Role of Voluntary Organisations in Prevention and Treatment of Curable Blindness

1979

Proceedings of 15th Annual Conference of National Society for the Prevention of Blindness

PROCEEDINGS OF THE XV ANNUAL CONFERENCE

NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS-INDIA

&

XIV NATIONAL SYMPOSIUM

ON

"ROLE OF VOLUNTARY ORGANISATIONS IN PREVENTION AND TREATMENT OF CURABLE BLINDNESS"

June, 10th & 11th, 1979

Edited by :

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Ludhiana District Branch N.S.P.B,

Organised by :

Department of Ophthalmology

DAYANAND MEDICAL COLLEGE & HOSPITAL

LUDHIANA.


XVth ANNUAL CONFERENCE
NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS
Organised by :
Deptt. Of Ophthalmology, DAYANAND MEDICAL COLLEGE & HOSPITAL, LUDHIANA
10th & 11th June 1979.

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"ROLE OF VOLUNTARY ORGANISATIONS - IN PREVENTION AND TREATMENT OF CURABLE BLINDNESS"

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11. Dr. N.S. Baweja	Eye Specialist, Jullundur.

Report on XVth Annual Conference of N. S. P. B. India Held on 10th & 11th June 1979 at Ludhiana.

WELCOME ADDRESS

(Prof S. S. Grewal)

XVth Annual Conference of National Society for the Prevention of Blindness India, Organised by Department of Ophthalmology, Dayanand Medical College & Hospital, Ludhiana, was held on 10th & 11th June, 1979. Over 75 delegates from all over India attended the conference. Before welcoming the delegates Prof. S. S. Grewal, Organising Secretary, introduced the Chief Guest, Dr. P. N. Chhuttani, President of National Academy of Medical Sciences. He also introduced Dr. Sushila Nayar, President of NSPB, Dr. L. P. Agarwal, Vice President, Dr. U. C. Gupta, Secretary and Dr. M. R. Chaddah, Secretary, Panjab State Branch of NSPB.

"Prof. P.N. Chhuttani, Dr. Sushila Nayar, Prof. L.P. Agarwal, fellow delegates ladies and gentlemen. It is my proud privilage welcome you all to Ludhiana for XVth Annual Conference of NSPB and XIVth Symposium "ROLE OF VOLUNTARY ORGANISATIONS IN PREVENTION AND TREATMENT OF CURABLE BLINDNESS".

Ludhiana essentialy an industrial town is famous for its hosiery and woollen goods and a visit to Ludhiana is not complete unless these wollen mills are visited specially by ladies. It has also progressed in the field of cycle and steel industry. The agricultural university which is venue of our conference is a pride of Ludhiana. It has brought green revolution to the state which is feeding half of India. Besides this it has a beautiful and colourful campus. Visiting this campus one cannot imagine that Ludhiana also happens to be a congested industrial town. Ludhiana is a great educational centre besides over a dozen arts and science colleges we have an engineering college, college of education & two privately run medical colleges. Public of Ludhiana has been rendering medical services to suffering humanity through these two medical institutions.

In our programme of prevention and cure of blindness team spirit between public and medical men has played a great role. We are lucky that we are in a ideal situation to render eye care service to the remotest part of this district because

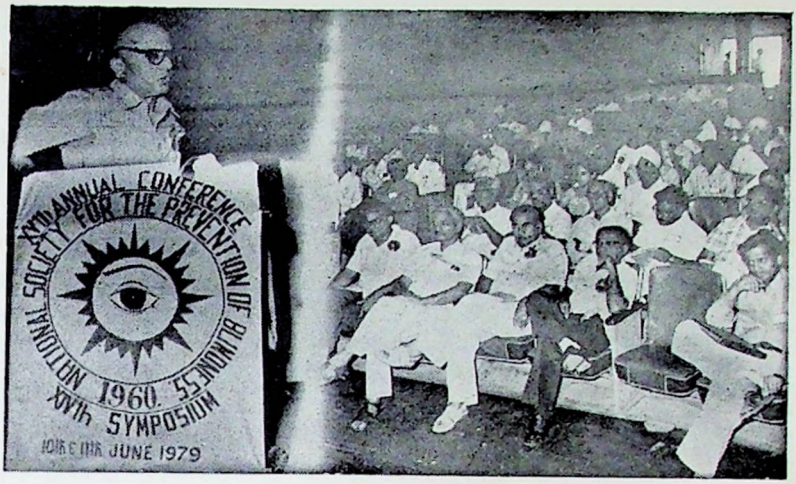
of good road system, quick and frequent bus service and awareness of public about their eyes and most of all, co-operation and help of service organisation like Rotary Club, Lions Club, Jaycee's and various other charitable organisations. Such organisations have also helped us to look after the eye care of school children where we can create consciousness specially in rural children about cleanliness and importance of eye.

State branch of NSPB was started at Amritsar one and a half years ago under the able stewardship of our state secretary Prof. M. R. Chaddah. This membership has increased to over 400 out of which 80 are life members and it held eye camps during the last year in collaboration with rotary and lion club and D.M.C. Ludhiana branch of NSPB was started only last month under the presidentship of our very able dynamic and likable deputy commissioner Sh. G. S. Cheema.

This conference will help us all to share our experiences in the field of prevention and cure of blindness and to discuss our difficulties in dealing with such a health problem. Let us not concentrate our energies on just holding eye camps, but we should in the international year of the child lay stress on as to how we can preserve a good eye sight of our children and prevent the preventable. This aspect I feel has been neglected so far and I hope through our discussion you will be able to suggest some concrete steps to this end. This conference has also given us fellow Ophthalmologists and social organisations an opportunity to develop friendship, fellowship and good will.

We were given only 6 weeks for holding the conference and we have to shift the date by one day as desired by our president and vice-president. Any inconvenience in this change of date caused to some members is regrettable. I hope you have a comfortable stay here and will go back with hot memories of Ludhiana. Those of you who attended All India Ophthalmological Conference in Amritsar will know that Punjabi's are not only brave in the cold but also brave in this intense heat.

I once again welcome you to this conference and sincerely hope that you will overlook any short coming in your brief stay here. I wish you good and pleasant time ahead. In the end Prof. P. N. Chhuttani, I welcome you once more and I am grateful to you for accepting our invititation to inaugurate this conference."



Prof. P.N. Chhuttani President National Academy of Medical Sciences Inagurating the Conference

Inaguration

Dr. Sushila Nayar President N.S.P.B. India
Chairing the Symposium.

Prof. L.P. Agarwal reading the progress
report of National Plan

In his inaugural address Dr. P. N. CHHUTTANI said "India had the dubius distinction of having he largest number of blind people in the world. In Punjab and Haryana, the blind constituted about 3 percent of the total population. This number included a large number of women. According to a survey conducted at the P. G. I. the financial loss because of the incapacitation of such a large number of people amounted to over Rs. 100 crores per annum. Medical colleges in Punjab and Haryana could play a big role in the eradication of blindness from these States. We should implement the 20 years programme to eradicate blindness launched by the Govt. National Plan".

Dr. SUSHILA NAYAR in her address thanked the organisers for hosting the conference at such a short notice. She stressed the role of voluntary organisations in the prevention & treatment of blindness. She said that the eye sight of the 95 percent of the blind in the country could be restored. She maintained that small-pox, one of the major causes of blindness had been removed from the country and now only malnutrition was to be tackled.

Dr. L. P. AGARWAL, disclosed that the department of Ophthalmology of the medical college will be converted into the departments of community Ophthalmology and provided with additional equipment in a phased manner under the National Plan. After that Dr. U. C. Gupta, read the annual report of the society. Mr. G. S. Cheema, Deputy Commissioner, Ludhiana and President of District Branch of NSPB, thanked the chief guest for inaugurating and the delegates for attending the conference.

After the inaguration ceremony, coffee break & photograph, the XIVth symposiun "ROLE OF VOLUNTARY ORGANISATIONS IN PREVENTION AND TREATMENT OF CURATIVE BLINDNESS" was held. 13 papers by different speakers were read. There was a good and healthy discussion after each paper. After the evening session of symposium various meetings of different bodies of NSPB was held. The conference recommended as follows :-

1. In this International Year of the Child more stress should be laid on the the eye care of school children. Schools should be supplied with free vision charts and teachers should be taught to test the vision of the children.
2. Theme for prevention of blindness week from 2nd to 9th Oct. will be "Help Visually Handicapped Child."

3. Examination of three lacs population including rural population especially school children and industrial workers.

4. To establish District co-ordination committees with the Deputy Commissioner as its chairman for regulation and the working of various eye camps held in the districts so that the quacks are forbiden to hold eye camps.

5. To hold 200 eye camps and operate 5000 eyes.

6. To enroll institutional members, like factory and other institutions, of the society.

7. Establishment of community Ophthalmic Research Centres.

Delegates were entertained to a cultural programme at the open air theatre at Punjabi Bhawan in the evening. The drama "Mard aur Aurat" by Mr. Harpal Thiwana was very well appreciated by the delegates and Dr. Sushila Nayar, President of Society congratulated Mr. Thiwana for putting up a wonderful show. Later on delegates were entertained to dinner at residence of Dr. S. S. Grewal, where delegates had opportunity to meet the citizen of Ludhiana and after dinner speeches by Dr. Bhatnagar, Dr. Madan Mohan, Dr. S. S. Grewal, Dr. Mrs. Bajaj and Mr. G. S. Cheema the conference came to end as Dr. Grewal informed the delegates that since there were only two papers left for next day, they should be taken as read. He again thanked the delegates for making the conference a success.

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Annual Report For The Year 1978

Presented by Dr. U. C. Gupta Secretary General

Hon'ble Chief Guest–Dr. Chhuttani, Madam President, Respected Dr. Agarwal, President Ludhiana Branch.– Shri Cheema, Dr. Geewal, Respected Guests, fellow delegates and gentlemen.

It is with great pleasure that I present one report for 1978 of the National Society for the Prevention of Blindness. The detailed report has already been circulated to the members for their scrutiny and comments. At this moment, I propose to highlight only the important aspects of our activities during the year under report.

