

COMMUNICATION SESSION B

THE WAYS FOR IMPROVING THE QUALITY OF EDUCATION OF PH WORKFORCE

Stojgniew J. Sitko, PhD., mxsitko@cyf-kr.edu.pl
Katarzyna Czabanowska, MSc.
Institute of Public Health, Fac. of Health Protection,
Medical College, Jagiellonian University

Purpose

The main purpose of this presentation is an analysis of the most important factors influencing the quality of training of PH professionals using the input-process-output system model of educational institutions such as SPH.

Introduction

Nowadays the process of change and dynamic development of Public Health (PH) sector results in the emergence of new challenges for PH professionals. This comes along with the current EU policy directed towards enhancing quality in the higher education sector (Copenhagen Declaration, Nov., 2002). This also reflects the perceived needs of different key stakeholders: universities, employers, students and graduates. According to the Lisbon Strategy (March, 2000) special emphasis is to be put on vocational training: access to education, lifelong learning and mutual recognition of diplomas and certificates acquired in different European educational settings.

Methods and materials

There is a number of different approaches towards the QI of education. Using the system model of organization one may argue that all three: the quality of input elements, quality of processes inside the organization and the quality of output are strongly interconnected and influence the total effect of a final product on the market. This approach applied to the educational institution reveals some specific elements of analysis. Recruitment of students and staff members, ways of absorption on the educational market and new developments are examples of input areas, whereas the educational method, practice and organization (technology) are the main component of a process. Graduates' success on the labour market, the ways of career development, feedback from the graduates might be enumerated as the examples of output elements. The qualitative analysis of three different QI tools developed by ASPHER in a few cases of SPH has been carried out using this approach.

Results

The three quality assessment methods, currently practiced or planned to be implemented by ASPHER, namely PEER Review, SAQ (Self Assessment Questionnaire) and Accreditation have different values what concerns their influence on input, process and output quality of education in Schools of Public Health.

Discussion and conclusion

Each of three presented methods seems to have the sound influence on the quality of education of PH workforce, however, they differ with respect to the scope and area of main concentration. They are complementary to some extent and because of that need to be developed in future in an interrelative way. They are also important and specific brand products of ASPHER which have to be properly marketed.

Keywords: education, accreditation, assessment

The ways for improving the quality of education of PH workforce

*Stojniew J. Sitko PhD
Katarzyna Czabanowska MA
Institute of Public Health, Fac. Health Protection,
Medical College, Jagiellonian University, Krakow, Poland*

Goal:

To present the QA ASPHER philosophy – the attempt to the **triple** European project devoted to the development of the quality improvement process based on the **PEER** Review, **SAQ** (self-assessment questionnaire) and **ACC**reditation

Motto

→ *Nowadays there is a great challenge for the higher education establishments forcing them to **actively react to changes on the job market**, indirectly engaging them in the employment policy*

Quality improvement

1. Identification of the **gap** in performance
2. **Comparison** of the results
3. **Benchmarking**
4. Identification of „**best practice**”
5. **Continous** evaluation and improvement process **outcome oriented**

Quality Accountability

- Showing value of programs for the purpose of e.g. *accreditation*
- Allows **judgements** about performance

Research

- Educational studies
- Evaluation studies
- Comparative studies

One of the ASPHER
basic objectives is:

Improvement of Quality of Education

ASPHER „TRIPLE” approach to Quality Improvement



“Accreditation Framework” Accreditation Task Force, S.Sitko et al.,
v.4, November 2002. www.aspher.org/C_projects/Accreditation

since 1993

PEER

Public Health European Education Review

- an ASPHER „product”:
- a tool of external,
- supportive,
- quality evaluation
- over 20 SPHs reviewed

*Criteria in: QI and ACCR of Training Programs in PH („BlueBook”),
ASPHER - Foundation Merieux, Lyon, June 2001
- see ASPHER web site*



Euro-ACCReditation

- initiated by APhER
- EUPHA partnership, WHO-Europe support
- European Accr. of PH Education
- Elaboration of standards and procedures
- *Accreditation Procedure Document* – draft ready
- PH-ACCR LdV Project succeeded

Partners:

ASPHER, EUPHA, Maastricht (NL), Copenhagen (DK),
Rennes (F), Scheffield (UK), Sofia (BG), Krakow (PL),



What is SAQ?

