Free Eye Treatment Camp at Amarpurkashi

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Project Visitor from Oct. – Dec. 2005

10 o'clock Monday morning

Clusters of women and perhaps a dozen men squat on dusty rugs in the courtyard of Gramodaya Primary School, shielding their eyes from the sun. Across from them, a panel of three is seated at a large trestle-type table. A sign in Hindi announces 'Registration'.

Even at this early hour the sun is fierce, and the registration team soon move into the shade of the verandah. The sponsor arrives and we sit, quietly, watching. As a white, well-dressed, Western woman, I find myself the subject of scrutiny. Some mistake me for the doctor, or at least someone who can advise them as they queue to register.

The process of registration is simple: Name, Father's /Husband's Name, Village, Age, Caste. These details are taken down, and a scrap of A4 complete with waiting number is handed over. One by one, or more commonly in groups, the registered join the others to sit and wait for the doctors' arrival.

That the doctors have still not arrived by noon is seen as no cause for concern by the registrars. Later I am told, 'the doctors always arrive two or three hours late.' And so they do, four men and a woman, at around one pm.

A new wave of impatience runs through the crowd as someone takes charge of the microphone. Is it my number? Each one is summoned by forename and village for a basic eye-check. There are no special instruments here: operable cataracts can be identified straightforwardly by shining a torch into the affected eye.

Day Two

Armed with the important words, *daktor koee aur hai* - 'I am not the doctor' (lit. 'the doctor is another person)' I return to the school. Not content with my phrasebook vocabulary, this time I have engaged an interpreter.

My interviews begin with a young teacher from the primary school. Living in the nearby town of Bilari, Jyoti has been working at APK for the past year (presumably since finishing her own Intermediate education). What is the problem? Her eye is red, itchy. Aggravated by dust, it waters. She has had this trouble for a year or so, on and off. Bathing it with water has not resolved the trouble.

Maybe the doctor can do something.

As we begin to question another woman, who describes the symptoms of *modia bind* (cataract), we are interrupted by a fretful father. Again he wants to believe I am an expert, or that I have some power to advise. His son, Guljal, a small boy though his father estimates his age as 'eight or nine', had an accident six months ago. He was playing with a stick and some kind of splinter got into his eye. They have consulted a doctor in Chandausi who gave medicine (tablets) and eye-drops. Though these ease the pain, the boy's eyelid is shut tight. He rubs it and squirms as his father talks to us. It seems he hasn't been at school since the accident.

There are others too: Anissa, 60-something, probably needs a new pair of spectacles; Nasreem, 20, troubled with pain in her right-eye since she was a small girl; Hanipha and Munne Dabi who describe the symptoms of cataract.

Over the course of these two days, almost 500 people have a check-up. Eighty or so are identified for cataract operations. The others receive eye drops, and occasionally some advice: 'Go to the general hospital', 'Your cataract is not yet mature. Come back next time'.

We meet Guljal and his father again. The father is upset, angry. The doctor has told him that nothing can be done. Do *I* think this? The man is desperate to help his son. He has determined to go to Moradabad or Delhi to seek help. (It is only later that I realize the doctor is himself from Moradabad.) My translator thinks perhaps there is hope. How can we say otherwise?

Anissa, too, is disappointed. They only used a torch, she says. They only looked for cataracts. She feels rejected.

Cataracts

Cataracts account for half of blindness worldwide[i], but they are estimated to be responsible for nearly 80% of blindness in India [Taylor: 1999]. Europeans typically develop cataract symptoms in their sixties and

seventies. Asians begin to show symptoms more than a decade earlier, many during their working life [Wijenaike: 2004; cf. also Meyer et al: 2005].[ii] While by age 75, 25% of British adults will develop cataracts, 67% of over-70s in Punjab have cataracts in one or both eyes [Chatterjee et al: 1982].

