

ICEH Webinar: What is Open Education

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[Sally Parsley] Hello, everyone. I hope you can hear me. I'm delighted to welcome you to our very first webinar on what is open education and why is ICEH using open education as part of our education strategy. My name is Sally Parsley, and I'm the technical lead on the Open Education Programme at the International Centre for Eye Health here at the London School of Hygiene and Tropical Medicine.

I'll be hosting this session today. So this is the first in a series of five webinars that we're hosting over the next few months, which aim to explore some of the positive innovation we think digital technology and e-learning might help to bring to support eye care training around the world

In particular, through the concept of openness and open education, which are both topics Dasksha is going to be talking about in more detail today, which we think have been gaining interest among educators around the world over the last few years and which we are also working on.

So we had 100 people to register interest for this webinar. So this is fantastic, and we're really excited to see so much interest from the eye care education community. So I hope you enjoy the next 45 minutes and get to take away some useful thoughts and ideas for your own practice.

I'm now delighted to introduce our very first speaker, Professor Allen Foster, the co-director of ICEH. Originally from Lancashire in the UK, Allen graduated with honors in medicine from the University of Birmingham in 1973. He was a general medical officer at the Mvumi, [Allen, I'm terrible, sorry] Hospital in Tanzania from 1975 to 1985 where with others, he helped develop a national eye care plan and established a clinical training program for doctors and ophthalmic assistance, training over 200 people from all over Africa.

Up to 10 years in Tanzania, he returned to the United Kingdom to work for CBM as their international medical director and later their chief executive. And he also took on the leadership of our group, ICEH at the London School of Hygiene and Tropical Medicine.

He was closely involved in the development of the VISION 2020 strategy to end avoidable blindness. And he's probably best known as a passionate advocate and teacher for it. So it's Allen's unique experience of academic research and teaching on three continents, which has facilitated and driven the development of ICEH's education strategy. And he's the ideal person for me to introduce to you to talk about the big picture in human resource development for eye health. OK, Allen, thank you very much.

[Allen Foster] Sally, thank you. Good morning, good afternoon, good evening. I'm good talk about visual impairment, a global perspective. Then I'm going to talk about human resources initially globally, but then focusing particularly on Africa-- where the greatest need is. Then I'll speak a little bit about what ICEH does in terms of education.

So first of all, the number of people blind and visually impaired in the world-- the top two lines are from the World Health Organization. 1990-- WHO estimated 38 million blind and 110 million visually impaired, and those visually impaired from refractive eye wear were not included at that time.

By 2010, WHO said the number of blind was 39 million and visually impaired 246 million. The lower two rows are from the global burden of disease estimates. So in 1990, the estimate there was 32 million blind and 172 million visually impaired, and by 2010, 32 million blind-- 191 million visually impaired.

I think one should point out that over that 20-year period, the population in the world increased quite dramatically. And also, the people over the age of 50 increased significantly. So the fact that blindness was not increasing probably means that services were improving. And the number of people with avoidable blindness was decreasing.

So if we summarize that, and I'm using the global burden of disease figures here, we have 32 million blind people-- 191 million between 6/18 and 3/60-- giving the total of 223 million with visual impairment less than 6/18 with a global population of 7.3 billion.

This is a complex slide, but an important slide, and let me just explain it to you. First of all, the blue lines are dated from 1990. The yellow orange lines are for 2010. Down on the left-hand side, we have the regions of the world and then a global figure for the whole world at the bottom.

And then what we're measuring is the number of blind people per million population. So if we look at the world figure at the bottom, you can see that in 1990, there were 6,000 blind people per million population on average in the world. That equates to 0.6% prevalence-- 0.6 per 100. By 2010, this had reduced to 4,700 or 0.47%.

If we look at the regions, you can see that there was a decrease in every single region over that 20-year period, but also that the amount of blindness in the poorest regions of the world is three to four times the figure that we find in high-income countries. And again, this is indicating to us that there is still a significant proportion of avoidable blindness in the world, either preventable or treatable diseases.