- a **prototype web-based self-assessment tool** - LdV pilot project called „Improving Employability of Public Health Graduates“ (IPH Jagiellonian University, Maastricht University, SchARR)
- Evaluated and monitored by external experts (nominated for the best LdV project award in Europe)



Innovative approach - SAQ

1. Measures the Q of **output** of education
2. Allows **monitoring** showing the dynamism of the rapidly evolving PH
3. **Promotes partnerships** between academic institutions, employer organizations, graduates/alumni organizations and policy makers
4. Tool/methodology has a potential for **transfer** to other areas and disciplines

An **SAQ** enlargement LdV project is currently in preparation

Conclusions

- Quality improvement process is a “**must**” of each School of Public Health on its way to efficiency
- There is a need to develop and establish a QI system for Public Health education in **Europe**.
- PEER ACCR and SAQ are **ASPHER** supported steps towards this goal in Europe

References

- PEER: www.aspher.org
- SAQ: www.healthgraduates.info
- ACCR: www.aspher.org

MAXIMISING THE PUBLIC HEALTH ROLE OF COMMUNITY NURSES

Selena Gray, selena.gray@uwe.ac.uk
Glenys Hook Neil Brocklehurst
University of the West of England

Purpose

To highlight the changing roles of community nurses in the UK and its impact on their contribution to the public health workforce and to stimulate debate in this area maximised merits further exploration and debate.

Introduction

Many parts of the world have expressed concern about capacity in public health systems, highlighted in the responses to the SARS epidemic (1). As well as those in clear public health leadership roles at strategic level, a large number of practitioners make an important contribution to the public health workforce, although they may not be identified directly as such.

In the UK, changes in the registration process for nurses, under the umbrella of the Nursing and Midwifery Council has led to the establishment of a register with 3 parts; nursing; midwifery and specialist community public health nurses (1). This latter group will include those who work with both individuals and a population, and could include health visitors (ie family nurses who work in the community with a focus usually on young children), occupational health nurses, school nurses and those who work on infection control within the community.

Methods and materials

Community public health provision is focussed on social groups such as families and communities, and operates in a variety of settings, including homes, schools, workplaces and local area. The standards for this part of the register have now been extended beyond the previous competencies used for community healthcare and nursing to include the 10 key public health standards used in the UK to define public health practice; grouped into four domains:

- Search for health needs
- Stimulation of awareness of health needs
- Influence on policies affecting health
- Facilitation of health enhancing activities.

These changes represent a potentially radical change to traditional roles and offer an opportunity to develop and enhance public health skills amongst the community nursing workforce. We will describe how one UK University is using these changes to develop this group further.

Results

In response the University of the West of England is undertaking a variety of steps:

- Changes in curriculum for the existing courses are planned to provide further integration with the existing Master's level provision
- A programme of local learning sets has been run with existing community nurses and environmental health officers.
- Consideration is being given to extend existing provision for school and occupational health nurses and public health nurses to ensure a strong public health element to the work.

Discussion and conclusion

The role of contribution of community nurses to the public health workforce and how this can be maximised merits further exploration and debate.

Keywords: Community public health nurses

Maximising the public health role of community nurses

Selena Gray, Professor of Public Health UWE
Glenys Hook, Senior Lecturer, Health and Social Care UWE
Neil Brocklehurst, Independent Consultant in Public Health Practice



Context

- Concern about capacity in public health systems
- Highlighted in the responses to the SARS epidemic
- Public health workforce requires strategic leaders and hands on practitioners



UK Nursing Registration

- UK Nursing Midwifery Council changes to the Register in 2004
- A new 3 part register:
 - Nursing
 - Midwifery
 - Specialist community public health nursing (migration of existing staff)



Specialist community public health nursing (NMC)

“aims to reduce health inequalities by working with individuals, families and communities promoting health, preventing ill health and in the protection of health. The emphasis is on partnership working that cuts across disciplinary, professional, and organisational boundaries that impact on organised social and political policy to influence the determinants of health and promote the health of whole populations.”



Who is included?

