Our Vision

To be widely recognised as a significant contributor to the prevention of blindness worldwide, by funding training and medical research.

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For many years this charity has chosen to support the education and training of future leaders in the international struggle to alleviate the burden of blindness and impaired vision. The focus has been on seeding the development of eye care services where they are most needed. Are we achieving the desired result? The details of the careers of Dr Kalua in Malawi, Dr Mathenge in Rwanda and Dr Abdull in northern Nigeria, all described in this review (pages 8-13), provide great encouragement. They are now leaders who are actively pushing forward with local training and research in centres that they have helped to develop and consolidate. You can also read reports from our Boulter Fellows (pages 14-17) from which it is clear not only that the Fellows value this training highly, but also that it enables them to play a vital role in developing services in their home countries, just as their predecessors have done.

As the economies of individual nations advance it is sometimes difficult to be sure when the transition from being a “developing country” to becoming a “developed” one has been completed. The process seems slow and often hesitant. During the transition and possibly for a long time afterwards there seem to be inequalities in healthcare between the different communities in a country, especially when rural is compared with urban. Progress is often inhibited by a shortage of skilled personnel and when the budget of a country does become strong enough to fund more services to identify and treat eye disease the people we help to train are particularly effective.

We have a clear view of our role in the effort to cut the distressing burden of avoidable blindness. This does not require a high profile brand image and I feel it is something our perceptive and discerning donors will understand. A low key, carefully targeted policy is efficient and effective. Sometimes the results are dramatic, as you will appreciate from the report of progress in the diagnosis by smartphone project led by Dr Bastawrous.

This year Professor James Morgan and Dr Claire Walker retired from Council. We thank them both for important contributions, James as chairman of the Advisory Panel and Claire as Honorary Secretary. I welcome Miss Brenda Billington and Mr David Hughes who join the Trustees. Both have valuable experience in the practical and administrative aspects of eye disease in the UK and overseas. Their sound advice will be very helpful.

Finally I invite you to visit our website, www.bcpb.org. It gives all the details of our aims and achievements, the grants for research and training that we make, now ranging from £5,000 to £180,000, and the personalities who support us as well as those whom we support.

Dr Jeffrey Jay CBE, BSc, FRCS, FRCOphth

"Mighty oaks from little acorns grow"
VISION 2020: The Right To Sight (www.v2020.org) is a worldwide concerted effort to eliminate avoidable blindness by the year 2020.

The programme will enable all parties and organisations involved in combating blindness to work in a focused and co-ordinated way to achieve the common goal of eliminating preventable and treatable blindness.

The BCPB and VISION 2020: The Right To Sight

- Somewhere in the world, a child goes blind with every passing minute
- In eight out of ten cases blindness is avoidable – treatable or preventable
- Blindness causes suffering not just for those people directly affected. The impact of lost productivity, as well as the direct costs of rehabilitation, has a significant effect on families and communities, particularly in developing countries, where 90% of blindness is concentrated.

The BCPB fully supports the aims of VISION 2020: The Right To Sight and we are committed to playing our part in eliminating avoidable and treatable blindness by funding:

- Practical research into the causes of blindness, more effective treatments, and preventive methods
- The training of eye care professionals from the developing world to enable them to implement blindness prevention programmes in their home countries.
Our belief and our wish is that no-one, anywhere in the world, should lose their sight if this can be prevented.

Our Vision For Change

- 90% of the world’s 68 million blind people live in low income countries
- Over 1.2 million people become blind every year
- Somewhere in the world, a child goes blind with every passing minute
- 80% of this blindness is avoidable - treatable or preventable now.

We aim to contribute to VISION 2020 goals by:

- Providing trained personnel to lead the development of eye care where it’s most needed, in low income countries
- Funding research to develop new treatments and better methods of delivery, and to foster local knowledge and best practice to improve blindness prevention in low income countries.

Key achievements

- Work funded by BCPB led directly to the discovery of Ivermectin, now used widely in Africa to prevent onchocerciasis, or ‘river blindness’, which once blinded millions of people
- Over the last 10 years BCPB has made grants totalling over £2.3m for research and training in the field of blindness prevention
- Since 1980, we have part-funded over 100 eye care professionals from low income countries to train at Masters level in Public Health for Eye Care at the London School of Hygiene and Tropical Medicine
- BCPB Fellows have already become national leaders in blindness prevention in Rwanda and Malawi
- Our research has led to greater understanding and better treatment of diseases including glaucoma, Age Related Macular Degeneration, trachoma, and childhood cataract. Over 150 scientific papers have been published in the last 5 years alone as a result of BCPB funded research
- The people we train pass on their knowledge and skills over the course of their career to thousands of others. Based on our research, we estimate that each person we train will in turn train 200 others in the course of their career. This ‘skills cascade’ is at the heart of our work.
# Research and Training Projects Currently Funded

