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Light for the World is a European confederation of national development NGOs committed to saving eyesight, improving the quality of life and advocating for the rights of persons with disabilities in underprivileged regions of our world.

Our priority countries are Burkina Faso, Ethiopia, Mozambique, South Sudan, North East India, Pakistan and Bolivia. In addition, we are active in nine partner countries in Africa, Asia, the Pacific, Latin America and Europe. Light for the World has been actively involved in Blindness Prevention Programmes in developing countries for over 20 years. We strive to achieve the goals of VISION 2020 in aligning our work to national prevention of blindness strategies. We support comprehensive eye care programmes, trachoma and onchocerciasis control, and human resource development for eye care professionals. Our focus is on removing barriers and creating fully accessible eye health services for local communities, especially for those who are poor or excluded.

In 2010 our programmes reached over 700,000 people and more than 40,000 cataract surgeries were performed. 40,000 cataract surgeries were performed.

Of the 284 million people who are visually impaired and the 39 million people who are blind worldwide, 90% live in developing countries. Loss of sight often means loss of livelihood, access to education and independence – yet, 80% of blindness remains avoidable or treatable.

In order to eliminate avoidable blindness, create sustainable eye health services and to ensure that people who are blind and visually impaired are fully integrated into society, eye health interventions must be part of wider development programmes. In the area of school eye health, for example, we need to move beyond random refractive error screenings and look at integrating eye health into general school health programmes. Such programmes must involve all stakeholders – the children, their parents and families, and the teachers and local communities.

In this issue of Vision & Development you can read in more detail about links between school eye health and education and health policies. This issue also includes details of a major global eye health partnership to screen 1 million children in Pakistan and Nigeria, as well as initiatives in Burkina Faso, Mozambique and North East India. These examples form part of Light for the World’s commitment to invest in the eye health of children and young people, which we believe is essential to their development.

We call upon governments to invest in comprehensive school health systems that incorporate eye health. This is a wise investment, as many children and youth who would otherwise drop out of school and not reach their potential can go on to contribute to their countries’ economies.

There is good news from us: Light for the World has increased its membership. The Dutch foundation, Dark & Light, has decided to become part of the European Confederation of Light for the World, joining national associations in Austria, Belgium and the Czech Republic. With their joining, Light for the World increases its geographical coverage, number and quality of our programmes.

We ask for your continuing support in promoting eye health in developing countries,

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A chance to address visual impairment in comprehensive school health programmes: Inclusive Education

Johannes Trimmel, Director International Programme Support and Policies, Light for the World.

Adults and children with disabilities have been largely denied their right to education. Children with disabilities are less likely than those without to start school and have lower rates of ongoing attendance and progression in schools. Enrolment rates for children with sensory or intellectual impairments are lower than for children with physical impairments. The correlation between disability and low educational outcomes is stronger than the correlation between low educational outcomes and gender, rural residence or low socioeconomic status. One study showed that visual factors are better predictors of academic success than race or socioeconomic status. The study showed that visual factors are better predictors of academic success than race or socioeconomic status.

Education for All in an Inclusive Setting

In many developing countries only a limited number of special schools in urban settings have provided educational opportunities for children with disabilities. To include all children in mainstream education a systemic change is necessary: children with disabilities must be included in the general education system, while receiving the individual support they need. Article 24 of the UN Convention on the Rights of Persons with Disabilities, ratified by more than 100 countries, demands equal access for children with disabilities to an inclusive education system at all levels.

This shift to inclusive education systems makes the internationally agreed goal of primary Education for All achievable. If truly inclusive, a child-centred pedagogy will augment the quality of education.

Furthermore, the realisation of inclusive education systems in developing countries has huge potential to detect and treat visual impairments within comprehensive school health programmes. The inclusion of blind, visually and otherwise impaired children in general education necessitates not only addressing the individual educational needs of children such as communication in sign-language or the provision of Braille literature, but also their specific health needs. To address these health needs a multi-stakeholder approach is most effective, including teachers and school staff, parents and families, specific services by health professionals, and the active participation of the school children themselves. All stakeholders have particular responsibilities and roles, and need to be adequately addressed to ensure their participation.