- those who work with both individuals and a population and could include:
 - health visitors
 - occupational health nurses
 - school nurses
 - community infection control nurses



New standards of proficiency

- 4 domains of Health Visiting:
- Search for health needs
 - Stimulation of awareness of health needs
 - Influence on policies affecting health
 - Facilitation of health enhancing activities
 - 10 key areas of public health practice now mapped into the 4 domains



Opportunities

- Explicit link to public health skills and partnership working with other agencies
- Radical change to traditional roles
- Opportunity to develop and enhance public health skills amongst the community nursing workforce.
- Provides a career framework



Programme

- 52 week course
- 50% in practice based settings- both specific to discipline and public health
- Recommended 2 years minimum of nursing training



UWE response:

- Changes in curriculum
- Widening practice placements on existing courses for health visitors and school nurses
- Further integration with the existing MSc in Public Health provision
- Local learning sets run with existing community nurses and environmental health officers.



Local learning sets

- Health visitors (family nurses), school nurses, health promotion staff and environmental health officers
- All have geographical focus
- Working together to identify community problems and to address them in partnership
- Demonstrate lack of understanding of roles



Examples of family centred public health role

- Group for postnatal depression; focus on mothers; massage, support infants; reduces one to one visits
- Pre-school literacy development- one to one; play talk; family talk
- Older peoples groups; addressing isolation; accident prevention; exercises
- Improving local environment; litter & parks



Conclusion

- Community nurses are an important part of the public health workforce
- Recent changes to the register in the UK provide an opportunity to enhance this role
- How this can be maximised merits further exploration and debate.

A MINIMUM HEALTH INDICATOR SET FOR PH-SEE COUNTRIES

Ulrich Laaser, ulrich.laaser@uni-bielefeld.de
On behalf of the PH-SEE Collaboration Group
Centre School of Public Health, Belgrade

Purpose

The Stability Pact includes a programme for the development and reconstruction of training and research in public health in South Eastern region of Europe (PH-SEE). One of the identified priorities of national public health development is the definition of a Minimum Indicator Set for all countries of SEE and some of their neighbour countries.

Introduction

Methods and materials

Methods: A Task Force of the PH-SEE Network has proposed a Minimum Indicator Set on the basis of the list of 224 indicators of the World Health Organization (WHO) Health for All (HFA) 21 strategy. The indicators selected follow the selection criteria as defined by expert groups of WHO and the European Commission. A meta-database describing the indicators was established.

Results

A list of 30 indicators was finally agreed at the 3rd PH-SEE Conference, Tirana, Albania, in May 2002. All indicators are included in the WHO HFA DataBase indicator set.

Discussion and conclusion

Conclusion

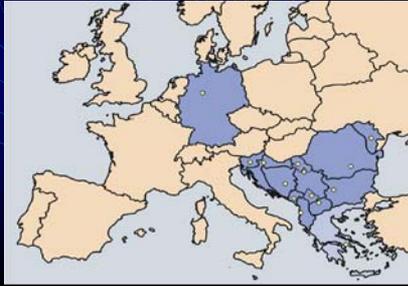
After principal agreement of the expert group on the list of indicators, further practical steps were done, among which building a logistic network for realizing the Minimum Indicator Set. This includes a pilot phase, a revision of the Minimum Indicator Set, data collection and data analysis. Further steps should include the transfer of the project into a continuous surveillance and monitoring system.

Keywords: Health surveillance, health indicator, health planning



STABILITY PACT FOR SOUTH EASTERN EUROPE

Public Health Collaboration in South Eastern Europe (PH-SEE) Programmes for Training and Research in Public Health



04.10.2005

1

Final Report on the PH-SEE Minimum Health Indicator Set (MHIS)

Working group: Doris Bardehle, Germany
Genc Burazeri, Albania
Doncho Donev, Macedonia
Lijana Kragelj-Zaletel, Slovenia
Ulrich Laaser, Germany

04.10.2005

Minimum Indicator Set

2

Objectives of the MHIS

- To use health indicators for health reporting (Indicator-based health reporting)
- To compare the data between the countries of South Eastern Europe and with EU countries
- To develop benchmarking criteria
- To create a circle of health targets, health indicators and health reporting
- To include the MHIS into the PH curriculum

04.10.2005

Minimum Indicator Set

3

Selection of Indicators (2nd)

- The main source of indicators is the list of the 224 indicators of the WHO Health 21 strategy (HFA21).
- Structure:

Demography / Social Economy	03
Mortality-based Indicators (+5)	16
Morbidity / Hospital Discharges (+1)	03
Environment / life style (-4)	00
Health Care Resources (-2)	04
Health Care Utilization / Costs (-1)	02
Maternal and Child Health (-1)	02
Together	30

04.10.2005

Minimum Indicator Set

4

Rules and Metadatabase

- All indicators have to represent a determinant of health or to satisfy different stakeholders (primary, secondary)
- To limit the MHIS to approx. 30 indicators
- The database is completed by a metadatabase
 - definition of indicator
 - the source of data
 - description of method of data collection
 - description of measurement of data
 - assessment of quality & limitations
 - why this indicator was preferred.

