

EVALUATION OF NGO INVOLVEMENT IN THE CATARACT CONTROL PROGRAMME IN INDIA

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Abstract: Aim. This study presents findings of the evaluation of performance of NGOs under the World Bank Assisted Cataract Blindness Control Project in India. **Method.** 15 NGOs were covered in 3 states of Maharashtra, Andhra Pradesh and Tamil Nadu. The study was conducted in base hospitals and their hinterlands in 2002-2003. The field study involved visiting selected villages where the scheme was implemented and conducting interviews with beneficiaries and non-beneficiaries. **Results.** The performance of NGOs were assessed on the basis of their matching contribution, achievement of development targets, case selection through camps, number and type of surgeries performed (performance targets) and quality of follow up services. Successful models developed by grantee NGOs should have good geographical camp coverage, better planning, efficient and effective utilization of resources. The reasons for poor performing NGOs were poor geographical coverage, unavailability of skilled manpower, poor follow up services, etc. **Conclusions.** Though the Scheme has been successful in streamlining the involvement of the NGOs in addition to capacity building to a great extent, it is doubtful that the prevalence of blindness in the assigned area has been reduced. Further studies are required to identify the reason for the high prevalence of cataract, to understand the role of each risk factor and to improve the service delivery through both public and private sector.

Key-words: cataract, evaluation, Government-NGO collaboration, public-private partnership, National Blindness Control Programme

Rezumat: Scop. Studiul prezintă constatările evaluării performanței ONG ce acționează în cadrul Proiectului privind Controlul Orbirii prin Cataractă în India, proiect asistat de Banca Mondială. **Metodă.** Au fost incluse 15 ONG din 3 state, Maharashtra, Andhra Pradesh și Tamil Nadu. Studiul a fost efectuat în spitalele municipale și ambulatoriile lor, în perioada 2002 – 2003 și a constat în vizitarea satelor selectate, unde a fost implementată proiectul prin efectuarea de interviuri cu beneficiarii și non-beneficiarii. **Rezultate.** Performanța ONG a fost evaluată în funcție de gradul contribuțiilor, realizarea sarcinilor, selectarea cazurilor din teritoriu, numărul și tipul performanțelor chirurgicale (obiective de performanță) și calitatea serviciilor de supraveghere. Modelele de succes dezvoltate de ONG implicate trebuie să aibă o acoperire geografică corespunzătoare, o planificare mai bună și utilizarea mai eficientă și efectivă a resurselor. Motivele unor performanțe mai slabe a ONG au fost acoperirea geografică deficitară, disponibilitate redusă a personalului specializat, servicii de supraveghere insuficiente etc. **Concluzii.** Deși proiectul a avut succes în organizarea implicării ONG și a extinderii infrastructurii, autorii nu se așteaptă la reducerea prevalenței orbirii în zonele în care a fost implementat proiectul. Sunt necesare studii suplimentare pentru identificarea cauzelor cataractei, înțelegerea rolului fiecărui factor de risc și pentru îmbunătățirea furnizării serviciilor atât pentru sectorul public cât și pentru cel privat.

Cuvinte cheie: cataractă, evaluare, colaborarea Guvern-ONG-uri, parteneriat public privat, Programul Național de Control al Orbirii

INTRODUCTION

Recent global review of a large number of surveys on visual impairment by WHO estimates that, there were 161 million persons worldwide with visual impairment in the year 2002, including 37 million with blindness (1, 2, 3). Though, the actual burden of visual impairment worldwide, including that caused by uncorrected refractive error, may be substantially higher than the commonly quoted WHO estimate which is based on best-corrected visual acuity (4).

Blindness is one of the most significant health related social problems in India. Cataract and refractive errors are major causes of blindness and low vision. Most blindness and low vision burden is avoidable (5-13). Both national level surveys and micro-level studies have shown extremely high level of blindness caused by cataract in India (14). The WHO/NPCB (National Programme for Control of Blindness) survey done in 1980 has shown that there is a backlog of over 22 million blind eyes (12 million blind people) in India, and 80.1% of these are blind due to cataract. The annual incidence of cataract blindness is about 3.8 million. The present annual level of performance is in the order of about 1.6-1.9 million cataract operations. To clear the backlog of cataract cases and to tackle the rising incidence, 5-6 million cataract operations annually will have to be performed as against the present rate of 1.7 million per year (15).

