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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Blindness:

- Somewhere in the world, a child goes blind every minute.
- 80% of this blindness is avoidable. With adequate funding it could be treated or prevented.
- 90% of the world’s 39 million blind people live in low income countries.
- Interventions to prevent blindness are amongst the most cost-effective: a blind person requires care and rehabilitation and cannot usually work, so saving sight makes economic sense as well as transforming lives.
- Training one person to be a leader, trainer and advocate creates a cascade effect when they pass on their knowledge and skills to others who can go on to build eye care programmes in developing countries, to save the sight of many people and promote the development of new knowledge to help treat eye conditions.

Our key achievements

- We have funded some 160 eye care professionals from the world’s poorest countries to train in planning and managing eye care at regional and community level, and to undertake research into how best to prevent blindness in their own countries. They have gone on to become new leaders in blindness prevention in their home countries.
- Each of these new eye care leaders will save the sight of up to 40,000 people in the course of their career, and will on average train a further 200 people to save sight.
- Research funded by BCPB led directly to the discovery of the breakthrough eye medication Ivermectin. This is now used widely in Africa to prevent ‘river blindness’ (onchocerciasis) - a condition which once blinded millions of people.

About BCPB

The British Council for Prevention of Blindness (BCPB) is a registered charity which funds innovative research and training work that seeds the development of local resources – skills, knowledge and expertise – to build programmes to save and restore sight in low income countries. BCPB fully supports the aims of Vision 2020: The Right To Sight

Our belief and our aim is that no one, anywhere in the world, should lose their sight if it can be prevented.
It is self evident that there can be no single way to prevent blindness and to date many methods have been used throughout the world with varying degrees of success. Improvements in public health often hold the key. In the case of insect-borne disease, control of the vector can reduce transmission. Thus simple improvements in sanitation can reduce the incidence and severity of trachoma infection that is spread by flies. Mass drug treatment of at risk populations can also be a cost effective way of controlling disease as shown in the case of use of the drug Ivermectin in the treatment of river blindness.

Blindness due to diseases such as diabetes and glaucoma can only be prevented by timely detection. Delay in treatment can mean irreversible changes have already taken place. Education and screening programmes offer the best chance of early recognition and treatment in such diseases and finding cost-effective ways of delivering these in the developing world will be the key to success.

Forty years on, BCPB can look back with pride on its contributions to many successful projects such as the use of Ivermectin and, more recently, the development of the PEEK photographic screening project. However, as populations continue to grow and age, the challenge remains and the work of BCPB must continue apace as there is still much to be done.

We shall continue to award grants not only to support primary research into disease prevention, but also to fund the education and training of overseas ophthalmologists. By supporting training in ophthalmic public health, practitioners can be provided with the necessary skills to identify the challenges and offer solutions in their work in blindness prevention in their home countries. Not only are they better equipped to enlist the support of governments and local politicians, a key element for any public health programme, they are also able to pass those skills to others on their return home, thereby widening the effectiveness of their training.

We remain firmly committed to continuing this important work as well as funding other programmes, such as the mentorship of ophthalmologists in the developing world by UK based experts in blindness prevention.

We believe that high quality research, education and training is crucial to the fight against blindness, and BCPB is committed to continuing its support in these areas.

Paul Hunter, Chairman

Forty years ago, the British Council for Prevention of Blindness was founded to promote research into ways of preventing blindness around the world. At that time there were considerable efforts being made by charities to treat those affected by blindness in the developing world but it was evident that still more needed to be done by way of prevention if the scourge of blindness were ever to be overcome. Two men – John Wilson and Eric Boulter, who were already working with charities involved with the alleviation of blindness, recognised this need and decided to set up a body with the specific object of promoting research into ways in which blindness can be prevented, particularly in the developing world. Their vision led to the formation of the British Council for Prevention of Blindness.

“Training is crucial to the fight against blindness”

Paul Hunter FRCP FRCS FRCOphth
In the lifetime of BCPB the economic progress of the world has been impressive. Terms such as third world or underdeveloped, developing and low income country no longer provide an adequate description of the distribution of wealth across the globe because within a country there is often great inequality between different communities. Similarly, the causes of blindness are changing. In its early years, BCPB played a crucial part in the eradication of river blindness (onchocerciasis), now it is more often engaged in the struggle to contain the diseases of richer countries, such as diabetic retinopathy as they spread to all parts of the world.

In providing a conduit between donor and beneficiary, BCPB acts within the framework which regulates registered charities but the concept of charity goes far beyond the rules set down by the Charity Commission. I find it difficult to offer an explanation of what drives us to give voluntarily to those in need. Although it is an obligation placed on us by all the religions which dictate the proper conduct of society, I suspect that ancient religions derived it from an earlier and deeply intrinsic human recognition of the importance of giving assistance to others who need our help. Some would say that the altruism in this is driven by a selfish motivation to secure a favourable position in the afterlife.

That was certainly a dominant theme in medieval Europe. For my own part, I prefer the approach of Spinoza who recommended that goodness, including the assistance of others, is its own reward. Whatever the motivation of our donors, BCPB will continue to provide the opportunity for them to contribute to the fight to diminish blindness.

In 1976, the year when Concorde made its first commercial flight, Harold Wilson resigned as Prime Minister of the United Kingdom and China emerged from the straitjacket of the cultural revolution, the British Council for the Prevention of Blindness started work. The role of BCPB in these 40 years has been to act as a go-between to help donors who wish to give relief to the many people and communities who suffer the blight of blindness in all its forms. Although there are numerous registered charities dedicated to this purpose, BCPB has taken a special position by using its expert knowledge to find and train professionals who will be able to develop services and research ability in their own countries, so that financial support from BCPB becomes a self-propagating investment. During my six years as chairman I was impressed that there are so many talented and motivated individuals; scientists, doctors, nurses, optometrists and health service managers, all keen to make good use of the training and support we provide, but who are constrained by adverse economic and political circumstances.