04.10.2005

Minimum Indicator Set

5

List of indicators eliminated from the 1st version of PH-SEE MHIS

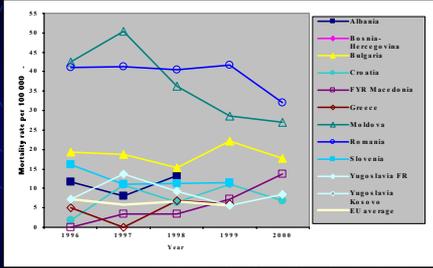
- *DMFT-12 index*
- *Population % connected to water supply*
- *Population % with access to hygienic sewage disposal*
- *%000 PHC units*
- *%000 nurses*
- *% infants vaccinated against tetanus*
- *% vaccinated against pertussis*
- *% vaccinated against measles*

04.10.2005

Minimum Indicator Set

6

Figure 7: Data for MHIS PH-SEE indicator 05 - Maternal deaths, all causes per 100 000 livebirths, 1996 – 2000 (Main data source: WHO Health for All Database 2002)

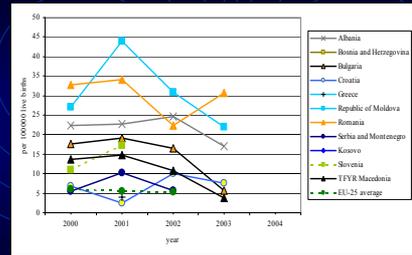


04.10.2005

Minimum Indicator Set

7

Maternal deaths, all causes per 100 000 livebirths, 2000– 2003

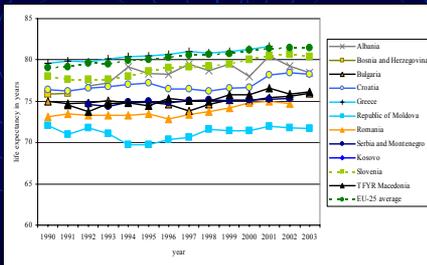


04.10.2005

Minimum Indicator Set

8

Indicator 5: Life expectancy at birth, in years, female, SEE-countries, 1990-2003

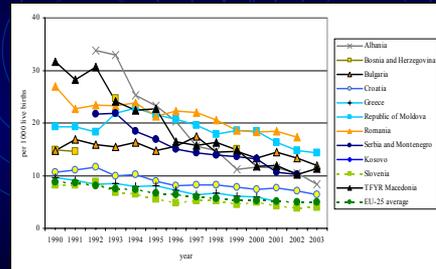


04.10.2005

Minimum Indicator Set

9

Indicator 6: Infant deaths per 1,000 live births, SEE-countries, 1990-2003

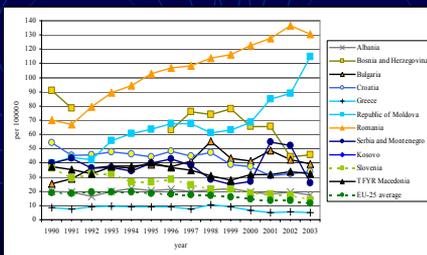


04.10.2005

Minimum Indicator Set

10

Indicator 20: Tuberculosis incidence per 100,000, SEE-countries, 1990-2003



04.10.2005

Minimum Indicator Set

11

Results of the analysis of indicators (+)

- The deterioration of health status has been stopped
- Life expectancy is increasing
- Infant mortality is decreasing
- The number of hospital beds and the length of stay decreased

04.10.2005

Minimum Indicator Set

12

Results of the analysis of indicators (-)

- **The incidence is too high in some countries**
- **The Min-Max ranges have been increasing from 2000-2003**

04.10.2005

Minimum Indicator Set

13

04.10.2005

Minimum Indicator Set

14

Historical Background

The PH-SEE identified the development of a MIS as priority goal in Febr. 2001

The MHIS was accepted in May 2002 in Tirana

The data collection and metadatabase were prepared and continued during the Summer School in Ljubljana, July 2002

The Final Report was prepared by Lijana Zaletel-Kragelj during her stay in Bielefeld at the end of 2002.