India was the first country in the world that has launched a 100% public

funded programme for the control of blindness. This programme has the distinction of emphasizing evidence based practice for planning and policy formulation from its very inception (16-19). A nationwide survey was undertaken in 1999–2001 to document the magnitude and causes of blindness. Blindness control efforts seem to have played a part in arresting the increasing prevalence of blindness in India and there is hope that the goals of the “Vision 2020 – right to sight” initiative can be achieved if there is strong political will (20). The inception, implementation, and identification of appropriate strategies have always been guided by meticulously collected data. The country may now see a recession in blindness prevalence in the future (18).

Cataract also presents an enormous problem in terms of economic cost. Cataract renders a significant size of population economically dependent for their rest of their life. In the absence of proven measures of primary prevention, secondary prevention in the form of surgical intervention is currently the common remedy to the problem of blindness due to cataracts. Although there are various therapeutic approaches in cataract extraction, the conventional ICCE (Intra Capsular Extraction) with Spectacles and the newer ECCE (Extra Capsular Extraction) with IOL are the popular approaches presently adopted on a mass scale (21).

In India a large number of cataract patients usually try their fortunes with the quacks, Ayurvedic and Homoeopathic treatment to get rid of the problem. A majority, however, prefer to get

EVALUATION OF NGO INVOLVEMENT IN CATARACT CONTROL

allopathic cure. Unlike most other public health problems, cataract requires only a minor surgical procedure for cure. The expansion of IOL surgery for unilateral blindness is a favourable trend in ensuring financial sustainability of delivery systems; patients can be operated on while still economically productive and able to pay rather than waiting for bilateral blindness and a less favourable economic and social impact. With the availability of low-cost intraocular lenses (IOL) and ophthalmologists trained in extracapsular surgery, it is now practical to intervene successfully in the unilateral case (22). But this facility is not easily available to the rural masses due to non-availability of infrastructural facilities and lack of qualified medical practitioners. Taking into consideration all these, the government since last few years decided to provide outreach programmes by sponsoring eye operation camps in base hospitals of authentic and experienced Non Governmental Organizations (NGO) in a number of states.

MATERIALS AND METHODS

The National Programme for Control of Blindness was launched in 1976. Due to various administrative and technical reasons the quantum of cataract surgeries has shown significant increase only in the last two decades. Government achieved the sharp increase in the quantum of surgeries since 1990 through building strong partnership with private/NGO providers and by making service delivery more efficient. A preference

is being shown towards shifting from conventional ICCE surgeries to ECCE/IOL and small-incision IOL surgeries. From earlier approaches of camps, temporary OTs, and mobile OTs, the programme has shown a preference to screening eye-camps and residential (in-patient) hospital based surgeries. Yet another important strategy was to carry out intensive campaigns at the state and national levels against cataract blindness in order to substantially increase the demand for cataract services (15).

Government of India with the help of World Bank started various schemes to enlist the involvement of NGOs. The purpose was to increase the quantum of surgeries done, better case selection, extend services to underserved rural and tribal areas and to develop capacity for sustainable eye care delivery in the NGO sector. In the process Public-Private Partnership (PPP) was created between Government health services and NGO sector. Important features of this initiative included giving attention to spread the cataract blindness programme in rural and tribal areas, emphasis on modern ECCE/IOL as the preferred surgical technique, developing institutional capacity, devising appropriate co-ordination mechanisms for collaboration between the NGO and the public sector to expand coverage to the most disadvantaged populations.

In this initiative two approaches were considered: i) reach-in approach by NGOs having eye care facilities for recruitment of cases and ii) reach-out approach through screening camps. These two approaches were influenced

by the guiding principles like to ensure long term sustainability even after cessation of the World Bank assistance, to provide quality eye care in the base hospital, to bring about a shift from “camp approach” to “base hospital approach” and to promote resource participation by the NGO.