Comprehensive School Health Systems

The needs of children with disabilities must be integrated across school systems, including school health systems to ensure effectiveness.

A multi-stakeholder, comprehensive school health system for all children in school, linked to their families and communities:

- addresses the specific health needs of children with disabilities to achieve high educational outcomes
- detects and identifies impairments of school children, their relatives and teachers
- provides access to treatment and assistive devices
- sensitises the school community, children, teachers and parents
- limits disabling effects of impairments and reduces school dropouts
- brings children with impairments back into the educational system
- informs public health planning and services on necessary community action
- supports and requires a coordinated effort of various government ministries and services in charge of education, special education (in a number of countries a different Ministry than the Ministry of Education) and health.

Good health and nutrition are imperative for high educational outcomes. Educationally relevant health disparities impede motivation and ability to learn through at least five causal pathways: sensory perceptions; cognition; connectedness and engagement with school; absenteeism; and dropping out.

Integrating eye health

Poor vision and eye health significantly affect the capacity of children to learn and succeed academically. Critical vision skills specifically related to learning include tracking (i.e., ability to move across a line of text when reading), teaming or binocularity (i.e., communication between the eyes and the brain) and focusing (i.e., ability to focus accurately at various distances, to change focus quickly and to maintain focus as long as necessary). In practical terms this will crucially affect the reading and writing speed of a child.

Visual clues are important to how a child learns to understand and function in the world. Impaired vision can affect a child’s cognitive, emotional, neurological and physical development by potentially limiting the range of experiences and the kinds of information to which the child is exposed.

Children with disabilities must be included in the general education system, while receiving the individual support they need.

Therefore it is of the utmost importance that eye health is integrat-ed into comprehensive school health systems, to ensure that all students have an equal chance for a sound educational grounding, which is the basis for self-determined development, social interaction, effective communication and employment.
Moving From School Screening For Refractive Errors To Eye Health In Schools

Hannah Faal has worked for over three decades in eye care programme development and retired in April 2011 as Programme Development Adviser on Health Systems with Sightsavers. Her work continues in development, health and disability in her home country of Nigeria.

All countries which signed up to the Millennium Development Goals (MDGs) in 2000 committed to every child completing primary education by the year 2015. By 2006, the net enrollment ratio exceeded 90%1, placing an increasing number of children within primary schools. Ensuring that children are healthy and able to learn is an essential component of an effective school system. 2 Global initiatives; Education for All, the Convention on the Rights of the Child, which enshrines the right of children to education and the highest attainable standard of health, and Early Childhood Care and Education investing in the preschool years to ensure a high yield in the formal schooling years all focus on children. In 2007, the UN Convention on the Rights of Children with Disabilities drew the world’s attention on the Rights of Children with Disabilities. In 2007, the UN Convention on the Rights of the Child, which enshrines the right of children to education and the highest attainable standard of health, and Early Childhood Care and Education investing in the preschool years to ensure a high yield in the formal schooling years all focus on children. In 2007, the UN Convention on the Rights of Children with Disabilities drew the world’s attention on the Rights of Children with Disabilities. In 2007, the UN Convention on the Rights of Children with Disabilities drew the world’s attention on the Rights of Children with Disabilities.

quote “The child’s name is TODAY”. Although school provides a captive environment for children and teachers alike, the child is the bridge between the school, the home and the play ground, and in many developing countries, the workplace. School health programmes developed as part of community partnerships provide one of the most cost effective ways to reach school age children, adolescents and the broader community and are a sustainable way to promote healthy practices.3 These principles are part of the WHO Health Promoting Schools4, UNICEF Child Friendly Schools (CFS)5 and the interagency initiative FRESH (Focusing Resources on Effective School Health)(Box 2).