BRIEF HISTORY OF THE SOCIETY :

We are all aware that loss of sight is one of the greatest tragedies that could befell a human being. This human tragedy is further compounded with the economic repurcussions not only on the individual but also on his family and imposes a particularly heavy burden on the Society at large. According to the W. H O. estimates, there are about 27 million blind in the world. India alone accounts for about 9 million i.e. one third of the estimates for the whole world. In addition there are about 45 million people who have impaired vision but not blind.

Before the establishment of this Society, there was hardly any organisation working in the field of prevention of blindness. At the 1959 convention of the National Association for the Blind, idea of forming a National Society for the Prevention of Blindness, was conceived by Late Dr. Mohan Lal of Aligarh. It was blessed by the Govt. of India and the Society got registered on 24th August, 1960 under the Society's Registration Act 1860. The Society has the honour of having elected Late Pandit Jawahar Lal Nedru as the first Chief Patron. The then Union Health Minister Late Smt. Raj Kumari Amrit Kaur, was the first President and Late Dr. S. N. Mitter was the first honorary Secretary of the Society. In june 1964, our present President. Dr. Sushila Nayar took over as President since she succeeded Smt. Raj Kumari Amrit Kaur as the Health Minister. In March 1965, Prof. L. P. Agarwal, was elected as the Honorary Secretary. Under the able guidance of Dr. Nayar as the President and under the dynamic leadership of Prof. Agarwal as the

Secretary the Society grew in stature and registered healthy developments. In 1977, Prof. Agarwal was elected as the First Vice-President and I took over as the Secretary General.

PRESENT STATUS

The Society has now successfully entered into its Nineteenth years. Its net work has spread to 17 states resulting in formation of State Branches. Some of the State Branches have been able to establish District Branchas which are 37 at present. Uttar Pradesh State Branch has established six district branches during the year and more are in proccessing. Some of the State Govts. being aware of the magnitude of problem have taken initiative and issued directive to their Civil Surgeons and Chief Medical Officers to help in forming district branches of the Society to tackle the problem of blindness. By organising State and District Branches, the Society hopes to spread its activities throughout the whole country so that not only the objects of the Society are achieved, the Society could also usefully contribute to the effective implementation of the National Programme for the Prevention of Visual Impairment and Control of Blindness launched by the Govt. of India on the recommendations of this Society.

OUR MEMBERSHIPS

The year under report has registered appreciable increase in the membership in comparison to the previous year. According to the information made available by some of the branches and considering the direct membership, our strength on 31st Dec, 78 was 738 life members, 2120 ordinary members and 342 institutional members against 343 life members, 1823 ordinary members and 238 institutional members in the previous year. Reports from some of the branches are still awaited. It is hoped that our total membership is near about 5,000.

OUR ACTIVITIES

The Society functions in close collaboration and with participation of its State and District Branches and carries out activities at the Headquarters at Delhi as well. The Society has been actively engaged in various projects. This year greater stress was laid on holding more eye camps and bringing out educational material. As per reports received, 96 eye camps were organised in the year, where about 2 lakh persons were examined and 23,800 operated. The most encouraging feature of the camps was that they were just not Cataract oriented camps. Proper follow up facilities

were ensured and comprehensive eye health care services rendered to the community as far as practical.

Society lays greater priority to the preventive & promotive aspects. It is well known that large percentage of blindness is preventable and blindness can be avoided if the community at large is made aware of the problem and advised to take right attitude towards the eye diseases. The impairment of vision is not an Ophthalmic problem alone, it is very intimtely linked with the socio-economic and cultural fabric of the community. Thus mere development of the Ophthalmic Services only will not help tackling the problem until and unless standards of living of the masses also go up. In order to bring scientific concepts to the masses, active health education is very necessary. During the year under report, the society has given due priority to this aspect and has brought out many educational aids. Various other publicity and educational media like Radio & T. V., Press publictions, periodicals, exhibitions, film shows and dramas etc., have been fully and effectively exploited by the Society's Headquarters and the State and District Branches.

Every year the Society holds a Symposium on an important aspect of the problem and makes suitable suggestion and recommendations for implementation by the authorities concerned. In 1978, the subject of the symposium was "Prevention of Occupational Hazards in Industries, a cause of impairment of Vision". The participants of the symposium represented various professions and different levels of administrative bodies. Their contribution reflected a wide range of interests and richness of experience.

COMMUNITY RESEARCH

The Society encourages community Ophthalmic Research and has developed a few centres. The centre at Modi Nagar in U.P. built with munificient grants from M/s Modipon Ltd., and Modi Science Foundation is doing excellent work. The special feature of the Centre is its location. Modi Nagar is an industrial area which provides ample opportunity to study the ophthalmic problems of the Labour Community. With the rapid industrialization in our country, the health problems of the labour call for proper attention on our part. The Symposium of the year has made very useful recommendations which will go a long way in dealing with the problem if accepted and implemented by the concerned anthorities.

The other Centre under development is at Raison in Kulu district of Himachal Pradesh. There it is mostly garden and quarry labour and their problem is different than at Modi Nagar.

Another Centre has been developed at Moti Nagar in Delhi which is providing good research-cum-ophthalmic care to the people of that area who are mostly daily wages workers working in Delhi.

Negotiations are in progress to establish a Centre at Faridabad.

Society has undertaken eye examination of School Children, College Students, Industrial workers, D. T. C. Drivers etc. It has under taken survey of Blind Schools with a view to determine as to how many blinds in different blind schools can be restored sight by surgical interference and also if some Visual Performance can be improved by low vision aids with a view to convert them into useful citizens.

The Society runs Optical Research Unit and a Contact Lens Research Unit at Dr. Rajendra Prasad Centre for Ophthalmic Sciences at Delhi. These units are doing very useful work and rendering service to the Community.

The Society also undertakes rehabilitation activities through its Centre at Dr. Rajendra Prased Centre for Ophthalmic Sciences assisted by the Deptt. of Social Welfare. The details have been given in the Annual Report circulated.

OUR FINANCES

The Society derives its financial support mainly from membership fee, muificient donations by the philanthroptists and grants in aid from the Central and State Govts received from time to time. The Royal Commonwealth Society for the Blind INLAK foundation and variovs National and International Social organisations support the eye camps. The Society had a closing balance of Rs. 8,31,515/- on 31st December, 1978 against Rs. 7,01,412/- at the end of 1977. The total assets of the Society at present are over Rs. 40 lakhs.

SUM UP

This is a short resume of our activities during the year. The Society endeavoured its best to accomplish the set aims and objects. It has succeeded to an appreciable extent in projecting its image in the minds of the people. Considerable degree of success has also been achieved in carrying the message of eye health care in rural areas. With the continued co-operation and unstinted support the Central Headquarter is receiving from its branches and various other social and voluntary organisa-

tions, national and international organisations and the various concerned departments of the Central and State Govts. I do hope, Society marches ahead to intensify its activities and achieve its goal. The Society has taken up the challenge and I am confident, it will accomplish the task assigned.

ACKNOWLEDGEMENT

I take this opportunity to thank the State and District Branches who have given their whole hearted co-operation and shared my responsibilities. It was from these branches, I drew strength as the Secretary General of the Society. Those branches who could not be active during the year, I entreat them to please rise up to the occasion and extend their active co-operation to meet the challenge, the Society has accepted.

I would be failing in any duty if I do not express my gratitude to my President, Dr. Nayar, under whose able guidance and leadership I functioned. I offer my grattitude to the Vice-Presidents for all the encouragement, I received from them. I would specially mention Prof. Agarwal, who inspite of his terribly busy schedule, could always spare his valuable time to me to discuss important matters and gave his guidance and advice with full understanding of my limitation and lack of experience in administering a Voluntary Organisation.

I gratefully acknowledge the co-operation, I received from the Treasurer and the Joint Secretaries of the Society.

For Dr. N. K. Bhatnagar, I have all administration for him the way he organised the Symposium. It was a great success.

I am thankful to the Director, All India Institute of Medical Sciences, for granting E. H. S. facilities to the N S.P.B. staff; and to the Chief Organiser, Dr. Rajindra Prasad Centre for Ophthalmic Sciences, for the various facilities provided to the Society at his Centre.

Last but most important, I express my sincere gratitude to the National Society for the Prevention of Blindness Staff working in various projects. I would specially mention my Executive Secretary–Shri Nirmal Singh and my Accountant–Shri A. P. Bansal, for their valuable contribution.

I do admit the achievements have been very modest but appreciable. The credit for all the achievement goes to all my colleagues at the Headquarters and at State and Distrist Branches. I personally own full responsibility for all the mistakes, short comings and acts of omission.

Role of Scientifically Conducted Rural Eye Camps In Prevention of Blindness

(Dr. B. Shukla Secretary N.S.P.B. Madya Pradesh)

What is ideal is rarely practical. If one waits for the ideal conditions to work such a situation may perhaps never come. Hence one has to strike a compromise between the ideal and practical ; between quality and quantity. As regards eye camps there are many people who hold extreme views. For many the success of an eye camp is synonymous with the number of operations performed and hence their target is to perform the greatest number of operations in shortest period of time. Obviously such an emphasis on quantity would be at the cost of quality with a high percentage of failure which is rarely accepted on the other hand about the eye camps and consider it a sanctified quackery. They are not willing to accept any thing less than the hospital standard of sterilisation and arrangements.

Inspite of some validity of the latter view when one considers the appaling number of curable blinds in the country and the great paucity of hospital accommodation one cannot deny the justification of eye camps with all their drawbacks for another 10 to 15 years. Nevertheless discrimination and caution are equally essential to curb the over enthusiasm for raising the number of operations at eye camps.

The concept of scientifically conducted camps implies service to adequate number of persons without making much compromise with surgical priciples and a good after care. It also enisages some dissemination of knowledge of eye care and prevention of blindness to the area catered. As stated earlier this is not possible with large eye camps or hurriedly organised camps. A prior detailed planning is essential to get the maximum results.

Broadly speaking the eye camps can be classified as mini camps, average camps and mass camps. The number in mini camps is usually between 30 and 50. The average camps consist of 100 to 200 operations where as in mass eye camps the

NATIONAL SYMPOSIUM ON

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number usually exceeds 500. Although there is a great back log for cataract operations alone, to be scientific and well planned it is desirable to limit to mini and average eye camps. To compensate for the number the frequency of smaller camps can be raised.

