

**USER MANUAL**  
**OF**  
**WHO CBS**  
**(CHILDHOOD BLINDNESS SOFTWARE)**  
**AN ANALYTICAL TOOL FOR THE**  
**EYE EXAMINATION RECORD**  
**FOR CHILDRENS**  
**WITH**  
**BLINDNESS AND LOW VISION.**

# **Contents**

## **1. HARDWARE AND SOFTWARE REQUIREMENTS**

## **2. THE INSTALLATION GUIDE**

### **a. THE LOGIN SCREEN**

### **b. THE DATA ENTRY**

### **c. HOW TO SEARCH/MODIFY A RECORD**

### **d. HOW TO VIEW THE REPORT**

## Hardware and Software Requirements

Below are the minimum hardware and software requirements that need to be ensured prior to installation of the software. Much of this information can be checked by doing the following

**Step 1:** Right click on the My Computer Icon on your desktop

**Step 2:** Select properties. The screen will provide information on the software that is operating on the system.

**Table 1: Minimum Hardware & Software Requirements**

S No.	Hardware / Software	Details
HARDWARE		
1.	CPU	P4, 2.4 GHz or Higher
2.	RAM	128 MB DDR RAM or Higher
3.	HDD	40 GB HDD or Higher
4.	FDD	1.44 MB
5.	CD-ROM	52 X CD-ROM Drive or higher
6.	MODEM	56 KBPS (Internal / External) or higher
7.	MONITOR	1024 x 768 Pixel Colour Monitor
8.	KEY BOARD	104 ASCII Character Set USA
9.	MOUSE	Windows Compatible
SOFTWARE		
1.	OPERATING SYSTEM	Microsoft WINDOWS 2000 Operating System For Microsoft Windows 2000, the system should have service pack 4 installed. For Microsoft XP, the system should have service pack 2 installed.
2.	SOFTWARE	OFFICE 2000 (Complete)
		Internet Explorer 6.0
OTHERS		
1.	PRINTER	As Per Requirement
3.	POWER BACKUP	UPS Installed

### ***Issues to be addressed prior to installation***

Successful software installation also requires the following:

- Preparation of suitable contingency plans for taking care of any problems that may be encountered in the computer system where the software is being installed. (for example, ensure that all material on the system is backed up and that Virus scan's are updated)
- If the computer system has been in use for several years and many application installations have already taken place on it, the registry of that system may have become incompatible with the new software. In that case, reformat and clean the hard disk of computer system (**after taking appropriate backup**) before the installation for avoiding any wrong configuration or missing DLL files.
- It may be worthwhile to call an engineer during the time of installation so that any technical deficiencies in the system can be tackled.
- If a complete version of OFFICE 2000 with Windows 2000 is not in place the CB STUDY CENTRES should make provision for its installation before the software installation.
- The required DDR RAM is 256 MB or higher. If the present system have 128 MB RAM or less than it then you are requested to upgrade the same to 256 MB DDR RAM.
- Since Installation will be done by a Compact Disk, it is important that the system has a 52X CD ROM Drive or Higher.
- Ensure that the system should be virus free before installation of the WHO CB software. It is important to ensure that updated anti-virus software is installed in the computer prior to installation.
- Acquire/Creation of System Initialization File - This file is extremely important in respect to usage of the software. This file contains encrypted information of the valid users of the software at a particular location

## Installation Guide

The installation of the WHO CB software is quite simple, as the software has been developed in visual studio Version 6.0 on platform of the windows 2000/XP. One should be ready with the hardware and software as specified in the earlier sections before installation of the WHO CB software.

Please look at the demo module that has been provided for any problems.

Please follow the following steps for the installation of the **WHO CB software**.

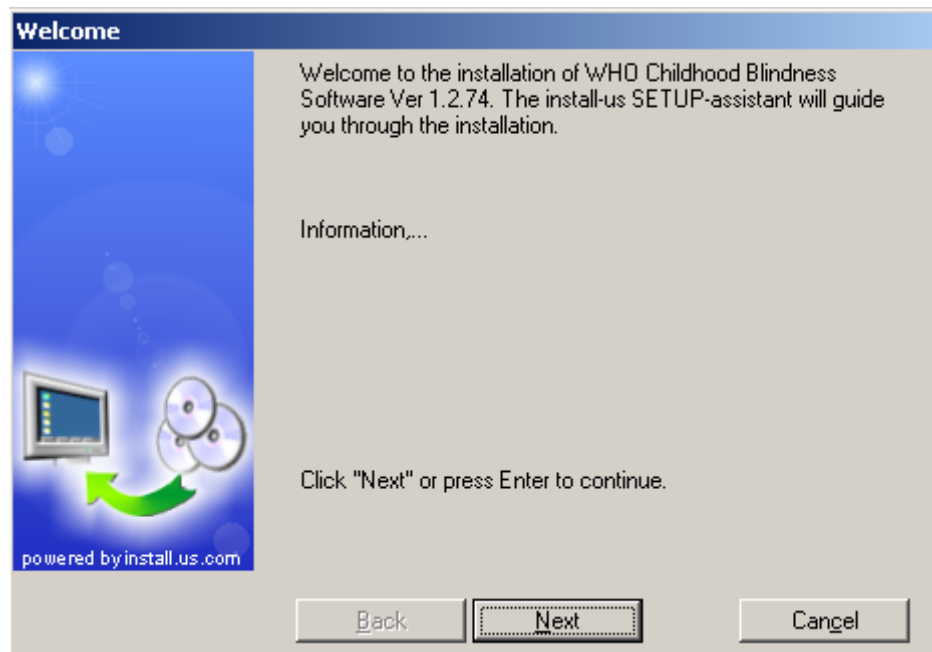
**Step 1:** Please insert WHO CB software CD provided to you in the CDROM drive.

