Study of four schools for the blind in Sri Lanka

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Introduction

The committees that manage schools for the blind in Sri Lanka include either the Chairman of the Provincial Council, Additional Government Agent or the Government Agent, the principal of the school and selected members of the community. The education ministry remunerates teachers, and the living expenses of the children are borne by the Social Services Department. The current world opinion is that blind children need not be institutionalised but educated in the general education system with help from adequately trained teachers (1). In Sri Lanka too the Ministry of education has trained many teachers for educating blind children in the integrated education system (1). But schools for the blind still continue to function in Sri Lanka.

Objectives

To determine the criteria for entrance to schools for the blind, degree of visual impairment of inmates, rehabilitation facilities available, and the level of education of a blind child as compared to a sighted peer of similar age in the general education system.

Methods

Four schools for the blind were selected at random, two in the Central province, one in the North Central province, and one in the Uva province. With permission from the principals of the respective schools to examine the children, a team from the Centre for Sight comprising a medical officer trained in ophthalmology, an optometrist and a helper, visited the selected schools.

The principal of each school was questioned with regard to the entrance criteria, facilities available for the children and administration of the schools. The data obtained by interviewing and examining the children were entered in the WHO/PBL eye examination record form for children with blindness and low vision (2). A child with visual acuity of <3/60 in the better corrected eye or a field of less than 10° in the better corrected eye was considered blind (3). <6/60 to ≥ 3/60 was defined as severe visual impairment, <6/18 to ≥ 6/60 as visual impairment and ≥ 6/18 defined as normal vision as per WHO classification (3).

Children were referred back to the Centre for Sight for further investigation and management if visual acuity was ≥ 3/60 in any one eye after correction or when surgical intervention was thought to be necessary. If surgery was required, the surgical procedure and prognosis was explained to the patient and the parents. Surgery was carried out at the Centre for Sight with parental consent.

Results

A total of 50 children were examined (Table 1). Their ages ranged from 7 to 18 years. No report from an ophthalmologist was needed to enrol a child in a school for the blind, but a report from the Grama Niladhari and the principal's recommendation were essential.

Table 1. The number of children who were considered blind or not blind by the WHO definition

	<3/60 in better eye (Blind)	*≥3/60 in better eye (Not blind)*	*Total*
Dodanwela	11	4	15
Kaikawela	0	0	0
Monaragala	3	10	13
Anuradhapura	13	9	22
Total	27	23	50

Only twenty-seven children (64%) in these schools were blind according to the WHO definition of blindness, but 23 children (46%) had low or normal vision with correction (3). Table 2 shows that 3 children had visual acuity of 6/6 (normal vision) in the unaffected eye with no correction. The vision of 3 children could be corrected to <6/18 to ≥ 3/60 and classified as low vision (3).

Table 2. The visual acuity and number of children who had low or normal vision in the better eye

Visual acuity	*Corrected/ not corrected*	*Number of children*
6/6	Not corrected	3
>6/18	Corrected	3
6/18 to ≥3/60	Corrected	13
Potential for better vision by surgery		4

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Table 3. Distribution of teachers in each of the schools for the blind

	Number of Children	*Number of trained teachers*	*Number of untrained teachers (volunteers)*	*Trained teacher to student ratio*
Dodanwela	15	16	5	0.9
Kaikawela	0	3	0	0
Monaragala	13	1	6	13
Anuradhapura	22	8	2	2.8
CP* integrated system	13	20	0	0.7

*CP: Central province

Table 3 shows the distribution of teachers in the schools for the blind. 62% of the children had fallen back by 2 years or more when compared to their counterparts in the general education system (Table 4). Only one student from these schools was eligible for University entrance during the past 5 years.