One of the major defects in eye camps is improper sterilisation in operation room. Although the operation theatre of a district or tahsil hospital would be ideal at least the operation room of a primary health centre must be available. Rooms of a good school building can also be converted into a workable operation theatre. Operations under tents is highly undesirable. Another source of infection are flies and every possible method should be employed to prevent them. A small plastic fly spat is a very useful tool for the rural theatre. Equally common source of infection is due to free entry of organisers (non-medical), officers, leaders, press men and photographers. This trend has to be strongly denounced although curious enough some surgeons tend to encourage it. If no antibiotics are used the infection rate in such camps would be little short of 100 per cent.

In many camps the surgeon waves his hand after taking out the knife from the last case. At least the first dressing must be done by the senior surgeon and further dressings for one week by a qualified assistant who should be capable of dealing with the usual post-operative complications. Inadequate follow up care has aroused much criticism of eye camps. At the time of discharge proper medicines and instructions should be given and it is desirable to call the patients once again after a month or so for follow up and glasses by refraction or subjective testing. To many patients an ordinary +10D lens is far from satisfactory. Care of glasses is as important as the care of eyes and hence should be properly explained.

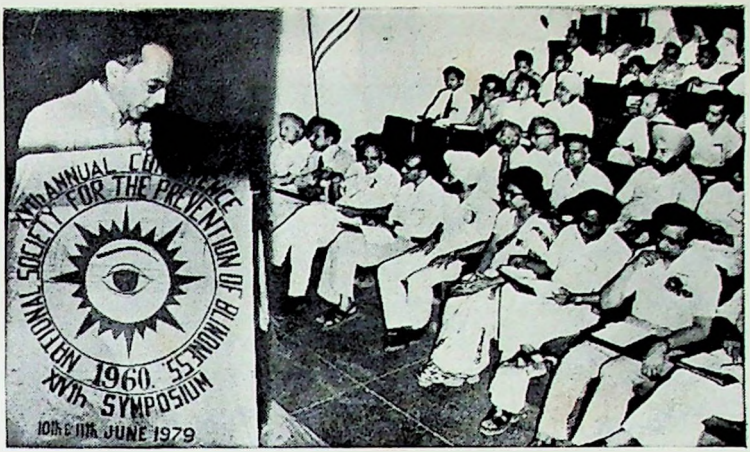
Like the size of the camp the site of camp is equally important in conducting it scientifically. Again there are two extreme views. Some people feel that for proper sterilisation and cleanliness it is better to hold camp in cities or district towns where all facilities are available. Others believe that the utility of the camp is more served the more remote area is chosen. The basic idea of camps is to serve the rural population and hence the purpose to some extent is defeated if it is held in big townships, no matter how nicely they are conducted. At the same time it is also true that in a very remote village it is virtually impossible to conduct the camps in a scientific way for want of basic facilities unless huge sum of money is spent. Because

of lack of adequate transport facilities few people from the neighbouring areas are able to take advantage.

It is therefore suggested that to be of optimum utility the camps should be conducted preferably at Tahsil level, or in a small district or a large village a little away from the main township. At a relatively bigger place there are educational institutions where talks on eye care and prevention of blindness can be arranged or vision testing can be taught and conducted. For the camps usually adequate care is taken of the surgical team and it is rather unfortunate that in most camps the services of social workers is not utilised who can give general guidance to patients and their relatives and spread eye care information in the township in general.

For scientific camps arrangement of cots is desirable. It ensures proper spacing, limits contamination from the ground dust and prevents the surgeon from getting a severe backache after the dressing. This would be only possible if the number is not too large and the place is not too small. Application of corneo-scleral sutures in camps is controversial subject. Many surgeons depend on a large conjunctival flap for healing and in large camps this perhaps not possible for want of time. Nevertheless it can not be disputed that even if one corneo-scleral suture is given in each case the results would be certainly better and if the number of patients is not too large it should not be difficult.

From the above discussion it is obvious that to make the rural eye camps more scientific and productive in preventing blindness they should not have very large number of patients, the place should neither be a big city nor a very remote village; at least a month prior planning should be done to work out the details and a social worker may be added to the surgical team for publicity and propaganda work.



Prof. S.S. Grewal addressing the delegates

Prof. Madan Mohan reading his Paper

Dr. N.K. Bhatnagar giving his after dinner speech

PGI Pattern Eye Relief Camps

(Prof. I. S. Jain PGI. 'Chandigarh)

Medical Institutions, private practitioners as well as unqualified people conduct eye relief camps in our country. Where as the first two achieve good success rate, the last invariably add to the misery of people by causing complications.

The camps conducted by the qualified people though undertaken under scientific care are still conducted to a set pattern by usually a single surgeon some times assisted by relatively quite junior people, mostly by para-clinical staff. Also the follow up of patients is insignificant or none at all.

We at PGI have tried to fill in these lacunae and present a pattern which can reasonably be adopted by all. We are conducting these camps without having any separate unit for mobile eye care. We also keep complete day to day record of the operated patients and follow these patients upto six weeks after surgery. Thus we are in a position to give the exact rate of success of eye camp as we also refract all the operated cases at the end of six weeks and some of them who can afford glasses enjoy the luxury of seeing quite well by the correct glasses rather than by the stock number of +10D. sph. lens supplied free.

As the people coming to eye relief camps are quite poor and for most of them it is a last hope of getting vision or never hence we are particular to send one senior faculty member to these camps (Professor, Associate Professor, Assistant Professor and Lecturer). They are assisted by junior eye surgeons who have already done their MS and by two or three third year residents (who have put in 3 years in Ophthalmology). This helps manifold in the sense that by presence of a senior member confidence of people is increased and the senior member is exposed to reality and magnitude of problem in rural area. Side by side younger people who would be on their own in short time are trained both in community ophthalmology as well as clinical.

Now coming to the Eye camp proper we try to conduct surgery there in the same way as we do at our Institute.

After preliminaries i.e. date of camp, publicity and support of some local body has been obtained, a preliminary team consisting of a senior faculty member, junior surgeon, refractionist and rehabilitation officer visit the area. Proper site for the conduction of camp is .selected depending on local availability of space, (school building, sarai etc.). A room which is relatively airy and clean is selected for operation. This room is washed and scrubbed by carbolic acid ; in some cases white washing of walls, if possible, is done. Arrangements for the stay of operated cases are also made and other necessaties like water, food and toilet facilities for patients.

On the actual day of the camp, the senior faculty member, junior surgeon and two or more third year residents as well as refractionist and other theatre staff reach the site. OPD is conducted for two days before surgery. Cases for operations are admitted. In these cases, where needed, tonometry is done as well as urine examination and B. P. are checked and compounder is instructed to instil antibiotic drops (chlormycetin) every 2 hours or so.

Rest of the cases in OPD are treated for varying ailments, refraction where needed is done. People who need institutional therapy are directed to visit the same. Cases needing entropion and other surgeries are given specific dates. Record of all cases is kept with positive clinical feature and diagnosis.

From the third day onwards operations are conducted and they go on for an average period of three days. Premedication of 50 mg. pethedine and 25 mg. phenargan is used in all cases of intraocular surgery. Two or three tables are run at a time. Anaesthesia (facial and retrobulbar) is given. Two or three sets of instruments sterilised in a sterlizer are available all the time. Sterlization is done under the care of a senior technician well versed with it. After giving lid and superior rectus sutures a conjunctival flap is made in all cases. Three 7/0 black silk sutures are given at limbus in a gutter made by blade knife from 3—9'O clock position. Anterior chamber is opened by keratome and section completed by corneal scissors. Peripheral or complete iridectomy as indicated is done. Lens extraction is done by forceps, tumbling method or in cases where indicated by extracapsular extraction.

After repositing iris, sutures are tied and conjunctival flap reposited back. Ltd and rectus sutures are removed. S/C injection of streptopencillin is given. Pad and bandage to both eyes is given for 24 hours and patient is transported in a stretcher from the theatre. Surgeons, assistants and compounders all use autoclaved gowns, mask and cap during the surgery. These as well as the dressings are autoclaved at our Institute and taken to site and replaced at intervals in order to have no shortage. Stretcher bearers are also made to use masks and caps. In the post operative period, first dressing is always done by the senior surgeon. So he stays one day more than the last day of surgery. On the rest of the days dressing is done by the junior surgeon who stays till the last day of the camp. Record in files is entered of all cases of operative and post operative progress. Camp is closed usually from 5–7 days after last day of surgery.

On the day of discharge after giving local medicines to people they are given a date for follow up usually after 2 weeks of discharge. On this day, junior surgeon assisted by 3rd year resident go to the site and remove sutures and also examine the cases. Again patients are called after three weeks i. e. 6 weeks after surgery and examined by the junior surgeon. On this day refraction is conducted. Observations of these two visits are recorded. Thus overall results of the camp are available.

Contrary to the belief of many nearly 100% of patients turn up for follow up.

By adchering to the above pattern we have got comparable results in our camps as in the Institute.

PGI Ophthalmic Unit has organised 45 eye relief camps in various places of Punjab (28), Haryana (8) UP (7) and J & K (2) since 1968 to April, 1979. In the camps 46 thousand four hundred and ten patients were examined and treated. In total 6203 operations were performed.

The Role of Scientifically Conducted Eye Camps in Prevention & Treatment of Curative Blind in India

(Dr. R. Daniel, Dr. S.K. Chopra, Dr. A. Chatterjee,
C.M.C. & Hospital, Ludhiana.

It is quite alarming to know the present situation in our country where according the N. S. P. B. report there is 45 million visually handicapped and 9 million blind population. And it is more so when we realise, that more than 70% of this blindness can be prevented or cured, indicating a low degree of public health care, widespread ignorance and serious inadequacy of Ophthalmic facilities.

In this modern age every medical service instituted should be scientific, and eye service is no exception to this. We are glad that today we are talking about scientifically conducted eye camps and not mere "Eye Camps", because there is vast difference in these two services. There are thousands of eye camps held every year all over the country, but how many of them are really scientific ? The role of scientifically conducted eye camps in the prevention and treatment of curable blind in our country is indisputable, where 80% of the population resides in the villages, and many of them are deprived of basic medical and Ophthalmic care.