**Step 2:** Open CDROM drive from “My computer>CDROM”

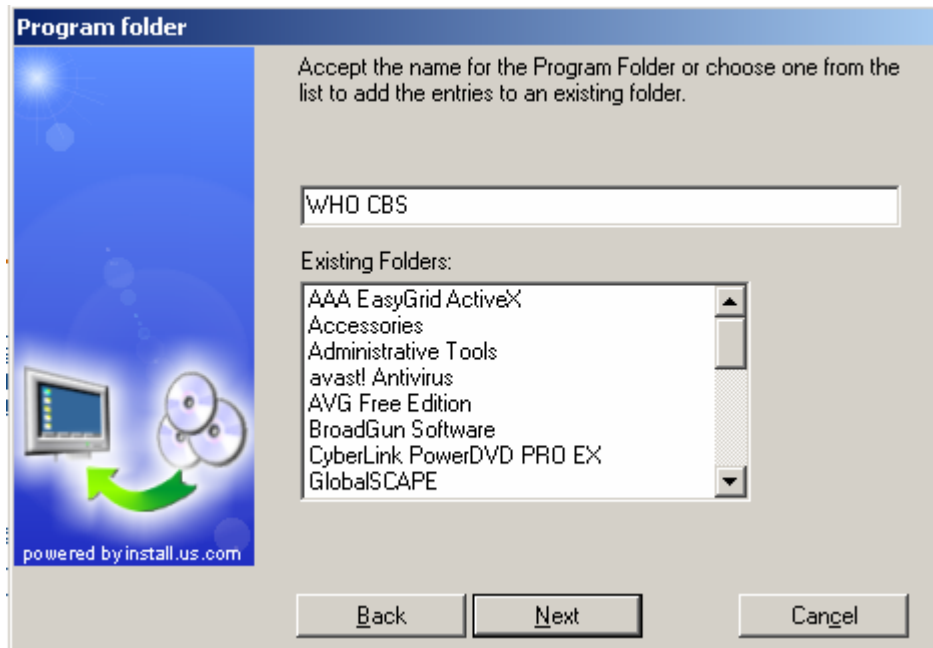
**Step 3:** Double click on cbsetup.exe file

**Step 4:** The welcome screen for installation appears. Please follow the images:

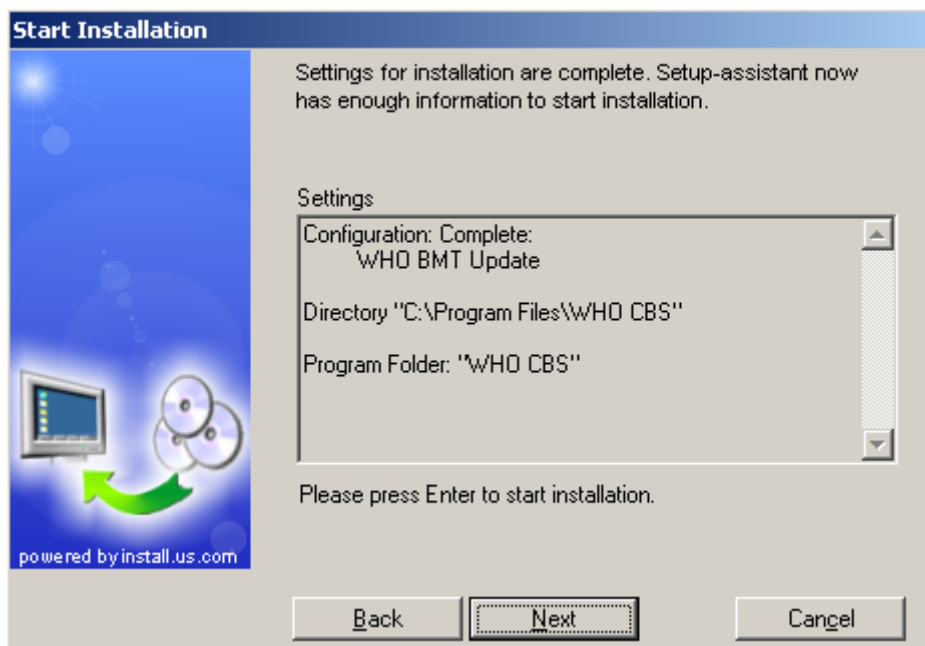
**Step 1:**



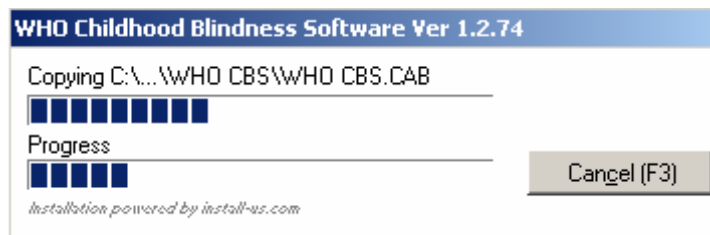
## Step 2:



## Step 3:



## Step 4:

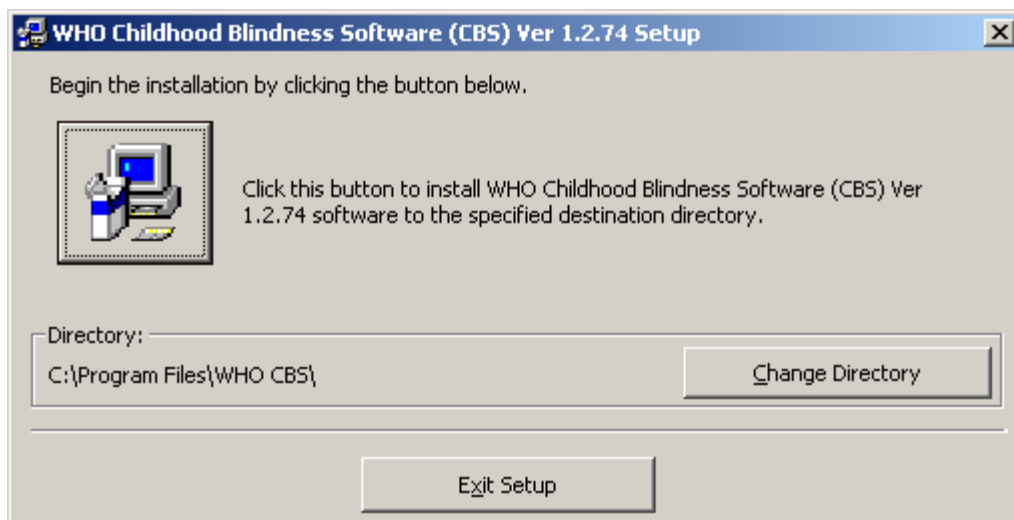


**Step 5:** Setup will start decompressing the DLL files as displayed above.

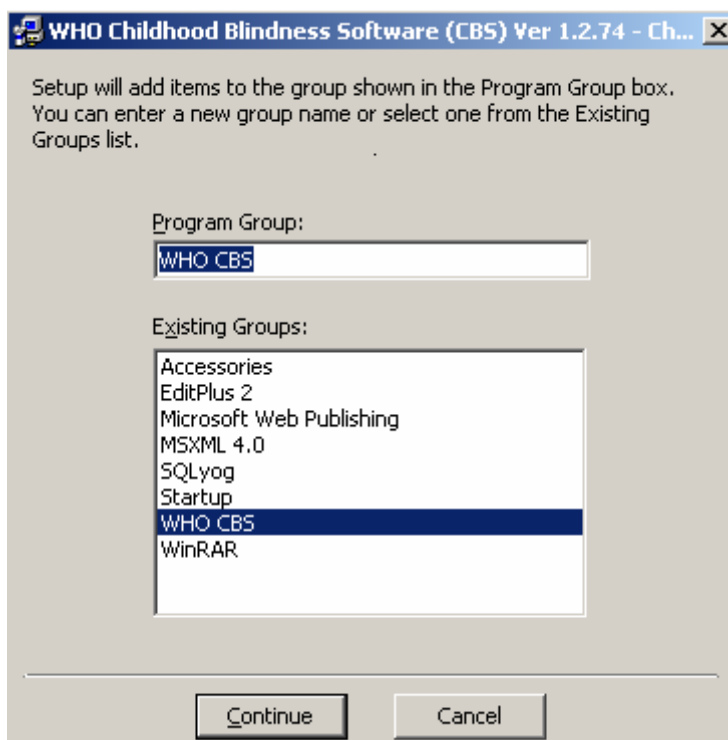
**Step 6:** Setup will start after decompressing the DLL files please see image below



**Step 7:** Welcome screen will appear with a message box please click “OK” and wait for the next message box to appear (see below).

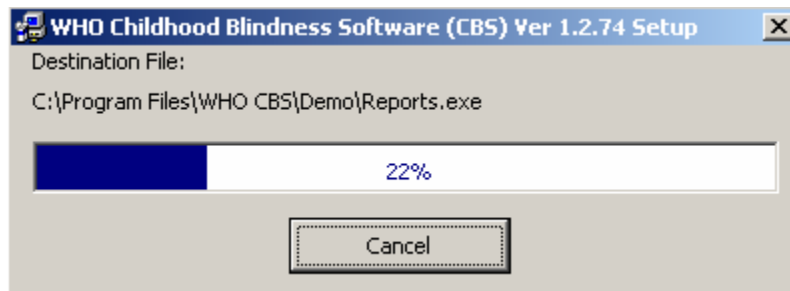


**Step 8:** To begin the installation please clicks on the computer icon as shown above. And wait for the next message box.

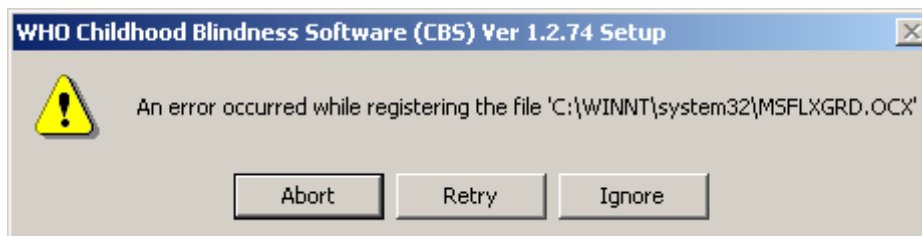


**Step 9:** User will get a message box “Choose Program Group” please press button “Continue”. (**WHO CB Software** Cause should already be selected)

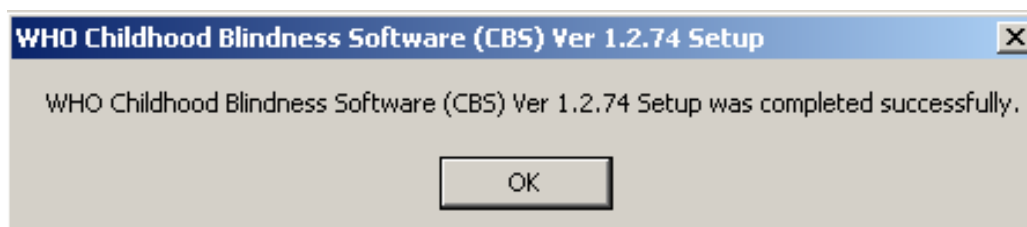
**Step 10:** Setup will start copying file to Hard Disk (see image below)



**Step 10(b):** In case you get the following screen error while installing your setup (see image below) always press [Ignore] button.



**Step 11:** User should get the screen above at the end of the setup process as a confirmation towards the successful completion of the **WHO CB software** setup (see image below)



