

Evidence-Base for Low Vision Rehabilitation

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Evidence-based practice means asking the question “what is the evidence for the effectiveness of a given intervention and how much of a difference might it make to the well being of your patient?” When all medical intervention has been tried to prevent or alleviate the effects of visually disabling disease, all that can then be offered is help to make the best possible use of residual vision. How is this best achieved?

This is of course a complex problem since rehabilitation covers many different aspects of activity; mobility is one (use of a cane or guide dog) and reading aids another. Other aspects include help in the home with daily tasks and social rehabilitation; ensuring particularly elderly visually impaired



people do not become isolated. The need for psychological support must not be forgotten since losing sight is often compared with severe bereavement and much help can be provided to people who need help to come to terms with their loss and get on with their lives.

Some of these interventions are delivered in the context of social services, so research underlying the effectiveness of these methods falls within the domain of social rather than medical science. But this does not mean that good evidence is not needed. Low vision therapists often argue amongst themselves about what they believe to be the best way, citing examples of individual successes, but in the end these arguments are nothing more than expressions of opinion. Often views can be very strongly held which means that the necessary scientific objectivity to conduct unbiased investigations is

lacking.

In terms of the medical model for low vision interventions, such as vision aids and mobility and orientation training, there is little good evidence to be found. On the Cochrane library, there is one review on mobility and orientation and another protocol on vision aids for reading. Another review from the USA is listed in the Database of Abstracts of Reviews of Effectiveness and a total of 19 randomised controlled trials of some relevance to low vision in the Central Controlled Trials register. The review on mobility and orientation found no studies meeting the inclusion criteria, and comments on the paucity of good evidence in the whole field.

One problem is that these studies need validated outcome measures, including quality of life as well as vision. While an increasing number now exist, there is a need for researchers in the field to agree on common standards which can be used by different groups to allow comparisons and summaries to be made of the findings.

There is growing awareness among participants in this area of research that the evidence base is poor and steps are now being taken to remedy the situation.

Abstract

Strengthening capacity in developing countries for evidence-based public health: the data for decision-making project

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K Wilkins

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M Malison

B Otto

RE Churchill

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Public Health officials and the communities they serve need to: identify priority health problems; formulate effective health policies; respond to public health emergencies; select, implement, and evaluate cost-effective interventions to prevent and control disease and injury; and allocate human and financial resources. Despite agreement that rational, data-based decisions will lead to improved health outcomes, many public health decisions appear to be made intu-

itively or politically. During 1991-1996, the US Centers for Disease Control and Prevention implemented the US Agency for International Development funded Data for Decision-Making (DDM) Project. DDM goals were to: (a) strengthen the capacity of decision makers to identify data needs for solving problems and to interpret and use data appropriately for public health decisions; (b) enhance the capacity of technical advisors to provide valid, essential, and timely data to decision makers clearly and effectively; and (c) strengthen health information systems (HISs) to facilitate the collection, analysis, reporting, presentation, and use of data at local, district, regional, and national levels.

Assessments were conducted to identify important health problems, problem-driven implementation plans with data-based solutions as objectives were developed, interdisciplinary, in-service training programs for mid-level policy makers, program man-

agers, and technical advisors in applied epidemiology, management and leadership, communications, economic evaluation, and HISs were designed and implemented, national staff were trained in the refinement of HISs to improve access to essential data from multiple sources, and the effectiveness of the strategy was evaluated. This strategy was tested in Bolivia, Cameroon, Mexico, and the Philippines, where decentralization of health services led to a need to strengthen the capacity of policy makers and health officers at sub-national levels to use information more effectively. Results showed that the DDM strategy improved evidence-based public health. Subsequently, DDM concepts and practices have been institutionalized in participating countries and at CDC.

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Exchange

Community Eye Health is introducing a forum for exchange of inspiring experiences and insights in community eye care. If you have achieved something exemplary, or learnt something interesting in your work, please send us a short description in no more than 200 words. Since inviting contributions in the last issue, we have received a number of interesting stories, some of which are included on pages 13 and 14.

Please send your contributions to: **The Editor, Community Eye Health, International Resource Centre, ICEH, London School of Hygiene & Tropical Medicine, Keppel Street, London WC1E 7HT.** Email: victoria.francis@lshtm.ac.uk