One of the schemes started by the Government was Non-recurring Grant-In-Aid (GIA) to NGOs for expansion or up gradation of eye care units in tribal, underserved or backward rural areas. Under this scheme 30 Non Governmental Organizations (NGOs) from 8 States were sanctioned a Grant in Aid (GIA) by Government of India under the World Bank Assisted Cataract Blindness Control Project in 1994 – 1995.

Long term sustainability of the programme after cessation of World Bank assistance being one of the objectives, the scheme provided for development / up gradation of infrastructure (building, vehicle, equipment and furniture). Varying degrees of funds were sanctioned to the grantee NGOs. For some NGOs the grant was sanctioned for all the four purposes. The criteria for fund allocation were the existing infrastructure of NGOs, the grant requested by the NGOs and willingness to provide matching contribution. This GIA was upto a maximum of Rs. 17.75 lakhs (equivalent to approximately 27,000 Euros) for each NGO.

Accordingly all grantee NGOs were given developmental targets in each of the above four areas in commensurate with the grant given. In addition to development targets, the NGOs were

also given performance targets. They were expected to carry out absolutely free cataract surgeries on people staying in underserved areas in given time frame. The areas were identified by the Government. The calculation of target was based on estimate of Rs.400 for conventional surgery (ICCE) and Rs.600 for ECCE/IOL surgery. The DBCS (District Blindness Control Society) was expected to provide sutures and Intra Ocular Lenses as assistance in kind. If due to any reasons, such items were not provided, the NGO was to be reimbursed the cost of sutures and IOLs at Rs.50 and Rs.200 respectively.

NGOs receiving grant under this scheme were expected to carry out following activities: A) must hold OPD six days a week, B) Screening of population (50+years) in all the villages/ townships in the assigned area and population. C) Preparation and maintenance of village wise blind registers as per standard format. D) Identification of cases fit for cataract surgery and their motivation. E) Transportation (including one attendant if required to and from to the base hospital. F) Pre - operative examination and investigation as required at the base hospital. G) Performance of cataract surgery by ICCE or ECCE / IOL as targets indicated. H) Post - operative care including management of complications, if any and post-operative education and counseling regarding do's and don'ts, importance for using glasses etc. I) Follow-up services including refraction and provision of aphakic glasses providing best possible correction (not standard

EVALUATION OF NGO INVOLVEMENT IN CATARACT CONTROL

+ 10 D glasses). J) Provide & maintain individual cataract surgical records as per prescribed format. K) Submission of village - wise monthly reports and quarterly monitoring reports.

In 2002-03, Government of India evaluated the performance of Grantee NGOs under this scheme. It authorized then Department of Health Services Studies (HSS) (now School of Health Systems Studies) in Tata Institute of Social Sciences (TISS), Mumbai along with Indian Institute of Health

Management Research (IIHMR), Jaipur, for the evaluation of the performance of these NGOs, under the World Bank Assisted Cataract Blindness Control Project. Each of these two Institutes was assigned 15 NGOs for evaluation.

The current paper presents findings of the evaluation study done by TISS in 6 NGOs of Maharashtra State, 7 NGOs of Andhra Pradesh State and 2 NGOs of Tamil Nadu State. Thus 15 NGOs were covered in these 3 states (table 1).

Table 1. State-wise Distribution of NGOs

No.	Name of the NGO / Hospital	Location
1.	Jnana Prabodhini Medical Trust	Maharashtra
2.	Mahatma Gandhi Mission Hospital	Maharashtra
3.	Talegaon General Hospital and Convalescent Home	Maharashtra
4.	Rotary Eye Care Trust	Maharashtra
5.	Akot Rotary Charitable Sanstha	Maharashtra
6.	Lions Comprehensive Eye Foundation	Maharashtra
7.	Rajavalli Radhyram Lions Eye Hospital	Andhra Pradesh
8.	Rotary Netra	Andhra Pradesh
9.	Lions Club of Suryapet Eye Hospital	Andhra Pradesh
10.	Ashoka Eye Hospital	Andhra Pradesh
11.	Rotary Service Complex Trust	Andhra Pradesh
12.	Ram Reddy Lions Eye Hospital	Andhra Pradesh
13.	Smt. Rajeshwari Ramkrishnan Lions Eye Hospital	Andhra Pradesh
14.	K.G. Eye Hospital	Tamil Nadu
15.	Sankara Eye Hospital	Tamil Nadu

IIHMR evaluated the NGOs from Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh States. The objectives of the study were to assess achievement of developmental targets given to grantee NGOs, to measure performance of grantee NGOs after grants, to identify factors affecting

performance of NGOs and to suggest changes after analyzing the scheme for future policy development.