<table>
<thead>
<tr>
<th>Project</th>
<th>Total Cost of Project (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen Gichuhi, International Centre for Eye Health (ICEH): The epidemiology and management of ocular surface squamous neoplasia in Kenya</td>
<td>£180,005</td>
</tr>
<tr>
<td>Dr Mohammed Abdull, ICEH: Improving control and early detection of glaucoma in Nigeria: a pragmatic, randomized trial of enhanced explanation of glaucoma and its treatment to adults newly diagnosed with moderate/advanced glaucoma</td>
<td>£179,915</td>
</tr>
<tr>
<td>Professor Paul Foster, UCL Institute of Ophthalmology: Long-term changes in anterior segment configuration in primary angle closure suspects with or without prophylactic laser iridotomy</td>
<td>£59,978</td>
</tr>
<tr>
<td>Dr Andrew Bastawrous: Ophthalmology In Your Pocket: validating the use of smartphones for the diagnosis of eye diseases in Nakuru, Kenya</td>
<td>£59,980</td>
</tr>
<tr>
<td>Dr Nicholas Beare: Treatment of Diabetic Retinopathy in Malawi</td>
<td>£59,570</td>
</tr>
<tr>
<td>Boulter Fellowships: part-funding for 3 eye care professionals from developing countries to undertake MSc or Diploma in Public Health for Eye Care at the International Centre for Eye Health, at the London School of Hygiene and Tropical Medicine</td>
<td>£40,800</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£580,248</strong></td>
</tr>
</tbody>
</table>

Most of these projects are funded across more than one Financial Year.

A patient has their retina examined by a community healthcare worker using PEEK in their home.
BCPB's research grants are aimed at providing seed funding for promising new avenues of research. The ‘Smartphone Diagnosis’ project described below is just one example.

In low-income countries there are not enough trained personnel and ophthalmic equipment available to detect potentially blinding conditions, so that many people do not get identified as being at risk of blindness, nor receive the necessary treatment. Cost and portability are the main hurdles to the availability of the equipment in these settings. However, smartphones are relatively cheap and, of course, mobile – they can be taken to the patient. This project tests the use of mobile phones, adapted to include special hardware allowing measurement of vision as well as the detection of eye conditions (including refractive error and cataract). The adapted smartphones – named the Portable Eye Examination Kit (PEEK) - take a photo of the back of the eye, which is then assessed by an ophthalmologist to diagnose the eye condition. The researchers then compare these measures against ‘gold standard’ methods of diagnosis, using much more expensive equipment, to assess the accuracy of the smartphone diagnosis.

The project forms part of the Nakuru Posterior Segment Eye Study 5-year follow up. The original survey was funded by BCPB, and carried out by Dr Wanjiku Mathenge, who was the recipient of BCPB’s first Sir John Wilson Fellowship (see pages 10-13), in 2006. The researchers doing the follow-up, which is funded by the Medical Research Council and Fight For Sight, will examine around 3,000 participants aged 55 and over; of whom 25% were blind or visually impaired at baseline. BCPB is funding the ‘smartphone diagnosis’ element of the research.

The testing in Kenya was completed earlier this year and now the data is being analysed and three papers being written up for publication. The team are comparing the results of smartphone diagnosis against standard equipment and aim to publish their results later this year.

Case Study:

Margaret had walked for two hours to catch the bus, then travelled for a further three and half hours to bring her to the main town for her annual eye examination. Being diabetic she had been advised how important it was to have regular check ups to ensure she didn’t lose her vision, something she took very seriously after her older brother had gone blind from diabetes.

The problem was, she didn’t always have the money to travel to town and a day away from home meant she couldn’t work or her support her children. On the bus journey, Margaret’s sugar levels became very low and she almost passed out, fortunately a fellow passenger was able to share some food with her.

When she eventually arrived at the eye clinic she was asked to wait in the long queue for a retinal examination. Margaret tried to be patient but worried about missing her transport home and was anxious that the examination may reveal she had problems at the back of her eye.

Fortunately her eye exam revealed the changes in her eyes were mild and that she was not currently at risk of sight-loss. She must however come back again for another examination in six months. This she knew would not be easy, particularly as it would be the harvesting season and a day away is not something she could afford.