Table 4. Educational proficiency of the children in the schools for the blind as compared to a sighted peer in the general education system

Fall-back years compared to normal child	*Number of children*
>2	19
≥2	10
3	10
4	4
≥5	7

Discussion

The prevalence rates for childhood blindness are yet to be established for Sri Lanka. A study in the Central province in 1999 and 2000 showed the prevalence of childhood blindness as 0.72 per 1000 (Edussuriya and Abeysinghe, unpublished data). The number of schools for the blind in Sri Lanka is also not documented. A child who is blind could enter a school for the blind, the general education system or a vocational training institute. The usual practice is to refer any severely visually impaired child to the closest school for the blind, the advisor in most cases being the Grama Niladhari officer.

The degree of visual impairment of the child for enrolment is assessed by the child's reading ability and navigational ability. Admission to these schools is at the discretion of the principal and a panel nominated by the school. A scientific assessment was not used, and clear selection criteria were not available. None of the schools required an ophthalmologist's recommendation or report on the child's visual disability for admission. Continuous ophthalmological assessment was not carried out on the inmates of the schools for the blind and their visual progression was not monitored. It was observed that 46% of the children in these schools were not blind according to the WHO criteria (3).

Included in this category were 3 children who were blind in one eye but had 6/6 vision in the unaffected eye. The conditions in the affected eye were non-progressive and were not known to lead to any visual impairment of the unaffected eye. These children learnt Braille but were also taught to read and write. They were institutionalised and had limited opportunities to socialise or keep company with peers or children in their age group. The rationale for learning Braille was not clear, and the future prospects for employment or educational progression was not defined. The reason for entry of the children into these schools was not investigated, and it would be interesting to probe whether the reason was economic or social.

In the three children with correctable vision, there was a myope, an astigmat and a myopic-astigmat whose vision could be corrected to 6/6 in at least one eye with lenses. These children had never been seen or reviewed in an ophthalmologic clinic, and had bypassed the ophthalmology facilities available due to ignorance and poor educational background of the parents. In spite of corrective lenses provided to these children, they are still in the schools for the blind, but we hope to counsel their parents and encourage them to be sent to schools in the general education system. The presence of the above two groups of children in these schools cannot be justified and show that poor selection criteria have been used. This may limit their prospects in education and employment.

In 13 children lenses and magnifiers improved their vision to the level of low vision as defined by the WHO (3). The visual support offered to them eg low visual aids, bright lights, contrasting colours and sensory clues were not apparent in any of these schools, indicating a lack of knowledge and awareness by the staff in rehabilitating children with low vision.

Among the 4 children who had potential for good vision, 2 were high myopes where a lens extraction or con-

tact lenses might have helped, but these 2 children did not come in for re-assessment. In the other two, who had congenital cataracts, lens extraction had been done in the past but no corrective lenses had been given. We suspect amblyopia due to sensory deprivation, as they were not corrected post-operatively.

The recommendation by the ministry of education is that one teacher is needed for every 5 disabled children (4, 5). Considering the children only in the Central Province, there were 28 blind children and 36 trained teachers. From this group 15 children were in the schools for the blind, with 16 teachers, and 13 children in the integrated education system with 20 teachers. It is apparent that the number of teachers in both systems is in excess and that there is mal-distribution of staff among the different schools for the blind studied.

The reason for a fall in educational proficiency of 2 years or more in 62% of children may be due to their handicap, lower than normal IQ or poor training. The number of university entrants was very low. It was noted that the children who ended their education in the schools for the blind had left the institution for their homes. Their whereabouts and their livelihood were not known. Giving these children an education with no vocational training seems of little value for day-to-day life.

Recommendations

If schools for the blind are to continue, guidelines need to be formulated for entry by the Ministry of Health, Ministry of Education and Ministry of Social Services. It would be useful to provide a system of counselling for the children and their parents with regard to education and career prospects. Defining objectives and goals of education on an individual basis, assessing and recording the visual progress, improving visual rehabilitation facilities by an expert, ensuring that the optimum conditions are available for the children with low vision are of vital importance. Developing a database to determine the value of education and progression in life after passing through the school would be necessary for future program modification.

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