The term "Eye Camp" many a times carries the stigma of poor service and quackery, of which many untrained personnels take the advantage of sporadic activities for their personal gains Some surgeons hailed in newspapers reports as healing benefactors leave behind a trail of poorly cut Corneas, adherant leucomata and distorted central parts of Cornea turning many curable blind into incurable.

The possible factors which have lead to the above state in our country are :-

1. Lack of general Ophthalmic care due to the paucity and imbalance in the distribution of Ophthalmic personnels i. e. in the urban and rural areas, resulting in lack of Ophthalmic services at the rural level, where most of our population resides.
2. Inaccessibility of various parts of the country.
3. Quackery and malpractices by inadequately trained medical personnel.

4. Lack of finance and general economic development.

If a Mobile eye service visits 25—30 stations in a year, it serves a great role in this cause of prevention and treatment of curable blind in our country. Realizing the need of such a service the N. S. P. B. has already launched a nationwide project to fight against this calamity. The role of voluntary organisations in this national endeavor is a vital one. Institutions like ours who are concerned mainly with training of personnel and providing such services can play a very significant role in complementing the efforts of our Government. We feel that the most effective way to do this is to reach the masses and render this service in their own environment. Realizing the need of such a service our institution started the Mobile Eye Services in 1958 under the able and dynamic leadership of Dr. Victor C. Rambo, who is the pioneer of the scientifically conducted eye camps in India. He had the foresight to anticipate the

MOBILE EYE SERVICES C. M. C. HOSPITAL, LUDHIANA.

GENERAL STATISTICS 1970—1978

Year	No. of Sites	Out Pts. Clinic	Surgery	Cat. Surgery	Refraction	Glasses Given
1970	11	11045	1395	854	2450	1622
1971	12	11034	1550	944	2176	1326
1972	12	10700	1833	854	2786	1665
1973	13	12666	1569	1007	1608	1238
1974	14	13528	1631	987	3178	1785
1975	18	15775	2100	1436	4207	1763
1976	20	16213	2251	1720	4840	2047
1977	21	18961	2049	1445	9041	2011
1978	34	22990	2825	1895	8624	2646
TOTAL	155	1,32912	17,203	11,142	38,910	16,103

These sites are situated in the states of Punjab, Haryana, Himachal and Jammu and Kashmir.

future problems and needs of our general population, and the right approach to solve them effectively. Thus the Mobile Eye Services became a permanent feature and extension of the Eye Department of our Institution. It is serving throughout the year in the rural areas of Punjab, Haryana, Himachal & Jammu and Kashmir. To make our Mobile Eye Services effective, meaningful, comprehensive and complementary to our national efforts we work with following aims and objectives, which are mainly, Service and Teaching.

1. It is an extension of the Eye Department of the Medical College Hospital to the community It maintains its Medical College Eye Department standard where trained personnel, equipment and services are concerned.
2. It aims at providing total Ophthalmic care to the Community in the rural areas in their own enviromment. Ophthalmology is such a speciality where it is possible to do so.
3. It provides guidance and referral services for the difficult eye cases to the base hospital.
4. It exposes the junior dectors undergoing ophthalmic training to the village situation. They are able to see the different ocular morbidities in their true perspective, thereby realizing the need of such services in the country.
5. Undergraduate medical students get experience of locally prevalent eye diseases in its rural situation, where 80% of our population resides.
6. It provides ample opportunity to educate the rural population about minor eye ailments with the help of charts, slides and talks.
7. Ophthalmic screening of school children wherever possible helps to detect a case at an early stage, because nearly 40% of our total population is below the age of 15 years, i. e. school going age.

STATISTICS

At present unfortunately there is no definite criteria, whereby an eye camp may be labelled as scientific or unscientific. A surgeon conducting an eye camp may claim that whatever he is doing to the best of his ability and knowledge under the

circumstances is scientific, and no one can dispute it unless we have certain standard to call a camp scientific. The usual term "Eye Camp" gives an idea that it is only surgically oriented, where a surgeon screens certain number of surgical cases, and operates upon them in one day under whatever facilities are provided to him, The post-operative care is left in the hands of a paramedical personnel, without any facilities for follow-up services for the operated patients. The term scientifically conducted eye camp is quite different, and according to our understanding probably means, that it is an extension services of a base hospital, rendering comprehensive eye care, consisting of thorough eye examination of cases including slit lamp examination where ever indicated, giving medical and surgical treatment no different from the base eye hospital, refraction, screening of school children where ever possible, and arranging screening programmes like Glaucoma from time to time. It is a fully equipped eye unit to render services in the rural areas just like a hospital, and aims at providing mordern scientific services in the patients own environments.

With a well designed, and carefully executed approach blindness can be considerably reduced in India by curative efforts. Nevertheless eye camps conducted with the best of intentions, where motivation is service, and no publicity can affect the situation adversely, if diagnostic skill fails, rules of sterility in surgery are not adhered to, and postoperative care is inadequate. Let me emphasise here that we are not trying to standardize surgical techniques in Ophthalmology, we are suggesting a workable standard of mobile eye units in rural India. There is certainly room for variations to meet the local conditions in different areas, and one should adjust according to the situation and make the best use of them keeping at the same time the scientific standard of the service.

We suggest that once we attain the suggested criteria and the standard for a scientific eye camp, we should call it"Mobile Eye Services"or "Mobile Eye Hospital", rather than "Eye Camp", which as the stigma of the eye camps of the past.

"Eye Camps" could possibly be registered under the Health" Ministry, or banned in principle, as in certain states, but licenced on individual basis. One of the conditions could be, that a detailed report be submitted not of the number of operations performed, but of the quantum of visual restoration achieved.

A scientifically oriented mobile eye service should be a permanant feature of every teaching institution and Eye Department of a district level hospital. It should be able to render round the year services in the surrounding rural areas. To be meaningful and complementory to the efforts of our Government we should try to give comprehensive eye care in these mobile units. In a mobile eye unit comprehensive eye care is desirable, but may not be practical everywhere to start with, because of various problems like finance, lack of trained personnels, conveyance and time. But these obstacles can always be overcome by personal interest and efforts.

India is a multi-racial, multi-cultural, multi-lingual nation. Any technique utilised will, of necessity, be a multipronged approach, for the problem of prevention of blindness is too wide to permit any single approach. Basically the problem can be tackled under two main routes preferably instituted together, (a) community development and education, the preventive part of the scheme, and (b) Mobile Eye Services, the therapeutic part.

It is very heartening and encouraging that our Government has already taken very definite steps towards the present day eye problems in the Country, and has embarked upon this nationwide project, and is ready to help in our efforts. We should realize that the task is herculean. The fight against blindness is not a fight for the Government or Opthalmologists alone. It is a challange to the nation's activities, and is a problem for which a functional answer can only be given by united efforts of people of all status of our society to efface this blemish from our land, and lessen the socio-economic burden of the nation.

ROLE OF SCIENTIFICALLY CONDUCTED RURAL EYE CAMPS

By Dr K. Lall New Delhi

INTROUCTION

Health care of the people in our country mostly remained in the domain of voluntary action in the past. This was mainly due to the indifference of the alien rule. Eye-care was one of the major activities for individual philanthropists and community organisations committed to welfare of the people.

CAMP APPROACH

The camp approach for rendering eye-care to the people at their door-steps dates back to early part of this century. The activity of organising eye camps for cataract extraction was initiated by Late Dr. Mathura Das of Moga in Punjab. Among others who pioneered in the field was Dr. Har Bhajan Singh of Gujra (Punjab) and some others from different parts of the country. Finding it a satisfying and rewarding activity people without formal education in modern medicine picked up the operative skill by assisting Surgeons thus initiating entry of unqualified people into the camp activity. This eventually attracted many others of such background to jump into the field making it an era mostly for the un-qualified Surgeons to exploit the philanthropists and arrange eye camqs where publicity, cheap popularity and quantity was preferred to quality.

SCIENTIFIC CONDUCTION OF THE CAMP THE FIRST CASUALTY

The cataract camps so organised lacked in many respects due to limited resources of the organisers and unlimited demands by the public. The first causuality in these camps was lack of scientific capproach.

The success of operations remained more or less limited to restoring the vision that may enable the beneficiary to count fingers from a reasonable distance. Still a greater tragedy was apathy on part of specialists at the Medical Colleges who neither discouraged them nor diluted their efforts by conducting scientific camps as an alternative, May be they were too busy in their teaching & private practice to get involved in community ophthalmology. During the past decade however, some medical colleges have started conducting eye camps primarily to provide eye care

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services and train their post gradute students in the art of field service. Having personal first hand knowledge of one of these, I have no reason to believe that they are not conducted scientifically. However, we cannot ignore the fact that people today, who are aware of their rights, expect much more as their right rather than mercy. As such, rational, effective and scientific services alone should be welcomed by the people.

NATIONAL PROGRAMME

Government of India has launched a gigantic programme for prevention of visual impairment and control of Blindness. The Programme envisages establishment of permanent eye-care services within 20 years at peripheral, intermediate and central sector with availability of graded expertise at different levels. And, until these services are fully established, there is a provision for deployment of 80 mobile units @ one per 5 adjoining districts.

The services so being developed are however inadequate and the voluntary organisations have their role to play to supplement Government efforts. Cognizant of this fact, Central Govt. provides incentives to recognised voluntary organisations to enable them to expand their eye-relief measures and improve the quality of camps. Suitable guidelines have also been issued to conduct scientific and comprehensive eye care camps.

Modern concept of eye-care camp in rural areas :

I Organisational aspects.

II Surgical aspects.

I ORGANISATIONAL ASPECT

1. Span of activities :

Ideal eye-care camp has scope wider than to serve the cataract patients alone. The camps in addition to surgical services for indoor patients can take up eye-check-up and vision testing through O. P. D. Survey ; school eye health, health education and rehabilitation activities. Then alone the broad spectrum of preventable blindness will be covered.

2. Follow up

Hit and run method of earlier camps left little scope to see what had ultimately happened to the persons operated upon. This had resulted in false sense of service on the part of organisers and frustration on the part of many who were served.