In a nearby village, a friend of Margaret was being examined as part of a study comparing hospital eye equipment and a mobile phone which could be used to examine eyes. As Margaret’s friend told her about this the following week, she was amazed to hear it could be used to measure vision, take photos inside her eye and most importantly, it could all be done in her own home. The retinal pictures were then sent to the hospital and a text message report sent back. With this new technology the hospital would effectively come to her and she would only need to travel if absolutely necessary.
Our Fellowships are fully funded by BCPB and lead to the award of PhDs and MDs. Sir John Wilson Fellowships are awarded to researchers based overseas who come to the UK for a part of their project, whilst Barrie Jones Fellowships are awarded to UK based researchers who travel to a low income country to carry out their research.

The aims are:

• to provide top level eye care personnel in low income countries, in order to build knowledge and skills in eye care where they are most needed. Fellows from developing counties are selected partly on their ability and ambition to disseminate knowledge and skills through teaching and training

• to build the knowledge base about how best to prevent blindness in low income countries

• to foster links between UK institutions and those in low income countries, in order to facilitate a mutually beneficial transfer of knowledge in eye care.

To achieve these aims, an Advisory Panel was established to select and monitor projects. (see table opposite).

BCPB is a member of the Association of Medical Research Charities (AMRC) and complies with its guidelines for best practice.
Advisory Panel

**Professor Paul Foster**
Chairman
BMedSci(Hons) PhD
FRCS(Ed) FRCOphth
Professor of Glaucoma Studies
Department of Genetics and
Epidemiology UCL Institute of
Ophthalmology, London

**Mr Peter Ackland**
Overseas Advisor
Chief Executive Officer
International Agency for the Prevention of Blindness

**Dr Matthew Burton**
PhD MA MBCh DTM&H
MRCP FRCOphth
Senior Lecturer International Centre for Eye Health, London

**Mr Andrew Cassels-Brown**
MBBS FRCS (Ophth)
FRCOphth MScCEH
Consultant Ophthalmologist & Consultant Community Eye Health, Hon Senior Clinical Lecturer University of Leeds

**Professor Simon Harding**
MB ChB, FRCS, FRCOphth, MD
Professor of Clinical Ophthalmology, Honorary Consultant Ophthalmologist and Head, Ophthalmology Research Unit, School of Clinical Sciences, University of Liverpool

**Professor Andrew Lotery**
MD FRCOphth MB ChB BAO
Professor of Ophthalmology University of Southampton

**Professor Caroline MacEwen**
MBChB MD FRCS(Ed), FRCOphth, FESEM
Head of Department & Consultant Ophthalmologist, Ninewells Hospital, Dundee and Vice President of the Royal College of Ophthalmologists

**Miss Winifred Nolan**
MBChB FRCOphth MD
Consultant Ophthalmologist MoorFields Eye Hospital, London

**Mr John Salmon**
MD FRCS FRCOphth
Consultant Ophthalmologist Oxford Eye Hospital

**Professor Peter Scanlon**
MD DCH DRCOG DO PG Cert Med Ed FACP FRCOphth
Consultant Ophthalmologist Cheltenham General Hospital

**Dr Elena Schmidt**
BA MPH PhDc
Head of Research, Sightsavers

**Professor John Sparrow**
MBBCh DPhil DO FRCS FRCOphth
Consultant Ophthalmologist Bristol Eye Hospital (Appointed May 2012)

**Dr David Yorston**
MBChB FRCOphth
Consultant Ophthalmologist Greater Glasgow & Clyde Health Board
Glaucoma is a condition that can cause blindness, usually due to a build up of pressure within the eye. The eyeball contains a fluid called aqueous humour that is constantly produced by the eye, with any excess drained away through tubes. Glaucoma develops when the fluid cannot drain properly and pressure builds up, known as intraocular pressure. This can damage the optic nerve (which connects the eye to the brain) and the nerve fibres from the retina (the light-sensitive nerve tissue that lines the back of the eye).

Dr Abdull was a BCPB Boulter Fellow in 2007-8 (see pages 14-17), and we are delighted that he has progressed to Doctoral level, and is leading blindness prevention in his region, where he is a Chief Consultant Ophthalmologist at Abubakar Tafawa Balewa University Teaching Hospital, Bauchi State, Northern Nigeria.

The prevalence of blindness due to glaucoma is higher in Africa than other regions. The reasons for this include disease factors (earlier age at onset and more aggressive disease), patient factors (lack of awareness, poor adherence to eye drops, low acceptance of surgery) and a lack of trained personnel and equipment for diagnosis and treatment. In developed countries counselling has been shown to improve acceptance of and adherence to treatment for glaucoma, but until now no research testing counselling interventions has been undertaken in Africa.