The study was conducted in base hospitals and their hinterlands. Base hospital study involved interviewing administrative head and staff of the hospital, looking at relevant documents

and physical verification of facilities and assets. An open-ended questionnaire for formal interview and informal discussions with administrative head and staff was developed. The field study involved visiting selected villages where the scheme was implemented and conducting interviews with beneficiaries and non – beneficiaries. A semi – structured schedule was prepared for this purpose. The interview schedule elicited information on demographic, socioeconomic background of individuals, services received during pre-operative, operative and post-operative phases, and perceived level of satisfaction. These tools were tested by a pilot study.

Beneficiary was any person who underwent surgery for cataract with the NGO during the project period. *Non-beneficiary* was any person who was identified by NGO to be fit for cataract surgery but did not get operated for some reason. The following criteria were used to select the beneficiaries: a) distance from the base hospital (near and far), b) hilly area and population from tribal area, c) cataract operated patient before, during and after the project period and d) representing the range of socio-economic status.

Few non beneficiaries using above criteria were also interviewed. To identify villages fulfilling these criteria, mapping of the project area was done, locating the camp villages with information on coverage, distance, time (month and year) of camps and whether camps covered the marginalized sections of the society (tribal population).

While interviewing the beneficiaries, cataract discharge cards and payment slips were crosschecked / compared with the documents made available by the NGO for their authenticity. Specific enquiries were made in the community for any known cases of post-operative complications and the same were followed up. Emphasis was given on patient's satisfaction, expenses incurred and restoration of vision. It was achieved by verification of spectacles, testing visual acuity and the presence of IOL. Enquiries were also made regarding non-beneficiaries and reasons thereof. Any specific lead regarding a particular case from a beneficiary/non-beneficiary was followed up subsequently in the community. Thus a cross-reference was made through snowball sampling technique and beneficiaries / non –beneficiaries were traced to get their responses. It is seen that 60.5% of the respondents were female in contrast to 39.5% males. The age composition of the respondents showed that 88.9% of them were more than 60 years of age (7.2% are more than 80 years!) while only 11.1% are less than 60 years.

Besides, Government health officials, community leaders and individuals from any other organizations working in that area involved in ophthalmic activities were consulted. This was done to get their opinion on the functioning of grantee NGO before, during and after the project period.

RESULTS

The performance of grantee NGOs were assessed on the basis of their matching contribution, achievement of

EVALUATION OF NGO INVOLVEMENT IN CATARACT CONTROL

development targets, case selection through camps, number and type of surgeries performed (performance targets) and quality of follow up services.

The positive features (strengths) of the scheme were identified as follows. It was found that almost all the grantee NGOs had satisfactorily achieved the developmental targets. Also most of them were able to generate matching contribution successfully. The scheme has definitely built the capacities of grantee NGOs in terms of infrastructure which in turn has helped them to substantially improve the quality of surgeries through capacity building. The scheme was quite successful in bringing out a shift from a 'camp approach' to 'base hospital approach' in most NGOs.

Some NGOs had reached far beyond the allotted project area. A few NGOs had shown a close collaboration with other NGOs as well as Government system. Most NGOs of Maharashtra and all NGOs of Andhra Pradesh and Tamil Nadu States had performed much higher number of surgeries than expected by the end of the project period. Before the project period, most of the NGOs were performing conventional i.e., ICCE type of cataract surgeries. During the project period, they shifted from ICCE to ECCE/IOL type of cataract surgery. The number of ECCE/IOL surgeries has increased vis-à-vis conventional ICCE surgeries. It was noticed that 68.5% of the beneficiaries had undergone ECCE/IOL surgery in contrast to 31.5% beneficiaries with ICCE. This trend was found to be continuing after the project period.