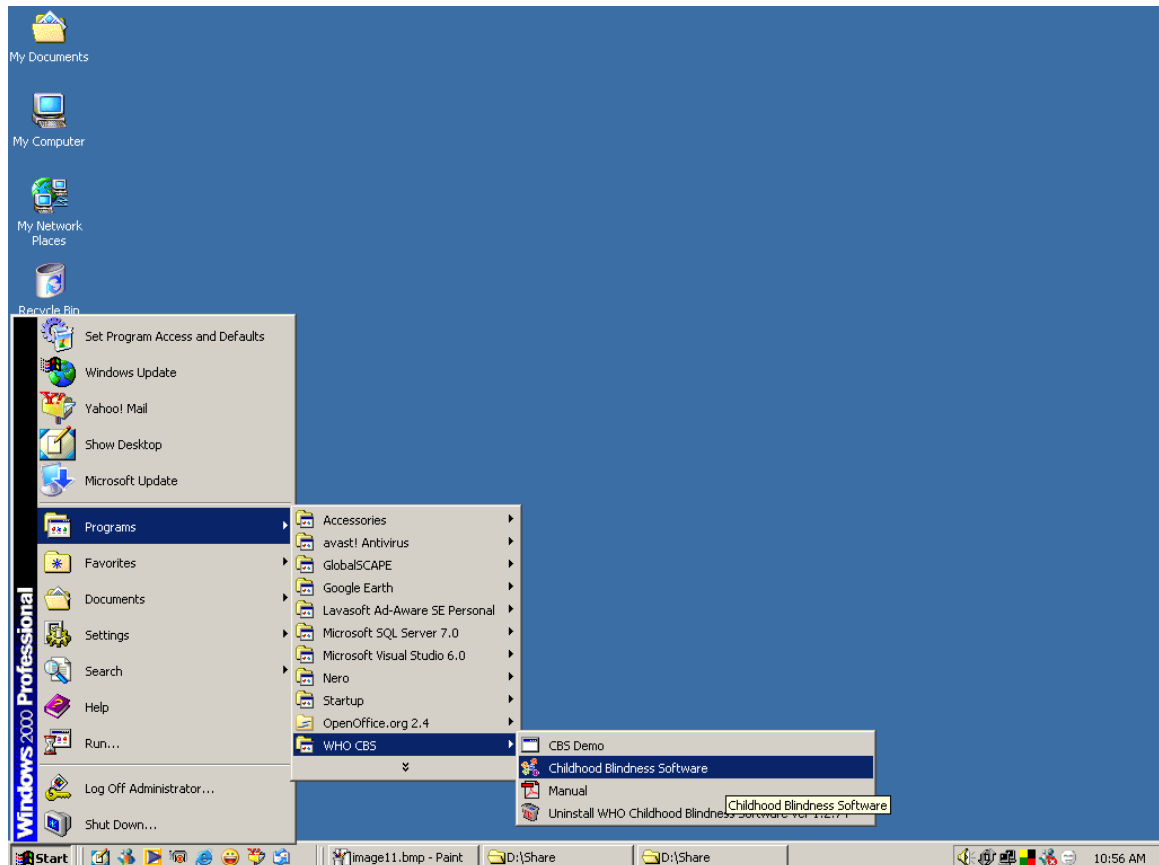


## a. The Login Screen

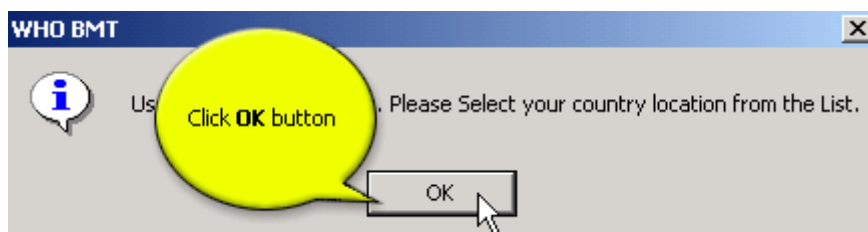
The Login Manager restricts the unauthorized access to the Backend Database of the **WHO CB software**. It also limits the amount of access a user has to the software (i.e. who can do data entry, data viewing, analysis, administration work, etc.). The Administrator decides the rights of a user.

The log-in procedures are described below. Please follow the procedure carefully.

**Step 1:** Go to Start > Programs > **WHO CBS** > **Childhood Blindness Software**



**Step 2:** A dialog box appears for the selection of Country Name. Click OK to proceed further.



**Step 3:** Select your country name from the given list.



**Step 4:** The WHO CBS Login screen appears and in there the software version is also mentioned.



Please follow the procedure in order to login in to the software.

**Step 1:** Enter a valid user name and password in their relevant edit boxes.

**Step 2:** Press Enter key or click Login to logon to the system.

If you receive error message for invalid user name and password then please re enter the user name and password and try again. If you receive an ODBC error then either your backend database is non functional or ODBC functionality is not available, please reinstall ODBC component from MS office CD as a part of add remove components from MS office.

**Step 3:** After you enter the Username and Password, the software Homepage appears.

WHO Childhood Blindness Software (CBS) Ver. 1.2.74  
Database Data Input Search / Modify Reports Help

 **World Health Organisation** Anguilla

Childhood Blindness software (Eye examination record for children with blindness and low vision)

90% of blind children do not go to school in developing countries



 Every minute a child goes blind in the world



1.4 Million Children are blind world wide

Less than half of childhood blindness is avoidable



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Keppel Street  
London  
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Tel 020 7958 8359  
[www.iceh.org.uk](http://www.iceh.org.uk)



## b. The Data Entry

Following are the steps mentioned pertaining to the data entry in to the software.  
Please follow the steps carefully to do the data entry:

**Step1:** Log in to the software and Click on **Data Input >> WHO Childhood blindness Form** from the Menu bar.

The screenshot shows a software window titled "WHO/PBL EYE EXAMINATION RECORD FOR CHILDREN WITH BLINDNESS AND LOW VISION". The window has a "Next >>" button in the top right corner. The form is divided into several sections:

- WHO/PBL EYE EXAMINATION RECORD FOR CHILDREN WITH BLINDNESS AND LOW VISION** (Header)
- A.1 CENSUS - BLIND SCHOOL / HOSPITAL STUDIES**
  - Country no: [3][5][6] Sch/Hosp no: [ ][ ][ ] Child no: [ ][ ][ ][ ][ ]
  - Sch/Hosp: [ ] City/Town: [ ]
- OR**
- A.2 CENSUS - POPULATION BASED SURVEYS**
  - Country no: [3][5][6] Cluster No: [ ][ ][ ]
  - Household No: [ ][ ] Child No: [ ][ ]
- B. PERSONAL DETAILS OF CHILD**
  - Name: [ ]
  - Home Town/Village: [ ]
  - Ethnic group (optional): [ ]
  - Age: [ ][ ] In months ( 0 - 11 months ) Sex: ☐ Male ☐ Female
  - [ ][ ] In years ( 01 - 25 yrs old ) ☐ Female
  - Age at onset of visual loss: [ ][ ]
    - 00 Since birth
    - 88 First Year of life
    - 01 - 25 in Years
    - 99 Unknown
  - Family history: Is there a family history of the same condition ?
    - ☐ Yes
    - ☐ No
    - ☐ Unknown
  - If yes, who is similarly affected? [ ]
  - Is there a history of consanguinity? ☐ Yes ☐ No ☐ Unknown
  - If yes, relationship: [ ]

Image: Data Entry Pg.1

**Step 2:** Please enter the data in the space provided in the data entry form as per the hard copy.

**Step 3:** Please click on the Next Button in order to go to the Next Page.

[Next >>](#)

X

**WHO/PBL EYE EXAMINATION RECORD FOR CHILDREN  
WITH BLINDNESS AND LOW VISION**

**A.1 CENSUS - BLIND SCHOOL / HOSPITAL STUDIES**  
Country no  Sch/Hosp no  Child no.   
Sch/Hosp:  City/Town:

**A.2 CENSUS - POPULATION BASED SURVEYS**  
Country no  Cluster No.   
Household No.  Child No.

**B. PERSONAL DETAILS OF CHILD**

Name:   
Home Town/Village:   
Ethnic group (optional):

Age:  In months ( 0 - 11 months )  
 In years ( 01 - 25 yrs old )

Sex: ☐ Male  
☒ Female

Age at onset of visual loss:  
 00 Since birth  
88 First Year of life  
01 - 25 in Years  
99 Unknown

Family history:  
Is there a family history of the same condition ?  
☐ Yes  
☒ No  
☐ Unknown  
If yes, who is similarly affected?