There are so many talented and motivated individuals scientists, doctors, nurses, optometrists and health service managers, all keen to make good use of the training and support we provide. ”
Tribute to Professor Andrew Elkington CBE FRCS FRCOphth

Professor Andrew Elkington, Chairman of BCPB from 2000 - 2008, died in 2014. He was a distinguished eye surgeon who played a central role in the foundation of the Royal College of Ophthalmologists and served as its third President (1994-1997). He wrote (with Peng Khaw) “The ABC of Eyes”, the leading work on treating eye conditions used in general practice, and (with Helena Frank) “Clinical Optics”, a leading work for optometrists.

After junior ophthalmology posts at Southampton, Westminster and Moorfields he was appointed as a consultant and senior lecturer in ophthalmology at Southampton University. There he wrote papers on eye injuries, glaucoma (a special interest) and on many other topics, and helped to nurture and inspire a generation of young eye doctors who went on to make their marks all over the world. He contributed to more than 70 publications on a variety of subjects. His other books include; ‘Ophthalmology for Nurses’ and ‘Aids to Ophthalmology’. He founded the charity ‘Gift of Sight’, which raises funds for the Eye Unit in Southampton General Hospital, and was President of the Ophthalmology Section of the Royal Society of Medicine.

At BCPB he was instrumental in introducing Fellowships, funding provided to researchers in the field of blindness leading to Doctorates, thus providing both trained leaders in blindness prevention and the means to produce innovative research. On his Chairmanship of BCPB, our Vice-Chairman, Stephen Brooker, described him as “A skilled chairman who always brought out the best in people and yet wasn’t afraid to offer strong leadership when needed.”

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Having known the enthusiastic founders of BCPB, I can safely say that they would wish to congratulate all who have been involved in the prevention of blindness over these forty years by supporting research and training on an ever-increasing scale. However, their enthusiasm would ask “What next?” Looking forward, the heights BCPB has now achieved can be but the foothills of tomorrow’s achievements.

It is a great pleasure for me to hear you are celebrating the 40th anniversary of BCPB, working for whom was always very close to Barrie’s heart. It is good to know that prevention of blindness in underdeveloped countries continues in this way. My fond greetings and congratulations to you all.

It is with pleasure that I take this opportunity of including some memories in BCPB’s 40th anniversary publication. When BCPB was founded in 1976 I was the Legal Officer of St Dunstan’s (now Blind Veterans), and subsequently became its CEO. St Dunstan’s provided modest accommodation for BCPB and I was glad to offer my own support and encouragement. I gave the charity’s fundraiser David Chesterman our full backing, including a modest rent-free office, access to essential office facilities and scope for recruiting volunteer helpers from amongst St Dunstan’s staff.

David organised a series of amazing concerts held at the Royal Albert Hall and other prestigious venues, which achieved packed concert halls raising very large sums for BCPB. An important feature of these concerts was an interval appeal, giving graphic descriptions of the tragedy of blindness and how much could be done to prevent blindness or alleviate its devastating effects.

I later accepted office as Secretary of BCPB and witnessed the charity growing from strength to strength. My involvement having begun in BCPB’s earliest days, I stood down in 2005, and am glad to have made a contribution to the enormously important work of this splendid organisation.
40 years on ...
Examples of BCPB projects

In 2014 the World Health Organization estimated that there are 285 million visually impaired people worldwide, of whom 39 million are blind, 80% of which is preventable, and that about 90% of the world’s visually impaired people live in developing countries. Treating this number would be a huge challenge, if indeed possible; however, keeping people’s sight healthy is a better solution. Since 1976 the British Council for Prevention of Blindness has been able to play its part. We have been fundraising for UK and overseas research into the prevention of blindness in developing countries and for the training of eye care workers in those countries. We fund a number of projects each year in the fight for blindness prevention. An example project for each of the last forty years follows.
A lasting legacy of BCPB’s funding has been the establishment of the Blantyre Institute for Community Ophthalmology in Malawi.

**1970’s**

1976/7 – The need for a specialist charity to raise funds for research into preventing blindness in the UK and overseas was recognised by the Royal Commonwealth Society for the Blind (comprising Sightsavers, St Dunstan’s and the Royal National Institute for the Blind.) They jointly founded the British Council for Prevention of Blindness.

1978 - £3,000 to UCH Medical School London for research into diabetic retinopathy.

1979 - £5,000 to the International Agency for the Prevention of Blindness towards an emergency programme in Bangladesh to train ten general medical practitioners and 30 to 40 ophthalmic auxiliaries to undertake cataract operations.

**1980’s**

1980 - £1,068 to Leeds General Infirmary for the purchase of inclined binocular assistant’s microscope for use in cataract surgery in young children.

1981 - £10,000 to St John Ophthalmic Hospital in East Jerusalem towards an Outreach Project to assess the prevalence of trachoma and other infectious eye diseases in the local population to initiate early treatment, prevention and education of the community.

1982 - £6,430 to support the World Health Organisation Medical Team in the Maldives to set up an Eye Camp to test and treat the local population for eye disease.

1983 - £10,684 to Bristol Eye Hospital towards the cost of a pilot study to improve the storage and supply of eyes for corneal grafting.

1984 - £900 to Srina Garind Hospital in Thailand for equipment for use in the introduction and evaluation of prescriptive screening for ocular defects in young children in Thai villages.

1985 - £11,434 to St Woolos Hospital in Newport, Gwent towards the cost of a research project involving the mass screening of diabetic retinopathy and retinopathy of prematurity.

1986 - £2,000 to the National Rubella Council to make 300 copies of a film to alert adult women to the risks of contracting rubella in the early months of pregnancy.

1987 - £7,000 to Chattisgarh Eye Hospital in India to fund an evaluation survey of cataract surgery in eye camps in India.

1988 - £12,500 to King’s College of Medicine London for research to identify genetic markers in diabetic retinopathy.