This project has two broad objectives: to develop a counselling intervention for glaucoma through interviews and discussion with the local population; and then to use this intervention in a clinical trial to test whether this leads to improved acceptance of and adherence to treatment among glaucoma patients in Bauchi, Nigeria.

Sir John Wilson Fellowship

Dr Mohammed Abdull: Preventing Glaucoma in Nigeria

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Dr Abdull explains:

We adapted Motivational Interviewing (MI) as the vehicle to use in counselling our patients. I attended courses in Motivational interviewing in Cardiff, Wales and Venice Italy. With the training acquired, I trained two more interviewers in the techniques and together we have been practicing to perfect it. We have received favourable feedback from experts in the field.

Next we carried out a pilot study for 4 months where we compared 2 groups of patients — those randomized to have MI plus a standard explanation about glaucoma, with those receiving only a standard explanation with no MI. The data from the pilot study was analysed and the information was used to further refine the protocol and finalise our data record forms. Results from the pilot study showed that MI improved acceptance of surgery in the patients needing it. Acceptance of surgery among those who had MI was 47% while among those who had no interview it was 37%.

Through funding by the BCPB we are now able to offer more treatment options than we previously had to our patients. We now offer an alternative laser treatment for those who fear conventional glaucoma surgery called trabeculectomy. And as a result of the MI patient acceptance all forms of treatment have increased greatly with many more patients having the surgery needed to save their sight.

My department is now the site of a clinical trial sponsored by the London School of Hygiene and Tropical Medicine (LSHTM) and funded by the BCPB to test the effect of MI and laser treatment in management of glaucoma and prevention of blindness. We have over the last 2 years treated over 2000 patients with glaucoma with about 300 having laser as primary treatment. Many patients like Ummi — see below - are now beneficiaries of our improved management of glaucoma.

Case Study: Ummi

Ummi is a 20-year-old woman who wanted to study to be a nurse but had to drop out because she could not see well enough to continue with her studies.

She presented to us 3 years ago with blindness in one eye and very advanced glaucoma in the other eye - demonstrating the aggressive nature of the disease in Africans, typically starting at a very young age and progressing rapidly. Treatment with maximally tolerated eye drops has not controlled her very high intraocular pressures. Her disease was so advanced that we were afraid surgery would wipe out her remaining vision. So instead we offered her the new laser treatment.

The results have been very pleasing so far. Ummi has been with us now on regular follow-up for 2 years following her laser treatment. Without this intervention she would have been totally blind by now given the rate of progression we noted at the time she was diagnosed. Many more patients like Ummi are now being helped, thanks to the support that I have received from BCPB both in terms of the current research project and my prior MSc in Community Eye Health.
Epidemiology and management of ocular surface squamous neoplasia in Kenya.

In East Africa, ocular surface squamous neoplasia (OSSN) is a relatively common and particularly aggressive eye disease affecting younger adults, causing great distress, visual disability and even death. New cases number some 19,000 a year in Sub-Saharan Africa.

Management of OSSN is challenging for various reasons: its causes and risk factors are unclear; cases present late, early diagnosis is problematic and recurrence after treatment is high. Studies have implicated HIV, human papilloma virus (HPV) and solar radiation in its causation. However, about 30% of cases are HIV negative. Some studies have found an association with HPV and others have not. The importance of vitamin A for a healthy ocular surface is known, yet its role in OSSN is not. The reasons for late presentation have not been investigated. OSSN appears similar to other conjunctival tumours and accurate diagnostic services are frequently unavailable in Africa. Treatment usually involves surgery to remove lesions. However, up to 30-66% recur within 2½ years. There is no trial evidence that the various treatment alternatives in clinical practice are effective.

The researchers, led by Stephen Gichuhi in Kenya, are conducting a large case-control study to investigate risk factors that may contribute to the development of OSSN. They are evaluating a special dye called Toluidine Blue for making the diagnosis, investigating reasons for late presentation to identify factors that could lead to patients coming forward earlier for treatment, and finally, conducting a randomised controlled trial of 5-Fluorouracil chemotherapy eyedrops given after surgery to see if this can reduce the recurrence of the lesions.
Updates from Former BCPB Fellows

The following two stories show the benefits of BCPB Fellowships unfolding over a number of years, as Fellows develop their expertise and progress to leadership positions in eye care within their regions. We call this the ‘skills cascade’.

