Groups were allowed to refer patients to the clinic or to the eye hospital for treatment, and the hospital referred trachoma cases to the patients’ local Care Group for further health education. The same system was later used for malnourished children. In a few places where the prevalence of trachoma was especially high, mass treatment through the local Care Group was organised to cover the whole community. But even with no, or only occasional treatment, prevalence decreased significantly in settlements where Care Groups were active, while there was no change in comparable villages which had no Group.

After 3–4 years the Groups abandoned their preoccupation with trachoma, as they were satisfied with the results of their campaigns, and turned to general health care, vegetable gardening and community development. Our fear, that the incidence of trachoma could rise again when the Groups discontinued their specific preventive activities against the disease, was not substantiated. On the contrary, its prevalence continued to fall. This is demonstrated in Fig.3, where all population surveys on trachoma in the area where Care Groups operated are summarised. After 5 to 10 years trachoma was no longer blinding, and had ceased to be a public health problem. Accordingly, patients with entropion presenting at the hospital had become rare. This development was surprising, as unemployment and poverty in the area was rather on the increase. Other factors may also have contributed to the control of the disease, such as improved water supply and a general change in people’s attitudes, which meant that despite low incomes, better housing and improved hygienic standards were considered to be important. Unfortunately, it has not been possible to perform control studies in comparable regions which had no Care Groups to exclude confounding factors.

Conclusion
The impact of Care Group activity on the improvement of health factors such as personal and environmental hygienic conditions or the prevalence of trachoma has been measured, and proved to be statistically significant. However, social and human values which determine the quality of life, even more than health does, cannot be measured and expressed in actual figures. Over the years we observed many remarkable changes in the Care Group members’ attitudes to themselves and their communities. They discovered their skills as health advisors, in problem solving and in leadership, and experienced that as a Group they were strong and could achieve much. This boosted their self-confidence and helped them to regain their human dignity as Black rural women, which the discriminatory tribal and apartheid society had denied them.

Now, more than 20 years since its beginning, the Care Group Project is still thriving and continues to adapt to the changing needs. There are Care Groups in almost every settlement in the region, amounting to approximately 250 Groups with a total of 10,000 women. The Project differs from the majority of other community health institutions in its emphasis on Group action rather than individual health workers. Such a system is more stable, especially as the Groups are networking with each other, aided by strong and capable regional management teams composed of Care Group members, who have taken over responsibilities for the Groups in their area. Thus, variation in motivation or changing interests can more easily be accommodated. The continuous presence of the Groups and the size and popularity of the movement have contributed to an ongoing high level of health consciousness in the population.

References