Duration of the camp should, therefore, be eight days after the last operation. And in addition proper follow-up must be ensured with the local health set up to offer proper post-operative care.

The scientific aspects of eye surgery in camps should broadly include the following.

II SURGICAL ASPECTS

1. Operation Theatre

(a) Proper selection of operation room to prevent flies, dust and glare. A clean pucca room may be preferred.

(b) Regular disinfection of the room after every operation session.

(c) Least traffic in the operation theatre.

2. Preparation of patients

* Proper pre-operative investigations to exclude local eye infection, raised intraocular pressure, diabetes mellitus and systemic hypertension.

* Irrigation of conjunctival sac.

* Face of the patient to be covered with sterile linen.

3. Operational procedure :—

a) Operations by qualified surgeons.

b) Wearing of sterile gown and masks by all those attending to operation.

c) Applying corneo-scleral sutures in all cases of cataract surgery.

d) Aseptic preparation or autoclaving of all drugs used for instillation into the eyes.

e) Proper sterilization of surgical instruments.

f) Autoclaving of theatre linen and dressings.

g) First post operative dressing by the surgeon himself or his experienced colleague.

h) Following daily dressings by qualified ophthalmologist and

i) Proper attention to untoward complication during post operational period.

Results of such camps may, in the first instance not seem encouraging in terms of quantity, but in the long run there will be less number of pan-ophthalmitis, less number of post operative complications and less number of man made blind.

Such scientifically conducted camps will go a long way in improving the image of eye care camp.

My thanks are due to Mr. H. T. Kansara and Mr. Thapar for their assistance.

Role of teachers & parents in Prevention & Detection of eye diseases.

(Prof. S. S. Grewal DMC & Hospital Ludhiana)

The human eye is a wonderful instrument, so marvellously efficient as to be almost unbelievable but like so many other parts of human body, it often becomes impaired resulting in any one of a number of conditions which, if neglected, may lead to blindness. Blindness is one of the major health problems in India. The life of a blind is a saga of misery and proverty, not so much because of loss of sight but mostly because of psychological trauma due to desertion of relatives and friends. He is lonely figure in his own darkened world and he is a constant burden on society. It is estimated that there are about 9 million blind in the country and about 45 million people are visually handicapped. Rehabilitation of the blind is a mammoth task but we should try to undertake a lesser mammoth task of prevention i. e. the prevention of blindness which is more practical and which can be achieved without too much help from the Govt. It is here that social organisations can help us.

RURAL CHILDREN :–This is an international year of the child so we decided to do something for the school children of rural areas, which constitutes 80% of the future generation of India.

We have been experimenting for the last 4 months as to find out how we can be helpful in the prevention & cure of preventable blindness in school children of rural areas. For th is purpose a voluntary organisation, Sri Gurdev Dharm Arth Naiter Hospital Society has supplied us with a fully equipped ophthalmic van in which we have facilities for refraction and slit lamp examination. We have selected one central village, Narangwal which is the base head quarter and we want to survey the ocular health of all the school children within the radius of 5 miles.

Our team consisting of one doctor and one intern examines 50 to 100 school children in the forenoon. So far we have surveyed over 3000 children in which the incidence of bilateral blindness was nil and unilateral blindness was 0.34% as shown in table No. 1

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India

TABLE I

INCIDENCE OF BLINDESS

No. of Cases Examined 3231

No. of bilateral blindness... ... ... Nill

No. of unilateral blindness 11 (0, 34%)

The main causes of blindness in these children were congenital anomalies, high myopia, phthisis bulbi & post traumatic enucleated eyes as shown in table II.

TABLE II

CAUSES OF BLINDESS

DISEASES	NO. OF CASES	% OF BLINDNESS
Congenital anomalies	2*+2	36.36
High myopia *	3	27.22
Phthis bulbi	2	18.18
Enucleated eyes (Post traumatic)	2	18.18

* Curable blindness

Out of these 36.36% cases of congential anomalies and 27.22% cases of high myopia were of curable blindness.

The incidence of various eye diseases in the school childten is shown in table No. III

TABLE III

VARIOUS EYE DISEASES IN 3231 SCHOOL CHILDREN

DISEASE	No. Of Cases	Percentage
Trachoma *	395	10.94
Conjunctivitis	131	4.08
Refractive Error	84	2.60
Blepharitis	51	1.61
Squint	29	0.86
Miscellaneous	76	2.35
Total	766	22. 4%
* Incidence increased with age		9.8– 15.04

You will notice from this table that the incidence of trachoma has markedly decreased. It is due to better hygne, clean water supply in these villages. All the villages in this area have Pacca roads leading to them and people are mostly educated as you can see from the number of schools in this area and they are health conscious.

You will notice that we did not find any case of xerophthalmia, so diseases due to lack of viteamin A are not a problem in Punjab. We rarely see a case of keratomalacia in the local population and over 95% of the cases of this disease are found in the imported labour from Bihar & East U. P. ete.

As you see from table III that 2.60% of children were having refractive error and 90% of them were without glasses. Myopia, as you know, changes the whole personality of the child and two children had vision less than 6/60 and were not wearing glasses and this comes under the category of blind. That is another field where the school teachers can help us. We intend supplying all these schools with vision charts and teachers will inform us about any child having vision less than 6/9.

Blepharitis as you see is quite high amongst school children. It is again due to lack of cleanliness and it is here we are going to lay strees on the parents and teachers.

TABLE IV

SQUINT

Total Population Examined 3231

Children having squint ... ... 28 (0,86%).

Uniocular / Alternating	5-8 Yrs.	8-12 Yrs.	12-15 Yrs.
Uniocular	0.23%	0.60%	0.16%
Alternating	0.23%	0.79%	0.46%
Total	0.46%	1.39%	0.62%

Amblyopia in uniocular squint=5 cases.

As you see from table IV that squint is another field where parents have to be educated. They do not expect children to wear spectacles or submit to surgery. They think glasses or surgery are meant for old people only.

At the time of examination the school teachers are working with the team and they are taught as to how to take the vision (Slide 12) and taught the basic hygiene of the eye i.e. cleanliness of hands, face, eyes with soap & separate towels, avoidance of playing in dust & sending a child with red eye home till condition clears up. Any child with a diseased eye is also shown to them. Any child needing treatment is asked to bring his/her parents to school next day and the parents are told about the disease in the simple rural language. They are advised to get the treatment. If any medication is required the parents are told how to use the medicines and if any surgery is required the child is sent to the department of Ophthalmology of our college and the child is again followed up by this mobile unit.

Our experience shows that parents & teachers are very co-operative with us and they tell us that this is the first time any organisation has come to them just to look after the health of the eyes of their children. They only knew about eye camps which were meant for old people only. Our aim is to check up children with the diseases mentioned above at least once a year and survey of the rest of the children hand in hand. Our goal is to completely eradicate the eye diseases in children within 5 miles radius of this village. Certainly blindness cannot be prevented but we are endeavouring at least to prevent the preventable blindness like early detection of eye diseases and their cure so that the children of this area will be future healthy citizens of this country.

So far we haven't met with any resistance from the parents or the children though when we started the survey we examined the junior classes first and the children were afraid to come near us and co-operate with us. Later on we started examining the senior classes first and junior children got confidence from the senior children and easily submitted to the examination. We have not yet surveyed the preschool going children but any child who has defect like refractive error or squint, his parents are encouraged to bring the younger siblings for examination.

So the notion by some peopie that school teachers and parents cannot be used for voluntary work is wrong. It is we who have to involve ourselves with the parents and teachers. You can't just leave it to them by sending a few hundreds of Terram-

ycin eye ointment tubes for use on children. This school programme, I am sure will help in the restoration of better eye-sight of our future generations. The task is gigantic and we need more doctors and vans for this work. This is our pilot project and we have been doing this work for the last 4 months and after a year we will be able to come to some conclusion as to how much staff and equipments we need. I feel it is the initial survey which will be difficult and once we know about the defective eye-sight of the children, we can have a yearly foliow up of these children. I think after seeing our results, more voluntary organisations like Sri Gurdev Dharm Arth Naiter Hospital Society will come to our aid.

Role of Teachers & Parents in Prevention & Detection of eye Diseaser

Dr. T. K. Chaku C. M. C. Ludhiaha

Eyes comprise sense organs par-excellence. Their versatility in function is unmatched by any other part of the body. They are responsible for feeding us with eighty to ninety per cent of total information that we gather from all our sense organs. Eyes are highly sensitive to any insult however trivial that may be and in attention to the elimination of the offending cause leads to the ultimate fateful result of visual failure varying from partial to total loss. Fortunately most of the blindness prevalent is preventable and curable provided corrective measures are instituted in time and in the initial stage of disease process. Delay and improper handling meets the same unfortunate end as it would have been in case the ailment was left totally unattended.

Therefore, we derive that ignorance to perceive the gravity of the ocular disorder together with negligence, delay & inadequate care are the root causes of breeding visually handicapped people in astronomical figures. Further introspection into the problem leads us to comprehend that all these maladies in the society are on account of total deprivement of health education (I mean ocular health in particular) among masses both urban and rural. The rural masses though comprising eighty per cent of the population are under privileged, therefore, bear the major brunt of this distressful situation.

This envisages upon us to mount a massive ocular health education drive throughout the country. To make a plea for it on this forum is easy but to work out the modalities to put the idea into practice needs a sacrificial service from the society in general. It demands active involvement of all those who constitute a society but there are limitations to such a course, like if responsibility is given to every one in the same measure then it loses its sanctity and bite. Therefore, the task of educating the masses about the ocular health has to be assigned to a cross section of the society.

To salvage the humanity in general and our country in particular from the curse of blindness, voluntary organisations have a tremendous role to play. A country like ours cannot cope up with a staggering budget of millions of rupees to do this stupendous and astounding task single handed. Govt. agencies cannot be expected to cater to this gigantic problem with so little resources at hand. Therefore, voluntary

institutions have to gird their loins and take up the challenge to every corner of the country.

In this respect I feel that teachers and parents constitute the answer to our need of mass ocular health education programme that will ensure prevention and detection of ocular morbidity and culminate in the maintenance of optimal ocular health.