Global health programmes aimed at children out of school or in informal schools

Inclusion of visually impaired and otherwise disabled children in the provision of services and the training of sighted children in relationships with people with disabilities

Eye health in special programmes aimed at children out of school or in informal schools

Participation in school garden programmes and water and sanitation programmes6

Knowledge on and control of eye related nutrition problems, eg vitamin A deficiency, trachoma

Table 1: The possible components of a comprehensive integrated eye health programme

<table>
<thead>
<tr>
<th>Component</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration of eye health into early childhood programmes</td>
<td>Inclusion of eye health into the routine child health programmes allows for prevention, and early identification and referral of eye problems and of visually impaired children, eg children with cataract</td>
</tr>
<tr>
<td>Vision testing as part of a full physical examination</td>
<td>Eye health is perceived as part of holistic care</td>
</tr>
<tr>
<td>Self testing with school vision corridors</td>
<td>Heheightens an awareness of the need to check visual status with a simple tool to families and into adulthood</td>
</tr>
<tr>
<td>Refractive error services with appropriate access to cosmetically acceptable glasses for pupils</td>
<td>Vision correction in the post primary school years builds a bridge between the school health programmes at primary and post primary schools. Post primary students have, in some programmes, taken on responsibility for school health clubs in primary schools. Cosmetically satisfactory glasses prevent stigmatisation and bullying.</td>
</tr>
<tr>
<td>Low vision services and inclusive education</td>
<td>Provision of a continuum of care to every visually disabled child</td>
</tr>
<tr>
<td>Primary eye care</td>
<td>Early detection and management of minor eye conditions, early referral of unresolved cases and injuries</td>
</tr>
<tr>
<td>Eye disease control programmes, eg trachoma</td>
<td>Link to or integration with other disease focused programmes such as the Neglected Tropical Diseases Programme</td>
</tr>
<tr>
<td>Eye health education</td>
<td>Commitment of teachers and improvement in their performance</td>
</tr>
<tr>
<td>Screening of teachers for presbyopia and the provision of glasses</td>
<td>Early detection of familial conditions and introduction of the concept of family health</td>
</tr>
<tr>
<td>Screening of siblings and parents</td>
<td>Fast tracking of health education messages to families, identification of diseases and encouragement in uptake of services, eg trichiasis in mothers and cataract in grandparents</td>
</tr>
<tr>
<td>Eye health in Child to Child education programme</td>
<td>Enhancement of the development of an inclusive society</td>
</tr>
<tr>
<td>Inclusion of visually impaired and otherwise disabled children in the provision of services and the training of sighted children in relationships with people with disabilities</td>
<td>Eye health needs of all children are met including the marginalised</td>
</tr>
</tbody>
</table>

BOX: Most marginalized children

- Out of school
- Poor
- Rural
- Ethnic / linguistic minorities
- Children with disabilities
- In armed conflict zones
- Socially unstable homes

815 million school-aged children require some form of vision correction.

1 http://www.undp.org/mdg/progress.shtml

2 Don Bundy School health at a glance World Bank. March 2002

3 Don Bundy School health at a glance World Bank. March 2002

4 www.who.int/schoolyouthhealth/gshi/en

5 www.unicef.org/lifeskills

7 www.childinfo.org

8 WASH campaign – Water Supply and Sanitation Collaborative Council and the global Sanitation Fund
Vision screening can serve to trigger eye health as part of the holistic care of children in primary school.

Zanzibar school health programme in its 2009/2010 report demonstrated the success of a comprehensive approach to the health needs of children in primary schools. A needs based programme, it addressed ear and hearing problems, eye diseases and refractive error correction, skin problems, physical disabilities in children and corrected presbyopia in teachers. Parents and teachers participation was remarkable as all wanted a holistic approach to the care of children.

Vision screening is specific to eye care programmes, it can serve as a trigger or entry point for eye health into the holistic care of the child in primary school.

This would need to be supported by a structure which brings together all the stakeholders, ensures collaboration and a good child eye health back up referral as suggested, Table 1.