So if we then ask what are the causes of blindness, again, this is the global burden of disease data for 2010. And you can see the cataract and uncorrected refractive error, which are obviously very treatable conditions, make up more than 50% of all the blindness in the world.

Trachoma is preventable. This is gradually decreasing with the Global Elimination of Trachoma Program. And then we have emerging conditions such as glaucoma and diabetic retinopathy together with some children's problems like retinopathy of prematurity. And putting these together, they are now about 13%, 14%, 15% of global blindness. And they would be preventable, but obviously more difficult to prevent than the conditions such as trachoma and vitamin A deficiency. And lastly, we have conditions where treatment is more difficult-- macula degeneration and many other causes in white at the bottom.

So moving on now from a review of global blindness and the causes to a discussion around human resources. And we don't have an exact figure of the number of ophthalmologists in the world. But it's estimated to be between 150,000 and 200,000.

One should point out that not all ophthalmologists are trained in cataract surgery. So for a global population of 7.3 billion, on average, we have 20 to 30 ophthalmologists per million population, but not equally distributed.

Here is a kind of figure which gives you an indication of the number of ophthalmologists per million population in different parts of the world. In North, Central, and Southern America, it's usually more than 50 ophthalmologist per million-- up to 100. Western Europe tends to be between 20 to 60 ophthalmologists per million.

The major population countries of India and China are more than 10 and up to 20 ophthalmologists per million population. Whereas most of Africa is less than 5 ophthalmologists per million and some places less than 1. So obviously, the big need for more eye care resources in terms of people and ophthalmologists is the Africa region.

This is a geographic map showing the countries in dark orange, which are felt to have a shortage of ophthalmologists-- mainly Africa with a few countries of the Americas and some of Southeast Asia.

So I'd like to now focus on Africa for a few slides. Africa has 10% of the global population and approximately 5 million of the 32 million blind people in the world. However, in terms of resources, or health expenditure, or in terms of ophthalmologists, Africa only has 1% of the global health resources and global ophthalmologists.

So if we look at the distribution of ophthalmologists in Africa between anglophone countries, francophone, and lusophone, Portuguese speaking, one can see, on average, Africa has three ophthalmologists per million in the anglophone countries, slightly less in the francophone, and much less in the six lusophone countries.

This gives a little bit more data if we say that a minimum target is one ophthalmologists per quarter million-- so four ophthalmologists per million. Then by 2010, we would need 4,000 ophthalmologists in Africa for about 1 billion population by 2010. And available at present is less than 2,000. So we have a shortfall of 2,000 ophthalmologists by the year 2020.

The line on optometrists is probably the minimum figure there-- 1 per 250,000. It should now really probably be increased to 1 per 100,000, which would mean we would need 10,000 optometrists, and we have about 7,000. So we actually have a shortfall of about 3,000.

And then allied eye health personnel are nurses-- clinical officers. And again, we need 10 per million population. And so we would need 10,000 by 2020. And we have about 5,000-- so a shortfall of 5,000. So overall, one can see that in Africa, there is a very significant gap between the minimum number required, not the ideal number, but the minimum number required of what is actually available in terms of ophthalmologists, allied eye health professionals, and also probably optometrists as well.

So the question is what about training centers for these cadres of eye staff? So if we look at the anglophone for training centers for ophthalmologists of the third row down. We have 39 anglophone centers, nine francophone-- only two in lusophone-- giving a total of 50 training centers for ophthalmologists in Africa for a population of over 800 million. So one training center per 16 million.

Some of those training centers train one or two optometrists or ophthalmologists a year. And some train 8 or 10 per year. So there's no set figure. But the actual number of training centers is insufficient. And this also applies to optometrists-- 24 for the whole of Africa-- and allied health personnel-- 36 training centers for the whole of Africa.