The Final Report for the period 1996-2000 was presented and modified at the 4th Coordination Meeting of PH-SEE in Sinaia, Romania April 12-15, 2003

The second edition for the period 2000-2003 has been published 2005.

04.10.2005

Minimum Indicator Set

15

Selection Criteria for Health Indicators (2)

- relevant (regarding priorities)
- valid (regarding determinants of health)
- measurable (in quantitative or qualitative terms)
- sensitive (to change and differences)
- comparable (interterritorial)
- repeatable (for time series)
- affordable (in terms of relative costs)
- useful (for intervention)

04.10.2005

Minimum Indicator Set

16

List of indicators for the 2nd version of PH-SEE MHIS (1)

- No 1 % of population aged 65+ years
- No 2 Life births per 1,000 population
- No 3 Unemployment rate in %, 15-64yrs
- No 4 Life expectancy at birth, in years, males
- No 5 Life expectancy at birth, in years, females
- No 6 Infant deaths per 1,000 live births
- No 7 Perinatal deaths per 1,000 births
- No 8 Maternal deaths, all causes, per 100,000 live births
- No 9 Maternal deaths, abortion, per 100,000 live births

04.10.2005

Minimum Indicator Set

17

List of indicators for the 2nd version of PH-SEE MHIS (2)

- No 10 SDR, all causes, all ages, per 100,000 males
- No 11 SDR, all causes, all ages, per 100,000 females
- No 12 SDR, circulatory system diseases, all ages, per 100,000 males
- No 13 SDR, circulatory system diseases, all ages, per 100,000 females
- No 14 SDR, malignant neoplasms, all ages, per 100,000 males
- No 15 SDR, malignant neoplasms, all ages, per 100,000 females
- No 16 SDR, external causes, all ages, per 100,000 males
- No 17 SDR, external causes, all ages, per 100,000 females
- No 18 SDR, infectious & paras. dis., all ages, per 100,000 males
- No 19 SDR, infectious & paras. dis., all ages, per 100,000 females

04.10.2005

Minimum Indicator Set

18

List of indicators for the 2nd version of PH-SEE MHIS (3)

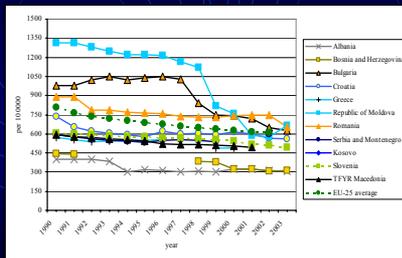
- No 20 Tuberculosis incidence (all forms), per 100,000 population
- No 21 Incidence of measles, per 100,000 population
- No 22 Incidence of diphtheria per 100,000 population
- No 23 No of hospital beds per 100,000 population
- No 24 No of physicians per 100,000 population
- No 25 No of general practitioners per 100,000 population
- No 26 No of dentists per 100,000 population
- No 27 Average length of stay, all hospitals
- No 28 Total health expenditure as % of GDP
- No 29 % of infants vaccinated against diphtheria
- No 30 % of infants vaccinated against poliomyelitis

Table 53: Data for MHIS PH-SEE indicator 25 - Total health expenditure as percent of GNP (Gross Domestic Product), 1996 – 2000 (Main data source: WHO Health for All Data-base 2002¹).

Country	1996	1997	1998	1999	2000
Albania	-	-	-	-	-
Bosnia-Herzegovina	-	-	-	-	-
Bulgaria	-	-	-	-	-
Croatia	-	-	-	-	-
FYR Macedonia	-	-	-	5.00	4.50
Greece	8.80	8.70	8.50	9.30	8.70
Moldova	6.90	6.00	4.30	2.90	3.00
Romania	2.80	2.60	2.60	-	-
Slovenia	3.80	3.70	3.70	4.20	4.00 ²
Yugoslavia 19 ³	8.00	8.10	7.50	6.90	7.50
Kosovo	-	-	-	-	-
EU average	8.58	8.44	8.40	8.52	-
MN PH-SEE	2.80	2.60	2.60	2.90	3.00
MAN PH-SEE	5.50	5.10	3.80	3.20	3.70