Dr Khumbo Kalua: Eye Care for Children in Malawi

The story of BICO demonstrates the value of BCPB’s seed-corn funding. The Fellowships we fund are leading not only to greater local expertise and leadership in eye care where it is most needed, but also to a growing eye care infrastructure.

BICO was established by Dr Khumbo Kalua in Malawi in 2008 with funding from a Sir John Wilson Fellowship awarded by BCPB in 2007. This Fellowship project looked at new methods of referring children at risk of blindness in rural villages for hospital treatment, using both trained volunteers and healthcare assistants. The final report and Doctoral thesis emerging from this research is expected in 2015.

Meanwhile, a lasting legacy has been the establishment of BICO. Its mission is the prevention and control of blindness in Malawi and neighbouring countries in the Southern part of Africa through conducting practical research, teaching, training, consultancy and advocacy in eye care delivery. Under the leadership of Dr Kalua, children’s eye care needs are being specifically addressed. So far some 150 children with visual impairment have been helped with glasses, or surgical treatment where necessary.

BICO has now become a prominent eye care NGO in Malawi, employing 8 full-time staff, and leading research work, with grants from and collaborations with NGOs internationally.

BICO has published over 15 articles in peer reviewed journals over the last 3 years, and Dr Kalua has recently been made an Associate Professor at the College of Medicine, University of Malawi.

More details can be found on BICO’s website: www.bicomalawi.org

Dr Ciku Mathenge: Developing Eye Care in Rwanda

Dr Ciku Mathenge was our first BCPB Fellow, some 8 years ago.

Ciku is currently Director of Training and Research at Rwanda International Institute of Ophthalmology (RIIO), which works jointly with Dr Agarwal’s Eye Hospital (DAEH) Rwanda, providing both ophthalmic care and training.

Dr Ciku Mathenge writes...

“Since completing my PhD I have been able to set up a large retinal clinic at DAEH Rwanda that provides medical and surgical retina services to patients from several countries. Through RIIO I hope to set up the first eye care Fellowship Programme in the region.”
The BCPB’s Boulter Fellowship scheme - named after the late Eric Boulter, one of the founders of BCPB - has been running since 1982. Since that time BCPB has part-funded more than 100 eye care professionals from the developing world to train at the London School of Hygiene And Tropical Medicine (LSHTM) to acquire the specialist skills so greatly needed in their country of origin.

The Boulter Fellowship Programme

The BCPB makes a contribution towards both tuition and living expenses for the Boulter Fellows, who come to London to undertake a Master of Science Degree in Public Eye Health at the International Centre for Eye Health, within the LSHTM. Training in Public Eye Health extends the trainees’ expertise in clinical ophthalmology, which is applied to individual patients, to cover the eye health of whole populations – how their needs can best be evaluated and met, and how the challenges of doing this in low income countries can be overcome. Sharing knowledge with other eye care professionals and maintaining contact after the course via the alumni network are key elements.

The VISION 2020 global programme for the elimination of avoidable blindness (see page 4) has human resource development as a key component. This course is designed in keeping with the objectives, priorities and strategies of VISION 2020 and aims to equip eye care professionals with the knowledge and skills they need to implement the VISION 2020 programme at national and regional level. The students, once trained, return home to help set up and manage eye care programmes to save and restore sight.

Boulter Fellows 2013 -2014

Isaac Baffoe
Optometrist
Watborg Eye Services, Kasoa Central Region
Location: Ghana

Jane Nyawire Mwangi
Lecturer
Kenya Medical Training College
Location: Kenya

Prabath Piyasena
Senior house officer
Sri Lanka National Eye Hospital
Location: Sri Lanka
Dr Ada Aghaji, Lecturer and Consultant Ophthalmologist, University of Nigeria Teaching Hospital, BCPB Boulter Fellow 2010-11. She estimates that she now cares for around 1200 eye patients and trains 5 members of staff every year, who in turn look after some 12,500 patients over the course of a year.

This year’s Boulter Fellows speak about the course and the benefits it offers

Dr. Affiong Ibanga, Nigeria, Boulter Fellow 2011-12, presents prizes for an essay writing competition on eye care in a school.

The Skills Cascade

“I was trained to be a clinical ophthalmologist, but this course has reoriented me into thinking like a community ophthalmologist.

When a patient comes into the clinic with an eye problem, I now think, where is this patient coming from? How many more in his/her community have this problem? What made this patient come here today? How about the others who haven’t come, what prevents them from coming here?