Is there a history of consanguinity?  
If yes, relationship:

☒ Yes  
☐ No  
☐ Unknown

Click on the  
**NEXT** Button to  
go to the **Next**  
Page

Image: Data Entry Pg.1

**Step 4:** Please enter the data in the space provided in the data entry form as per the hard copy.

**Step 5:** Please click on the Next Button in order to go to the Next Page.

<< Back
Next >>

**C. VISUAL ASSESSMENT**

**1) Distance Vision :**    **With present glasses** ☐   

**unaided** ☐

**Test each eye separately, then together.**

	Right	Left	Right and Left
6/6 - 6/18	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
less than 6/18 - 6/60	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
less than 6/60 - 3/60	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
less than 3/60 - PL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No light perception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot be tested			
Believed sighted	<input type="checkbox"/>	<input type="checkbox"/>	
Believed blind	<input type="checkbox"/>	<input type="checkbox"/>	

**2) Functional Vision :**    **Test each eye separately**

	Yes	No	Not Tested
Can see to walk around	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can recognise faces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can see print	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Believed useful residual Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3) Visual Fields :**    **Test each eye separately**

	Right	Left
Full field	<input type="checkbox"/>	<input type="checkbox"/>
Hemianopia	<input type="checkbox"/>	<input type="checkbox"/>
Constricted to less than 10 degree	<input type="checkbox"/>	<input type="checkbox"/>
Other field loss	<input type="checkbox"/>	<input type="checkbox"/>
Cannot test	<input type="checkbox"/>	<input type="checkbox"/>
Not tested	<input type="checkbox"/>	<input type="checkbox"/>

Specify type of test:

Click on the  
NEXT Button to  
go to the Next  
Page

*Image: Data Entry Pg.2*

**Step 6:** Please enter the data in the space provided in the data entry form as per the hard copy.

**Step 7:** Please click on the Next Button in order to go to the Next Page.

<< Back
Next >>

**D. GENERAL ASSESSMENT**

Additional disability	Tick all that apply
None	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>
Mental retardation	<input type="checkbox"/>
Physical handicap	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>
Other	<input checked="" type="checkbox"/>

Specify xyz

**E. PREVIOUS EYE SURGERY**

	Tick all that apply	Right	Left
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corneal Graft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optical Iridectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery, type unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other,	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Specify xyz

Please give full details including dates, if available,

Right eye <span style="border: 1px solid black; padding: 0 20px;"></span>	Left eye <span style="border: 1px solid black; padding: 0 20px;"></span>

Click Next  
Button to go to  
Next Page

Image: Data Entry Pg.3

**Step 8:** Please enter the data in the space provided in the data entry form as per the hard copy.

**Note:** You can click Back button in order to go to Previous Pages.

<< Back
Next >>

Click **Back**  
Button to go to  
**Previous Page**

**D. GENERAL ASSESSMENT**

Additional disability	Tick all that apply
None	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>
Mental retardation	<input type="checkbox"/>
Physical handicap	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>
Other	<input checked="" type="checkbox"/>

Specify

**E. PREVIOUS EYE SURGERY**

	Tick all that apply Right	Left
None	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Corneal Graft	<input type="checkbox"/>	<input type="checkbox"/>
Optical Iridectomy	<input type="checkbox"/>	<input type="checkbox"/>
Removed	<input type="checkbox"/>	<input type="checkbox"/>
Surgery, type unknown	<input type="checkbox"/>	<input type="checkbox"/>
Other,	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Specify

**Please give full details including dates, if available,**

Right eye <input style="width: 100px;" type="text"/>	Left eye <input style="width: 100px;" type="text"/>
<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>
<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>

Click **Next**  
Button to go to  
**Next Page**

Image: Data Entry Pg.3 – Previous and Back Buttons.

**Step 9:** Please click on the Next Button in order to go to the Next Page.



<< Back

**F. EYE EXAMINATION - Site of ABNORMALITY leading to VISUAL LOSS**  
 For each eye mark one major abnormality And all others that contribute to visual loss

Next >>

	Right Eye		Left Eye	
	Major	Others	Major	Others
<b>Whole globe:</b>				
Phthisis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anophthalmos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Microphthalmos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buphthalmos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorganised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cornea:</b>				
Staphyloma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keratoconus	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Opacity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lens:</b>				
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aphakia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Uvea:</b>				
Aniridia	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Coloboma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uveitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Retina:</b>				
Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Albinism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ROP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinoblastoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Optic Nerve:</b>				
Atrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypoplasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other, not listed</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Globe appears normal (complete after refraction see Section G)</b>				
Refractive error	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortical blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Idiopathic nystagmus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Not examined</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**THE MAJOR SITE OF ABNORMALITY LEADING TO VISUAL LOSS FOR THE CHILD.**  
**SELECT RIGHT OR LEFT EYE.**
☐ Right
☐ Left

Image: Data Entry Pg.4

**Step 10:** Please enter the data in the space provided in the data entry form as per the hard copy.

**Step 11:** Please click on the Next Button in order to go to the Next Page.

<< Back
Next >>

**G. REFRACTION/LOW VISION AID ASSESSMENT**

	Yes	No	Not Indicated
Vision improves with a pinhole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refraction performed now	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision assessed with low vision aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**1) If refraction performed, visual acuity with corrective lenses**

Distance: Test each eye separately, then together

	Right	Left	Right & Left
6/5 - 6/18	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than 6/18 - 6/60	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than 6/60 - 3/60	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than 3/60	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Specify corrective lenses and visual acuity**

**Right eye**  **VA**

**Left eye**  **VA**

**Near: Test with both eyes together**

	Yes	No
Can discern print/ symbols equal to Or smaller than 5mm (<=5mm)	<input type="checkbox"/>	<input type="checkbox"/>

**2) If assessed with low vision aid (LVA), visual acuity with LVA:**

Distance:

**Specify type of LVA and visual acuity**

**Right eye**  **VA**

**Left eye**  **VA**

Near:

**Specify type of LVA and near acuity**

**Right eye**  **VA**

**Left eye**  **VA**

	Right	Left
Can discern print <=5mm	<input type="checkbox"/>	<input type="checkbox"/>
Can discern print >5mm	<input type="checkbox"/>	<input type="checkbox"/>
Can discern print	<input type="checkbox"/>	<input type="checkbox"/>

Click on **Next** button to go to **Next** page

Image: Data Entry Pg.5

**Step 12:** Please enter the data in the space provided in the data entry form as per the hard copy.

**Step 13:** Please click on the Next Button in order to go to the Next Page.

<< Back
Next >>

**H. EYE EXAMINATION - AETIOLOGY OF VISUAL LOSS**  
**Select one of the categories 1-5 for each eye**  
**Tick all that apply within the selected category.**

		Right eye		Left eye	
		Definite	Suspect	Definite	Suspect
<b><u>Hereditary Disease:</u></b>	Chromosomal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mitochondrial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Autosomal dominant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Autosomal recessive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	X-linked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot Specify		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Intrauterine factor:</u></b>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Toxoplasmosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Drugs/alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Specify</b>		<input style="width: 100%;" type="text"/>			
<b><u>Perinatal / Neonatal factor:</u></b>	Cerebral hypoxia/injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	R.O.P.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ophthalmia neonatorum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Specify</b>		<input style="width: 100%;" type="text"/>			
<b><u>Postnatal / Infancy / Childhood factor:</u></b>	Vitamin A deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Neoplasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Harmful Trad. Practices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Specify</b>		<input style="width: 100%;" type="text"/>			
<b><u>Cannot determine (Unknown Aetiology)</u></b>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Glaucoma/Buphthalmos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Retinoblastoma, no FH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Abnormality since birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Specify</b>		<input style="width: 100%;" type="text"/>			
Other,		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Specify</b>		<input style="width: 100%;" type="text"/>			

**THE MAIN AETIOLOGY OF VISUAL LOSS FOR THE CHILD**  
 SELECT ONE FROM POSTIONS 134-183(-----)

*Image: Data Entry Pg.6*

**Step 14:** Please enter the data in the space provided in the data entry form as per the hard copy.

**Step 15:** Please click on the Next Button in order to go to the Next Page.

<< Back

Next >>

**I. ACTION NEEDED**

**1) Optical** Tick all that apply

None ☐

Refraction later ☐

Spectacles ☐

Low Vision Aid ☐

**2) Medical/ Surgical** Tick all that apply

None ☐

Medication ☐

Surgery ☐

Specify

Other, ☐

Specify

**J. PROGNOSIS FOR VISION** Tick one box only for each eye

	Right eye	Left eye
Could be improved	<input type="checkbox"/>	<input type="checkbox"/>
Likely to remain stable	<input type="checkbox"/>	<input type="checkbox"/>
Likely to deteriorate	<input type="checkbox"/>	<input type="checkbox"/>

**K. EDUCATION**

**1) Present Schooling** Tick one box only

Special school for the blind ☐

Special school for the multiple handicapped ☐

Integrated education ☐

None ☐

Other ☐

Specify

**2) Recommendations**

Change in schooling recommended	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify <input style="width: 150px;" type="text"/>		

**L. FULL DIAGNOSIS** Specify full anatomical and aetiological diagnosis:

Right eye:

Left eye:

**M. EXAMINER:** Examined by

Date   (MM)   (YY)

Click on the Save Button to save the Data Entry Form

Save

*Image: Data Entry Pg.7*

**Step 16:** Click on the Save Button in order to save the records.

**Step 17:** A dialog box appears pertaining to the confirmation on the records been saved.

**I. ACTION NEEDED**

**1) Optical** Tick all that apply

None ☐  
Refraction later ☐  
Spectacles ☐  
Low Vision Aid ☐

**2) Medical/ Surgical** Tick all that apply

None ☐  
Medication ☐  
Surgery ☐  
Specify   
Other, ☐  
Specify

**J. PROGNOSIS FOR VISION** Tick one box only for each eye

Could be improved Right eye ☐ Left eye ☐  
No improvement Right eye ☐ Left eye ☐  
Worsened Right eye ☐ Left eye ☐

**K. RECOMMENDATIONS** Tick one box only

Specify

**2) Recommendations** Yes No

Change in schooling recommendation ☐ ☐  
Specify

**L. FULL DIAGNOSIS** Specify full anatomical and aetiological diagnosis:

Right eye:   
  
  
Left eye:

**M. EXAMINER:** Examined by   
Date   (MM)   (YY)

Save

WHO BMT Ver. - 1.1.42

Childhood blindness form has been saved.  
Please note down the form number -> [ 35600500081 ]

