**LOW VISION Services, a Global Right**

**Setting the Standards in Europe**

 **EBU Low Vision Conference**

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**Abstract**

**Optometric rehabilitation in all age groups is an art of team work in professional eye care**

In 1978 the LOW VISION WORKSHOP in Uppsala, Sweden, defined the difference between rehabilitation of persons with congenital low vision compared to persons with acquired low vision.

The first group with congenital low vision should focus on training cognitive and perceptual abilities while the second group should focus on psychosocial aspects along with technical and educational adaptations to less vision than before.

CHILDREN WITH LOW VISION

Children should integrate abilities to expand their visual reach in order to make it easier to integrate concepts, denotations between words and objects and try to enjoy using vision with the right methods and corrections, stimulated to do so by competent teachers and peers/parents.

This way not only visual acuity and visual field and colour vision are important parameters, but more so new concepts like Visual Desire, Visual Memory, Visual Efficiency, Visual Strategies and Visual Confidence can be trained. In early developments of “Schools for the Blind” many low vision children are brought along with blind students and are taught Braille. It is a matter of competence, service quality and resources when you find countries where schools and Resource Centres for VI Children can make this happen. Training to use monocular and camera zoom of Smart Phones should start as early as 2,5 to 3 years of age. (Project SEE MORE 2005).

ADULTS WITH ACQUIRED LOW VISION

When you grow older of when you acquire low vision after the age of 18 to 20 years old, you can use strategies first established in 1975 in the book LOW VISION TRAINING (Bäckman, Inde). Five groups are now described in relation to low vision training and use of optical correction and magnification correction.

1. Persons with central scotomas with BCVA less than 0,1
2. Persons with Nystagmus
3. Persons with restricted peripheral fields
4. Persons with low visual acuity, down to 0,1
5. Persons with VFD, visual Field Defects

In all these groups old and new methods have been developed and described. The website [www.exfix.se](http://www.exfix.se) explains and trains eccentric viewing for the first group.

 Nystagmus patients should train head and text movements to compensate for uncontrolled saccades when they read and keep on using what they learn as children.

 Persons in the third group should learn to train using EST, Explorative Saccadic Training using VISIOcoach and while reading using shorter fixation movements.

 Persons with low BCVA should compensate for this with magnification correction up to 0,5 in order to read 8 points font size and see more in the paragraph concerning older persons.

 The training for persons with VFD (group 5) is described in the Project SMS, Stroke Means Sight Problems. EST is also here a classic method in conjunction with the ability to move the head depending on hemi- or quadrantanopia.

OLDER PERSONS WITH AMD

The average patient (according to most clinicians in LVC every work are older persons with wet or dry AMD. The SEEnior Project developed materials for dry AMD in order to make optometric rehabilitation more standardised. Starting already from Reduced Vision (0,7-0,3) you can add more magnification along the line of loosing cones in the macula with more and more magnification, starting with high power optics ending up using CCTVs along with audio books.

EMOTIONAL ASPECTS OF OPTOMETRIC REHABILITATION VISION

The personal effects of loosing vision varies, but it is in most all cases a traumatic experience to travel from full sight to low vision (below 0,4).

You loose driving, reading, recognizing people and many other things. Integration of a negative feature in your personality and come out as person with a visual impairment is crucial for a successful assessment of devices and low vision training. You can for instance train to say: “My eyes are bad but I am good” since this is what you learn in the book SEE BAD FEEL GOOD.

dr Krister Inde



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