A detailed situation analysis will feed into the development of a comprehensive programme which strengthens and integrates into a school health service. Interventions can be agreed on, and evidence built through pilot programmes to validate effectiveness, efficiency and sustainability. This will provide material for advocacy for policy and practice change and alignment with the FRESH Framework (Box 2). In view of the comparative advantages of a comprehensive integrated school eye health programme over vertical, single focus school screening for refractive errors, planners should make the paradigm shift required.

BOX 2 – FRESH Framework

- Comprehensive school health policies
- Water, sanitation and the environment
- Skills based health education
- School based health services

Supporting strategies

- Partnership between teachers and health workers
- Involvement and support of parents and communities
- Active participation of young people in FRESH programmes

China could obtain excellent vision and good accuracy with self refraction. Addressing vision impairment due to refractive errors through a screening programme should target the age group with the highest prevalence (10–17 years) who are usually the age group with the highest prevalence. Addressing vision impairment and good accuracy with self refraction programmes should target the majority of school health programmes which focus on the primary school years and early childhood.

Higher in prevalence than refractive errors are other conditions affecting children, including epidemics of viral conjunctivitis, allergic conjunctivitis, ocular injuries which, if not managed properly, could have great impact on vision and learning.

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One of the model programmes that it undertook was screening for eye health in 1 million children. This was a major global initiative through a partnership between the International Council of Ophthalmology, International Council of Ophthalmology Foundation and Light for the World, to undertake this programme in two countries, Pakistan and Nigeria.

To implement this programme in Pakistan and Nigeria, it was agreed that the Lions Institute of Community Ophthalmology, India, Comprehensive Health and Education Forum International, Pakistan, Jos University Teaching Hospital, Nigeria, created a partnership. The objectives of the programme were:

- to screen 1 million children for eye health ($500,000 in Plateau state Nigeria and $500,000 in Khyber Pakhtoonkhaw Pakistan)
- to provide adequate eye care services at community level (schools & communities) through the vision van and mobile eye health team.
- to impart eye health education in order to change the behaviour and attitudes of communities, especially school going children and parents, towards eye care
- to train personnel at school and community level
- to carry out operational research on uncorrected refractive errors
- to advocate with the government, relevant ministries and ophthalmological societies for inclusion within the framework of school health programmes and national programmes for comprehensive eye care.

Screening of 1 Million School Children for Eye Health
an International Council of Ophthalmology and Light for the World Global Initiative

Dr. M. Babar Qureshi is an Ophthalmologist and currently the Chairman of the ICO task force on uncorrected refractive errors, CEO of Comprehensive Health and Education Forum International and Senior Medical Advisor CBM.

The International Council of Ophthalmology (ICO) recognising the magnitude of uncorrected refractive errors, constituted a task force on the issue. The task force has a mandate to look into advocacy, model programme development, curriculum development, human resource development and research within the context of uncorrected refractive errors.

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Major components of the programme

School Eye Health Programme

- Health Education
- School Screening & Primary Eye Care
- Research & Advocacy

- Teacher Testing
- Sibling Testing

www.scholandshealth.org
Practice Mozambique

Screening for eye health

**Target Group**
All school-going children in both public and private primary schools aged 5–12 will be screened by teachers trained by the programme to identify certain eye complications (vitamin A deficiency, ptosis, refractive error, squint, white pupil, discharge and red eye). Those needing refraction and those needing major eye care treatment will be referred to nearby eye care centres.

Children identified as having significant refractive error will be followed up on and their siblings will be tested for visual health.

Furthermore, all teachers in each school being visited will have their vision tested and glasses provided as necessary.

**Health Education**
A very important element of the project is the improvement of community awareness in eye health as well as the provision of general health education, including personal hygiene, in the schools.

This is being done through the distribution of health education materials (posters and flipcharts), and health education sessions at schools.

**Research & Advocacy**
Uncorrected refractive error is the commonest cause of ocular morbidity and visual impairment. Though there are some data on the magnitude of refractive errors, there is a lack of information on various areas as far as the school eye health programmes are concerned.