OK

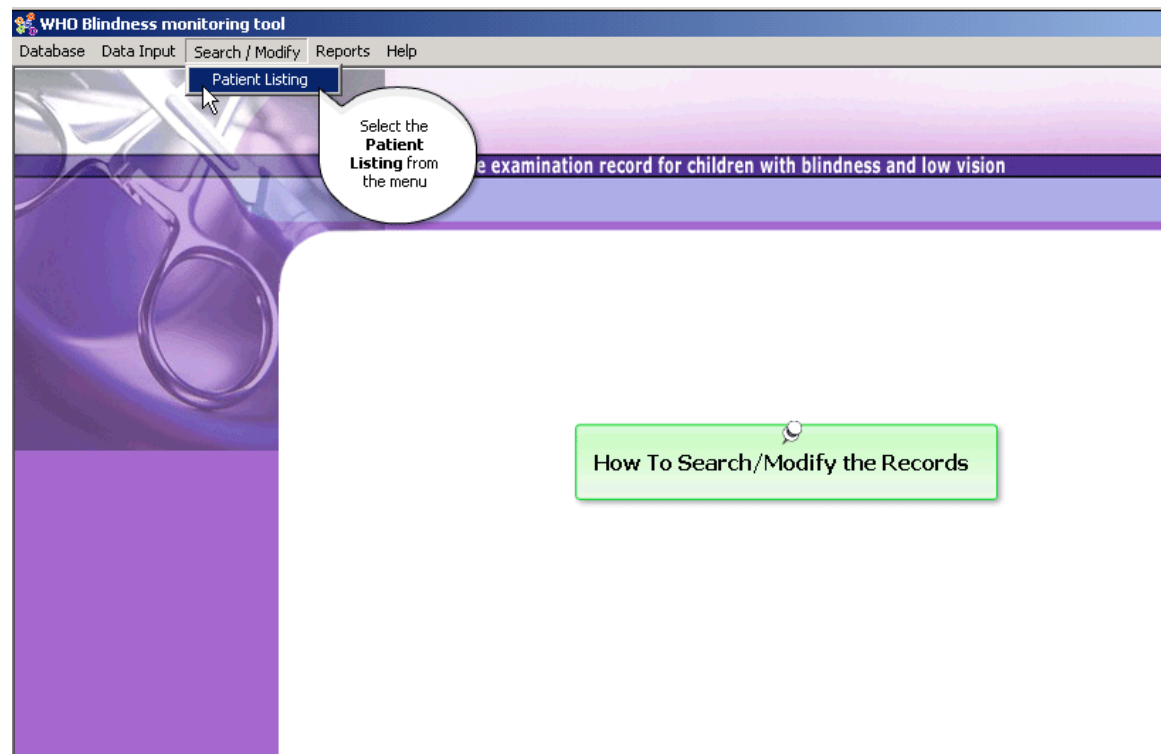
Click OK button

**Step 18:** Click on the OK Button. The records have been saved successfully.

## c. How to Search/ Modify a Record

Please follow the following steps in order to search or modify a record.

**Step 1:** Click on Search/Modify >> Patient Listing in the menu bar.



**Step 2:** Select your country name, School/Hospital Number, Child No., Age in months, Age in Years and Gender.

The screenshot shows the search form in the WHO Blindness monitoring tool. The form includes fields for 'Country..', 'Sch/Hosp No..', 'Child No..', 'Age in months', 'Age in years', and 'Gender'. A callout bubble points to the 'Country..' dropdown menu with the text 'Select your Country Name'. Another callout bubble points to the 'Sch/Hosp No..' field with the text 'Select School/Hospital Number'. A third callout bubble points to the 'Child No..' field with the text 'Select Child Number'. The 'Gender' field has radio buttons for 'Male' and 'Female'. A 'Search' button and a 'Reset' button are also present. Below the form, there is a table with columns: 'Code', 'Country Name', 'Sch/Hosp No', 'Child No', 'Name', and 'Home Town/Village'. The table has one row with the code '1' and the country name 'Afghanistan'.

Code	Country Name	Sch/Hosp No	Child No	Name	Home Town/Village
1	Afghanistan				

**Step 3:** After selecting every indicators, click on the Search Button in order to search a record.

WHO  
Eye examination record for children with blindness and low vision India

Country:  Sch/Hos No:  Child No:

Age in month:  Age in Years:  Gender: ☐ Male ☐ Female

	Code	Country	Sch/Hos No	Child No	Name	Home Town/Village
1	<input type="text"/>					

**Step 4:** The list appears in front of the screen based on the indicators selected.

Country:  Sch/Hosp No:  Child No:

Age in month:  Age in Years:  Gender: ☐ Male ☐ Female

	Code	Country	Sch/Hos No	Child No	Name	Home Town/Village
1	826	United Kingdom	003	00066		
2	826	United Kingdom	004	00083		
3	826	United Kingdom	004	00081		
4	826	United Kingdom	003	00073		
5	826	United Kingdom	003	00072		
6	826	United Kingdom	003	00070		
7	826	United Kingdom	003	00069		
8	826	United Kingdom	003	00071		
9	826	United Kingdom	003	00068		
10	826	United Kingdom	003	00067		
11	826	United Kingdom	003	00065		
12	826	United Kingdom	003	00078		
13	826	United Kingdom	003	00063		
14	826	United Kingdom	003	00079		

**Step 5:** Click on the desired record to be modified and then click on the Edit Button.

	Code	Country	Sch/Hos No	Child No	Name	Home Town/Villa
26	826	United Kingdom	003	00066		
3	826	United Kingdom	004	00083		
4	826	United Kingdom	004	00081		
5	826	United Kingdom	003	00073		
6	826	United Kingdom	003	00072		
7	826	United Kingdom	003	00070		
8	826	United Kingdom	003	00069		
9	826	United Kingdom	003	00071		
10	826	United Kingdom	003	00068		
11	826	United Kingdom	003	00067		
12	826	United Kingdom	003	00065		
13	826	United Kingdom	003	00078		
14	826	United Kingdom	003	00079		
15	826	United Kingdom	003	00063		
16	826	United Kingdom	003	00079		
17	826	United Kingdom	003	00062		
18	826	United Kingdom	003	00061		
19	826	United Kingdom	003	00058		
20	826	United Kingdom	003	00057		

Click on any record to modify

Click Edit button to Modify

Edit

**Step 6:** You can modify the desired fields and in order to save the modified fields, please come to the last page and press on the save Button.

**I. ACTION NEEDED**

**1) Optical** Tick all that apply

None ☒ ☐  
 Refraction later ☐  
 Spectacles ☐  
 Low Vision Aid ☐

**2) Medical/ Surgical** Tick all that apply

None ☒ ☐  
 Medication ☐  
 Surgery ☐  
 Specify   
 Other, ☐  
 Specify

**J. PROGNOSIS FOR VISION** Tick one box only for each eye

Right eye Left eye

Could be improved ☐ ☐  
 Likely to remain stable ☒ ☒  
 Likely to deteriorate ☐ ☐

**K. EDUCATION**

**1) Present Schooling** Tick one box only

Special school for the blind ☒  
 Special school for the multiple handicapped ☐  
 Integrated education ☐  
 None ☐  
 Other ☐  
 Specify

**2) Recommendations** Yes No

Change in schooling recommended ☐ ☒  
 Specify

**L. FULL DIAGNOSIS** Specify full anatomical and aetiological diagnosis:

Right eye:   
  
  
 Left eye:

**M. EXAMINER:** Examined by

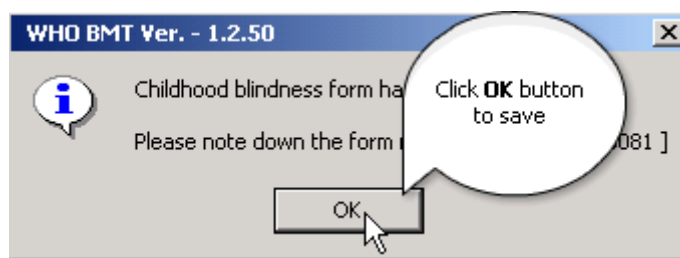
Date 06 (MM) 2007 (YYY)

