

## Indian Supplement Editorial Board

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## Creating Demand for Cataract Surgery & Meeting it: the Sankara way!

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Cataract has been documented to be the most significant cause of bilateral blindness both in India and globally.<sup>1,2</sup> In India cataract has been reported to be responsible for anywhere from 50 to 80% of all bilateral blindness.<sup>3</sup> The cumulative loss over the lifetime of the blind is estimated to be Rs. 2,787 billion (US\$ 77.4 billion) at 1998 prices with substantial contributions to this loss by cataract blindness.<sup>4</sup> The number of persons in whom blindness is being averted due to cataract surgery in India is currently a fraction of the number blind from cataract and there is a need for the annual number of cataract surgeries to be increased at least threefold from the current number between now and 2010 if cataract blindness in India is to be eliminated.<sup>5</sup>

The Sankara Eye Care Institutions over the years have been successful in implementing the "Gift of Vision", Rural Outreach Eye Care Programme which applies an innovative approach to meet the cataract demand.

### 1990 – as we look back

The inequity in health care in India was similar to most developing nations, with

most services centres in urban areas. Awareness among the rural poor on curable blindness was very low. With little formal education preventive eye care was rudimentary at best. The location of surgical care in district centers and state capitals made it not only difficult and expensive to travel to these faraway places but also culturally unacceptable to the rural folk who constitute the majority of the Indian population.

### "Gift of Vision" - Rural Outreach Eye Care- two decades of community eye care

In 1990, an ambitious programme was started to reach out to the rural poor with a base hospital concept. The programme has achieved success on different fronts.

**Increased awareness:** A designated area for the screening was earmarked 8 weeks in advance. This allowed for not only publicity among the masses but adequate door-to-door surveys to counsel and bring to the venue people with eye ailments. A major impetus to the programme was the involvement of field workers at the district level and primary health care workers who were trained as primary eye care

personnel. Being from the local population, they were able to identify, counsel the patient and his/her family on the need for intervention and follow up on the patient after surgical care.

### Comprehensive screening camps:

Though the thrust was on cataract, the screening programme has been a comprehensive service treating all surgically curable eye ailments including glaucoma, squint, paediatric cataracts, retinal and corneal ailments over the years. Thus the rural poor were able to approach us for any eye ailments without the fear of being turned back without any curative service.

### Partnership at the grassroots:

The success of our programme can be attributed to the fact that the Institution identifies itself with the local people. In order to build familiarity and to help develop the confidence of the villagers, Sankara always works with a local village group, whether a service organisation, youth forum or a women's group/mahila mandal as its partner. Due recognition and acknowledgement are provided to these local partners – the co-sponsoring agency.

**Base Hospital Services:** Keeping in mind the possibility that many beneficiaries might experience a culture shock, the hospital was planned with adequate greenery and a little away from the urban center to make the patients feel more comfortable. The setting also provided the opportunity to educate patients on hygiene and clean toileting.





### High-quality, High-volume eye care:

Realizing the need for large volume corrective surgery, we identified a rapid, cost-effective high-quality technique that provided rapid visual recovery. The temporal small incision cataract surgery is today known as the “Sankara”, technique. Not only is the post operative astigmatism low, the absence of sutures and elaborate instrumentation makes it less symptomatic for the patient and affordable for the institution.

**Subsidized eye care:** While the institution provides free eye care to those below the poverty line, it also subsidises cost of surgery for those from the rural centers who wish to pay, to popularize the treatment while making it affordable, thus eliminating cost as a barrier to uptake.

**Transportation:** As in other rural outreach programmes, we realized the target population would be more likely to access services through programmes that provided transport from rural areas; they are less likely to come to the hospital on their own.<sup>6</sup> Patients were picked up and dropped back to within 20 kilometers of their native village. Patients from a same village were brought together along with one caretaker for every 10 villagers, therefore the barrier of relatives not willing to accompany each patient was overcome.

**Follow up:** We earned the credibility of the rural poor by establishing a system wherein no operated patient missed a postoperative examination at the end of 4 weeks. We revisited the site of the screening camp where most patients reported. Those who did not turn up were reminded by post to attend the next camp. If the patient had not reported, thereafter in a proactive manner a trained primary eye care worker visited the home of the patient, recorded his visual acuity,

performed a torchlight examination, counseled and accompanied the patient to the base hospital if needed.

### Optimizing the services through a pyramid approach:

We realised that the resources both human and equipment were scarce and adopted a sectorial approach to ease administration and logistics. The 500 bed specialty eye hospital is located in Coimbatore, the district headquarters. The hospital caters to a surrounding area of approximately 400 kilometers. The catchment area has been divided into 4 sectors with a larger town in each sector serving as the headquarters. Each district or a population of 1.5 lakhs is assigned a field worker. This worker coordinates with the workers at the grassroots. This enables us to ensure that each sector is covered through a weekly screening camp so that no patient needs to travel very far for primary eye care.



The base hospital at the top of the pyramid, followed by sectoral headquarters, field workers at district level and the partner organizations at the village level has proved to be a perfectly stable and effective working system. Despite the large area of coverage, and the distance between the base hospital and the beneficiary, the constant flow of communication and the network established has brought the beneficiaries closer to the Institution and its philosophy.

### Involving the local ophthalmologists:

Though there was initial skepticism, we were able to involve local ophthalmologists as screeners and also referred to them those patients who required medical care and refraction. Thus we were not perceived as a threat but a partner in the mission to eradicate curable blindness.

**Conclusion:** Our experience shows that the elimination of curable blindness is a real possibility and that meticulous planning and careful implementation can bear fruit. This is also a working example of a healthy partnership between a non-governmental organisation, the Government and the District Blindness Control Society, INGOs like Rotary, Lions, Sight Savers International, Mission for Vision Trust, ORBIS International and private service organizations providing comprehensive eye care.

Providing high quality eye care with empathy, incorporating a fool-proof follow up system, building an ideal atmosphere to constantly create awareness on curable blindness, networking with various stake holders, Government, service organizations, INGOs and grassroots agencies and building an overall team spirit with “unanimity of purpose” are the important parameters for successfully creating adequate demand for cataract surgeries.

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