

Community Eye Health

Volume 17 Issue No.49
2004

Indian Supplement - Official
Publication of the
"Vision 2020: The Right to
Sight - India Forum"

Supported by
Orbis International
India Country Office



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Journal of Community Eye Health

Aim

To promote eye health worldwide.

Objectives

- To facilitate continuing education for all levels of health workers, particularly in developing countries.
- To provide a forum for the exchange of ideas, experience and information in order to encourage improvements in the delivery of eye care.

The Indian Supplement will be the official publication of the "Vision 2020: The Right to Sight - Indian Forum" and will provide a forum for the sharing of ideas and experiences related to community eye health activities in the country, focusing on the problems and issues of eye health in underprivileged communities.

Setting up Low Vision Care Services in the Developing World

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Introduction

When a patient cannot be treated by routine vision management practices, doctors have a tendency to give up, saying (and thinking) that they have reached the end of the road in eye care. However, the eye care fraternity can indeed make a difference if orientation, training and enabling services can be set up.

Children and adults are considered to have low vision when, due to disease, hereditary conditions, or trauma, they experience severe visual impairment that either reduces or restricts their ability to use vision to carry out everyday functions, with a negative impact on their quality of life, (e.g., employment, independent living, orientation, experiences, education).

A recent population-based study has shown the prevalence of low vision to be 1.05%

in India.¹

Surveys in schools for the blind in India have shown that 50% of children enrolled have low vision and are not blind.² Reports indicate that only 3% of all blind and visually impaired children in developing countries have access to basic low vision care.³ Low vision care of children with visual impairment early in the life could potentially minimise long-term permanent visual disability and reduce the number of blind years.

Low vision care is recognized as a priority in "VISION 2020: The Right to Sight" programs.⁴

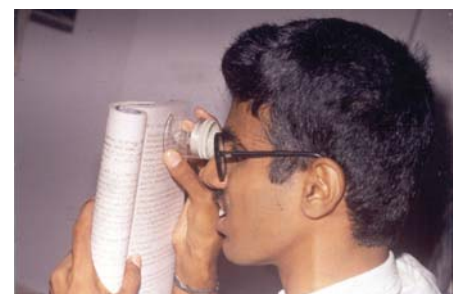
The major constraints in the delivery of low-vision care in the developing world are:

- Lack of emphasis on low vision in existing eye care programs.
- Lack of awareness among eye care professionals and community.
- Non-availability of good quality, low vision training programs.
- Non-availability of low cost, good quality, low vision devices.

- Socio-economic condition precluding use of advised low vision devices.

Comprehensive Low Vision Care

Despite the diversity of settings and differences among them, there are certain elements that are essential to successful delivery of a low vision service. These are: trained personnel, material, infrastructure, integration of low vision care, and evaluation.



Trained Personnel

Comprehensive low vision services can rarely be offered by a single service provider. It is more often a team approach and needs skills of appropriately trained

ophthalmologists, optometrists, ophthalmic nurses and rehabilitation workers. Briefly, low vision evaluation includes history, refraction, functional vision assessment, prescription of devices, appropriate and timely follow-up; and making appropriate referrals to other services if required.

The relevant rehabilitation services include instructions in device use, training in activities of daily tasks, orientation & mobility, patient education, counseling, and educational and vocational guidance.

Material

a. Basic Diagnostic Equipment

1. Refraction instrumentation
2. Acuity charts for distance and near
3. Continuous text reading cards with graduated print size
4. Functional tests: Contrast sensitivity test, Amsler grid, Ishihara test chart and Titmus fly test

b. Optical Devices

1. High powered spectacle devices
2. Hand & stand magnifiers
3. Distance vision telescopes

c. Non-optical Devices

1. Felt-tipped pen
2. Typoscope
3. Overhead reading lamp
4. Reading stand
5. Absorptive lenses (grey, brown & yellow tints)
6. Adaptive & assistive device (closed circuit television & computer magnification software)

Infrastructure

There should be sufficient space and equipment to support:

- Waiting room
- Low Vision Examination room for functional tests
- Instructional & training room for training in use of devices
- Counseling room for patient education

Integration of Low Vision Care

Low vision care could be offered in a variety of settings, including: hospital clinics, private practices, vision rehabilitation organizations and teaching

institutions. Each setting has its own unique characteristics and constraints.



Evaluation

There should be an effective quantitative and qualitative evaluation mechanism that measures consumer satisfaction, outcome measures and cost-effectiveness of the services provided to the clients.

Strategies for service delivery

a. Awareness: There is a need to increase awareness of low vision services among eye care professionals, other health care providers and the community (parents and teachers) through mass education using web-based information, media, brochures or flyers, publication of periodic newsletters and organizing events around World Sight Day. Those who have no access to the media can be reached through appropriate traditional methods.

b. Accessibility: Low vision care should not be exclusively determined by clinical parameters such as visual acuity but should take into account social, emotional, psychological educational and occupational effects. It is important to sensitise eye care professionals to the referral criteria for low vision services.⁵

c. Epidemiology: Planning for low vision services is hindered by paucity of population-based data about low vision and its magnitude.

d. Human Resources: The multi-disciplinary team needed could be broadly categorised as institutional based and community based. The institutional based core group includes an ophthalmologist, optometrist, orthoptist, and rehabilitation specialist (multi-skilled worker). The community-based personnel included primary health care and eye care field workers, community based rehabilitation workers and teachers.

e. Training: Lack of technical expertise or training support services has also hindered provision of low vision care. This can be addressed by appropriate short-term reorientation and continuous medical education programmes and a longterm fellowship programme at the institutional level. Low vision must be made a part of the regular curriculum in ophthalmology and optometry training programs.

f. Low Vision Devices: Attempts have been made to make available simple optical devices at an affordable cost.⁶ These low vision devices should have an acceptable appearance and be comfortable to use. The production, distribution and marketing strategies will depend on creating awareness, demand for services and developing accessibility.

Conclusion

Making low vision care accessible to those in need could make an enormous difference in their quality of life. Eye care professionals must educate themselves about the benefits of low vision care so that they may evolve appropriate strategies to address the problem in ways that are relevant to the developing world, based on the available resources.

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