1989 - £2,526 to Ahmadu Bello University Teaching Hospital in Kaduna, Nigeria to study the effects of Ivermectin, a treatment for river blindness.
1990’s

1990 - £9,600 to the International Centre for Eye Health London to work with the African Medical & Educational Foundation in Nairobi, Kenya to study the control of trachoma within the nomadic Masai tribes.

1991 - £37,763 to the University of Wales to investigate the cause of cataracts using isolated lens tissue.

1992 - £12,185 to the Institute of Ophthalmology London for a pilot study of the outcome of congenital cataract surgery in Southern India.

1993 - £15,550 to the Aravind Eye Hospital in India for research into childhood cataracts.

1994 - £12,867 to the Western Eye Hospital London to research the prevalence of eye disease among British Asian people.

1995 - £15,220 to Mater Misericordiae Hospital in Dublin for research into pre-attentive visual mechanisms in glaucoma diagnosis.

1996 - £17,186 to the Institute of Ophthalmology London for a trial of chlorhexidine gel as a primary treatment for suppurative keratitis in Ghana.

1997 - £22,466 to the University of Edinburgh for research into novel approaches to glucocorticoid sensitivity in disorders relating to intraocular pressure.

1998 - £49,785 to Queen’s University Belfast for research into blood retinal barrier in diabetic retinopathy.

1999 - £384,920 to the International Centre for Eye Health London for community eye health courses in South Africa, Tanzania, Ghana, Nigeria, Pakistan, India and Colombia.

2000’s

2000 - £80,496 to Queen’s University Belfast for research into differential gene expression in retinal vascular cells.

2001 - £33,550 to the Institute of Ophthalmology London for research into pregnancy and childbirth risk factors for cataracts in women.

2002 - £3,403 to University College London for a study into retinitis pigmentosa.

2003 - £28,555 to the International Centre for Eye Health London for research into the outcome of childhood cataract surgery in developing countries.

2004 - £50,000 to the International Centre for Eye Health London for research into screening for primary angle closure glaucoma in Mongolia.


2006 - £139,679 to the International Centre for Eye Health London for a fellowship surveying the leading blinding diseases within the Nakuru district of Kenya.

2007 - £154,313 to the International Centre for Eye Health London for a fellowship comparing different ways of identifying blind children in local communities in Malawi and referring them for treatment.

2008 - £20,000 to the University of Southampton for research into age related macular degeneration.

2009 – £120,007 to Queen’s University Belfast for a fellowship looking into the genetic basis of glaucoma in India.
2010’s

2010 - £47,165 to the University of Liverpool for developing eye drops to reduce the need for corneal transplants, which are impractical in much of the developing world.

2011 – £180,005 to the International Centre for Eye Health London for a fellowship on the epidemiology and management of ocular surface squamous neoplasia in Kenya.

2012 - £59,980 to the International Centre for Eye Health London for validating the use of smartphones for the diagnosis of eye diseases in Nakuru, Kenya.

2013 - £59,570 to the University of Liverpool for research into the treatment of diabetic retinopathy in Malawi.

2014 - £14,450 to the Institute of Ophthalmology for mentorship to build research capacity in a community hospital in Tanzania.

2015 - £50,530 to Moorfields Eye Hospital London for an exploratory study to evaluate the impact of tablet computers and low-vision software on education and learning in children and young people with low vision in India and the UK.

2016 - £199,961 to the International Centre for Eye Health London for a fellowship on up-skilling ophthalmic surgeons for high quality and high volume cataract and glaucoma surgery in Sub-Saharan Africa.
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 developing 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 countries 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 developing countries, in order to facilitate a mutually beneficial transfer of knowledge in eye care.

To achieve these aims, our Advisory Panel selects and monitors projects and advises on a variety of issues.

BCPB is a member of the Association of Medical Research Charities (AMRC) and complies with its guidelines for best practice.
In 2012, BCPB part-funded the testing of PEEK – the Portable Eye Examination Kit, which is a smart phone–based ophthalmic testing system that has been developed to perform comprehensive eye examinations. Shortages in ophthalmic personnel, the high cost, and the difficulty in transporting equipment have made it challenging to offer services, particularly in rural areas. PEEK offers a solution for overcoming barriers of limited access to traditional ophthalmic testing methods and has been pilot tested on adults in Nakuru, Kenya, and compared with traditional eye examination tools. The results of the testing have been published: here is a summary.

This qualitative study evaluated the acceptability and usability of PEEK in addition to perceptions regarding its adoption and nationwide deployment. Semi-structured interviews were conducted with patients and analysed using a framework approach. This included analysis of interviews from 20 patients, eight health care providers (HCPs), and four key decision makers in ophthalmic health care provision in Kenya. The participants were purposefully sampled. The coding structure involved predefined themes for assessing the following:

1. the context, that is, environment, user, task, and technology
2. patient acceptability, that is, patients’ perceived benefits, patient preference, and patient satisfaction
3. usability, that is, efficiency, effectiveness, learnability, and flexibility and operability of PEEK
4. the benefits of PEEK in strengthening eye care provision, that is, capabilities enhancer, opportunity creator, social enabler, and knowledge generator. Emerging themes relating to the objectives were explored from the data using thematic analysis.

Patients found PEEK to be acceptable because of its benefits in overcoming the barriers to accessing ophthalmic services. Most thought it to be fast, convenient, and able to reach a large population. The HCPs perceived it to satisfy the criteria for usability and found PEEK to be acceptable, based on the technology acceptance model. PEEK was also found to have features required for strengthening ophthalmic delivery by aiding detection and diagnosis, provision of decision support, improving communication between provider and patient and among providers, linking patients to services, monitoring, and assisting in education and training. Some of the deployment-related issues included the need for government and community involvement, communication and awareness creation, infrastructure development including capacity creation, and training and maintenance support.