¹ - If not stated otherwise, the data sources for present table is WHO/HU-All-2002
² - The data source of data additionally provided by PH-SEE countries
 Slovenia: Institute of Public Health of Republic of Slovenia
³ - No data on additional data available till the end of production of the report
 - Data with known

Indicator 23: Hospital beds per 100,000, SEE-countries, 1990-2003



PUBLIC HEALTH OPHTHALMOLOGY COURSE FOR EYE CARE PROFESSIONALS IN ARMENIA

Naira Khachatryan, nkachat@aua.am

Ovsanna Najaryan, Lilith Kirakosyan, Varsenik Hakobyan

Garo Meghriyan Eye Institute for Preventive Ophthalmology, Center for Health Services Research and Development, American University of Armenia

Introduction

The causes of blindness are embedded in each community and a public health perspective is required to measure the extent of blinding diseases, to characterise the unique risk factors that each disease poses and to develop effective and practical approaches to prevention and treatment.

In March 2005 the Garo Meghriyan Eye Institute for Preventive Ophthalmology (GMEIPO) of the American University of Armenia delivered a two-week course Introduction to Public Health Ophthalmology (PHO). Jinishian Memorial Fund sponsored the course.

Aims and Learning Outcomes of the Course

The course was designed for ophthalmologists in training, practising ophthalmologists, optometrists and ophthalmic nurses with a career interest in public health programs in eye care.

- Aim: the primary objective of this course was to equip students to develop a community eye care program.
- In order to achieve the Aim of the course the following Learning were chosen. By the end of the course the student should be able to:
 - (i) Describe the basic epidemiology of the major blinding eye diseases
 - (ii) Distinguish the various types of studies designed to assess community eye health needs
 - (iii) Interpret the results of eye surveys
 - (iv) Understand the basic issues surrounding program planning, resource mobilisation, management and evaluation of local comprehensive eye care programmes
 - (v) Conduct a Community Eye Care Needs Assessment
 - (vi) Critically Appraise and select appropriate control strategies for the major blinding eye diseases
 - (vii) Develop presentation skills to sell the programme

Description of the Course

- This course was designed as a mixed-type course incorporating aspects of discipline-based, experiential, competency based and problem solving course designs.
- Throughout the course a variety of teaching methods were employed including:
 - (i) Lectures, usually not more than 40 minutes long, which incorporated exercises built into the presentation.
 - (ii) Group work (brainstorming, open discussions, and rounds)
 - (iii) Experiential learning methods such as project work were enhanced by time for self-reflection and evaluation. Reflection was also incorporated into the other aspects of the course.

The first five days of the course were spent covering the theoretical background to community eye health, orienting students to a public health understanding of the major blinding diseases and their epidemiology, and equipping them to do a needs assessment. During the second week the student were though the various aspects of programme design, such as planning, budgeting, management and evaluation of eye care programs.

The assessment of the course was based on the individual work, including participation, results of the quiz, and presentation; and group work. Students were asked to work in groups of 2-3 people to design and write up an eye care program for a province of Armenia, not exceeding 2,500 words.

Results

Overall, 6 participants- 3 regional ophthalmologists and 3 ophthalmic nurses from Gegharkunik and Tavush marzes of Armenia were involved. All participants actively participated in the course. They were divided into two groups. Each group selected a topic of interest and worked on it throughout the course. By the end of the course the first group outlined an Eye health education campaign, the second group- an Outreach program for Geghrkunik marz of Armenia. They presented their programs during the last day of the course and were provided feedback from their peers and the course organisers.

All participants completed the course and were given the certificates of completion.

Conclusion/Recommendations

The participants positively evaluated the course and teaching, providing the following recommendations:

- To incorporate the course into the clinical residency program for ophthalmologists
- To deliver the PHO course on a regular basis as a refresher course for regional ophthalmologists

Public Health Ophthalmology Course for Eye Care Professionals in Armenia

Naira Khachatryan, MD, MPH
DrPH Candidate, LSHTM
Lecturer of Preventive Ophthalmology,
College of Health Sciences, AUA

Background

There are 291 ophthalmologists in Armenia, 82% work in Yerevan, and 18% in the rural areas.