Combating blindness cannot be done at a clinical level. It has to be done at a community level. It will involve all cadres of workers, especially at primary level. The programme has given me the skills to design an eye care curriculum for primary care workers.”
This year’s Boulter Fellows speak about the course and the benefits it offers - continued

We are aiming to implement blindness prevention strategies that are based on scientific evidence of positive impact. Thanks to the course I can review and critique evidence from other research projects and assess how applicable they might be in our setting, and I am now better equipped with knowledge and skills in areas like statistics to design and implement my own field research projects. Though Ghana has a number of activities and initiatives in place to prevent blindness, evidence on their effectiveness is lacking, but I can now see what needs to be done to improve things.

Dr Isaac Baffoe, Senior Optometrist, Watborg Eye Service, Ghana, Boulter Fellow 2013-14.

This MSc course covers the range of knowledge and skills needed for public health in eye care in any country. I learned the essential principles of epidemiology, statistics and health economics – which are the fundamental principles of all public health. The process of learning at LSHTM was excellent. Initially we were taught the principles, followed by practical applications and an assessment, applying those principles. These concepts were not just academic: I can now calculate the cost effectiveness of any intervention. This is one of the most crucial factors when you are working, as we are, in a resource poor setting, like Sri Lanka, where every single unit of currency matters in a health budget.

Prabhath Piyasena, Senior House Officer, National Eye Hospital, Colombo, Sri Lanka.
The training has given me skills in budgeting, proposal writing for funding of eye care activities, accessing technology for VISION 2020 and care of ophthalmic instruments. I will use these skills to ensure resources for eye care are mobilised and utilised optimally, since resources are quite limited. This will contribute to enhancing sustainability of eye care because losses and wastage will be minimised. Since we now know where to get assistance with equipment maintenance, equipment that has been lying unutilised because of the need for minor repairs will be put into use.

Skills gained from the course include academic writing skills. This means I can write scientific papers and also train others in my team to do the same. In this way we can improve the quality of scientific papers and journals written in my setting. Skills in literature search will enable us to access information published by other professionals in other parts of the world, so that it can be used to inform practice. Conference presentation skills will help strengthen knowledge translation and sharing in the context of continuous professional development.

I have also increased my understanding of cross-cultural approaches to eye care. In addition, my perception on the role of gender issues, socio-economic differences, lifestyle variations and how these contribute to the epidemiology of blinding eye diseases has increased. I am now conscious of the need to address issues like inequity and poverty for they contribute to the eye diseases that we treat, such as trachoma and childhood blindness. I also recognise the value of local and international efforts in eye care - VISION 2020 and funding for interventions from developed countries like the UK.

Dr Nyawira Mwangi, Ophthalmology Training Programs Co-ordinator and Principal Lecturer at the Kenya Medical Training College.
Supporting the BCPB

Our work in preventing blindness cannot take place without the generosity of individuals, trusts and companies.

**Gift Aid**  All gifts made to charity now qualify for tax relief. In effect this means that, simply by signing the declaration below, all your donations will increase in value, at no extra cost to you. For example, a donation of £25.00 in 2014-2015 will become £31.25, or more if you pay tax at the higher rate.

**Making a Will**  Whether you have already made a will or are thinking of doing so, please consider making a charitable bequest to the BCPB. Legacies can make an enormous difference to our work and what we can achieve.

**Regular Donations**  By giving regularly, you can make it much easier for the BCPB to plan important projects - providing income we know we can rely on.

**Website**  You can donate on-line at www.bcpb.org

To make a single or regular donation please fill in the appropriate sections below and send to the British Council for the Prevention of Blindness, 4 Bloomsbury Square, London WC1A 2RP

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### SINGLE DONATION

You can also make donations on-line. Simply go to www.bcpb.org/donations.html With step by step instructions it is easy, fast and convenient.

Please accept my / our donations towards preventing blindness and restoring sight:

- £25  □
- £50  □
- £100  □
- £ __________________________

(Whatever you can afford to help our work)

Name __________________________  Address __________________________

________________________________________  Postcode ________________

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### GIFT AID

Signing this declaration will enable us to reclaim the tax you have paid on your donation, increasing the value of your gift at no extra cost to you. I would like all gifts to the British Council for Prevention of Blindness, registered charity no. 270941, paid on or after the date of this declaration to be Gift Aid donations.

I pay tax at the □ basic rate  □ higher rate  Signature ________________  Date __________

Please note: You must pay enough UK Income Tax or Capital Gains Tax to cover all your charitable donations for your gift to be eligible for Gift Aid.