Save

Click on the Save button



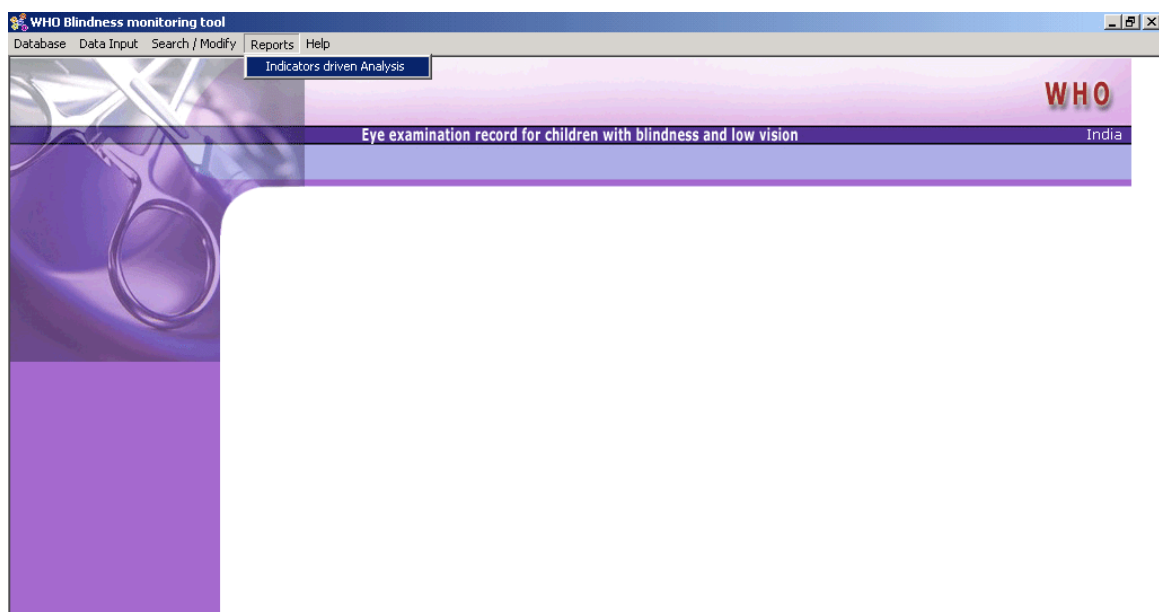
**Step 7:** A confirmation for saved data appears in front of the screen. Click on OK button.



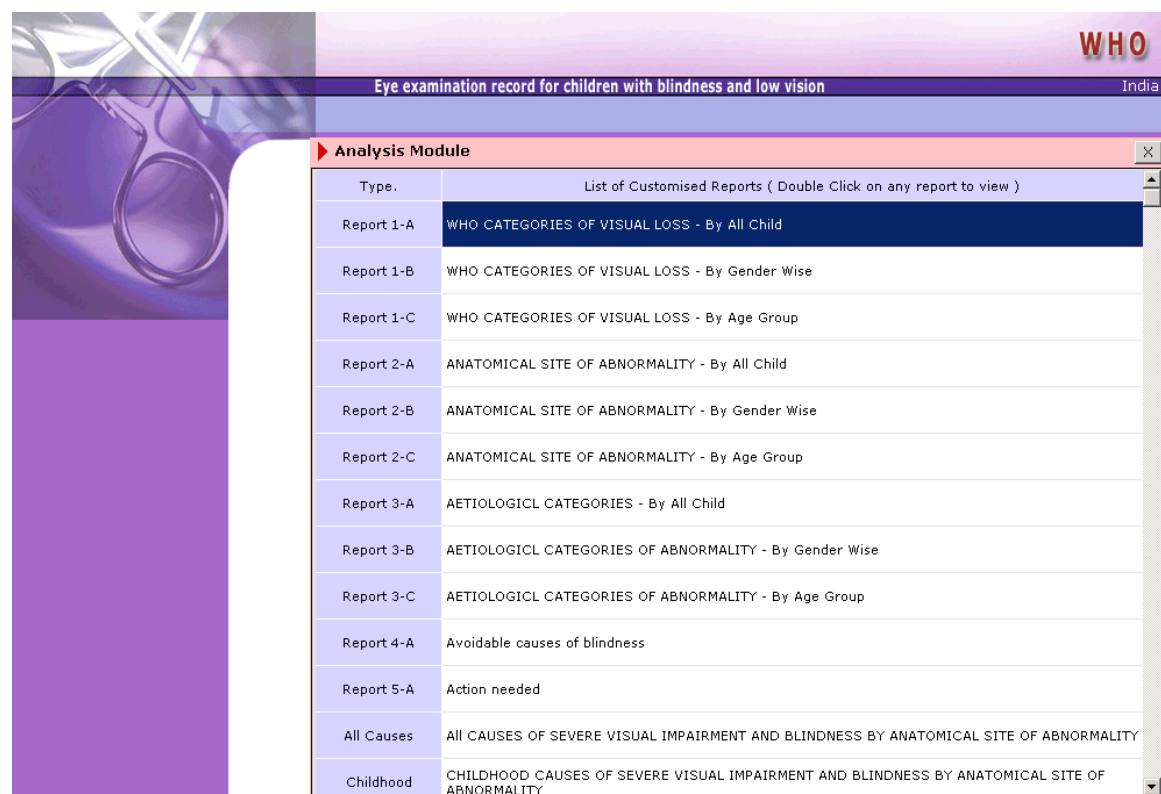
## d. How to view the reports

Following are the steps to view the report. Please follow the steps carefully.

**Step 1:** Click on the Reports >> Indicators Driven Values



**Step 2:** Double click on any of the reports to view.



**Step 3:** An Excel sheet appears on the screen. Click on the Report Button to view.

	A	B	C	D	E	F
1		<b>Table 1A. All children in the study</b>				
2			<i>Click here to generate the report</i>	Report		
3		<b>WHO Category</b>	<b>Vision in better eye</b>	<b>N</b>	<b>%</b>	
4						
5		<b>No impairment</b>	$\geq 6/18$		0	
6		<b>Visual impairment</b>	$< 6/18 - 6/60$		0	
7		<b>Severe visual imp.</b>	$< 6/60 - 3/60$		0	
8		<b>Blind</b>	$< 3/60 - NLP$		0	
9		<b>Cannot test</b>			0	
10						
11		<b>Total:</b>		0	100	
12						