So what would be a model for a population of 1 million? What would be an eye care team? This tries to give some justification for minimum figures. So if we start on the top row speaking about an ophthalmologist or a cataract surgeon and saying that we would like them to operate on 10 to 20 cataracts per week given the 50-week year, that would mean they would do 500 to 1,000 cataracts per year.

So if we want a cataract surgical rates of 2,000 to 4,000, which is the kind of minimum to ideal that's recommended per million, we would really need four cataract surgeons per million as a minimum figure.

Then moving to eye nurses and assistants, it's recommended to have at least two to three nurses or assistants per ophthalmologist. So if we have a minimum of four ophthalmologists, we need a minimum of 10 nurses or assistants. Moving on to optometrists, if an optometrist does 20 refractions a day. that's 100 a week. It's 5,000 a year.

And so with 10 optometrists, we would be able to refract 50,000 people per year per million population, which would be 5% of the population. And that would seem to be a minimum number, again, to provide an acceptable service. And then, lastly, community health workers- - if we ask one health worker to look after 20 families in a week, and each family's got five people, that would be 100 people. So that would be 5,000 people they would look after in the year, which means we would need 2,200 community health workers per million population.

So this is just to give a kind of framework. It's the minimum number that would be required-- so a minimum number-- 4 ophthalmologists, 10 nurses, 10 optometrists, and 200 community health workers or 1 million population. And most parts of Africa are significantly below that at the present time.

Why is this important? Well, the global action plan to address avoidable visual impairment and to bring about universal eye health-- the five year plan, 2014 to 2019, has three key indicators. One is the prevalence of avoidable visual impairment.

A second is cataract surgical coverage and cataract surgical rate. And the third key indicator is human resources-- the number of ophthalmologists, number of optometrists, and the number of allied personnel. And countries are asked to monitor the number per million population within their country to try and meet the minimum requirements that we've addressed in previous slides.

So what is the International Centre of Eye Health doing in terms of education activities. I'll summarize this quickly on this slide. The key activity is the master's training in public health eye care, usually with 15 to 20 students per year training them in public health for eye care planning really for leadership positions back in the ministries of health, or universities, or NGOs working in their home countries.

At the grassroot level, we produce the Community Eye Health Journal. Four issues are done each year. It's sent free of charge. It's also put on the internet. It's in English, French, and

there are also Chinese versions, and occasional Spanish versions. And this is really education for the grassroots worker, be it the community health nurse or the ophthalmic assistant, the ophthalmic nurse, and also ophthalmologists working in the field.

We have had a variety of short, one-week courses in international eye health and planning for eye care. And particularly for Africa, we have the Links Health Partnership Program. The purpose of this is to improve the quality and quantity of eye care training within the training centers in Africa. And we do this through partnering training centers in Africa with the UK ophthalmology departments in a linked program to help improve training.

And then, lastly, what we've started the last few years is the Open Education Programme, which Daksha will be talking more about in a few minutes. So I hope this has given you a quick overview of global blindness, the health resources around the world to address blindness, and then focusing in on Africa where the greatest need is. Thank you.

[Sally] Thank you so much, Allen. That was super interesting, and it's so clear the huge challenge in human resources that eye care is facing to help support the global action plan. I'm pleased to see we've got some questions in already, and that's great. And we'll address those after our next presentation.

So now we're going to turn to Dr. Daksha Patel. And she's going to go into some of the new opportunities that this idea of open education might help bring to eye care educators. Dr. Patel is the e-learning director at the International Centre for Eye Health. Originally from Kenya, she practiced as a physician and ophthalmologist in East Africa for over 8 years before coming to ICEH to study the master's in community eye health, as it was then, in the mid '90s.

Her interest and passion lie in human resource development for eye care. And she ICEH's master's course director for public health for eye care for 14 years. During this period, more than 300 students from across the globe came through the corridors of ICEH, and in the process, shared their frustrations and experiences with the training facilities in their own settings.