Describing the typical impact of cataracts, the UK Department of Health web site instances the inability to read or drive. (viz. The luxury of being a literate pensioner, holding a driving licence, and possessing a vehicle.) The indirect effects of cataracts on a poor family in rural India may be significantly more serious. The sight loss of an adult can rupture the household economy, whether a breadwinner becomes another dependent mouth to feed or a grandmother is no longer able to provide primary care for the children.

That evening, setting up camp, relatives carry bed frames to the school. The women are to be accommodated inside the classrooms. But perhaps there is not space for all the beds. Can they sleep on rugs? As I pass through a doorway one woman reaches for the hem of my kameez, seemingly in the hope that I can do something for her and another woman who have missed the check-ups.

Day Three

The operations take place at the civic hospital in the nearby town of Bilari. Patients are ferried to and fro using a hired van. We join the project director in a visit to the hospital.

It is dark inside, but perhaps largely in contrast to the bright sunlight outside. The bars on the windows cause another observer to remark 'like a jail'. But it is cool.

Inside the operation room (no special garments required), we are invited to observe as the surgeon inserts a new lens into one patient's eye. (Was I the only one wishing I hadn't lunched quite so recently?) On the next bed a junior doctor is finishing off the previous operation. To one side a man appears to administer some kind of sedative. I ask what kind, but the answer – some mixture with adrenalin – means nothing to me.

The room is dimly lit, with three bare light bulbs strung across, one suspended over each bed. The steel bowl in which the instruments are laid is not the shiny sterile vessel I would expect to see in Britain. Despite the skill and dexterity of the surgeon – and his undoubted dedication for how else would one achieve 26 operations in a day? – the overall impression is of a conveyor belt as the patients are shuffled on and off beds.

In a nearby ward we observe half a dozen patients laid out, waiting for the van to bring them back to APK, each covered with the regulation red blanket. One is completely shrouded, corpselike, as if reality is too painful just now. Eyes bandaged. None of them is keen to speak. But a couple of relatives greet the project director with warmth.

For the next few days, the patients are accommodated as before in the school-rooms. Soft food and *chai* is prepared in the compound next door,. For the children, lessons proceed 'as normal', albeit on the school's roof rather than inside the classrooms.

Blindness in India

India is home to 23.5%[iii] of the world's 45 million blind [WHO:2002]. As we have seen, cataracts are the dominant cause. But what causes so many cataracts? Diabetes is one answer.

The chance of developing senile cataracts is 40% higher among diabetics when compared with non-diabetics [Wijenaike:2004].[iv] It is for this reason that six-monthly eye checks form part of the standard health monitor for diabetics in Britain. In contrast, a survey conducted in South India showed that only 6.7% of diagnosed diabetics living in urban areas had visited an opthalmologist [cited by Meyer, Changguan et al: 2005]. If we extrapolate from South India to North, from urban to rural, and from diagnosed to undiagnosed (more than 70% of diabetes is understood to go undiagnosed in rural India [Meyer, Changguan et al: 2005]), the very prospect of regular eye checks is fantastic.

The high incidence of diabetes among British Asians – they are 4-5 times more likely to develop Type 2 (adult onset) diabetes compared with British Caucasians – has occasioned a body of specialist research. The conclusions indicate that alongside lifestyle factors such as diet (excess of fats and sugars), exercise (absence of), there is a genetic predisposition to diabetes present in South Asians. [cf. Wijenaike: 2004]

The occurrence of diabetes among India's poor is lower than that in Britain's Asian community – a simpler diet and heavier workload act as mitigating factors. Unfortunately its effects and complications are significantly greater in the developing world:

"The urban poor in developing countries have a lower incidence of diabetes but a higher rate of complications associated with the disease, compared

with the urban poor of developed societies." [Meyer et al: 2005]

Exposure to other factors linked to development of cataracts also sets the rural poor at a disadvantage: prolonged direct sunlight, dust, cheap cooking fuels, and low protein consumption. Low socioeconomic status and illiteracy signal an enhanced risk of development. Expecting a landless labourer, the lowest wage earner in rural India, to restrict the number of hours spent working in the field, eat a more nutritious diet, or even choose better, more costly fuels, is simply not rational. The poverty itself must first be tackled.