Some of the NGOs adopted very innovative methods for follow-up services like: Arranging of separate 'follow up camps'; Use of postcards reminding the patients about the date of follow-up (M. Ram Reddy Lions Eye Hospital, Andhra Pradesh); Setting up of 'vision centers', where the patients were asked to follow-up on a date informed to the patients by postcards (Ashoka Eye Hospital, Andhra Pradesh); Conduction of camps in a chain method i.e. setting of the next camp in a village which was nearer to the prior campsite than the base hospital (Rotary Netra, Andhra Pradesh).

NGOs which were otherwise little known have gained prominence and recognition from State and Central Governments. Few NGOs have shown a close collaboration with other NGOs. There was a good coordination with the Government Ophthalmic Assistant during the project period. However, there is no such coordination after the project period in Maharashtra and Andhra Pradesh States.

Although the involvement of NGOs in the cataract treatment effort along with the Government was quite successful, it is not that there were no lapses. There were certain negative features (weaknesses) of the scheme. There were certain deviations in the utilization of GIA. These deviations included delayed utilization of funds, funds diverted from one head to another and irregularities in fund utilization. Wherever there was delayed fund utilization, the interest earned on GIA for extra period was not accounted for. Only few NGOs

took the permission for diverting funds from one head to another. Camp sites were usually selected on the basis of accessibility to nearby villages. In such camps it was seen that tribal peoples and others residing in geographically difficult terrain had not been adequately covered by most of the NGOs.

There was an overlap and competition for arranging screening camps in well connected areas. This competition is among the grantee NGOs, other NGOs, as well as Government services working in the same area. A few big NGOs followed a fixed itinerary of sites every year. The dates and venue of the camps were publicized in and around camp villages through pamphlets and mobile public address system. Rural outreach was virtually neglected by them.

NGOs made little effort to visit tribal areas. It was reported that difficult terrain and lack of means of communication came on the way contacting the people. They apparently considered that tribals have fewer cataract problems. It was difficult to evaluate the performance as Government had not explicitly specified the targets, nature of the surgeries to be undertaken to most of the grantee NGOs. Different targets were set for each NGO without much reasoning.

Certain irregularities in accounting the number of patients served under the project were noticed. For instance, patients operated from non-project area and walk-in patients were accounted within the project, paid patients were shown to be operated in

free category, Non – IOL implanted patients were shown as IOL implanted and patient whose names were listed by one NGO had actually undergone surgery at some other Hospital. It was noted that, ECCE / IOL type of cataract surgeries was performed only by NGOs having more number of qualified eye surgeons.

Non-availability of full time eye surgeons at the base hospitals located in relatively remote rural areas was also a problem faced by smaller NGOs of Maharashtra and Andhra Pradesh States. It was noted that free transport services were usually restricted to performance of surgeries and discharge of patients only. According to the project guidelines, NGOs were supposed to provide free transport facilities to the patients along with attendants during screening camp, pre-operative testing and surgery, discharge and follow-ups. This was not followed by most NGOs.

The provision of follow up services was the least desired component of the programme except for two NGOs. Most often it was found that patients had to visit the base hospital on their own contrary to the project provisions. Here the time, cost and need for attendant become barriers for the patient. The package of services was supposed to be provided absolutely free. But it was noticed that most of the patients had to pay for amenities like dark glasses, spectacles, medicines, registration fees, follow up fees and transportation. Some NGOs even charged for IOL implantation. Few NGOs in addition were demanding donations after the surgery.

EVALUATION OF NGO INVOLVEMENT IN CATARACT CONTROL

It is seen that 80.3% of the beneficiaries were quite satisfactory about the performance of NGO. But 19.7% beneficiaries were not at all

satisfied which reflects on the poor quality of services given by those NGOs (fig. 1).

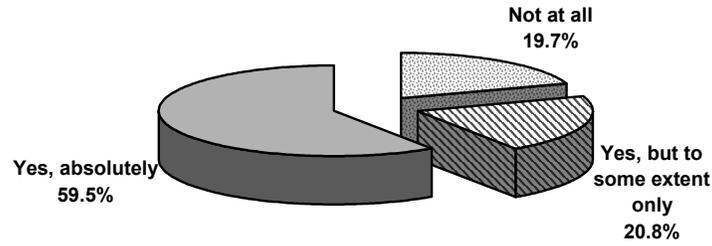


Fig. 1. Percentage distribution of beneficiaries as per their satisfaction with NGO performance

On the other hand when enquired about the quality of vision now, only 9.6% of beneficiaries were able to

carry out the normal activities of life (fig. 2).

