

	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



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

Photo: Liz Moulton

learn what a cataract and trichomatous 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.

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 Community Rehabilitation Worker assesses vision in a village

Photo: Liz Moulton

the blind are tax exempt!) are all possible methods to try.

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/served 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 north-eastern 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

the partner agency and SSI for a CBR project in the area, to cover a population of 500,000 over a period of five years.

Training and Development: CBR Coordinators

From the personnel of identified agencies, one person was selected to be trained as coordinator of CBR projects for the agency. Ten selected persons were given a 3-month training in the Blind Men's Association at Ahmadabad in two modules, each of 6 weeks.

The first module introduced them to:

- the epidemiological, clinical, sociological and psychological aspects of blindness
- services that could be provided
- exposure to traditional methods and CBR methodology.

These trainees went back to their own area for two months to do a quick survey and study of blindness and develop an understanding of the problem and present level of services.

The second module addressed:

- issues seen by them in their area
- programme management
- record maintenance
- cooperation with other agencies and government assistance.

These persons became the core cadre for actual project developments with the current partner agencies and, as motivators, trainers and resource persons for further partner and project development.

Methodology of Service Delivery: Clusters and Fieldworkers

The service area was divided into clusters of about 25,000 population each. Eight clusters were chosen for the initial phase of the project. One fieldworker from each cluster was selected with suitable gender mix. The eight fieldworkers, and two extra persons (to allow for drop outs), were given a six-week training programme of two modules (two weeks and four weeks each). The training was organised by the partner agencies in their own project area, normally combining two or three projects for each training session (25–30 trainees). The trainees were drawn mostly from local development personnel supplemented by some experts with experience in rehabilitation and CBR. On completion of the training, the project was initiated.

The identified clients were screened for curable and incurable blindness. The curable were assisted in obtaining services

from eye care agencies. The incurably blind were taken for rehabilitation services such as orientation, mobility and daily living skills. Each fieldworker normally dealt with five clients a quarter. The initial 200,000 population is normally covered within a period of two years. Thus the 500,000 population should be serviced in four to five years.

Community Participation

The new partner agencies already had acceptance and credibility in the community for other services given. The community became interested in the additional services and became involved in identification and motivation of the visually impaired in accepting services. The community leaders, who were impressed by the visibly dramatic improvement in mobility, daily living and social skills developed by the visually impaired, actively assisted in obtaining other facilities and concessions from the community, Government and financing organisations, all for the improvement of economic rehabilitation for the visually impaired. The process also involved gifted clients as motivators and facilitators, advising families of the visually impaired, community leaders and other rural service organisations in NGO and occasionally Government sectors.

As part of the project development, refresher courses were organised periodically for one week or two week durations. The participating agencies were encouraged to contribute to the agenda by sharing case studies, special aspects of their areas and specific and common difficulties. The refresher courses were planned to be interactive so that issues and projects were analysed and solutions evolved. The nearby Government officials, blind welfare organisations and eye care institutions were also invited as guest faculty.

In addition, seminars, workshops and social gatherings with blind clients were organised by partner agencies to increase awareness and thereby involvement of the community.

The projects, which were originally handled only by fieldworkers trained in rehabilitation, started involving general community based workers giving them basic training in orientation and mobility. This brought in continuity after the initial prevalent visually impaired population had been serviced. The provision of curative services developed links between eye hospitals and rehabilitation agencies. The case finding and mobilisation of patients for eye care to the hospitals became integrated into the programme, benefiting the community as well as the eye hospital.



Bilateral cataract

Photo: Murray McGavin

There are a number of rural hospitals with eye care facilities that are little used due to lack of awareness, accessibility and affordability. A few eye care partners of SSI were encouraged to take on CBR as an add-on to their programme. At nine locations such linked projects are in place. This gives good outreach programmes from the base hospital and good eye care services to the community.

Summary

- The development of CBR projects in India complemented the activities of blind welfare agencies to include other community based service agencies
- Selected core staff of such agencies were trained in methodology as well as management of rehabilitation projects. They became useful in service delivery, training and proliferation of CBR projects
- Networking of CBR project partners geographically further expanded the movement
- Networking of blind welfare agencies and CBR project partners was implemented
- Linking eye care institutions to CBR partners and projects, as part of their outreach activities, became effective
- Motivation of general service providers in rural areas was encouraged to provide further services to blind clients.

Recommendations

1. To cover the blind population throughout the country, it is necessary that CBR becomes a part of the national agenda in dealing with disability. The coordination between Government departments of Welfare and Health will be useful in providing comprehensive eye care services.
2. As rural areas are at distances and populations scattered, providing training to general multipurpose workers in rehabilitation services would be useful.
3. It would benefit eye care centres to link with CBR projects. Also they should be

encouraged to add a CBR component to their outreach services.

- The facilities available for training of fieldworkers, project coordinators/managers, materials and literature available need to be enhanced by State funding. A proper syllabus, curriculum, faculty and authorised institutions need to be developed to standards appropriate to the countries concerned.

Conclusion

This report gives a brief outline of SSI's programmes over the last nine years in enhancing services to remote areas in India. The concept of a comprehensive eye care programme also evolved out of these efforts. All these may need to be modified to suit local conditions, involving the clients, their families, the community and other agencies. Integrating rehabilitation into eye care

programmes would be a right step forward in enlarging and enhancing services to the visually impaired in rural areas.

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Review Article

Community Based Case-Finding and Rehabilitation: Detection of Cataract Patients and Post-Operative Follow-up

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Introduction

The following recommendations are important for all those concerned with restoring sight to cataract patients and thus with getting these patients to attend an eye hospital.

Identifying Patients, Raising Awareness and Information

Remember that the patient may be blind!

1. Identifying Patients

Do not search for 'blind people' in order to find cataract patients but for those who are '**older with poor vision**'. Due to the usually slow process of becoming cataract blind, and adaptation to decreasing vision, cataract patients are often still quite active and so many do not consider them to be blind.

2. Raising Awareness

Most hospitals do not use enough ways of getting patients to the hospital. Patients and their families must be provided with the information required. This information can be passed on in different ways:

- Radio (which is often expensive).
- Through churches or other meeting places (ask for 10 minutes of the weekly sermon!).
- Through primary schools (there is virtually no primary school class without a pupil who has a cataract patient in his/her home. Collect names and addresses).

- Through local health units, projects, community activities, etc.

During all of these activities, use flyers, brochures and posters to get the required information across (see also 3 below).

3. Information

The information provided by any of your 'advertisements' (radio-messages, flyers, brochures, posters) should be comprehensive enough to answer the following questions:

- How much will the cataract operation **cost**?
- How many **days in hospital**?
- Is a **carer** required to accompany the patient?
- Is **food** provided/available at the hospital? What is the cost? Should food be brought to the hospital?
- What does a **cataract operation** involve? Is it a safe procedure?
- What is the expected **result**?
- Will the patient need to come back

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Once each year the CBR Programme, CCBRT, in Dar es Salaam, Tanzania organises a two-week workshop and training session for planners and managers of CBR. These CBR training sessions offer a practical and theoretical background for planning and management of comprehensive, cross-disability CBR programmes. This approach makes use of all the available human, material and infrastructure resources. The programme does not accept 'recipes' or 'formulae' for CBR, but requires creative managers with knowledge and vision concerning the real needs of 'disability' and of 'rehabilitation' in their own country or region.

These training sessions seek to promote this specific approach to CBR, which has very successfully been developed in several areas, and encourage discussion on those key issues that may determine the future of CBR services in the 21st century.

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