According to all parties interviewed, PEEK is an acceptable solution, as it provides a beneficial service, supports patients’ needs, and fulfills HCPs’ roles, overall contributing to strengthening eye health.
Professor Ciku Mathenge, Rwanda

In 2006 I was awarded the first Sir John Wilson Fellowship by the British Council for the Prevention of Blindness which allowed me to study for a PhD at the London School of Hygiene and Tropical Medicine.

Of all the scholarships I had applied for I was particularly pleased to get this one because I had always been awed by the legacy of Sir John Wilson. How could one man do so much in one lifetime? Even though I never met Sir John, I received a personal handwritten letter of encouragement from Lady Jean Wilson at the beginning of my studies and that single gesture inspired me so much to not let anyone down.

It is now almost six years since I finished my studies. Recently I was appointed a full Professor of Ophthalmology at the University of Rwanda. Teaching and passing on skills to those younger than me is something that I dedicate a lot of time to. Lack of trained ophthalmic workers continues to hinder prevention of blindness activities in my region. Ophthalmology is not a popular specialty in Africa but I will do my bit to change this in my lifetime.

I have been nominated as an Eye Health Hero for 2016 by the International Agency for the Prevention of Blindness and organisation founded by Sir John Wilson. My nomination is due to work done to ensure that even at the lowest level of the health system, health workers can perform a basic eye examination that distinguishes normal from abnormal eyes, and allows them to provide basic interventions and make appropriate referrals.

I am so lucky that my regular work in Rwanda at Dr Agarwal’s Eye Hospital, in partnership with the Rwanda International Institute of Ophthalmology, allows me to give world class care to my patients without restricting me from seeking out poor disadvantaged patients and giving them the same level of care.

BCPB invested in me and forever inspired me to invest in others.

“BCPB invested in me and forever inspired me to invest in others.”
The mission statement of the International Centre for Eye Health, London School of Hygiene & Tropical Medicine is “To improve eye health worldwide through working in partnership to achieve excellence in eye health research, education and translation of knowledge.” The British Council for the Prevention of Blindness (BCPB), through support to our education and research, has greatly contributed towards this mission.

Several PhD Fellowships have been awarded, and some of these PhD students had earlier been awarded BCPB’s Boulter Fellowships which enabled them to attend our Masters in Public Health for Eye Care, so developing their research skills and building awareness of the importance of evidence for planning and advocacy. BCPB has also awarded pump priming and research grants, and research mentorships.

These grants total over £1.2million and all have enabled significant new knowledge to be contributed, informing the design of eye health programmes or clinical practice. All the fellows have made multiple presentations of their research findings at national and international meetings. One example of how BCPB funding has led to further training and research is Mohammed Muhit, who set up a Masters in Public Health in Bangladesh and is now Dean of a medical school and training institute in Dhaka. He continues to engage in research in relation to different aspects of disability in children through the organisation he set up after his PhD, The Child Sight Foundation.

As a direct result of BCPB’s support to research 36 papers have been published in peer reviewed journals, and many more have been submitted or are being written. The research capacity and leadership abilities of ophthalmologists from some of the poorest countries in the world have been strengthened.

“The research capacity and leadership abilities of ophthalmologists from some of the poorest countries in the world have been strengthened.”
When I was awarded the Fellowship I was part way through Registrar training in ophthalmology in the UK. I had previously completed medical school training, general medical posts and several years of initial ophthalmic training. Gaining the Fellowship allowed me to take time out of clinical training to complete three years of dedicated research training and undertake a PhD.

This research was conducted with the International Centre for Eye Health and the London School of Hygiene and Tropical Medicine and was also supported by the Wellcome Trust. The School has a long history of research in a developing world context and is an established trachoma research centre. I was privileged to be able to work with dedicated and highly experienced colleagues and supervisors.

The research I undertook involved studying the pathogenesis of the scarring process in trachoma. While most children in trachoma endemic areas will be infected with chlamydia trachomatis, not all go on to develop blindness. We were interested in identifying what factors were involved in driving the scarring process. The research was conducted at the base of Mount Kilimanjaro in northern Tanzania, where high levels of trachoma exist. This is particularly the case amongst remote Maasai communities found in this region. Blinding trachoma results from a combination of poor water supply and facial hygiene, being surrounded by flies from cattle, and crowded living conditions.

An initial survey of 3500 people was undertaken in an isolated village, with 2500 individuals being examined for signs of trachoma. A cohort of 800 people with scarring from trachoma agreed to be enrolled into a study involving examinations every six months for two years.

An additional 300 individuals without scarring entered a case-control study for comparison. Swabs from the eye were taken for the presence of infection, and also for gene expression to look at molecular processes in affected tissue. We were also able to procure an in vivo confocal microscope.
This piece of high tech equipment is used to study the ocular surface in living patients and gives extremely fine detail, almost to the level of what would be seen from a tissue biopsy under the microscope in a laboratory. We carried the microscope around in a specially made foam case in the back of Land Rover, a novel use for this expensive piece of kit. I worked with a field team of five Tanzanian field workers and it was an enriching experience getting to know each other. Laboratory work was undertaken at the Kilimanjaro Christian Medical Centre (KCMC) where microbiology tests for infection were performed.

This research resulted in a number of publications in peer-reviewed journals and presentations at international meetings. I was also successfully awarded a PhD by the University of London in 2012. I believe that we made some progress in the fight against blindness from trachoma.

I feel very fortunate to have worked with some inspirational figures during my research training - Matthew Burton, Robin Bailey and Helen Weiss at LSHTM, and Phil Luthert at the Institute of Ophthalmology.