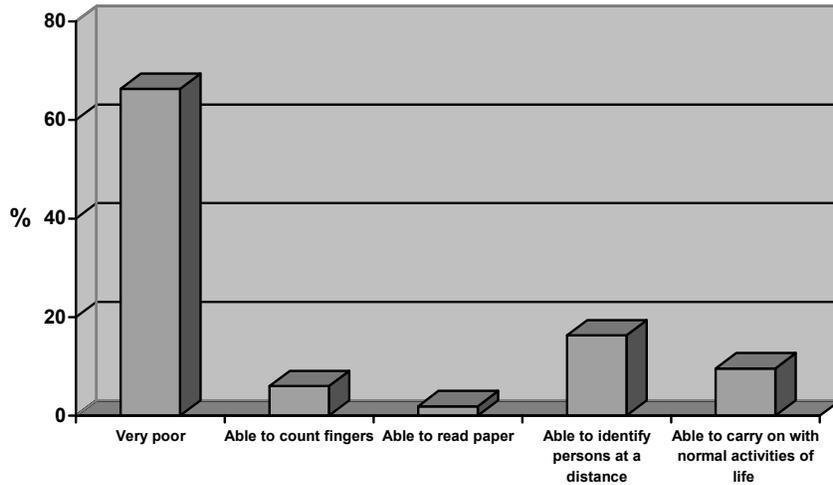


Fig. 2. Percentage distribution of beneficiaries as per their current quality of vision

It was also noticed that most of the NGOs were poorly maintaining the records. As per the guidelines NGOs had to maintain village wise blindness register compiled on the basis of a baseline survey. No proper training was imparted to the staff for this. Almost all NGOs did not maintain village wise blind register. Case registers, however, were found to be maintained satisfactorily by all the NGOs.

At the same time the programme could not make a big dent in the existing backlog of cataract surgeries. One of the main reasons stated that the backlog is too huge and it would require involvement of more number of NGOs. Not all NGOs may be able to sustain the services after the cessation of the World Bank Assistance. NGOs selected were not distributed evenly across the regions, especially in Tamil Nadu. Since the scheme provides only non-recurring capital cost, it becomes difficult for some smaller NGOs to mobilize funds for meeting recurring expenditure. In spite of Government support, response from them was usually delayed. There were few visits by State Government officials to the NGOs during the project period. However, generally there was a good cooperation with DBCS during the project period. But after the project period all links disappeared.

Successful models developed by grantee NGOs can be better understood by differentiating between better and poor performing NGOs. Following reasons were found to be significant in better performance of some of the

NGOs: Good geographical camp coverage; A camp timetable prepared well in advance and supported by sound IEC strategy; Optimum utilization of the infrastructure; Collaboration with the Government counter parts and other NGOs during the project period; Skilled Ophthalmic and Para-ophthalmic manpower support; Use of innovative methods for follow-up as mentioned above; Computer aided record maintenance; Successful in generating other collateral funds through efficient networking with funding agencies, etc..

The reasons for poor performing NGOs were as follows: Poor geographical coverage of the project area; Unavailability of skilled manpower especially in remote areas; Highly dependent on other NGOs / Government system for organizing camps; Poor follow up services; Financial mismanagement; Sub optimal utilizations of resources; Lack of competition, etc.

DISCUSSION

The findings of this study are quite similar to that of the midterm review of the programme conducted by GOI during 1998. The Government and NGOs dealing with the problem of cataract at the grassroots need to modify their practices for effective control of cataract.

The existing practice of providing financial aid as non-recurring grant may be continued by the government. Some of the NGOs had accounted for matching contribution through recurring costs. This practice did not make any meaningful contribution towards

EVALUATION OF NGO INVOLVEMENT IN CATARACT CONTROL

sustainability and building capacity of the NGO. The NGOs should be asked to contribute matching grants in the form of non-recurring investments only.