And even after the course, they continued to share their learning about how they went back and implemented what they had experienced on the course. This became a key inspiration for Daksha, and she grasped the first funding opportunity that came ICEH's way to start development of e-learning in 2014. And she now leads our Open Education Programme. OK, I'm going to hand over to you now, Daksha. Thank you so much.

[Daksha] Thank you, Sally, and thank you, Allen, for setting the backdrop and giving us an understanding of the high needs and the low resources that we're faced with. In 2014, we began to explore with innovative approaches for training specifically in the arena of open education. What we want to do today is look at what is open education? Is it relevant and applicable for eye care education. And what is available from here at ICEH.

And to do this, what I've done is I've broken down the words open education to look at open and education as separate entities. When we think of open, we're really talking about no barriers or lack of obstacles. Accessibility is a key component of that. And legally unrestricted, I think that is one of the main components of what we refer to any idea open--not working and functioning within silos, but becoming more collaborative.

And of course, the idea that open may suggest it's free will put a question mark next to it, because it's not free for development. There are development costs attached to it, but there are also accreditation costs that may be attached to it.

When we actually talk about education, people actually confuse it with a place like schools or colleges when seeing or hearing that word or perhaps even with jobs such as tutors or teachers. Education really is a process of inviting the truth and exploring the possibility or encouraging and giving time to discovery.

In this view, educators look to act with people rather than on them. And their task is to educate, or from that Greek word educere, which is to bring out or to develop potential. So I'd like to suggest that education is deliberate. We act with a purpose to develop understanding and judgment and enable action.

And as educators, we are all clear that education takes place on a linear plane within a curriculum usually when we're talking about formal education. But there is, I believe, room for informal education, perhaps even on that same continuum. And we like to think of that as perhaps self-directed education.

So really open education is about a philosophy to produce, to share, and build our knowledge. And proponents of open education believe that everyone in the world should have access to high-quality educational experiences and resources.

And this means we need to begin to address barriers such as cost of education, replacing, or removing outdated and obsolete teaching materials and then preparing legal mechanisms that allow collaboration to take place between scholars and educators.

So I thought it might be quite interesting to look at the origins of open education from reusable learning objects, to open educational resources, to MOOCs. And I've created this very brief time line. Of course, a lot more is happening than just what I've been able to put here.

But within the UK training systems, in about 1982, an interesting Nelson's Review took place about why the UK lagged behind the competitor nations in the use of IT within university education. What they actually concluded was if educators began sharing that expertise, the quality of education would likely to improve.

But more importantly, also there would be efficiency savings. But of course, in '89 came the invention of world wide web, and that was the biggest open thing that could have happened. And it gave rise to a number of different things that happened, and one of the things that came up was Reusable Learning Objects, RLOs, and these are still in use.

And this is specific content. I'd like to think of it as the LEGO bricks, which can be created. They're not always pedagogically supported. But they clearly allow a sharing of knowledge. And I'd like to think, for example, a video in cataract surgery is a good learning object.

Then came the creative commons license, which took away the restricted-- which took away the restrictiveness of sharing. The biggest open educational resource-- and that's a word coined by UNESCO-- talks about the biggest one I think is the open courseware launched by MIT.

But following on from there, there have been many innovations, and this includes the launch of Open Learn from the Open University here in the UK, in China, called CORE, the Khan Academy. And this has, of course, led to a number of different innovations as we now know as MOOCs and Coursera being one of the largest providers.

I draw your attention to the Cape Town Open Education Declaration, which has a very important point in that it looks at the issues that might be facing open education and its recognition and how can we address that particularly at policy level.

So coming from that perspective, we were really attracted to these perspectives of open, online, unlimited participants, curriculum driven, and certainly looking for reuse, retaining, revising, and remixing, and redistribution of our content.

We are aware that there is a lot of open practices out there. And these will certainly allow for used, reused, sharing, adoption, and flexible learning in eye care. But we don't forget there are continuous challenges in connectivity, digital literacy, lack of time, and institutional policies.

And what we've done is we're looking at this as a whole as open educational practice. The challenges that we face in our health education both lie at the training program level as well as at the individual practitioner level. We know that training facilities are under a lot of pressure.

