Community Based Rehabilitation and Prevention of Blindness in South West Uganda

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Introduction

Community Based Rehabilitation is hard work: visiting individuals and their families at home, identifying those with eye problems and those who are blind, encouraging and referring those whose sight can be improved or restored, providing care and guidance for the irretrievably blind and supporting the rehabilitation of those who return to their families and community after hospital and clinic care.

Concepts of prevention of blindness in developing countries have now drastically changed with the introduction of intra-ocular lenses (IOLs). Now we can consider unilateral cataracts as well as bilateral cataracts. After all, if we operate on unilateral cataract, blindness has been prevented if the second eye should lose sight! What a pity this was not the case when the CBR programme in Mbarara, South West Uganda was initiated in October 1995 – perhaps then results could have been even more convincing – that CBR has a role to play in prevention of blindness. Since many unilateral cataracts were left untreated we are now trying to find them again.

Much of CBR is not easily measurable or quantifiable:

- How will we know if the school lesson given by the Community Rehabilitation Worker (CRW) is the reason why the former schoolgirl will come to the eye clinic when she gets cataract in 50 years time?
- How will we know if the CRW has encouraged the person with red eye to attend the eye centre rather than the Traditional Healer?
- How will we know if the mother has taken her child for measles immunisation because of the CRW or was the mother going to go anyway?

Assessment day at the Health Unit with patients holding the survey forms

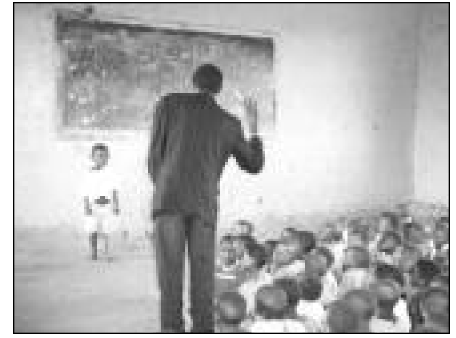
Photo: Liz Moulton

CBR in South West Uganda

The CRWs were trained to conduct the 'Count Fingers at 3 Metres' (<CF3M) test during their house-to-house survey. A survey form was completed for all those with bilateral blindness and the CRW had to indicate if the cause of blindness was due to cataract, trachoma or another eye problem. Those with other eye problems were referred directly to the eye clinic using a different form. (Now, I would change the methodology to the <CF6M test in either eye so that early unilateral cataracts would not be missed).

A population of around 120,000 was surveyed. The CRWs identified 456 people with vision <CF3M using both eyes. An eye worker then assessed 81% of the 456 identified, that is 371 patients. Of the 371 assessed, it was confirmed that 300 (81%) had bilateral vision <CF3M (0.3% prevalence). This prevalence rate seems low compared with the 1% prevalence rate that is often quoted. To date, 212 bilateral blind persons have had eye surgery from the CBR working area (70% of those identified). Fifteen other operations were done, for example, trachomatous trichiasis. Some readers may be disappointed that the prevalence rate seems low and would question whether the CRWs really did identify all of the blind people. It has been realised, however, that South West Uganda does seem to have fewer cataracts than other places, for reasons that we do not know. Since completing the survey, a further 71 patients have been identified. We have been especially pleased that 7 babies born with congenital cataracts have been correctly identified and referred by the CRWs via Traditional Birth Attendants and mothers.

The CRWs are now over 90% accurate in identifying cataract. If we consider the number of in-patients and out-patients attending the eye hospital (using CRW records) from the working area since the CBR programme started (October 1995) then we can be confident that CBR has had a role to play.



Teaching children in school how to carry out the 3 metre vision test

Photo: Liz Moulton

Discussion and Recommendations

It should be realised that those blind persons identified in the community are quite different from those who volunteer themselves to eye clinics. Perhaps this is where CBR can now be thought of as Can the Blind Respond? CRWs have an important role to play in motivating these blind persons for surgery. Identification and assessment is useless unless followed through to ensure attendance. This is where CBR has the most significant role to play. Identification and assessment is the easy part! CBR also allows for good follow-up of patients.

Eye clinics also need to appreciate that a lot of work has been involved in bringing just one of these people to their doors since they are unlikely to have made the effort on their own. Good co-operation between a CBR programme and the eye clinic is essential for good results. If the patient is turned away from the eye clinic, for whatever reason, this can prove to be very negative for the CBR Programme.

