

programmes must take responsibility.

Caregivers, (special) schools, and community-based rehabilitation programmes often give cost as a reason for a child not receiving the clinical components of low vision care. However, transport costs, hospital fees, and the cost of a pair of glasses compare well to the long-term costs of interventions, such as enlarging print using photocopiers, the use of Braille, and education in a special school, for children who may not actually need them.

The importance of refraction

The importance of accurate refraction is illustrated in the study of low vision programmes undertaken by the author in Asia.³ Among the children aged 4–15 years enrolled in these programmes, more than two-thirds could achieve a distance visual acuity of 6/60 or better after receiving the correct spectacles. For many children, this level of vision is sufficient to allow them to read a blackboard from the front row in a classroom; these children generally only require minimal additional support. However, only 36% of the children in the study already had spectacles when they presented, and half of those needed a new pair.

A total of 75% of the children examined achieved a best corrected near vision of 1.25M (N10) or better, and an additional 18% could read a large print size of 2–2.5M (N16–N20) after refraction and/or magnification. These children thus had sufficient near vision to read the print used in school books

(sometimes with some assistance). None of them needed to learn Braille (although some had already been taught it), and they gained the ability to attend local mainstream schools with their fully sighted peers.

This study illustrates that, even in the absence of a special clinical service dedicated to low vision, any eye unit can help many children with low vision, as long as it is capable of providing accurate refraction services.

It is important to recognise that any improvement in distance visual acuity for a child with low vision can make a big difference to his or her life; it can also improve near vision. This is particularly true for children with hyperopia, aphakia, or nystagmus. When providing low vision care for children, it is therefore vital to consider both distance and near vision.

The use of magnifying devices can be important for children whose near vision, after refraction, still remains insufficient to read print of the size used in their school books (children should be asked to bring their school books to the low vision clinic). Such devices are not necessarily expensive: in the 2005 study, 83% of the magnifying devices were locally produced and cost, on average, US \$5 (ranging from US \$0.5 to US \$10).

Another lesson learnt from the study is that interventions should not be provided free of charge. When parents are charged according to their ability to pay they tend to be more motivated and to value the services. This requires co-operation between all service providers.

In conclusion, eye care providers, community workers, and teachers should firstly direct their efforts towards organising access to eye care, then towards providing surgical and optical interventions, and lastly towards determining what educational support is needed by a child with low vision.

References

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2. WHO. Management of low vision in children. Bangkok, 1992.
3. Van Dijk K. Unpublished retrospective study of low vision programmes in Asia, 2005, which analysed data extracted from standardised clinical records of 1,823 children, aged from 0 to 15 years, attending six low vision programmes in India, Indonesia, and Nepal in 2002 and 2003.

'It is vital to consider both distance and near vision'

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