- Only 25% of ophthalmologists are surgeons; others are mainly doing refraction and outpatient treatment.

Background (cont)

The Yerevan State Medical University and National Institute of Health deliver the ophthalmic education.

- YSMU is a governmental academic institution under the supervision of the Ministry of Education and Science.
- NIH is also a governmental institution under the Ministry of Health. NIH has exclusive right to deliver Continuing Medical Education.

Background (cont)

Ophthalmic courses and programs:

- 2 week course for medical students, YSMU
- 2 week course for family physicians, YSMU
- 3 year clinical residency, YSMU and NIH
- 7-week refresher courses, NIH

The clinical aspects of ophthalmology are of the main focus of those courses

Background (cont)

A public health perspective is required to measure the extent of blinding diseases, to characterize the unique risk factors that each disease poses and to develop effective and practical approaches to prevention and treatment.

A two-week course “Introduction to Public Health Ophthalmology” was designed by the Garo Meghriyan Eye Institute for Preventive Ophthalmology.

Conducted in March 2005

Aim

To equip students to develop a community eye care program.

Audience

- Ophthalmologists in training, practising ophthalmologists, optometrists and ophthalmic nurses with a career interest in public health programs in eye care.
- Practitioners will be sent by their health district and participation in this course will constitute part of their Continuing Professional Development requirement.
- Students will enrol to prepare them to develop eye programmes in their district or to work in existing eye programs.

Learning Needs of Students

The students will be expected to have prior experience with:

- Clinical knowledge of the main blinding diseases and of their treatment
- Principles of prevention of the main blinding diseases (including early diagnosis and screening)
- Basics of hygiene, epidemiology and public health

Learning Outcomes

By the end of the course the student should be able to:

- (i) Describe the basic epidemiology of the major blinding eye diseases
- (ii) Distinguish the various types of studies designed to assess community eye health needs
- (iii) Interpret the results of eye surveys

Learning Outcomes (cont)

- (iv) Understand the basic issues surrounding program planning, resource mobilisation, management and evaluation of local comprehensive eye care programmes
- (v) Conduct a Community Eye Care Needs Assessment
- (vi) Critically Appraise and select appropriate control strategies for the major blinding eye diseases

Description of the Course

This course was designed as a mixed-type course incorporating aspects of discipline-based, experiential, competency based and problem solving course designs.

Description of the Course (cont)

The course is problem-centred rather than subject-centred, it focus on the problem of designing a programme rather than learning discipline of public health. This helps the course be directly applicable to students' future practice.

Description of the Course (cont)

Throughout the course a variety of teaching methods were employed including:

- (i) Lectures, usually not more than 40 minutes long, which incorporated exercises built into the presentation.
- (ii) Group work (brainstorming, open discussions, and rounds)
- (iii) Experiential learning methods such as project work followed by self-reflection and evaluation.

Description of the Course (cont)

The first five days of the course were spent covering the theoretical background to community eye health, orienting students to a public health understanding of the major blinding diseases and their epidemiology, and equipping them to do a needs assessment.

During the second week the student were thought the various aspects of programme design, such as planning, budgeting, management and evaluation of eye care programs.

Description of the Course (cont)

The assessment of the course was based on

-individual work, including participation

-results of the quiz

-presentation

-group work. Students were asked to work in groups of 2-3 people to outline an eye care program for a province of Armenia, not exceeding 2,500 words.

Results

Overall, 6 participants- 3 regional ophthalmologists and 3 ophthalmic nurses from Gegharkunik and Tavush marzes of Armenia were involved.

All participants were divided into two groups. Each group selected a topic of interest and worked on it throughout the course.

Results (cont)

By the end of the course the groups outlined and presented

- Eye health education campaign
- Outreach program for Geghrkunik marz of Armenia.

All participants completed the course and were given the certificates of completion.

Conclusion/Recommendations

The participants positively evaluated the course and teaching, providing the following recommendations:

- To incorporate the course into the clinical residency program for ophthalmologists
- To deliver the PHO course on a regular basis as a refresher course for regional ophthalmologists

Course supported by
Jinashian Memorial Fund

Materials used:

- PHO course at Dana Center at JHU;
- MSc in Community Eye Health at LSHTM;
- Teaching for Health Professionals Course at LSHTM