Radio announcements and information sharing will normally bring those persons forward who are eager to receive assistance. CBR concentrates more on reaching those persons who would never have made an effort on their own. CBR is not, therefore, a way of getting large numbers of patients. It offers a way of reaching a few and is, therefore, an expensive approach. A fully developed CBR programme, involving paid CRWs, is not the way to find quantities but it does encourage good quality service. The other advantage of CBR is that it allows for appropriate home-based rehabilitation programmes for the inoperably blind. A total of 62 received such a service by the CRWs who had undergone a 6 week training course on rehabilitation for the blind.

	In-patients	Out-patients
1993	32	322
1994	37	391
1995	51	677
1996	64	888
1997	75	1021
to Aug 1998	58(*99)	548(*939)

(projected figure)*

As previously mentioned, CBR can have many approaches. Personal experience in Tanzania teaching school children proved that they could identify the blind in their community. They easily learned the <CF3M test – I would again advocate <CF6M for either eye now. They could also learn what a cataract and trachomatous trichiasis look like. Children can be motivated by offering them a reward, for example, an exercise book, pen, pencil, rubber, etc., if they bring in, on the return assessment date, someone who failed the test. The best school can also receive a reward given to the school to help motivate the teachers. We are now trying this approach in Uganda and, although the numbers do seem to be disappointing, I consider that this is due to a low prevalence rate here. We are finding unilateral cataracts which may otherwise have been deferred. We have to realise that still the attitude in the village is 'wait until both eyes are bad', since this is the message we used to give to them. CBR can help to change that attitude.

A 'cataract motivator' encourages other patients that having surgery is very worthwhile

Photo: Liz Moulton

Since the CBR programme is working with all disability groups and not just blind people alone, time does not allow me to try other ways that CBR can work. Radio information programmes (not just announcements for mobilisation), working with Traditional Birth Attendants and Traditional Healers, use of successful patients as motivators, motivation of Health Workers, even visiting the graduated tax offices (note that the blind are tax exempt!) are all possible methods to try.

The Community Rehabilitation Worker assesses vision in a village

Photo: Liz Moulton

There should, however, be no misconceptions that CBR is a cheaper alternative. Definitely, it is not. It is expensive and it requires special people who do not tire of endless days on the road and who do not allow the frustrations of the community approach to disappoint them. There is much work to be done to encourage communities. Perhaps we should be describing these programmes as Village Based Rehabilitation at this stage as there are so many smaller settlements to be visited. If larger communities did exist, the work would not be nearly so hard.

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Review Article

Community Based Rehabilitation in India: Who Contributes to CBR Programmes for the Visually Impaired?

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Introduction

Traditionally rehabilitation of the visually impaired used to be institution based and provided by organisations concerned with the welfare of the blind. With the development of the concept of Community Based Rehabilitation (CBR), Sight Savers International (SSI) commenced supporting CBR projects in India. However, the practice of CBR, in quite a few projects:

- had the cultural 'hangover' of traditional rehabilitation approaches
- started in geographic areas where organisations of/for the blind were strong leaving the under/unserved areas as they were
- was more 'community-orientated' than 'community-based' or 'community involved'.

SSI's India policy, developed since 1990, stressed the need for development of services to the visually impaired in the deprived parts and States of India – specifically in the central, eastern and northeastern states. Since traditional blind welfare organisations were not available (both in numbers and capacity), in these areas the SSI India programme had to look for alternative agencies for service delivery through CBR. This article attempts to share this experience as well as some suggestions for further expansion of well-developed and networked CBR projects.

Partner Identification and Development

While the blind welfare services were few in number with very limited capacity, the target States had a number of good agencies dealing with one or more community issues such as water management, rural sanitation, adult/female literacy, afforestation, etc. Discussions with these agencies were initiated to motivate them to add rehabilitation of the visually impaired as part of their objectives and activities. Awareness was created of the magnitude of the blindness problem in rural areas and support towards training, materials, funds, resource persons, etc. was offered and assured. Also, agencies with interest were shown running CBR projects to get the feel of the project content and accomplishment. Active networking between blind welfare organisations and the new community based organisations was developed. Thereafter, a memorandum of understanding was developed between