OR								
If the waste is burned:								
A. The area is not accessible to other staff, the community, and domestic animals								
B. The waste is burned in a small designated area								
C. The waste is transported to the area just before burning								
D. During burning, there are flames								

E. Person in charge remains with the fire until it is out									
F. A layer of soil is used to cover the burned waste									
G. The grounds around this area are free of waste									

VISIT NUMBER (1ST, 2ND, 3RD ETC.)

Total of standards	
Total observed	
Total Achieved	

Based on the scores, work with the health care provider to develop a remedial plan using the action plan table.

NAME _____

DESIGNATION _____

SIGNATURE _____

DATES _____

KEY ISSUES RAISED _____

VISIT NUMBER (1ST, 2ND, 3RD ETC.)

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SECTION 5

Structures, Utilities and Job Aides

Name of health facility _____

Primary, secondary, tertiary facility _____

Ward health facility is located _____

LGA _____

State _____

For each item, mark whether the item is available and whether it is in satisfactory condition at the facility. Please use the comments box to provide additional information.

Please mark a an **X** for appropriate response.

ITEM	AVAILABLE	NOT AVAILABLE	REMARKS
Trained Eye Health Care Workers are available in the facility			
Number			
Category			
Water Supply			
Is there running water			
What is the source of water			
Infection Prevention Corner and Equipment			
Hand Washing Practice in place or Hand Sanitizers in use.			
Toilet facility or latrine			
Availability			
Cleanliness			
Light source			
Electricity			
Generator			
Others			

Emergency light source			
Telephone			
Eye Clinic space			
Adequate counselling space			
Waiting area (adequate chairs)			
Child Friendly Space			
Well equipped			
Eye Operating Theatre			
Clean			
Space adequate			
Specialized equipment for paediatric care			
Eye Health Job Aides and IEC Materials			
Storage area for Eye health medications, consumables and other supplies			
Refuse disposal bin with lid			

ITEM	AVAILABLE	NOT AVAILABLE	REMARKS
Eye Health Equipment are available for eye examination			
Referral Tools			
Registers			
Child Protection and Child Safeguarding Policy			

VISIT NUMBER (1ST, 2ND, 3RD ETC.)

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Total observed	
Total Achieved	

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DESIGNATION _____

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DATES _____

KEY ISSUES RAISED _____

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SECTION 6

Action Plan Development

Name of participant _____

Designation of participant _____

Name of health facility _____

Primary, secondary, tertiary facility _____

LGA _____

State _____

Date developed _____

Date reviewed _____

The action plan chart will provide a clear and concise way forward for bridging quality gaps identified and can be used for monitoring progress made since the last visit.

On first visit, develop the action plan based on present findings. If a revisit, review the level of the previous action plans implementation and also the gaps identified during this present visit. Synthesize information and use outcome to review /and or update action plans.

ISSUE	CAUSE/ REASON	INTERVENTION/ SOLUTIONS	RESOURCES	PERSON(S) RESPONSIBLE	DATE OF COMPLETION	REVIEW NOTES

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Design and Print by UPSHOT MEDIA LIMITED
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