Government Policy: Turning a blind eye?

The problems of eye health have not gone unnoticed by government. In 1995-6, the Uttar Pradesh administration launched a five-year plan specifically to target cataract-related blindness, with funding and support from the World Bank. As a result, the civic hospital in Moradabad (a 40km bus journey) provides free eye treatment for residents of the district, including Amarpurkashi and its surrounding villages.

But villagers don't take advantage of the standard services. Why? Because they know that the provision recorded on government paperwork is not all that it seems. In the words of Dr Jean Dreze, a sociologist based at the University of Delhi, "They will be poorly treated, pushed around *and* charged for it." (IJRS II.i.5 (19); emphasis mine.) In a city-based government hospital, villagers – perceived as 'illiterate peasants' - can expect to suffer worse discrimination than at a private clinic *and* face demands for payment from doctors desirous of a supplementary income. Low-level corruption is, sadly, ubiquitous in India.

Eye treatment at Amarpurkashi

Cataract operations have been a feature of APK's work since PN Sood first suggested (and sponsored) an eye camp in September 1987. The doctors' time, the operating room and expensive lenses are provided by the government. But sponsorship is necessary to cover the costs of medicines, the doctors' expenses, surgical supplies, publicity, aftercare and so forth.

Those treated via APK receive extensive attention post-operation. Food is provided, dressings changed and arrangements made for the doctor to visit. Medication to prevent infections is supplied free, and advice on avoiding hazards is given in careful simple language. Indeed, when I interviewed one patient, Karan Singh, two weeks on from the operation, it was this aspect he stressed: 'They took care of everything, distributing tea, the food…'

A recent article in a Bangalore newspaper provides a salutary comparison: eight patients (out of a total seventeen operated on) lost all sight in the affected eye following post-operative infections (Deccan Herald: 22/04/2005). Hygiene and good care are essential to any operation's success.

Of course the picture is not all rosy. The operation room in Bilari was not the super-sterile environment familiar from television serials. Outside the environs of APK, these vulnerable villagers were not always handled with the dignity they deserved. It was hard to watch as semi-conscious patients were bundled on and off beds. The journey to and from hospital was by no means a comfortable one.

And there are others not being helped. The joy of those recovering their sight could not diminish the disappointment of the hundreds for whom cataract surgery was not the answer. The funding at present is dependent on one-off donations. Eye camps are irregular and can only offer the most basic response to those not affected by cataracts.

A distinct health fund

For diabetic Hari Dhanoo, used to comprehensive six-monthly eye checkups on the British NHS, seeing the operations on cataract-sufferers in APK was eye-opening. It was at his instigation that a new health-care fund is now being established, with the specific aim of providing regular eye checks for the Amarpurkashi area.

It is the hope that in setting up a distinct fund, equipment can be bought to enable cataract operations to take place on site, under the implicit supervision of the Project Director. This equipment, particularly lighting, will also be used throughout the year by the project's health clinic. The existing check-ups will be expanded to include treatment for non-cataract problems, and should include preventative measures as well as palliative care.

Day Six

The doctor visited yesterday to change the dressings. Now the patients sit crouched in the school playground once again, receiving their instructions before each will be called in turn to receive protective sunglasses and medication. 'Any questions?' asks the speaker. A woman quickly raises her hand. Her question is simple. 'When can I have the other eye done?'

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[i] *HR Taylor, Epidemiology of age-related cataract, Eye 1999 13:445-8.*
[ii] *Dr Nishan Wijenaike, op cit. cf. also JJ Meyer, C Wung, D Shukla et al, op cit.*
[iii] *Information supplied by the World Health Organisation, 2002; cited in Opthalmology 2005.*
[iv] *Dr Nishan Wijenaike, Cataracts, www.diabetessuffolk.com (NHS web site) July 2004*

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