A form of non-recurring investment could be purchase of a suitable vehicle for the project activities. Government could also prescribe what type of vehicle could be purchased, so that it is appropriate for field requirements and may not be misused. Purchase of sophisticated micro – surgery instruments may be allowed from the GIA for NGOs having appropriately trained manpower. There can be flexibility in diversion of the funds from one head to another provided prior permission is sanctioned by GOI.

Written guidelines regarding the project activities and any revision thereof should be promptly communicated to all the NGOs. Government should make efforts to maintain regular and prompt correspondence with all grantee NGOs preferably through a designated project coordinator. The Project area should be clearly specified for each NGO in order to avoid overlapping of the target areas. The area allotted should be such that the NGO can provide its services and utilize its resources to its optimum extent.

If the project is considered to involve other NGOs: NGOs working in known tribal talukas (blocks) or districts must be given first preference; Second preference should be given to NGOs working in talukas (blocks) or districts with known geographically difficult terrain (e.g. hilly area, desert, forest & frequently flooded area).

NGOs may be encouraged to prepare an itinerary of camp programmes for each quarter in advance and communicate to the DBCS. Yearly mapping of the actual camps held in the project area should be done by the NGOs. This will give the geo – temporal perspective of the distribution of the camp locations. Such mapping would guide the NGOs for future actions. Each NGO should identify a nodal person for implementation of the project. This nodal person shall then be a contact person for the responsibilities of the NGO and shall be held accountable.

Appointment of a Camp Coordinator, who looks after the field activities of organizing camps in the project area, is necessary. The camp coordinator should be of a social science background. To verify extent of restoration of vision and to address the problem of postoperative complications, follow up camps should be organized at the location where screening camps were organized. The onus of seeking follow up services should not be put on the patients.

Use of computers for recording and maintaining of data should be emphasized. Registers such as Assets register, village wise Blind register and Complication register should be compulsorily prepared and maintained by all the NGOs. As the life expectancy and population is increasing, an increase in number of cataract cases is assumed. However, the backlog still has to be cleared. Hence intensification of screening camp activities is needed.

To ensure restoration of vision and social rehabilitation, at least two

follow up mini- camps at the earlier screening camps location should be organized. These camps can be held 8 days and 45 days after the discharge of the camp patients. Certain innovations for follow up provision should also be encouraged. Each year there should be mid term review of the progress of the project. Alternatively the GOI could authorize an agency for a limited period each year to visit and review the progress of each NGO and their project area.

Community based health education services for the prevention of blindness should be imparted by the NGOs during the camps. The messages should include measles immunization & Vitamin A supplementation, nutritional education, avoidance of harmful traditional practices. Preventing or delaying the formation of cataract will also reduce the surgical burden on the eye care system of India. Identifying potential risk factors for age related cataract will help in improving our understanding their role in cataractogenesis, target higher risk populations for screening programmes, and develop appropriate preventive strategies (23).

CONCLUSION

Though the Scheme has been successful in streamlining the involvement of the NGOs in addition to capacity building to a great extent, it is doubtful that the prevalence of blindness in the assigned area has been reduced. Still, on the basis of above results and discussion, it may be concluded that the Camp Approach linked to Base hospitals is quite efficacious for

countering the problem of cataract. This approach is culminating to the combination of peoples' initiative from the grass roots to the global drives and institutions. However, there is a catch that, in the process comparatively larger NGOs are gaining prominence. Besides, the government seems to be abrogating its own responsibilities. The Camp – Base hospital combination may in the long run be an impediment to establishing new hospitals and medical centers more widespread. This also will come on the way of regular check up, early detection and post-operational care – particularly for the old and destitute.

However, it must also be stressed that Public-Private Partnership in the health field is a reality and a necessity. It is important that the strengths are further improve and the weaknesses of the scheme are over come upon. Also further studies are required to identify the reason for the high prevalence of age related cataract, to understand the role of each risk factor for cataractogenesis and also to improve the service delivery through both public and private sector.

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EVALUATION OF NGO INVOLVEMENT IN CATARACT CONTROL

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