The task force of parents and teachers is present wherever the human race is stationed. They form a part of the society for which they have to work. They are aware of the orthodox and superstitious background of the society of which they themselves constitute an integral part. This cross section of the society if guided properly about the detection and prevention of ocular disorders can bring about transmutation to the fixed, false and dogmatic notions prevalent in the community which is responsible for poor or total lack of ocular health. I believe teachers and parents can be our best bet for revolutionising the response of the masses to ocular health care. This combination of teachers and parents should be given instructions on a war footing because the problem is footing colossal and there is no time to waste now. These sentivels of eye care must further propagate and disseminate this knowledge to the community around. The message as it will percolate to the grass root level is bound to pay the rich dividends.

In case of teachers it means imparting the basic components of eye care to the children as a part of the educational curriculum. Young children hold their teachers in high esteem and their pronouncements carry a high degree of credibility. Apart from their credibility among children teacher in a rural area is considered a source of wisdom though in an urban area this may not be true.

The teachers that I am talking about are the ones in the primary schools. The teachers at this level have mass contact on account of greater number of children attending the schools in primary classes after which majority dropout on account of socioeconomic compulsions. An advantage of utilising the services of these teachers is their local background. This makes the local population receptive to the new idea without arousing any suspicions. The whole thing becomes easy to assimilate in the local colloquic ideas coming from people being implanted from outside are always fraught with intrigue and ulterior motives.

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Therefore, wisdom demands that the perception of ocular health which encompasses prevention and detection of ocular disease should spring from within the community concerned rather than being forced from outside.

Parents apart from their own interests have the interest of their children at stake and therefore, will exhibit considerable zeal and gusto in carrying out the mass ocular health educaiion programme. Thus teachers and parents can act and work complementary to each other.

Now the big question that hangs fire is who is going to impart the basic preliminary knowledge about ocular health to teachers and parents. Here we can make use of the basic health worker who is already carrying out other health programmes. The basic health worker remains in close liason with the people of the area that he covers and therefore, can deliver the essentials of ocular health to people at their door step, Following are some of the recommendations that the baic health worker may pass on to the parents and teachers. Here I am giving a very broad out line as elaborate account is beyond the scope of present paper.

1. Stress the importance of eyes in the general well being of the individual.
2. Avoid treating eye ailments by home remedies or by quacks which does more harm than good.
3. Create an awareness about the symptoms such common but crippling eye disorders like trachoma cataract, glaucoma and corneal ulcerations that take a very heavy toll of the eyes. It should be stressed in no uncertain uncertain terms that medical care by qualified ophthalmologists should be sought when symptoms pertaining to the above mentioned diseases appear.
4. Eyes to be regarded as very delicate organs that keep on the legacy of the insult to scornful results.

I am sanguin that if the essentials of eye care involving prevention and easy detection of eye disorders are brought to the awareness of general public through the agency of teachers and parents there is no reason why blindness if not completely banished can be effectively brought down to a trickle.

Another asspect of the problem is that apart from the lack of facilities to tackle all the patients who are curable blind, the major problem is non-utilisation

of the present facilities to the optimum level by the people on account of total ignorance.

Unless and until this depressing ignorance about the ocular health is dispelled from every hook and corner of our country in particular and world in gensral miilions will continue to go blind even if facilities for treatment are available at their arms reach.

Blindness to an individual is not only a physical and a mental handicap for the patient but is crippling to the development of his personality. The individuals who support him also remain in a state of emotional agony and distress. The blind person in addition constitutes an economic burden to the unit concerned and a loss to the country.

The crux and the essence of the entire problem as I perceive it is the complete lack of ocular health education among masses. The day our masses get enlightened about the ocular health, the goal is not far off when blindness can be a rare commodlty. To conceive of such a mass education programme the modus operandi have to be the teacher and parent combination that form greater part of the society.

Mobilisation of Voluntary Organisations in Prevention and treatment of Curable Blirdness

(Dr. Madan Mohan Dr. Rajendra Prasad A. I. I. M. S. New Delhi.)

There is no death of voluntary organisations in our country. Some of them are big, others are small organisations engaged in numerous multifarious activities. Some organisations already have a very active involvement in sight conservation programme such as Lions International and Rotary International. These organisations can be further activised provided with technical leadership and information to intensify their work and to start newer projects concerned with prevention and treatment of blindness. There are, however. many other social and voluntary organisations who are not engaged in any continuing programme for the prevention of blindness. Traditionally they have been involved in religious or educational or other social work. Thus we may divide the voluntary organisations into

1, Which are traditionally working in the field of prevention of blindness and

2. Non-traditional voluntary organisations which need to be mobilised for adopting prevention of blindness as one of their objectives.

Today I would like to share my views on the methodology that can be adopted to

(i) How to activise the traditionally active organisations to intensify the work of prevention of blindness.

(ii) How to induct, motivate the non-traditional organisations to take up such activities on their charter of objectives, but in my opinion it can be achieved by getting into these organisations and gradually working within them bring a change and motivate them to take up the prevention of blindness work. It will be necessary also to delineate the role of the organisation as also of the individual members in the programme. Let each organisation earmark the area of its activities and let each member of such organisation adopt ten families for ocular health care.

The National Society for the Prevention of Blindness is primarily and solely concerned with the prevention & control of blindness. It should organise its activities and should try to bring about an understanding, co-operation and coordination of activities of various other voluntary organisations engaged in ocular health care and prevention of blindness.The Society,I understand, has under the leadership of President D . Sushila Nayar&Vice President, Dr. L.P. Agarwal made tremendous advancement & now has a good financial base and a large membership to be viable. The Society should have a planning and evaluation cell for continuous monitoring of our activities and should conduct research for further improvement in our efforts and analyse the factors as to why after twenty years of our existence we have failed to achieve greater involvement of other voluntary agencies in the prevention of blindness work.

Inspite of our achievements, you would agree with me we have made only a small bent in tackling of the problem. The Society still has not been able to reflect a national image but still is dominated on its executive and governing bodies by the Ophthalmologists and has not been able to induct social workers from other walks of life. Even in the meeting today I do not find many representatives of the voluntary organisations who are traditionally committed to sight conservation programme. I would suggest that we must have a minimum of 50% representation on our various executive and governing councils of members from different social organisations and other walks of life.

We should also try to raise our funds by direct donations and contributions from the community apart from life membership and annual subscriptions. We should try to reduce our dependence on the international agencies.

ROLE OF TRADE UNIONS AND EMPLOYERS IN PREVENTION THROUGH HEALTH EDUCATION

(Dr. R.N. Sud, D.M.C. & Hospital, Ludhiana)

Accidents in industry are becoming more and more common because of fast industrialisation of our country. Every year 30 lakh man—days are lost through accidents in industry.

What does a worker lose, as a result of accident ? He loses his wages. There is a suffering for him and his dependents. And what does the industry lose ? The industry loses in the form of compensation, has to provide medical care to the injured. There is decreased production and damage to the machinery and goods. What is nation's loss ? Nation loses in terms of production.

Ocular injuries form 3—5% of all accident occupational injuries. No industry is entirely immune from ocular hazards, but in general they fall into following main groups :—

(1) MECHANICAL : In this category, engineering workers are the commonest sufferers. The most frequent and most dangerous agents are small chips of flying metal producing an infected abrasion or a perforating wound. CORNEAL FOREIGN BODIES are by far the most common of all such industrial injuries. Ocular injuries can also occur due to molten metal.

(2) CHEMICAL : There is hardly any industry where some or other chemicel is not used, and their use in industry is increasing day be day. Eyes may be affected as a result of splashing of a chemical.

(3) RADIATION :

(a) U/V radiation : Mainly in arc weiding causes severe Keratoconjunctivitis (WELDER'S FLASH)

(b) High Intensity Visible Light.

Before actually going into the preventive aspect. I would like to present some statistics of cases of ocular injuries in industry seen in Dayanand Medical College & Hospital, Ludhiana during the past 4½ years

Affection of eyes among industrial workers is a big problem and so its

prevention is equally a big task. The solutions to the problem lie with the management, trade unions, the social and voluntary organisation and the government, and they all have to join hands to solve this problem. The day each realises its rosponsibilities, tangible solutions would be found out in prevention of blindness in industry.

It is amazing to know that over 95% of ocular injuries in industry are preventable, if proper precautions are taken. About 90% of ocular injuries are caused by foreign bodies, wouuds, burns and scalds, and by contusions and that the remaining 10% by infection, radiation, fall etc.

When a person gets injured while working, he undoubtedly, is going to get full compensation. But that is not going to bring back his damaged or lost eyesight.

PREVENTION OF OCULAR INDUSTRIAL INJURIES :

Prevention of this type of injuries assumes a very great importance because of the fact that 95% of them are preventable. Employers and employees probably tend to forget that the eyes of the workman are the choicest of his working tools and deserving care the most. The employers and the trade unions can do a great deal to help in the prevention of ocular industrial injuries.

ROLE OF EMPLOYERS : It is the moral and legal responsibility of the employers to provide protective equipment to workers and to enforce all the safety measures whole-heartedly. According to the majority of industrial safety researchers, the most important factor in prevention of industrial accidents is the attitude of the employers. If the employers exhibit a safety conscious attitude and back it up with an active safety programme, work accidents can be reduced to a great extent.

They can help in prevention of ocular accidents in following ways :—

1. Screen all the employees for various visual defects.
2. Provide safety equipment and teach the employees its use.
3. Must see to it that the safety equipment is used by the Employess.
4. Publicity regarding safety measures in the form of lectures, films and exhibitions at regular intervals.
5. Display of posters or pictures showing various safety measures at various strategic places or sections of the industry.
6. Adequate design and painting of the workshop and the machines so that dangerous moving machinery stands out clearly.
7. Fitting of guards on machines from which flying particles are to be

expected.

8. Incentives to employees or sections who are free of accidents.
9. Provide adequate goggles (which are comfortable to wear and through which vision is easy), eye shields and face masks.
10. Periodic check up of ocular fitness and timely treatment of any defect found.
11. Educating the employers in the use of first aid. This is important, more so in the case of employees in chemical industry, so that no time is lost in waiting for the doctor to come and irrigate the eye.
12. Provide first aid post for giving first aid treatment before patient can be shifted to a hospital.
13. Provide facilities for treatment of miner injuries e.g. removal of foreign bodies on conjunctiva or cornea.
14. Setting up of safety committees comprising of representatives of employees employer. Government and industrial safety experts, to go in detail into the causes of each accident and recommend necessary preventive measures to avoid any future recurrence.