Research is being carried out in three particular areas:
- cost of the school eye health programme vs its benefits
- perception (barriers) to wearing of glasses
- developing and testing a quality of life instrument for refractive errors

**Self Vision Corridor**
Self vision corridors are being created within schools, which contain a vision chart and a poster, which gives clear direction to school children about how to check their vision. If they cannot see properly then they should report to their teacher or school eye health team. This will raise awareness and introduce the practice of vision checks and the concept of being responsible for health.

**Eye Health Box**
An eye health box is being provided to all schools within the programme area which contains all the necessary items for eye care first aid and at primary level.

**Expected outputs are:**
- School Screening: 1 million children screened
- Teacher Screening: 10,000 teachers screened
- Teacher / HR Training: Training of 10,000 teachers
- Family Screening: Screening of 10,000 families
- Glasses Provided: Dispensing of 100,000 glasses
- Health Education: 1 million people educated
- Patients referred for further treatment: 10,000 referred and followed up on treatment

**School Vision Testing:**
a case study from Mozambique

Roughly 1% of the population in Africa has visual impairment from uncorrected refractive errors. The magnitude could be twice as much if all people with reduced vision due to refractive error are included. Uncorrected refractive error can reduce performance at school, productivity at work and quality of life in general. School children are one of the groups most affected by refractive errors. Fortunately, it can easily be corrected with appropriate eyeglasses. However, many in the developing world cannot benefit from such a cost-effective intervention due to limited coverage of eye health services. Refractive error is a priority disease in VISION 2020: The Right to Sight initiative. School vision testing is one of the strategies designed to tackle the problem of refractive errors.

Figure 1, Students tested in 2009 and 2010

<table>
<thead>
<tr>
<th>Factor</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students tested/eligible</td>
<td>10,320</td>
<td>97%</td>
</tr>
<tr>
<td>Total referred</td>
<td>269</td>
<td>3%</td>
</tr>
<tr>
<td>Refractive errors</td>
<td>108</td>
<td>1%</td>
</tr>
<tr>
<td>Other eye problems</td>
<td>161</td>
<td>2%</td>
</tr>
</tbody>
</table>

Figure 2, Breakdown of type of refractive errors

- 49% Myopia
- 40% Hypermetropia
- 11% Astigmatism

Strategic Partnership

Hospital central da Beira (HCB), with support from Light for the World, has been providing eye care services in the Sofala province of Mozambique for the last seven years. Half of all those attending the eye clinic at HCB have refractive errors or presbyopia. The project remained overwhelmed by clinic-based services undertaking a school eye health programme. In 2009, however, a joint initiative was established with the Italian NGO Centro Cooperazione Sviluppo (CCS). CCS has been rendering technical and material support for HCB to conduct the programme. The teachers also follow up for compliance with wearing of glasses and awareness of their children’s parents.

Key Activities

1. Training of School Teachers:
   An ophthalmic technician was responsible for training the selected teachers in testing vision and detecting some common eye problems. Trained teachers received a Snellen “E” chart, flashlights, forms and certificate of participation.

2. Conducting Vision Testing:
   After an eye health education session, the trained teachers tested all students in their school. They referred those cases with vision equal to or less than 0.67 (6 / 9) or those who had symptoms of eye disease.

3. Examination and refraction of referred students:
   A refraction officer or ophthalmic technician examined the children referred by the teachers at their village or school.

4. Providing eyeglasses:
   All children diagnosed with refractive errors received their eye glasses free of charge. The eyeglasses were fitted at HCB or purchased from the market when necessary.

Results

A total of 44 teachers were trained from 17 schools in 3 districts. They tested vision in 4,000 and 6,320 students in 2009 and 2010, respectively. The students were from 1st to 7th grades, aged 5 to 15 years and girls constituted 44% (Figure 1).

Myopia was the most common type of refractive error (Figure 2). The prescribed glasses were delivered to CCS for distribution to the children. The results are difficult to compare with similar reports from Africa because different methods and age groups are used.