After completing the PhD I returned to clinical ophthalmology training in the UK. I completed formal registrar training in 2015 and am currently completing the Corneal Fellowship at St Paul’s Eye Unit in Liverpool. I have maintained an active overseas research interest and have returned to Tanzania for follow up research visits, especially involving the confocal microscope. I have an honorary lecturer role at the LSHTM and have started co-supervising PhD students, including an ophthalmologist who is studying corneal infections in Uganda. I am also participating in NHS research, primarily using confocal microscopy on the ocular surface. For four years after I returned from Tanzania I acted as the main coordinator of the Vision2020 Link Programme between the University Hospitals Birmingham and KCMC in Tanzania. These partnerships work towards improving eye care services and reducing avoidable blindness. In the future, I am actively looking to combine a clinical ophthalmology role in the UK with overseas research and work into reducing avoidable blindness.

“**The research I undertook involved studying the pathogenesis of the scarring process in trachoma.**”
It is a pleasure to write a short piece for the 40th anniversary of BCPB. I thought I would start by recalling the first encounter I had with BCPB back in the late 1980s. The Council had funded an ophthalmologist to undertake preliminary work in Northern Nigeria in preparation for a study, leading to a successful application to the World Health Organization for a large controlled trial investigating the safety of community dosing with ivermectin for onchocerciasis (known as river blindness). I was part of that trial and can report the long-term results of the original BCPB support.

The trial proved the safety of large scale dosing with ivermectin and resulted in the wider scale distribution of this drug. As a consequence we are beginning to see the dream of elimination of the disease. This means the fourth most common cause of blindness in the world in 1990 is now the eighth most common and is heading for eradication… true prevention of blindness in action! The very communities we were working with are the first to be declared disease free in Africa. We hope to revisit these communities in the near future to assess the impact the disease eradication has had and will report back!

Bringing us to the present, we have just completed a research-strengthening grant from BCPB. In our efforts to find the optimal strategy for prevention of blindness from glaucoma in an African context we have completed a large controlled trial investigating combined cataract and glaucoma drainage surgery for newly diagnosed patients with the dual pathology in Dar es Salaam, Tanzania. Completing such essential studies is vital in informing rational therapeutic and public health strategies. BCPB, however, have recognised the value of strengthening research capacity within Africa to enable the growth of local research groups. Original research can thus be initiated in Africa, by Africa, for Africa.

To this end BCPB grant has supported our two stars in the glaucoma treatment project Kazim Dhala (surgeon and researcher) and Kapesa Imani (trial and data manager). Thanks to BCPB, both have been able to complete higher qualifications in research, and Kazim has been able to work for two week periods in the UK with myself and our statistician analysing and writing up the study. Kazim had his own idea for a nested treatment comparison study and we have had some exciting findings. Both papers are accepted for publication pending revisions.

Building on the work above BCPB are supporting a new project working with Kazim and Kapesa creating an economic model of glaucoma care strategies within Tanzania.

“BCPB have recognised the value of strengthening research capacity within Africa to enable the growth of local research groups.”
1995 was a memorable year in my life. With the dream of devoting my life to a career that could possibly change thousands of peoples’ lives, I started a seven-year program pursuing MBBS and MSc degrees of clinical medicine in the top medical school in China, the Health Science Center of Peking University. I became an eye doctor with a special interest in the surgical treatment of cataracts - the worldwide leading cause of blindness. I spent a year in the rural counties of South China, working as a volunteer eye surgeon coming into close contact with many patients struggling in darkness and poverty. I was constantly amazed by the dramatic changes blindness prevention programs could bring and I can still clearly remember those sparkling eyes filled with happiness and gratitude after receiving surgery.

In 2008 following completion of fellowship programs in the USA and Singapore, I ran an internationally collaborative research and blindness prevention project in China known as ZAP investigating the preventive strategies for primary angle-closure glaucoma (PACG), a highly prevalent but potentially preventable eye disease amongst East Asians. Nearly 12,000 people participated in the screening survey and 889 individuals were eventually enrolled as study subjects. This project, which was generously sponsored by BCPB, was the commencement of my colourful and fulfilling journey with BCPB. It was also via involvement in this project that I got to know my respected PhD mentor, Professor Paul Foster.

Three years after the commencement of the ZAP trial, I was selected as an awardee of the BCPB PhD studentship program at the UK UCL Institute of Ophthalmology. During this PhD program, which served as an extended development of the research based on the ZAP trial, I carried out a series of data mining projects that focused on the descriptive epidemiology of glaucoma in urban China and the prevention of PACG.

Upon completion of my PHD, I was licenced as an ophthalmologist and started practising ophthalmology at Moorfields Eye Hospital. Alongside this, I also became an honorary senior research associate at UCL. Thanks to BCPB’s generous sponsorship, I worked with Mr Gus Gazzard, Consultant Ophthalmologist at Moorfields, and successfully established a China-based sister study of a large scale, multi-centre randomized controlled trial in the UK (the LiGHT Trial) which aims at finding a relatively more optimal treatment pathway in terms of health-related quality of life, cost-effectiveness and clinical outcomes. Also whilst working at Moorfields Eye Hospital, I was appointed as one of the key members of Moorfields’ Far East business development team. With strong support from the British and Chinese governments, we were able to establish a strategic research and educational partnership between the two largest eye centres in China and the UK. Inspired by the business development experience at Moorfields, I started a business project focusing on international teleconsultation, which aims to serve as a platform for providing co-management between clinicians in the UK and China for Chinese patients suffering from severe and complex eye conditions. We have successfully set up a network of cooperating eye hospitals and clinics in 20 cities in China. For cooperating partners in China, we aim to assist health care providers in acquiring aid from the international community and to help train local doctors in China. For Chinese patients, we aim at supporting customers to overcome language barriers, lower financial thresholds and offer borderless care from globally renowned medical professionals in the UK. The project aims to benefit patients by offering second opinions at an affordable cost, and serves as a training service for junior doctors, which in turn will help serve millions of patients in China.
The diagnosis is challenging because most clinicians rely on their clinical impression; yet the tumours can look similar to benign lesions. It is usually treated by surgical removal but recurrence can be frequent. About 30-40% of tumours are reported to regrow in African series. Late presentation with large tumours the size of the eyeball is not uncommon. The disease does not receive much attention from both eye care and HIV care programs. This may be because it is not a leading cause of blindness and not part of the clinical definition of AIDS, so awareness may be low.