ROLE OF TRADE UNIONS :

We must realise that the employers may not be able to achieve much without the active support and cooperation of labourers with increasing trade unionism, and their hold on labour, trade unions can help a lot in prevention of ocular hazards in the industry.

They can :—

1. Impress upon the employers to provide all safety devices to the workers.
2. Convince each worker to use various safety devices for his own good.
3. Arrange periodic lectures, films or exhibitions to educate the workers in prevention of accidents.
4. Teach the employees in various first aid methods.
5. Must see to it that each worker uses various safety devices regularly and religiously.
6. Along with representatives of the management and Government, go into

detail of each accident and suggest means to prevent its recurredce.

7. Instruct the workers to report to the factory doctor, whenever there is an eye complaint and have treatment.

SUMMARY : With fast industrialisation of our country, ocular accidents are increasing in number. Prevention of these accidents assumes a special significance because of the fact that over 95% of them are preventable.

Statistics of industrial Ocular injuries seen during the past 4½ years in Ophthalmology deptt. of Dayanand Medical College & Hospital, Ludhiana, are mentioned. Role of employers and trade unions in the prevention of industrial ocular injuries is stressed and some suggestions for prevention are made.

(Illustrated with black and white slides)

□

ROLE OF ROTARY CLUBS IN PREVENTION OF BLINDNESS AND VISUAL IMPAIRMENT

(Dr. N.K. Bhatnager Allahabad)

"One of the basic human rights is the right to see. We have to ensure that no citizen goes blind needlessly, or being blind does not remain so, if by reasonable deployment of skill and resources, his sight can be prevented from deteriorating, or if already lost, can be restored.

—National policy pronounced by the central council of health at its meeting held in April; 1975."

THE PROBLEM

— Nine million are blind, 45 million are visually handicapped in India.

— Maintenance of the blind costs the nation Rupees 8100 million every year (Rs. 75/- per person per month).

— Loss of production (Rs. 5/- per man day) is around Rupees 10,800 million every year.

— Over 80 per cent of the blindness can be prevented or cured if eye-health-care services and education on eye-health care can reach the remotest area of the country.

— The problem of visual impairment is not an ophthalmic problem alone but it should be evaluated in a socio economic and cultural complex.

— Under the National Programme launched by the Government of India. Eye Camps envisaged therein are to provide comprehensive eye health care in the community.

INTRODUCTION

Eye-Camps hither to organised by the Voluntary/Social Organisations etc. have primarily been cataract camps. National Programme for the Prevention of Visual Impairement and Control of Blindness envisages organisation of Eye-care camp within the broader perspective of providing comprehensive eye-health care facilities to the people particularly to those giving in remote rural areas where eye-care facilities are practically non-existant.

OBJECTIVES OF COMPREHENSIVE EYE HEALTH CARE CAMP (NO MORE CATARACT CAMP)

— Provide consultation and medical and surgical treatment for the prevention and control of eye diseases including glaucoma and cataract operations.

— Educate people in the methods of prevention of eye diseases and proper care of the eyes in order to ensure better and lasting eyesight.

— Organise survey to assess the prevalence of various eye diseases and the incidence of blindness.

— Detect early visual defects and provide suitable glasses or low vision aids at cost price to the persons suffering from such defects.

— Help in the rehabilitation of the blind in their own surroundings by training the blind in the art of daily living and mobility and give them proper and suitable vocational training.

— Promote community participation in eye health care.

COMMUNITY PARTICIPATION (THROUGH CO-ORDINATION COMMITTEES)

— Planning and implementation of the programme will be guided and monitored by committees with respesentatives from the community, voluntary organisations, international voluntary agencies, and medical, health and other Government agencies from the periphery to Apex levels.

— These committees will strive to mobilise community participation in the implementation of the programme. The functions of these committees are :

* Planning of the programme.
* Mobilisation of resources.
* Fixing of priorities and implementing the programme.
* Conducting concurrent evaluation of the programme.

VOLUNTARY ORGANISATIONS

These Voluntary and Social agencies aim at providing the following services :

— Eye Health Education
— Organisation of eye camps
— Survey of the community for early detection of visual defects
— Distribution of spectacles
— Rehabilitation of visually handi-capped.

THE OBJECT OF ROTARY

The Object of Rotary is to encourage and foster the ideal of service as a basis of worthy enterprise and, in particular, to encourage and foster :

FIRST— The development of acquaintance as an opportunity for service:

SECOND— High ethical standards in business and professions: the recognition of the worthiness of all useful occupations, and the dignifying by each Rotarian of his occupation as an opportunity to serve society.

THIRD— The application of the ideal of service by every Rotarian to his personal, business, and community life.

FOURTH— The advancement of international understanding, good will, and peace through a world fellowship of business and professional men united in the ideal of service.

Rotary came to India	...1920
Total No. of Clubs in India	...over 800
No. of Rtns. in India	...over 30000
No. of Clubs in the World	...over 18000
No. of Rtns. in the World	...Approx. 8,40,000 in 152 countries & Geographical regions.

The magnitute of the implementation of any national programme through Rotary Clubs can be imagined by the above figures so far as the involvement of the community is concerned.

ROTARY AND THE INTERNATIONAL YEAR OF THE CHILD

One quarter of the children in developing nations are malnourished. At any given time, 10 million youngsters under age five suffer such severe malnutrition as to be actually on the verge of death. The United Nations Children's Fund (UNICEF) estimates that 350 million children in developing regions are beyond the reach of minimal health, nutritional, educational, and social services. And even in such "modern" nations as the U.S.A., a National Research Council Committee reports, one out of every six pre-school children (some 3 million) lives below the poverty line. What is more, one third of U.S. children (more than 20 million) never get such basic medical care as complete immunization and prompt treatment for disease.

"The first five years of life are the crucial, formative years, "says Dr, Labouisse". A child deprived of food and elementary health care may be hurt for life—if he aurvives at all—and never grow into a normal, productive adult."

ROTARY AND 3 H PROGRAMME

A wide-ranging new program called Health, Hunger, and Humanity has been

established by the board of directors of Rotary International to help clubs plan and carry out bigger and better child welfare projects. The purpose of the 3-H program is to improve health, alleviate hunger, and enhance human and social development of people—especially children-around the world. Specific programms will include immunization against communicable diseases; encouragement of better methods of food production and distribution, and projects to raise educational, social, cultural, environmental, vocational, and spiritual levels.

ROLE OF VOLUNTARY ORGANISATION—DECADE AGO

According R.R. Doshi "we are conducting eye camps through voluntary organization for the last 17 years in Gujarat. 15 eye specialists have joined and offered voluntary services for 2-3 weeks every year. Five to seven places are selected in different districts of the state where there are no eye hospitals or established eye clinics Follow up programme is carried out for 2 months at least after the camp is over.

Exhibition of posters is kept with film show and slide demonstration for prevantable diseases. Lectures by eye specialists and health educator are arranged in camp and surrounding villages.

Above programmes are conducted by seeking co-operation of social clubs at some places who are always eager to help us for our prevention programmes. At some places even single person comes forward and help whole eye camp unit. Teachers retired servants and students take keen interest for such activities. So I feel that such treasure of voluntary services should always be taped for any minor for major field operations.

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Role of service organisation such as Lion, Rotary Club, Indian Red Cross and Panchayat etc. in prevention of Blindness and treatment of curative blindness.

(Dr. M. Mathew, Dr. P. S. Sandhu)

It has now been estimated that there are 40 million blind people all over the world today and 80% of them are in developing countries. Two thirds of these are either preventable or curable blindness. The Indian Council of Medical research reported that there are 9 million blind in India of this nearly six million are cataract cases, which can be cured by operation. It is alarming to know that there are 45 million people in India alone who are visually handicapped. These hard and fearful facts should cause concern to all individuals, societies, organisations and the government to formulate plans with a view to reduce the economic liability of the country and mitigate serious social dependency of the blind population on their families and communities.

Apart from the physical handicap whieh are the lot of blind, the emotional trauma as a result of loss of eye sight is something which we as opthalmologists and others who are partners in the venture of prevention of blindness should be aware of. Though the opportunities of education and employment, do help in restoring the self confidence and self respect in the blind, the ultimate is still far away from ali mankinds effort, i. e. to take away the years and years of darkness infront of them.

Thus it is obvious that the problem of blindness facing our country is a collosal one, requiring urgent attention. Prevention of blindness must be given the highest priority and receive full attention and implementation at all levels, both at the Government and well established organisations.

I am here to delibrate on the role of service organisations in the prevention of blindness. Service as their motto, is the prime concern of the organisations like Lion's club, Rotary, Indian Red-cross and their active participation in curing the blind in the past should be recorded with gratitude. However much needs yet to be done. Therefore more voluntary organisation should be actively involved in taking care of the backlog of cataract operations that need yet to be done in our country.

There are various other organisation both religious and otherwise like

Aryasamaj, YMCA, YWCA, Mahavir Dal, Bharatiya Parishad, Vishal Hindu Parished to name a few. More than these the Panchayat should have more active part to play in the prevention of blindness and treatment of curable blindness.

In orher to achieve any target laid down, a well planned, well directed integrated strategy should be launched. Therefore the servlce agancies can take part 1. In changing individul's behaviour. This can be changed only if there is change in the standards of groups, its style of leadership, its emotional atmosphere of stratification into ehiques and hierarchies. People in contact with rural population should be first subjected to studies in Socio-physiological environments such as belief's, prejudicis and atitudes of various other lingustic groups. Local opinion should be activised because of their credibility, quality and persuasiveness is very effective on the minds of people. Hard core resisters should be exposed to situations of suffering and remedial treatments and its after effects. These can be effectively done by service organisations, which is really a, peoples participation.

