Low vision services for children in Tanzania

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The Kilimanjaro Centre for Community Ophthalmology (KCCO) has been involved in a five-year pilot project to improve low vision services for children in Tanzania.Low vision services were limited to a few tertiary hospitals and were accessible to only a few children.

Children with low vision were usually enrolled in schools for the blind, most of them without having received an eye examination or refraction. In these schools, many teachers believe that reading "destroys your vision" and that children with low vision should learn to use Braille; they also believe that all visually impaired children "will lose their sight in the long run."

To address this, better provision of low vision services and better linkages between education and eye care were needed. To improve provision of low vision services, it was decided to integrate low vision into existing district and regional eye care services, and to train the many optometrists already working at regional or district (population about 1 million) level. One of the key factors in the success of the programme was the appointment of a Childhood Blindness and Low Vision Co-ordinator (Elizabeth Kishiki) to co-ordinate, plan, and teach. Each trained optometrist was also given the lead role in his or her region with a strong report-back mechanism.

Elizabeth Kishiki

Many children have benefited from the low vision programme. TANZANIA

To improve linkages between education and health services, teachers were trained in the need for regular low vision care and assessment as well as the use of print (rather than Braille), when appropriate. Combining some of the training sessions to include both teachers and optometrists improved co-operation and collaboration. To ensure sustainability, low vision training was included in special education teacher training at the training college in Arusha.

Meetings were held to improve collaboration between government, non-governmental organisations, and private stakeholders in both education and eye care. This national consensus had to be translated into action at the regional/district and local level, mainly through training of education and eye care workers.

Follow-up was crucial. SMS reminders were used to ensure that children had clinical follow-ups on an annual basis. The co-ordinator made regular calls to the optometrists, and they would visit schools to troubleshoot as needed.

The training of district special needs education officers, who are responsible for annual budgeting, has in some districts led them to include low vision assessments, optical devices, spectacles, and non-optical devices in their district budgets.

While at the start of the programme, only 13% of children at annexes had been assessed by an eye care professional before admission, after four years, 82% had been assessed and were provided services. Some challenges remain, particularly because so many people and services have to co-operate to make low vision services work, but the benefits have made it worth doing.

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An integrated low vision service: Sri Lanka

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Unusually for a low- or middle-income country, Sri Lanka provides free health services through government hospitals and other outlets.

Before, services for the estimated 140,000 people with low vision in Sri Lanka were provided by just three low vision clinics at tertiary hospitals; this meant that few people received the help they needed.

When a national eye care plan was developed in 2007, international non-governmental organisations (INGOs) such as Sightsavers and the International Centre for Eye Care Education were able to make a strong case for including low vision. As a result, and thanks to the support of the ministry of health, low vision was part of the national eye care plan from the outset. The necessary linkages with education, rehabilitation, and social services could also be established.

Implementation started in 2008 and the first priority was to strengthen the three clinics at tertiary level so they could provide visual skills training, orientation and mobility training, and counselling services for people with low vision.

Ten secondary level clinics, with strong referral links to the three tertiary clinics, were then established within existing district hospitals. These are easily accessible to most people, and offer comprehensive low vision assessment, prescription and dispensing of low vision devices, and training in the use of low vision devices. People with complicated needs are referred to the nearest tertiary low vision clinic for further management.

Ophthalmic technologists provide the services in the ten new secondary level clinics. These eye care practitioners were already working in the eye units at district level, with their salary paid for by government. Their availability, experience, and existing refraction skills made them the ideal group to train for this task.

Significant progress has already been made. By 2010, nearly 8,000 people (10% of which were children) had been helped, five times as many as in the previous three years.

The next step is to extend low vision services through community-based rehabilitation (CBR) services in order to reach under-served areas and groups; this will form part of existing CBR projects.

Programme planning and implementation is driven by the National Focal Person for Low Vision, Dr Saman Senanayake, who works in consultation with the ministry of health and INGOs. The expansion of the programme has been achieved through co-ordinated national planning, advocacy, human resource development, and the availability of affordable and low cost equipment.