Funding from BCPB through the Sir John Wilson fellowship helped us conduct research studies. Two out of every three patients here are women, they are mostly young, and 75% of them live with HIV. It usually affects one eye.

The causes and risk factors are not well understood. We examined risk factors in our setting such as HIV with and without antiretroviral therapy, exposure to the sun and allergic conjunctivitis. We found that wearing hats was protective.
We conducted the first ever randomised controlled trial of fluorouracil (5FU) eye drops used post-operatively which we found was effective in reducing recurrence from 36% to 10% at one year after surgery. There is still much to do to understand the underlying molecular mechanisms by which the disease develops after exposure to these risk factors. We also need to promote early detection.

Take the case of Rhoda (fictitious name), a 41-year-old woman from Eastern Kenya. She lives on a half-acre piece of land that her husband inherited from his father. Her husband works at the local stone quarry. To supplement his income Rhoda grows food for the family and sells chicken eggs. She did not complete her secondary school education for lack of school fees. She and her husband have lived with HIV for six years now. They get free antiretroviral drugs from a nearby HIV care centre but their eyes have never been checked.

In May 2013 she developed an itchy lesion in her right eye of five months’ duration. When she first noticed it, she went to a chemist, bought some eye drops and used them for a week without relief. Two months later she decided to visit an eye clinic about 20 kilometres away. The clinical officer there saw a lesion that he suspected to be a tumour but it also resembled a benign lesion. As he could not tell the difference by clinical examination he referred her to the county hospital, a further 30 kilometres away. Two months later after saving some money for the trip, she went there. The lesion was excised and the specimen sent to the capital city, Nairobi, 150 kilometres away for histopathology. Surgery cost her 4000 Kenyan shillings, the equivalent of Rhoda’s one month’s earnings. When the results came back a month later, it was difficult to explain the term ocular surface squamous neoplasia so she was told that she had a cancer of the eye. There was no word to describe the disease in her local dialect. However, thanks to having some education, she understood that cancer was a serious disease. Unfortunately, the disease recurred three months after surgery. Rhoda was discouraged and decided to refer herself to a well-known mission hospital near Nairobi which happened to be one of our research study centres. The tumour was re-excised and again sent for histopathology which confirmed the diagnosis she got the first time. When the excision site healed, she was given some eye drops to apply four times daily for four weeks. She had some itching and redness for about two weeks but it resolved. Today, three years later, Rhoda has not experienced recurrence again. She is an ardent advocate to the neighbours. Recently she referred one lady to us who had visited a traditional healer several times with a similar lesion to the one Rhoda had.

I was recently awarded a PhD from the London School of Hygiene & Tropical Medicine from the research arising out of this work, but most of all I am delighted at the progress we made in improving the situation for a lot of patients suffering from this disease.
In 1995 as a junior ophthalmologist I embarked on my genetic research for my MD research degree. On about my second day in the lab my supervisor said well we can’t do much as you don’t have any consumable money! To her surprise I then successfully applied to the British Council for Prevention of Blindness (BCPB) for funding. BCPB took a chance on me and awarded me a grant of £10,000. Using this money I mapped a gene for an early onset form of macular degeneration and subsequently identified it. I was awarded my research degree and was set on an academic career. The research I did using BCPB funding encouraged Professor Ed Stone to take me on as a research fellow and so began four very productive years at the University of Iowa. I subsequently became the very first University Chair of Ophthalmology at the University of Southampton in 2002.

I have now built a vibrant research-active department which includes four senior academic staff. My translational research has been awarded with two NIHR senior investigator awards and my research team have published over 170 peer reviewed papers and we have achieved over £8 million of research funding. The relatively small grant BCPB gave me in 1995 of £10,000 has been a very good investment!

More recently in 2010 BCPB provided me with a further grant to further study the genetics of macular degeneration. This award of £59,820 assisted my student Dr Charles Pierce to obtain his research degree too. Charles is now planning to return to Barbados where he will head up their new diabetic retinopathy screening programme.

“\nI strongly believe that BCPB should be supported so it can continue to do great work.\n”

The two grants I have received from BCPB have both made a massive difference. They have allowed two young doctors to establish their academic careers (myself back in 1995 and Dr Pierce in 2010). They have resulted in the academic department of ophthalmology being established in Southampton and now a diabetic screening programme starting in Barbados. Useful research papers have resulted from both grants as well. Therefore I strongly believe that BCPB should be supported so it can continue to do great work like this and thus make significant contributions to defeating blindness.

Professor Andrew Lotery
Dr Geeta Menon

In 2011, Frimley Park Hospital Eye Unit, in Surrey, began work with the Kitwe Central Hospital Eye Unit in Northern Zambia as part of the International Centre for Eye Health’s Vision 2020 Links Programme.

Over the last five years, the teams have visited each others’ hospitals, sharing good practice, training and helping to develop ophthalmic services and research. An integral part of this working relationship was the development of a research mentoring programme funded by BCPB. The mentorship provided has led the teams in Kitwe and Frimley to work together to develop and implement a diabetic retinopathy screening programme in the Copperbelt province of Northern Zambia, providing significant improvements in the management of diabetic retinopathy. Diabetic retinopathy is a massive problem, with an estimated 2.5 million people affected worldwide, being the leading cause of blindness and visual impairment in the working age population in the developed world. However, there are no current published reports on the prevalence of diabetic retinopathy in Zambia.

Since 2011, over 3000 patients have subsequently been screened and 500 patients treated for diabetic retinopathy. We have used this novel screening programme as an opportunity to estimate prevalence of diabetic retinopathy in those with diabetes and explore factors contributing to its development in this mixed urban and rural population in Zambia.

Our findings from the screening programme are being published to a wider international audience. The link programme has also provided essential training for staff in Kitwe in the latest technology and treatment techniques.