2). **Enforcing preventive health practices, especially eye care**

This can be easily done at the level of village Panchayats. Eye care programme though lanched through Health workers in the communiiy, their work can be easily supervised by the Panchayat, to find out any lacunae and remedy them by orienting the higher authorities. Primary health workers and PHCS. in the villages should be made pivots to popularise preventive practices. Primary health centres can certainly function as clearing houses, for information which would be carried by local opinion service agencies. Primary Health centres can announce every season what varieties of vegetables and fruits are cheap and locally available food which would supply vitamin 'A' at that particular season. This would prevent nutritional deficiencies leading to bindness.

PHC can organise village to village eye care campaigns, identify cases and arrange for specialists attention at their centre atleast once a week. Any hospital would agree to this extension work gladly.

PHCS should be able to warn people against epidemics, that afflict in seasons and prescribe preventive measure as in Red eye syndrome. Therefore it is very essential to have close co-ordination proper linking, and integrated approach between the PHCS, service agencies and villages/urbanised villages for popularising informations, campaigns widely and in time. This co-ordination between voluntary agencies and villages in the PHCS, is lacking, and should be taken up for an integrated scientific approach to the problems of eye care and curable blindness.

3. Subsidies to local costs for Prevention of Blindness.

At present the scheme for setting up mobile eye hospitals cames from the top. It is considered that Ophthalmologist should go to villages and find out and set up eye relief camps, or mobile eye hospitals. I personally think the voluntary agencies should be totally engaged in the wallare of the community in villages and they should involve the village Panchayat and block authorities in co-peration with local health centres and get in touch with the nearest hospital to arrange for periodic eye relief camp. The voluntary agencies should mobiiise resources and finance to provide all facilities for such camps. Hospitals and Medical Colleges are hard pressed with their limited facilities and especially with medical personalle, authorities that also however should be oriented to the need of community and should not refuse the personalle and equipment to run short-term eye clinics, and eye relief camps and visiting PHC's periodically. Nursing personalle is always deficient in hospital itself let alone to be taken out to eye relief camps.

Perhaps the voluntary agencies, especially Women's wing of Youth Organisation, inner wheel club, should be educated in getting the nurses work tidied over in camps. In a situation such as this' it would be well, that the service organisations and PHC's and Panchayat be attached to each district hospital/Medical College, so that together they reach the masses where there is a need for treatment of curative blindness.

4. Assessment and evaluation of programme :

The prevention of blindness and treatment of curative blindness is a continued programme and its success, assessment and evaluation is very essential. Padchayat should follow up eye camps. A single failure of operation and treatment would give rise to to remours and sceptiscism in the entire village. Therefore they should keep a close watch and any complication should be reported immediately to the Health Centre who inturn should take expeditious action and if necessary call in the specialists to remove the cause of complaint.

5. Men power development.

It is feasible for every service agencies to have a strong education wing. This can take care of pregnant women and new-born children to educate them on pregnancy, and its demands, how to eradicate nutritional anaemia in pregnancy, how to take care new born babies eye and how to preserve sight. They can conduct regular classes on nutrition, education hygiene of eye. They could organise themselves to visit schools and to check-up vision and spearate out the children neediug an ophthalmologist and bring them to him or vice-versa, whichever is fessible in the circumstance. It is possible for these service organisation like Lion's, Innerwheel Clnb, Rotary Club, to

be pioneers and start new programmes. At present, they contribute in the way of finance and the banners for their publicity and fame. What is lacking is personal involvement in these eye relief/mobile eye hospitals camps. Many a time, from many camps it is reported that doctors have operated cases and they are under the mercy of a compounder or ward-orderlies, and is done under the auspicis of a service organisation. This should be strongly discouraged.

6. Supplise & equipment.

It is a well known fact that Government resources are not enough to meet the supplies and requirement of all hospitals. In such circumstances it is ideal that service organisation like Lion's club, Rotary, and Philantheropists can donate specific equipment and other badly needed iteams. If there is a co-ordination between the Government and service agencies, this problem can be easily surmounted.

Tcerefore a planning at a higher level is essential to involve the voluntary agencies in a proper manner. This can only be done at the Government level to benefit from such voluntary organisations to the maximum.

7. Mobilisation of resources.

At a local level, volnntary donations from individual religious organisation local government and any other local agancies like Lion's Club, Rotary club etc. can be mobilised.

These organisations can organise charity shows, plays and dances, and various other ways can collect funds for the purpose of eradication of blindness. I believe that these service organisation should be tagged to the various dispensaries, hospitals and medicals colleges or where-ever qualified ophthalmic persoualle is available and they alongwith the PHC and local Panchayat should be able to tackle the problem of blindness in villages. In the urban area it is not at all necessary to hold eye camps to treat curable blindness but the voluntary agencies can put in their mite by working among the low-income lower resource group. So that, that the needy should be reached to the hospital nearby for necessary treatment.

It is invariably found that people are only aware of big hospitals and these are over crowded, where as in small hospitals where facilities and expertise exist the ward has empty beds. This situation, exist of course in big cities, and as such can be avoided only by educating the population and teaching them virtually by hand. Of course this is only possible after winning their confidence. Here again the service organisation can help to overcome the problem. Administrators and planners should also be made aware of the social and economic benefits of the

programme by the service agencies and at a low cost, so that necessary guidelines can be drawn up by them, and the government is aware of the need, and the task ahead in the country. It is also necessary for them to visit such a camp or mobile hospital to orient themselves with the magnitude of the problem.

Therefore while taking note of the voluntary agencies, philanthroptists, National government, Inter national and United Nations agencies as possible sources of various forms of aid a co-ordinated attempt is necessary which is lacking at present to channelise these aids throngh all the hospitals in the country uniformily tnan a consolidated aid for few Institutions in a gigantic way. Such a co-ordinated well planned linked action between government, and voluntary agencies would go a long way to present blindness, and treating curable blindness.

Finally to quote Sir Wilson about blind people, they live in communities which are under privileged, under served under motivated undervalued, the very communities which are increasingly becoming the central focus of United Nation's stratigy. They are not just embarrassing statistics, they are individuls not rehabilitated blind people with jobs and status but people for whom blindness is a thing of bitterness, dragging their families into destitution killing hope.

In justifying the co-ordinated action between governmental, and voluntary agencies, we may have to modify the the laws and many regid rules and agree with Sir. Wilson that justification is not just the commitment of a scientis) to his scientist to his science, a planner to his priorities, but because it is a right of human beings to see and because no one-however poor, inarticulate, or economically negligiable should remain blind, if by the exercise of a single inexpensive skill can restore his sight.

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ROLE OF RELIGIOUS INSTITUTIONS IN PROMOTION OF PREVENTION AND TREATMENT OF CURATIVE BLINDNESS IN RURAL AREAS

(Dr. N. S. Baweja, Civil Hospital, Jullundur.)

I have for a number of years been posted and later on associated with a few places of religious importance in Punjab. These places were in rural and semirural areas. I have held about 30 to 35 eye camps in the religious institutions of these places (mostly Gurudwaras) and I will discuss very briefly my experience of these places and how further these religious institutions can be utilized in the prevention and treatment of curable blindness. Religious institutions with good building exist in almost all big villages of Punjab.

So far in Punjab many of these institutions are providing medical and surgical treatment for the control of eye diseases by holding camps periodically, generally twice a year, during the eye season i. e. March/April and October/November months. These camps are held with the help of Eye Surgeons either from the Mobile Eye Hospitals or Government Hospitals or from Ophthalmology Departments of Medical Colleges and sometimes by eminent private practitioners in Ophthalmology. However, it is the Eye Mobile Units which can and should utilise these institutions in fulfilling the task set forth in the national programme for the prevention of visual impairment and control of blindness in India.

The advantages of holding eye camps in these places in rural areas are—

(i) Accommodation

In the villages and semi-rural areas these places have generally the only good pucca buildings and they are invariably the cleanest buildings available with arrangements of fly proof wire-gauge doors etc. These places have many rooms meant for the stay of visitors and these can be converted into good Operation Theatres and Wards with facilities for bath-rooms and sometimes even flush-latrines.

(ii) Free Kitchen facilities

These institutions have already got free kitchens running for their visitors and in the eye camps they provide satisfactory free diet not only to the patients but also to their attendants. They also look after the boarding of the Mobile Unit teams. This saves all of them from lot of botheration because there are no hotels etc. in the villages.

This by itself is an added attraction to the patients to get themselves operated at these camps.

(iii) Medicines etc.

These institutions are generally sufficiently well financed so that they provide willingly all medicines required for use in the camps.

(iv) Free glasses

Operated cases are generally provided free Aphakic glasses by them.

In all these spheres these religious places are far better than any other institution in the rural area such as schools, panchayat ghars and Government Rural Dispensaries.

In the development of Community Ophthalmic Service at the peripheral level one of our other important aims is to educate people in the methods of prevention of eye diseases and proper care of eyes in order to ensure better and lasting eye-sight. These religious institutions are first class places for achievment of the above aims in the rural areas. At these places gatherings take place at regular intervals such as Amavas, Pooranmashi, Gurupurab etc. On a few occasions I have given lectures from these platforms about care of eyes and these were well received. Eye Mobile Units need to avail of these opportunities to educate people in the care of eye by giving lectures, film, shows holding mini exhibitions and free distribution of literature etc. If, at the same time, the Mobile Units set up one day visual defect detection camps at these gatherings, they can prove very useful for the people. The organizers of the religious institutions can, sometimes, be persuaded to subsidise and help in providing suitable glasses at cost price or even cheaper to the patients.

Another important field where the religious institutions can play their role is in the rehabilitation of the blind by training them in the art of daily living and providing them suitable vocational training. Already quite a number of musicians and Singers employed in the religious places are blind persons and many of them have learnt their art in the rural areas itself. The religious institutions have inclination, resources and accommodation available to do this type of work and with persuasion, encouragement and guidance from the national society for prevention of blindness many of them may become willing to run other vocational courses for the blind which can go a long way to rehabilitate them. Already in Puujab many of the Andh-Vidyalas are being run by the religious institutions.

In conclusion it is submitted that these religious places have a great role to play in prevention and treatment of curable blindness in collaboration with the Mobile Eye Unlts. Also they have a role to play in the establishment of Andh-Vidyalas especially in the rural areas.

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