They have small faculties, limited budgets, limited infrastructure, and at the same time, need to keep up with the changing students' learning styles, particularly that is influenced by about social networks and the internet. And the importance-- as Allen has suggested, the importance of the global action plan and the alignment of the national eye health strategy.

Individual practitioner levels-- particularly in remote settings-- access, cost, and time for learning is an issue. This is made worse by the lack of availability of professional development. And then the final stumbling block of selection criteria-- not enabling everyone to have equal access to learning.

So from our perspective and particularly we need to address public health and eye care, we did look at the good things we are doing, which is leadership through the masters. We realize that our programs can be expensive-- scholarships are few. We have a selection criteria. And it means clinicians are away from their families and their clinics. And we want knowledge to be applicable and relevant for the local level. And we wanted to address all these key issues.

So what have we done so far? We've created I would say three big courses-- one being on global blindness, planning, and managing for eye care services. This has taken the shape of both as a MOOC and also as an open educational course on the London School's open study platform.

And we're going to have our third run starting on the 20th of February on FutureLearn. We've had over 5,000 people who've done this course already. We have another course, which is in two parts, on ophthalmic epidemiology, which looks at the basic principles and how we are able to apply epidemiology to understand eye diseases. And both are now open and available for use on the open study platform here at the London School.

And the final one is on eliminating trachoma. We've already completed the first run with over 2,700 participants on it. And the second run is planned for the 17th of April this year.

What I'd like to highlight here is that each of these courses has several elements within it-- up to 60 different source resources within it. And you can take them as videos, as quizzes, as discussions, and articles.

What we want to see and develop are pathways for open education within local settings. And we think there are three clear pathways. They certainly are what individuals can do for self-directed learning either through the full course or to pick and choose the content the need, even to get accreditation and strengthen their own CVs.

For the educators, we are very keen that they would look at additions of this content to their existing curriculum and therefore bringing in flexibility and faculty support, adding it to their specific teaching sessions to what is now being called flipped learning. And in these webinars, we're going to be looking at this in some detail.

And we would encourage sharing and adaptation by educators to redesign their curricula. At the institutional level, we are looking to see if accreditation is an option that can be assigned to these open educational courses in IHEC.

We have a lot in the pipeline. We have Diabetic Eye Disease: From the Patient to the Health System starting in 2017-- Retinopathy of Prematurity in 2018-- Research Methods in ophthalmology in 2018-- and Glaucoma is going to be planned for 2019.

I do have to take time here to really thank support that we've got from the Seeing is Believing Program from the Standard Chartered [Bank] and the Queen Elizabeth Diamond Jubilee Trust, who've actually supported us to develop these open educational practices that are now going to go on in eye health. So thank you very much.

[Sally] Thank you so much, Daksha. You're busy, and so am I. Thank you both to both of our presenters and to everyone here. I hope you've enjoyed this. I think from Daksha's presentation, we can see that this idea of Open is a really powerful one. And I think it's already embedded in the knowledge sharing that so many eye care educators already freely practice.

So we're already used to sharing resources and ideas with each other. And what I think Open brings is a way of leveraging that so the institution-- we can use the internet. We can scale up the amount of sharing. Institutions can get involved and start sharing in a more formal way.

So I know we're a little bit short of time. So I could chat on, but I'm not going to. I'm going to be a good host. And we now have a bit of time for questions and answers. So I'm just-- oh, we've got quite a few. I'm going to start with two really tough ones from Michael Gichangi. So I've got one question for Allen from Michael which is, "Is the shift to comprehensive eye care likely to change our needs in terms of workforce training? What about task shifting and task sharing?"

And my other question to Daksha from Michael before I hand it over to Allen is, "How are we going to measure the change that comes from this open education program? How are we going to assess how effective it is and also the impact it has maybe in five years time?"