Conclusions

School eye health programmes are a challenging task to undertake particularly where human resources are limited. However, partnership and inter-sectoral collaboration is a viable strategy to address this huge problem. There is a need to evaluate and scale up this pilot programme to schools across the province. Ophthalmic officers working at primary eye care centers should integrate school eye health as part of their routine activity. A proper survey of refractive errors in the population will help to generate concrete information for more realistic planning.

A Comprehensive Approach to Eye Health among school children in Meghalaya, North East India

S.P. Saikia, A. Deka, V. Surong, S. Kumar
Ophthalmologists, Ophthalmic Clinic Bawri Nethralaya in Meghalaya

Since 2006 the secondary eye care hospital, Bawri Nethralaya, has developed a school eye health programme in the Northeast Indian state of Meghalaya with the objective of improving the quality of life and educational capabilities of school-going children by eliminating blindness and visual impairment due to uncorrected refractive errors.

Meghalaya covers an area of 22,429 km² with a population of 2.96 million people, 80.4% of which reside in rural areas. The causes of blindness in the state are inadequate and unequal distribution of eye care services, unequal distribution of population due to the hilly terrain, the low overall socioeconomic status of the population and lack of awareness on eye health.

The school health programme is based on regular school teacher vision training on health education, vision screening and common eye problems at the eye clinic of Bawri Nethralaya in Shillong, the capital of Meghalaya. The teachers are provided with vision testing kits at the end of the training session. Back at their schools, they conduct vision screenings on a continual basis to detect refractive errors among their pupils. The teachers also follow up for compliance with wearing of glasses and create awareness and acceptance among the students’ parents.

The school eye health programme covers both rural and urban schools where trained teachers carry out screening tests with single E optotypes. Children who are diagnosed with refractive error are further evaluated by the optometrist by Cycloplegic Refraction and provided with free glasses. Those children who do not improve with refraction are referred to the eye clinic for further management and evaluation.

Regular screenings in schools for the blind, especially on those children who are newly admitted to the school are conducted to diagnose treatable types of blindness and provide treatment. In addition, the ophthalmologists of Bawri Nethralaya assess low vision cases in order to provide specialised services to children who require low vision devices. Bawri Nethralaya also provides services to far and remote places through regular outreach camps for the community to enable those patients who cannot access eye care services by providing free services and also creating awareness about common eye problems and their basic management through community participation.

Assessment of training quality by cross-checking by skilled staff

The quality of the screenings done by the school teachers is systematically monitored. In a study conducted between June 2007 and May 2009, only 4.8% of false negative cases among the children screened by the teachers was detected. The screening done by teachers reduces the workload of eye care service providers and permits outreach to remote rural areas. The strategy to train teachers and community representatives to screen the population of their locality for common eye problems is very useful and increases the impact of eye health programmes. However, high numbers of false negative cases may be a concern, therefore proper training and monitoring of the trained teachers and community representatives is essential.
Inclusion of Visually Impaired Children

is on the move in Burkina Faso, West Africa

Lenie Hoegen Dijkhof,
Programme Officer for Inclusive Education,
Light for the World National Office, Ouagadougou, Burkina Faso

Burkina Faso in sub-Saharan West Africa is one of the poorest countries in the world, and has a population of over 14 million people. At least one third of the population live below the poverty line. Following international estimates, over 1.5 million people in Burkina Faso face disability in life, including around 210,000 people who are blind, short sighted or suffer from eye disease. Cataract, trachoma, xerophthalmia, glaucoma and refractive error are the main eye problems. In Burkina Faso children with a visual disability have very little opportunity to go to school. Of the estimated 150,000 visually impaired children, no more than 2% find a place in the primary schools that are adapted to their needs and have trained teachers. However, there are positive developments to improve this situation.

