Vision 2020: Right to Sight – India

Col (Retd) M Deshpande, vsm*

MJAFI 2008; 64 : 302-303

Key Words : Blindness; Cataract

“Partnership, Endeavour, Together making people see”

Blindness is not only a health problem but is one of the most important social problem worldwide with enormous economic implications. The total direct cost (economic loss) of blindness is estimated at \$ 25 billion globally every year and this figure would triple, if indirect costs are also included [1]. In the year 2000, the global burden of blindness was 50 million. This will grow to 75 million by the year 2020 unless special efforts are taken to arrest and reverse this trend [2]. Many organisations have attempted to combat the problem of blindness in the past. However it was felt that there should be an umbrella under which all these organisations could be unified for effective output. Towards this purpose, a global initiative called ‘Vision 2020 Right to Sight’ was launched as a collaborative movement by World Health Organisation (WHO) and International Agency for Prevention of Blindness (IAPB) [representing governments and non-governmental organisations] in Geneva on February 18, 1999 by the then director of WHO, Dr Gro Harlem Brundtland. Vision 2020 envisages collaboration between governments, WHO, IAPB, funding agencies, international and private non-governmental organisations (NGOs) that collaborate with the WHO in the prevention and control of blindness [3].

In our country there are an estimated 12 million blind people, of which over 90% live in rural areas. With the increase in life expectancy and projected increase in the country’s population, this number is likely to increase to more than 18 million by the year 2020 [2]. Blindness is mainly a problem of developing countries which is preventable in at least 80% of cases. India was the first country in the world to launch the National Programme for Control of Blindness in 1976 with the goal of reducing blindness. India is committed to reducing the burden of preventable blindness by the year 2020 by adopting strategies advocated by Vision 2020. To align

and collate the efforts of different sectors and organizations towards the national plan of action to achieve the goals of Vision 2020 in India, the “Right to Sight” India was founded in May 2004 as an NGO confederation parallel to the international body.

Right to Sight

National plan of action of the Government of India (GOI) focuses on under served areas with emphasis on community participation. It facilitates the formation of state level Vision 2020- plans of action and programmes, led by the state government along with intensive input from local and international NGOs. Vision 2020 organises World Sight Day, Eye Donation Fortnight etc. with the active partnership of GOI. The forum is also building a strong network of national NGOs to tackle the burden of avoidable blindness. It facilitates the development of training modules, models, manuals, protocols and guidelines, which are made available to eye care institutions. There are regular interactions for capacity building programmes and information dissemination for demonstrating the successful approach in the development of comprehensive eye care services and for the prevention of blindness. National events and regional conferences with Vision 2020 themes are held every year. Newsletters and journals are published by Right to Sight –India in joint collaboration with GOI, research institutes and international NGOs. The membership of Right to Sight – India is open to all organisations working in eye care sector, both governmental and voluntary including honorary membership. Organisations with “Holding No Office” condition can be associate members. Currently the membership of Right to Sight India consists of GOI, seven international NGOs, four centres of excellence and 41 service delivery institutes. The official website of this forum is www.vision2020india.org.

Vision 2020 has identified certain conditions which require immediate attention in India. These are cataract,

*Member National Executive Board, VISION 2020, Senior Director (Medical), HV Desai Eye Hospital, Pune.

childhood blindness, refractive errors and low vision, corneal blindness, diabetic retinopathy and glaucoma [3].

Cataract forms the main burden of blindness in many parts of the world. There have been many studies on the effectiveness of plans to prevent cataract induced blindness[4-6]. The common recommendation was to give more attention to vision impairment among the cataract-operated. Intra-ocular lens implantation (IOL) in the camps has increased from 5% in 1994-95 to 83% in 2003-04, with an increased demand for IOLs and suture-less surgeries [7]. At this juncture it is pertinent to note that suture-less surgeries are either the manual small incision cataract surgery (SICS) or the machine based phaco-emulsification surgery. The latter surgery has a steep learning curve and dislocation of the lens nucleus into the vitreous is a feared complication. These dislocated nuclei can be removed through the limbus by bringing them into anterior chamber (AC) or by phaco fragmentation in the vitreous cavity [8]. An article by Gurunadh et al [9], in this issue highlights their experience in managing cases of nucleus and IOL drop in Armed Forces following cataract surgery. The goal in a case of dropped nucleus is to remove the nucleus, rehabilitate the eye visually and prevent surgical complications like retinal detachment while removing the dropped nucleus. As brought out by these authors, per-fluoro-carbon liquids (PFCL) are seldom required in the management of dislocated nuclei.