[Allen] OK, thanks Sally and thank you Michael for the questions-- so just to go over it again. The MOOC comprehensive eye care-- does that change the needs in terms of numbers of eye care team members? And also, what's that mean for task shifting?

So the original VISION 2020 initiative focused on five diseases with the aim being that if the blindness was preventable treated from those diseases, we could reduce the amount of blindness in the world. The idea was that that was a focus. It was to create the priority setting for what would happen.

However, even within those five diseases, it was that there would be an eye care team delivering services for a population of 1 million. And the eye care team would deliver general eye care services or comprehensive eye care services. It wasn't that they would only do cataract or only do trachoma. It was that they would do everything. But using those five diseases to show what the focus and what the needs should be.

So coming back, does it change the needs? I don't think it changes the minimum needs. Of course, as one addresses the problems of trachoma, and cataract, and vitamin A deficiency, and begins to go on to improving services for glaucoma and diabetic retinopathy, then the skills and possibly the numbers of people trained to deliver those services will change.

So in the 1990s when VISION 2020 was being developed, we weren't talking about training people to do laser for diabetic retinopathy. So, yes, certain things are changing. And going back to it, the minimum numbers I think are still reasonably valid. I don't think that changes a lot.

The question of task shifting is perhaps the more important one. Given the fact that we don't have even the minimum numbers, particularly in Africa, then it's very important that the people that we do have are spending their time doing the jobs that are most important, which other people cannot do. So the simple thing of ophthalmology should be doing cataract surgery perhaps rather than refracting, which can be done by optometrists or by nurses.

And moving into the future with things like diabetic retinopathy, there's no reason why ophthalmic assistants can't be doing the screening for diabetic retinopathy. And although it's not yet been promoted, one may even think of people being trained specifically to provide treatment for diabetic retinopathy and leaving the ophthalmologists to be doing the surgery that they're trained to do.

So I think task shifting is an important issue which we've not yet done enough and which we need to think more and more about as we go forward, looking at what the job is and then specifically training people to do that job. Daksha.

[Daksha] So on the issue of how are we going to measure change, it's a fantastic question. And certainly, that preoccupies us or most of the time. But what I would like to share here is if, yes, of course we have to measure the impact. But we are going to have to mention the impact alongside the strong influence that technology is bringing to the whole educational frontier.

It is shaping education in a very different way, and our users of the education and the learners on our programs are very different now to perhaps what Allen and I were many years ago. So from an individual level and from the little experience that we've already had from our users,

which there are several examples on how changes occurred at an individual level. Practices have changed how they've gone about addressing their cataract surgical rate-- the numbers of people that are now doing school eye health as a result of having taken the courses.

So there are certainly measures that we would like to take forward as clear case studies at an individual level. When it comes to educators, what is the change that's going to come about at the curriculum level or in their teaching practices? What we are keen to capture is how many people have used this to strengthen their own curricula? And what are the different practices that are going to happen at that level?

And certainly, when it comes to the institutional level, what is the influence at the institutional level for accreditation and the development of policy for open education? Because we certainly want to understand that open education does not only promote a one directional movement of knowledge, but it is about the sharing. And to capture this both in terms of qualitative and quantitative will be our priorities-- perhaps to a range of analytics, pre and post course surveys, qualitative interviews. So there's a wide range of tools that we would like to implement in order to capture this very important shift through open education.

[Sally] Thank you, Daksha. Thank you, Allen. We've got quite a few questions. So I'm going to bunch them up again. So I'm going to give Allen a couple questions, and Daksha, and then we'll go back to Allen to answer the first one. So for Allen, Lila Puri has got in touch asking some questions about data. "With the data we have how are we doing in terms of VISION 2020? And is there are specific WHO recommendation for HR developments in Asian countries as well?"