The UN Convention on the Rights of Persons with Disabilities was signed and ratified by Burkina Faso in 2009. Subsequently, a national law for the protection of persons with disabilities was adopted in April 2010, which, among other things, guarantees inclusive education. The Ministry of National Education actively started developing a policy on inclusive education in 2007. Catholic education, an important education provider in Burkina Faso, decided to take up the challenge to include children with disabilities in their schools in 2008 and is actively working on awareness raising among parents and teachers as well as on special training of its teachers and adapting its schools. Light for the World signed a convention with both the Ministry of National Education and Catholic Education in 2009 in four regions of the country for a nationwide project for the inclusion of visually impaired children in public and private schools. The experiences of the stakeholders in Burkina Faso during the last decade have prepared the ground for such a large scale project.

There are still important challenges to face though. The monitoring and regular check up on the eye health and sight development of the children needs to become a systematic approach at a national level, the adapted teaching of children with low vision is yet to be developed, the availability of Braille books and materials is still scarce and a lot more capacity will need to be built. There are still important challenges to face though. The monitoring and regular check up on the eye health and sight development of the children needs to become a systematic approach at a national level, the adapted teaching of children with low vision is yet to be developed, the availability of Braille books and materials is still scarce and a lot more capacity will need to be built. There are still important challenges to face though. The monitoring and regular check up on the eye health and sight development of the children needs to become a systematic approach at a national level, the adapted teaching of children with low vision is yet to be developed, the availability of Braille books and materials is still scarce and a lot more capacity will need to be built.

There are 10 primary schools and 14 secondary schools in Ouagadougou who include blind children, while teachers and children are being coached and monitored by a special unit of the EJA School. Two thirds of the 168 EJA-school children are presently in regular schools and 9 study at university. EJA never chose to be a boarding school because this may disassociate the children from community and family life. An alternative was found and children coming from far away live with guest families in the neighbourhood of the school, who are being monitored and coached by two social workers of EJA.

In time, EJA has developed into an important resource and teacher training centre for the education providers and is also an active member of the network of private special schools for the promotion of inclusive education. EJA started a decentralisation pilot with Catholic Education in 2009 in four regions of Tenkodogo, Ouahigouya, Gaoua and Pô, aiming to include blind children in local Catholic schools. The development of this pilot is being closely monitored and copied by the Ministry of National Education in its pilot inclusive education projects.

It is possible to surmise that the inclusion of visually impaired children is on the move in Burkina Faso, but needs continuous attention and the input of human and financial resources to reach the objective of Education for All. The International Council for Education (ICEI) of People with Visual Impairment now has its eye on Burkina Faso as a priority country for a nationwide project for the inclusion of visually impaired children in public and private schools. The experiences of the stakeholders in Burkina Faso during the last decade have prepared the ground for such a large scale project.

There are still important challenges to face though. The monitoring and regular check up on the eye health and sight development of the children needs to become a systematic approach at a national level, the adapted teaching of children with low vision is yet to be developed, the availability of Braille books and materials is still scarce and a lot more capacity will need to be built.

With the right support, children who are blind can attend regular schools.

Children who are visually impaired often need specialised equipment to enable them to learn.
As an internationally active company which is devoted to the service of human health, CROMA has dedicated itself to improving people’s quality of life, not only in their commercial markets but also in underprivileged parts of our world in Africa, Asia and Oceania. Croma has been supporting Light for the World for many years now by donating IOLs and Viscoelastica. Thousands of people in developing countries owe their eyesight to Croma’s social commitment.

One of them is Celine, who had her cataract surgery at the eye clinic Zorgho in the east of Burkina Faso. The region is extremely medically underserved and did not have any eyecare services at all before Light for the World opened the eye clinic in Zorgho in 2005. The Zorgho eye clinic has to provide eyecare services for 1.1 million people. To offer access for people who cannot afford transport costs, the eye health team organises surgical outreaches to rural areas. There are still a lot of bilateral cataract surgeries. Many of the patients have been blind for years.

Croma’s owner Gerhard Prinz states “We have been aware of our social responsibilities since before it got hip to talk about it. We have committed ourselves to improve the quality of life of blind and visually impaired people. Our partnership with Light for the World enables people in developing countries to benefit from Croma products and our knowledge.