Vision 2020 deals with the major ocular morbidities. However, there are peculiar problems due to employment in different terrains as seen in the armed forces. A higher incidence of pterygium due to employment in the desert areas of Rajasthan and the cold desert area of Ladakh is seen in soldiers as compared to the general population. The key issue in pterygium surgery is to decrease the incidence of recurrence. At present the procedures employed after the excision of pterygium are the use of mitomycin-C pre-operatively, the use of amniotic membrane and conjunctival auto-graft. The use of adjunctive mitomycin-C in the management of pterygium was first reported by Dash et al [10]. However a subsequent report by Wan Norliza et al [11], highlighted scleral melting 16 years after pterygium excision with topical mitomycin C adjuvant therapy, thus making the procedure unacceptable. In fact Katirciođlu et al [12], found the graft techniques alone to be as effective as conjunctival autograft with mitomycin C. However, others [13,14], found the recurrence rates of amniotic membrane grafting unacceptably high. The conjunctival limbal auto-grafts have the least recurrence rates as highlighted by Jha et al [15] in this issue.

The Armed Forces Medical Services (AFMS) with a country wide network of hospitals can provide a helping hand to the Right to Sight India. It is worth a consideration that the AFMS should be a member of this forum, so as to participate in this national programme of reducing the burden of avoidable blindness.

References

1. Sharma YR, Sudan R. Community Ophthalmology. In: Concise text book of Ophthalmology. New Delhi: Elsevier 2007, 206-10.
2. Vision 2020 India News Letter September 2007. Article on Internet. www.vision2020india.org.
3. Tewari HK, Jose R, Bachani D, Murthy GVS, Gupta Sanjeev K, Azad RV. Vision2020: Right to Sight. CME Series No. 9. New Delhi. All India Ophthalmological Society.
4. Thulasiraj RD, Reddy A, Selvaraj S, Munoz SR, Ellwein LB. The Sivaganga eye survey: II. Outcomes of cataract surgery. *Ophthalmic Epidemiol.* 2002; 9 :313-24. Abstract on internet. www.pubmed.org.
5. Murthy GV, Ellwein LB, Gupta S, Tanikachalam K, Ray M, Dada VK. A population-based eye survey of older adults in a rural district of Rajasthan: II. Outcomes of cataract surgery. *Ophthalmology.* 2001;108 :686-92.
6. Nirmalan PK, Thulasiraj RD, Maneksha V, Rahmathullah R, Ramakrishnan R, Padmavathi A, Munoz SR, Ellwein LB. A population based eye survey of older adults in Tirunelveli district of south India: blindness, cataract surgery, and visual outcomes. *Br J Ophthalmol* 2002; 86 :505-12.
7. Park K. Health programmes in India. In: Park's Text book of preventive and social medicine. 18 ed. Jabalpur, Banarsidas Bhanot, 2005; 329-48.
8. Lingam G, Murthy KR, P Kathil. Surgical management of vitreo-retinal diseases. In: S Saxena, ed. Clinical practice in Ophthalmology. New Delhi: Jaypee Bros, 2003; 377-429.
9. Gurunadh VS, Banarji A, Ahluwalia TS, Upadhyay AK, Patyal S. Management of nucleus and IOL drop. *MJAFI* 2008; 64:315-6.
10. Dash RG, Boparai MS. Pterygium: Evaluation of management (primary & recurrent). *Indian J Ophthalmol.* 1986;34:7-10.
11. Wan Norliza WM, Raihan IS, Azwa JA, Ibrahim M. Scleral melting 16 years after pterygium excision with topical Mitomycin C adjuvant therapy. *Cont Lens Anterior Eye* 2006; 29:165-7.
12. Katirciođlu YA, Altıparmak UE, Duman S. Comparison of three methods for the treatment of pterygium: amniotic membrane graft, conjunctival autograft and conjunctival autograft plus mitomycin C. *Orbit* 2007;26:5-13.
13. Tananuvat N, Martin T. The results of amniotic membrane transplantation for primary pterygium compared with conjunctival autograft. *Cornea* 2004;23:458-63.
14. Luanratanakorn P, Ratanapakorn T, Suwan-Apichon O, Chuck RS. Randomised controlled study of conjunctival autograft versus amniotic membrane graft in pterygium excision. *Br J Ophthalmol* 2006;90:1476-80.
15. Jha KN. Conjunctival limbal autograft for primary and recurrent pterygium. *MJAFI* 2008; 64:337-9.