Integrated Education

- Under unavoidable circumstances, a concept or a lesson may have to be omitted.

Selection of an Appropriate Model of Integrated Education

In developing countries, awareness of integrated education is found among organisations working for blind persons and amongst professionals as well. There is a common consensus that integrated education should aim at normalising the life and education of the blind child but opinions vary to a great extent about how to realise the goal of integration. A minimum of ten models of integrated education are currently observed in developing countries.

Resource models with residential facilities are predominately found in many integrated programmes in developing countries but these are as costly as special school settings. The itinerant model, composite areas approach, and other contract specific cost-effective models have to be tried out to reach the currently unreached blind children in rural areas. There are claims and counter-claims about the superiority of one model over the other. In this professional debate on models, the real impact of integrated education should not be lost.

In deciding the cost-effective models of integrated education, three factors have to be considered.

- Number of blind children in a locality
- The nature of services required by blind children
- Expertise needed by a special teacher and general classroom teachers

More than 90% of blind children in developing countries are from rural areas, which are scattered. In a rural locality, it is difficult to find the required number of blind children for resource models. In such circumstances, the only cost-effective model would be an itinerant approach where one resource teacher can attend to the needs of more blind children in a cluster with the assistance of general classroom teachers. Research clearly indicates that resource models are academically superior to all other models of integration but duplication of resource models for mass implementation is not feasible.

Now inclusive education is increasing in special education and general education itself is sensitised to take care of the educational needs of blind children.

Blind children require different kinds as well as different levels of service. Children who are at the primary level will require the direct assistance of a specialist teacher whereas children at higher levels depend more on regular classroom teachers provided they are given the necessary materials for learning in the regular classroom. Therefore, selection of a model depends upon the nature of services needed by the blind children.

The success of integration also depends upon the extent of assistance provided by the general classroom teachers. In integration, the general classroom teacher and the specialist teacher are ‘two sides of the same coin’ and, therefore, the general education system itself should equip the regular classroom teachers in pre-service programmes to cope with the needs of disabled children in general and blind children in particular. Hence, blind children can be served effectively by a good combination of specialists and general classroom teachers.

Role of Special Schools

Special schools should change their role by serving blind children who cannot benefit by integration. Blind children with additional disabilities require special school services and, therefore, special schools will continue to provide services. In fact, they can become resource centres in a locality to promote the cause of integrated education.

Conclusion

In countries like India where the numbers of blind children are staggering, integration emerges as the only alternative to reach the unreached. Services for blind children in the country are more than 100 years old but the coverage of blind children in education is not even 10%. This scenario will change with the speedy implementation of integrated education.

Book Review

OCULAR INFECTION: Investigation and Treatment in Practice

Authors: D Seal, A Bron and J Hay

This really useful book comprehensively covers the field of ocular infections and is an important contribution to the prevention of blindness. Eight chapters cover general topics such as pathogenesis of infection, ocular immunology and pharmacology and epidemiology applicable to ocular infection, together with specific infections of ocular tissues and systems.

Professor Philip Thomas writes on tropical ophthalmomycoses. Chapter eight deals with hospital acquired infections, covering clinics, operating theatres, surgical prophylaxis and eye banking hygiene. Eight appendices contain very practical information on microbiological methods, formulations of antimicrobial agents and treatment regimens.

The authors are all experts of international renown in the field of ophthalmic infection and microbiology. The text is attractive, clearly laid out and beautifully illustrated with diagrams and coloured plates. Recommended reading and references are also given.

This volume will become indispensable reading for those dealing with eye infections as it presents essential information on patient management in both temperate and tropical areas. It is a ‘must’ not only for ophthalmologists but also microbiologists, infectious disease physicians, pharmacists, ophthalmic nursing staff and all medical and nursing libraries. At £35.00 it is a bargain. Perhaps a handy, cheaper paperback version would improve availability for developing countries.

E D Wright PhD FRCPath