And I'm just hunting with one more. "Is 2010 the latest data that we have for global burden of blindness?" And for Daksha, we have a question from Unudeleg Bayaraa in Mongolia. Hello. She was asked-- they were asking, "Are we planning on making our master's in public health eye care degree online available as distance learning online?" And a question from Susan Evans from the UK of-- the question is, "Given that there are large discrepancies between the distribution of eye staff within countries, are finding that these online courses are reaching staff outside the capital cities in more rural areas where they may have less comprehensive internet connectivity?" OK, I'm going to hand it over to Allen to answer the data question.

OK, and I'll try and keep it very specific. So the VISION 2020 model was that in the year 2000, there were an estimated 45 million blind people in the world-- that that would increase to 76 million by the year 2020, because of population growth and aging-- that if one addressed the avoidable causes of blindness so that one could make all the world similar to the most developed quarter of the world in terms of prevalence and causes of blindness. And instead of 76 million blind, there would be 24 million blind by the year 2020. So that was the model.

So then the question is how are we doing? Well, according to that model in 2010, if things were continuing to get bad or continuing to progress the way it was anticipated, we would have been at about 62 million blind. As it was, the data from WHO suggests about 39 million and, from the global burden of disease, 32 million. So if you like taking the middle figure there, that would be about 35 million.

So we're much less than what was projected. We're less than what it was in the year 2000. And we're actually less than what was projected to reach our 24 million by the year 2020. So

basically, vision 2020 in the year 2010 seemed to be on track and seemed to be that things are going well. Then there was a question, do we have any more up-to-date data? I don't. I know that data has been collected recently, and I think there is going to be a review of the data maybe for 2014 or 2015. But I haven't seen those figures.

So the latest published data we have, as far as I know, is 2010. Then we got an ophthalmologists and targets for Asia. I think the target for Asia was 10 cataract surgeons per million population. So when I say cataract surgeons, I mean ophthalmologists were trained to do cataract surgery. And again, going back to it, this should then be equally distributed.

So very often we take these take figures for a country, but of course, what we know is that the majority are in the capital cities and few in the rural areas. So what we're looking at is an equal distribution, but the target figure for Asia was 10 million ophthalmologists.

[Daksha] So to very briefly try and answer the question about will we be doing our masters online? The answer is that is a big leap to take. But we're certainly hoping that we can bridge the gap between what we have here within the London School and the need for similar public health education can be bridged using our open educational content that we're trying to put out.

So we are hoping that we can begin by building these bridges first and then perhaps examining that in the long term to see if a distance learning program is required. The second very interesting question is on the distribution and the reaching the remote learner using open education.

And that is certainly the individuals that we would like to reach through our various open educational resources. And to do this, we're actually looking to work with in-house country facilitators and educators who can not only support with localized content, but make it possible to reach them not just using the online medium, but also perhaps using what is most available for their learners in these remote settings.

So we would like to encourage people who are interested to get in touch with us. Let us know what are the challenges they're facing and how can we help them to bridge the challenge of making sure education gets to the practitioner in the remote settings.

[Sally] Thank you both. Thank you so much. There are a couple of other questions. But I'm hoping to answer them as I wrap up this webinar. So our next one will be on the February the 23rd. And what we're going to do next is look in more practical terms at, does Open Education actually work in practice?

So we'll be sharing our experiences which Daksha briefly touched on there about working with partners. And we're also very pleased to welcome Dr. Rob Farrow from the Open University. And they've just finished a big in-class study on how using OER changed educators' practice and knowledge.

So I very much hope you'll be able to join us there. I think if you're an educator, you will find it very interesting. We'll be sending out invites to this webinar through the ICEH email list again. So keep your eye out. And if you want to find out more about the other webinars, we've got another five in total coming up.

And each of them look at a different aspects. And we really try to make it appropriate to eye care educators needs. So it's really how you can use these materials, how you can access them, adapt them, share them, or even get started yourself. We're going to be looking at quite a wide range of uses of this open education idea.

So visit the web site. That's the address there for all the details on our Open Education Program. Finally, thank you again to our funders. None of this would be happening with them. So thank you very much, everyone. Have a great afternoon, or evening, or possibly the morning. Take care. Bye.

[Daksha] Bye.

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