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### BANKERS FORM (For regular donations)

To (Bank name) __________________________

Please pay: The British Council for Prevention of Blindness

4 Bloomsbury Square, London WC1A 2RP
Bank Sort Code: 40 01 06, Account Number: 81168150

The sum of £ __________________________

Amount in words __________________________

Start date* __________________________

(please allow at least one month from today’s date)

And afterwards on the same day each month/quarter/year until further notice (delete as appropriate).

* This cancels all previous orders.

Signature __________________________  Postcode ________________
## Income & Expenditure:

Year ended 31st March 2014

<table>
<thead>
<tr>
<th></th>
<th>Unrestricted Funds</th>
<th>Restricted Funds</th>
<th>Total 2014</th>
<th>Total 2013</th>
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<tr>
<td>Incoming resources from generated funds:</td>
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<td>Voluntary Income</td>
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<td>Investment income</td>
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<td>3,983</td>
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<tr>
<td><strong>Total</strong></td>
<td>493,226</td>
<td>100</td>
<td>493,326</td>
<td>254,411</td>
</tr>
<tr>
<td><strong>RESOURCES EXPENDED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of Generating Funds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fundraising and publicity</td>
<td>26,360</td>
<td>–</td>
<td>26,360</td>
<td>26,987</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>26,360</td>
<td>–</td>
<td>26,360</td>
<td>26,987</td>
</tr>
<tr>
<td>Charitable activities</td>
<td>183,104</td>
<td>5,000</td>
<td>188,104</td>
<td>144,833</td>
</tr>
<tr>
<td>Governance costs</td>
<td>21,444</td>
<td>–</td>
<td>21,444</td>
<td>15,732</td>
</tr>
<tr>
<td><strong>TOTAL RESOURCES EXPENDED</strong></td>
<td>230,908</td>
<td>5,000</td>
<td>235,908</td>
<td>187,552</td>
</tr>
<tr>
<td><strong>NET (OUTGOING)/INCOMING RESOURCES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrealised (loss)/gain on investments</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>NET MOVEMENT IN FUNDS</strong></td>
<td>262,318</td>
<td>(4,900)</td>
<td>257,418</td>
<td>66,859</td>
</tr>
<tr>
<td><strong>FUND BALANCES BROUGHT FORWARD</strong></td>
<td>411,302</td>
<td>8,000</td>
<td>419,302</td>
<td>352,443</td>
</tr>
<tr>
<td><strong>FUND BALANCES CARRIED FORWARD</strong></td>
<td>£673,620</td>
<td>£3,100</td>
<td>£676,720</td>
<td>£419,302</td>
</tr>
</tbody>
</table>
## Balance Sheets:

**Year ended 31st March 2014**

<table>
<thead>
<tr>
<th></th>
<th>Group 2014</th>
<th>Group 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FIXED ASSETS</strong></td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Tangible Assets</td>
<td>_</td>
<td>536</td>
</tr>
<tr>
<td>Investments</td>
<td>_</td>
<td>_</td>
</tr>
<tr>
<td></td>
<td>_</td>
<td>536</td>
</tr>
<tr>
<td><strong>CURRENT ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtors</td>
<td>335,986</td>
<td>264,080</td>
</tr>
<tr>
<td>Investment / Bank Deposits</td>
<td>136,970</td>
<td>131,886</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>321,724</td>
<td>244,202</td>
</tr>
<tr>
<td></td>
<td>794,680</td>
<td>640,168</td>
</tr>
<tr>
<td><strong>CREDITORS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts falling due within one year:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Committed grants</td>
<td>102,741</td>
<td>207,068</td>
</tr>
<tr>
<td>Accruals</td>
<td>15,219</td>
<td>14,334</td>
</tr>
<tr>
<td></td>
<td>117,960</td>
<td>221,402</td>
</tr>
<tr>
<td><strong>NET CURRENT ASSETS</strong></td>
<td>676,720</td>
<td>418,766</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS LESS CURRENT LIABILITIES</strong></td>
<td>676,720</td>
<td>419,302</td>
</tr>
<tr>
<td><strong>CREDITORS: AMOUNTS DUE AFTER ONE YEAR</strong></td>
<td>_</td>
<td>_</td>
</tr>
<tr>
<td><strong>NET ASSETS</strong></td>
<td>£676,720</td>
<td>£419,302</td>
</tr>
</tbody>
</table>

Represented by:

<table>
<thead>
<tr>
<th>UNRESTRICTED FUNDS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Designed funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boulter Fellowship Award Fund</td>
<td>54,400</td>
<td>40,800</td>
</tr>
<tr>
<td>BCPB Fellowship Award Fund</td>
<td>190,000</td>
<td>190,000</td>
</tr>
<tr>
<td>Fundraising Development Reserve</td>
<td>50,000</td>
<td>_</td>
</tr>
<tr>
<td>General Fund</td>
<td>379,220</td>
<td>180,502</td>
</tr>
<tr>
<td></td>
<td>£676,720</td>
<td>£419,302</td>
</tr>
</tbody>
</table>

Full financial details are available in our Annual Report & Accounts for Year Ending 31st March 2014.
Board of Trustees

The trustees during the year ended March 2014 were:

**Chairman**
**Dr Jeffrey Jay**
CBE, BSc, FRCS, FRCOphth
Past President of Royal College of Ophthalmologists

**Honorary Secretary**
**Dr Claire Walker**
BSc, PhD, MInstF
(to July 2013)

**Honorary Treasurer**
**Stephen Brooker**
MA, FCA
External member, House of Commons Audit Committee and Chair of the Worshipful Company of Glovers’ Charities

**Members of the Council**

**Miss Brenda Billington**
OBE MB ChB DO FRCS FRCOphth FEBO
Retired consultant ophthalmic surgeon. Past President of Royal College of Ophthalmologists (from November 2013)

**Mr Arvind Chandna**
MBBS MD DO FRCSEd FRCOphth
Consultant Ophthalmologist, Alder Hey Children’s Hospital, NHS Trust, Liverpool

**Professor Paul Foster**
BMedSci(Hons) PhD FRCS(Ed) FRCOphth
Professor of Ophthalmology, Ophthalmic Epidemiology and Glaucoma Specialist, Moorfields Eye Hospital, London

**Mr David Hughes**
MB ChB FRCOphth
Consultant Ophthalmologist, Royal Gwent Hospital, Newport (from November 2013)

**Professor James Morgan**
MA, DPhil, FRCOphth
Professor of Ophthalmology, Cardiff University (to October 2013)

**Dr Clare O’Neill**
PhD MBA FRSA
Management Consultant

**Principal Address**
British Council for Prevention of Blindness
4 Bloomsbury Square
London WC1A 2RP

Telephone: 020 7404 7114
Email: info@bcpb.org
Website: www.bcpb.org

Registered Charity Number: 270941

**Member of the Association of Medical Research Charities**

**Associated with:**
The International Agency for Prevention of Blindness (IAPB)

**Auditors**
Knox Cropper
8/9 Well Court, London EC4M 9DN

**Bankers**
National Savings & Investments
Glasgow G58 1SB

HSBC Bank Plc
90 Baker Street
London W1M 2AX

Charities Aid Foundation/Scottish Widows Bank
67 Morrison Street, Edinburgh EH3 8YJ
Independent Auditors’ Statement to the Trustees of the British Council for Prevention of Blindness

We have examined the summarised financial statements of the British Council for Prevention of Blindness on pages 20 and 21.

This statement is made solely to the Trustees, as a body, in accordance with the terms of our engagement. Our work has been undertaken so that we might state to the trustees those matters we have agreed to state to them in this statement and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trustees as a body, for our work, for this statement, or for the opinions we have formed.

Respective responsibilities of trustees and auditors

The Trustees are responsible for preparing the summarised financial statements in accordance with recommendations of the charities SORP.

Our responsibility is to report to you our opinion on the consistency of the summarised financial statements with the full financial statements and Trustees’ Annual Report. We also read the other financial information contained in the summarised annual report and consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the summarised financial statements.

Basis of opinion

We conducted our work in accordance with Bulletin 2008/3 'The auditors’ statement on the summary financial statement’ issued by the Auditing Practices Board for use in the United Kingdom.

Opinion

In our opinion the summarised financial statements are consistent with the full financial statements and the Trustees’ Annual Report of the British Council for Prevention of Blindness for the year ended 31st March 2014.

Knox Cropper
Registered auditors

2nd December 2014

The Trustees confirm that the financial statements on pages 20 and 21 are taken from the full set of financial statements comprising the Trustees’ Report and Accounts which were approved on 4th July 2014. The summarised financial statements may not contain sufficient information to allow a full understanding of the financial affairs of the British Council for Prevention of Blindness.

For further information the Annual Report and Accounts should be consulted. A copy of this document, upon which the auditors have reported without qualification, has been delivered to the Charity Commission and is available on request from the British Council for Prevention of Blindness, 4 Bloomsbury Square, London, WC1A 2RP.

By order of the Trustees.

Date: 2nd December 2014