There are exciting future plans for the diabetic retinopathy programme. The two hospitals will continue to work together to not only strengthen the awareness of the screening programme but to also ensure that staff continue to be trained. In October 2015, the screening programme was launched in other Zambian provinces including the capital, Lusaka.

Professor Khumbo Kalua, Malawi

A lasting legacy of BCPB’s funding has been the establishment of the Blantyre Institute for Community Ophthalmology (BICO) in Malawi in 2008, with funding from a Sir John Wilson Fellowship. I was awarded the Fellowship in 2007, to research new methods of referring children at risk of blindness in rural villages for hospital treatment, using both trained volunteers (key informants) and healthcare surveillance assistants (HSA). Field work was completed in 2010.

BICO’s mission is the prevention and control of blindness in Malawi and neighbouring countries in the Southern part of Africa through research, teaching, training, consultancy and advocacy in eye care delivery. So far some 1500 children with visual impairment have been helped with glasses or surgical treatment. BICO has now become the most prominent eye-care NGO in Malawi employing 42 full-time staff, and leading all Trachoma research work in Malawi in collaboration with international NGOs and WHO.

BICO has published over 35 articles in peer reviewed journals over the last five years, and I take a lead role at the College of Medicine, University of Malawi. More information about BICO can be found at www.bicomalawi.org
The Boulter Fellowship Programme

BCPB makes a contribution towards both tuition and living expenses for the Boulter Fellows, who come to London from the developing world to undertake a Master of Science Degree in Public Health for Eye Care at the International Centre for Eye Health. The course 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 name ‘Boulter’ refers to one of our most inspiring founders, Mr Eric Boulter. His daughter Jacqueline has sent greetings on BCPB’s 40th anniversary, and summarises his involvement:

“Eric Boulter was born in London in 1917. At the start of World War II he enlisted in the Royal Engineers, and was part of the British Expeditionary Force, fighting in France and Belgium, before eventually being evacuated to England during the Dunkirk campaign.

His experience in the war lead to a gradual loss of sight when he was working for the United Nations Relief and Rehabilitation Administration in Greece. It was here that he met Helen Keller, who offered him a position with her foundation, the American Foundation for the Blind (now the Helen Keller Foundation) for whom he eventually became head of the American Foundation for Overseas Blind.

While living in New York, he was elected and served as president of the World Council for the Welfare of the Blind. In 1970, he returned to live in the UK, became Director General of the Royal National Institute for the Blind, and co-authored the book ‘Blindness and Visual Handicap - the Facts’. In 1976, Eric Boulter became a founder member of BCPB and encouraged its formation and mission - to raise funds for research into prevention of blindness and the restoration of sight in both the UK and in the developing world.”
Boulter Fellows 2015/16 – Updates

Dr Abdullahi Idris  
Ophthalmologist and Senior Medical Officer at Aminu Kano Teaching Hospital in Nigeria.

Dr Hafsat Isa  
Senior clinical ophthalmic medical officer at Abubakar Tafawa Balewa University Teaching Hospital in Nigeria.

Dr Ranad Maswadi  
Ophthalmologist in Hebron/West Bank, Occupied Palestinian Territories.

Dr Kehinde Monsudi  
Ophthalmologist at Federal Medical Centre, Birnin Kebbi, Nigeria.

I have learnt the practical skills of carrying out both operational and epidemiological research in eye care plus programme planning, management and evaluation, and I now have the knowledge and skills necessary for the prevention of major blinding eye diseases including research methods. I plan to assist with organising seminars and tutorials in topics related to public health strategies for prevention of blinding eye diseases, and to carry out epidemiological research relating to blinding eye diseases and Vision 2020 goals. I also want to carry out research that will help in planning and managing programmes in eye care within my locality and become involved in local, national and international prevention of blindness activities.

The course has opened up new ways of learning and I am now able to apply a broader approach to problem solving. I have acquired skills in data collection, cleaning and analysis and in project writing. I have learnt of both immediate and distant barriers patients face when trying to access health care, so these problems should be addressed in a broader context of not just the patient as an individual but in totality encompassing his environment and social status in his society, because these are all the factors that determine health status. I plan to reorganise the eye clinic, using the health system building blocks, and look for ways to maximise its efficiency and effectiveness. I want to put in place a monitoring and evaluation system in the eye clinic which has not been in place before, so we can assess whether we are doing things the right way and know when things need to be improved. I hope to do some research and apply for a PhD.

I have gained skills in implementing eye related studies, situational analysis of eye care services in a certain setting, planning for an eye care service project/program, and skills in advocacy, health promotion and partnership making. I have learnt about global and national eye care initiatives and best measures to tackle each blinding disease at different health care levels. I plan to take an intensive course in cataract surgery and take the final part of the ophthalmology exam. I hope to find an ophthalmology post in the Occupied Palestinian Territories, and build relationships with eye care personnel, stakeholders in eye care, and representatives for national and international organizations interested in eye care in my region. I will be advocating for a national blindness survey in the OPT, as a stepping stone for future blindness planning and advocacy for interventions and policy change.

Dr Monsudi plans to train eye care providers in his community, conduct a survey using community eye health workers, conduct a school eye screening programme, introduce a community screening program, and work on a public eye awareness campaign. He also plans to help build up existing eye health services, so that the public health system can effectively treat and prevent avoidable blindness. He intends to reduce the backlog and incidence of cataract and other causes of blinding in Nigeria.
It seems just like yesterday when I submitted my dissertation at the London School of Hygiene and Tropical Medicine (LSHTM), signifying the end of my year-long Masters’ training in Public Health for Eye Care! Nine months on, and my days are fully occupied.

Prior to my training, I was doing clinical and administrative work at a referral hospital in the western part of Kenya. On my return, I was assigned a new role to train middle level health workers in eye care referred to as ‘Ophthalmic Clinical Officers’. This has involved giving formal lectures, supervising their clinical practice in the assigned clinical areas and supervising two of them in developing proposals for their dissertations. I have an input in the training of students doing their first diploma in clinical medicine and I am part of a team seeking to develop telemedicine in conjunction with e-learning at the college.

The head of the national Ophthalmic Services Unit (OSU) is an alumnus of LSHTM. On my return to the country, he assigned me a co-investigator role in doing the first ever Kenya Eye Health Systems Assessment. We have just completed data collection and are in the process of data entry, following which we will prepare a report. It has been exciting putting into use what I learnt at the LSHTM.

I am still in touch with the referral hospital and engage in clinical work there. Recently, the Governor’s wife organised an eye camp, in which 90 patients had cataract surgeries done.

As it is, my hands are full, not to mention my role as a wife and mother. I am grateful for the facilitation by British Council for Prevention of Blindness towards my studies at the LSHTM, which enabled me to make a greater contribution to eye health in my country now and in the future.

“I am grateful for the facilitation by British Council for Prevention of Blindness towards my studies at the LSHTM which enabled me to make a greater contribution to eye health in my country now and in the future.”
Since completing the MSc in 2014, I have continued work as a Principal Lecturer in Ophthalmology at the Kenya Medical Training College, Nairobi. I also work as a resource person with the Ophthalmic Service Unit, Ministry of Health, which co-ordinates eye care in the country.

I am currently a PhD student at the London School of Hygiene & Tropical Medicine, researching improvement of diabetic retinopathy services in Kenya. As part of developing public engagement with the research, I was one of six finalists in the three minute thesis competition. I am also part of the team conducting an eye health system assessment (EHSA) in Kenya to identify the strengths and gaps in the health system, and the appropriate interventions to improve the system.

Apart from teaching at the college and at the teaching hospital, I have responsibilities for developing institutional collaboration to improve ophthalmology training. The number of students receiving ophthalmology training has continued to increase.

Leadership in research makes a crucial contribution to the prevention of avoidable blindness. It is often the missing factor in the skills of researchers, who have other lead roles in eye care. In September 2015, I conducted a leadership training for PHD students under the ‘Lead Forward’ program organised by the Vision 2020 Links program.

The students have gone on to cascade the training in their countries, and multiple quality improvement projects have already been implemented.
The knowledge and skills that I have acquired from the extremely well organised and run MSc course have enabled me to successfully run research projects, analyse data, write study findings for publications, and deliver surgical treatment for thousands of people affected from trachoma in Ethiopia.

My PhD compares two WHO recommended and most widely used trachomatous trichiasis correction surgical procedures - Bilamelar Tarsal Rotation surgery versus Posterior Tarsal Rotation surgery, in a randomized controlled trial (RCT), and investigates the impact of trachomatous trichiasis and its surgical treatment on quality of life and daily living of affected individuals in case control and longitudinal studies. Most of the results of these studies have been published in different peer reviewed international journals and are shaping policies and guidelines globally.

Although trachoma has long been considered a disease of poverty, there has been surprisingly little direct data that formally quantifies the relationship between trachoma and economic poverty; and relatively little is known about the impact that trichiasis has on the lives of affected people with and without the presence of visual impairment. We found that trichiasis case households are significantly poorer than the non-trichiatic controls households by all economic measures. We also found that cases were significantly less likely to participate in economically productive activities, regardless of visual impairment and other health problems, more likely to report difficulty in performing activities and more likely to receive assistance in performing productive activities.

In terms of quality of life, we found that TT cases have significantly lower vision and health related quality of life than the trichiasis-free controls, regardless of visual impairment and other health problems, suggesting the burden of TT goes beyond visual loss.

Trichiasis surgery is primarily performed to reduce the risk of sight loss. However, it may also improve overall wellbeing in the long term. But there has been very limited evidence to assert this assumption. We found strong evidence that surgery substantially improves both vision and health related quality of life of people with TT, even when there is no improvement in vision, while there was no evidence of improvement in the quality of life of the trichiasis free participants. The results provide clear evidence that the benefit of trichiasis surgery goes beyond preventing the risk of blindness and improves quality of life even when there is no visual acuity change, indicating prompt surgical management is needed for Trachomatous Trichiasis patients worldwide.
Dr Srinivas Marmamula, India

After my optometry training at LV Prasad Eye Institute in India, I joined the research team of the Andhra Pradesh Eye Disease Study (APEDS) from 1996 - 2000. I was a co-author on several papers and then took my MSc at ICEH in 2002/3. Taught by stalwarts in the field such as Dr Allen Foster and Dr Clare Gilbert, I began to realise that every patient is a part of a family and a part of the larger society hence both the eye condition and its intervention impacts the family as a whole. I also understood that several socio-economic and personal factors influence the uptake of services even when they are available at no cost. I learnt to understand the intricacies of patient-centred care and community eye care at large. The course had a profound impact on me and changed my outlook from that of a clinician to a public eye health professional. It was also a stepping stone for my higher education in public eye health and an eventful career at LVPEI, where I continue active involvement in population based epidemiological studies, teaching biostatistics, epidemiology and public health.

Apart from my role as an optometrist and public eye health specialist at LVPEI, I had an opportunity to apply the skills that I learnt at ICEH during my PhD studies (part time) at the University of New South Wales, Australia during 2006 - 2011.

My post-doctoral training was at Wilmer Eye Institute in 2012/13. The recent award of Wellcome Trust / DBT India Alliance fellowship (2015 - 2020) is the highest peak thus far in my academic career. I became the first optometrist to secure this highly competitive and prestigious fellowship.

As a Wellcome Trust fellow working at a premier eye institute - GPR ICARE in Hyderabad, I aspire to continue my academic journey in public health in the years to come, extending the frontiers of eye research in India.

"I aspire to continue my academic journey in public health in the years to come, extending the frontiers of eye research in India."

"the course had a profound impact on me and changed my outlook from that of a clinician to a public eye health professional."
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