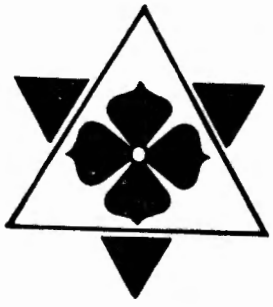
NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS – INDIA

GUIDELINES FOR ORGANISING EYE CAMPS

Sponsored by

Voluntary & Social Organisations/Institutions
and Hospitals
and for Grant for
FINANCIAL ASSISTANCE

(*Revised* 1987)



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PREFACE

A High Powered Committee, under the Chairmanship of Union Minister of Health comprising of Ministers of Health from States of Assam, Bihar, Maharashtra, Madhya Pradesh, Tamil Nadu, Uttar Pradesh assisted by technical experts, has reviewed and revised the existing guidelines and instructions issued by the Government of India in this regard from time to time. A summary of major recommendations is given below.

1. District Co-ordination Committees for control of blindness be set up where not yet formed. They shall plan, and coordinate eye care services in the district.
2. The District Chief Medical Officer shall exercise technical supervision on all eye camps held in the district.
3. Special care shall be exercised with regard to the selection of the site of operation theatre comples, methodology of sterilisation and other measures to minimise the risk of infection in the camps.
4. Technical guidelines for the actual conduct of the eye camp and for the operations should be made more specific in order to minimise surgical complications.
5. All eye camps shall be organised with the help of local Eye Surgeons, from within the district of neighbouring districts or state, as far as possible. Necessary training be organised for the local eye specialist for this purpose.
6. Arrangements for referal to government hospitals shall be made to take care of compliicated cases.
7. A code of ethics should be prepared for the voluntary organisations for the conduct of eye camps. To ensure better quality services to the people orientation Workshops have been proposed for Voluntary Organisations.
8. Constant supervision, evaluation and monitoring should be done to achieve better results.
9. The guidelines issued earlier under National Programme for Control of Blindness and recommendations of the Working Group on Control of Blindness will remain operative with the above mentioned additions and alterations.

The revised guidelines have been prepared on the basis of the above recommendations.

GUIDELINES FOR ORGANISING EYE CAMPS SPONSORED BY VOLUNTARY AND SOCIAL ORGANISATIONS/ INSTITUTIONS AND HOSPITALS, ETC., AND FOR GRANT FOR FINANCIAL ASSISTANCE (Revised 1987)

A. OBJECTIVES

Under the Scheme of National Programme for Control of Blindness, it is desired that the camps be so organised as to provide comprehensive eye care to the community in the rural and outreach areas. With this point in view, the aims and objectives of such camps should be:—

1. Educate people in methods of prevention of eye diseases and proper care of the eyes in order to ensure better and lasting eye-sight.
2. Provide medical and surgical treatment for the prevention and control of eye diseases including Cataract Operations.

B. FUNCTIONS

B

The main purpose of conducting such campsis to provide comprehensive eye health care services including preventive, promotive, curative and rehabilitative aspects. The functions therefore will be as under:—

1. Out patients' care — to examine all eye cases and provide treatment as out patients to cases not requiring admission. This will include proper arrangements for treatment of cases of refractive errors and ensuring availability of spectacles on reasonable cost.
2. Inpatients' care — to provide for admission of cases requiring surgery or treatment as indoor patients. This will include arrangements of a suitable operation theatre for safe surgery and also adequate post operative follow up of surgical cases.
3. Health Education of the community, with priority in schools, for observance of simple principles of personal hygiene, clean environment, nutrition and safety of eyes against injuries and diseases.
4. Screening of schools students and local community to detect visual defects and eye diseases especially Refractive Errors, Glaucoma, and those resulting from common systemic disorders.
5. Referral of eye cases requiring specialised care to institutions for adequate treatment/managment.
6. Arranging a follow up of the operated cases after 4-6 weeks of closing of the camp for examination, refraction and distribution of aphakil glasses.

C. ORGANISATIONAL ASPECTS

1. ORGANISATION OF EYE CAMPS

1.1 No camp shall be held without the permission of the competent authority.

1.2 The competent authority for granting permission to hold an eye camp, shall be the Chief Medical Officer of the concerned District, or his nominee. The competent authority shall

i) ensure that the voluntary organisation and the team of Eye Surgeons planning to organise the camp have the requisite experience for conducting such eye camps, and unqualified persons are permitted to operate in the camps.

ii) shall supervise the proper conduction of the eye camps and help to provide such assistance as may be required by the camp organisers, irrespective of whether they apply for financial assistance from the Government or other voluntary funding agencies.

1.3 Eye Surgeons conducting/performing operations shall preferably be from the same district/State. Eye Surgeons from other States may be permitted, provided the competent authority feels that eye surgeons with the requisite experience are not willing/available from the District/State, itself.

1.4 Ideally the number of operations performed in such a camp should not exceed 200, to be able to maintain the proper quality and safety of surgery sterilisation, and post operative care. However, the competent authority may permit such organisations who have experience of conducting bigger eye camps and have an adequate infrastructure, to hold camps to carry out more than 200 operations.

1.5 District Coordination Committees for the National Programme for Control of Blindness should be constituted where they have not been formed so far. The District Coordination Committee for the control of blindness shall play an active role for theplanning, programming and coordination for uniform provision of services and for successful organisation of the camp. The revised Constitution of District Coordination Committees is given at Appendix-I.

1.6 Local Ophthalmic Surgeons and doctors should be involved in the management and conduction of the camp to ensure long term post-operative care. This recommendation should be followed by all camps conducted by the Government mobile units or by the voluntary organisations.

1.7 Programme Officers should ensure coordination and cooperation between the Directorate of Medical Education and Directorate of Health Services to ensure efficiency and smooth functioning.

1.8 Various bottlenecks and constraints in the organisation of eye camps should be critically evaluated at appropriate levels and suitable measures adopted to eliminate them.

1.9 The State Health Directorates and the Central Coordination Committee should periodically review various issues brought up with regard to the organisation of eye camps, their critical evaluation and further recommendations.

1.10 Eye camp organising units:

a) Government Sector

i) Central Mobile Units
ii) State Mobile Units
iii) District Mobile Units.

b) Voluntary Organisations

i) Lions Club
ii) Rotary Clubs
iii) Zila Parishads
iv) Gram Panchayats
v) Others

c) Private Sector

i) Private Charitable Hospitals
ii) Nursing Homes
iii) Others.

2. REGISTRATION OF EYE CAMP ORGANISING UNITS

All such eye camp organising units shall apply with full particulars for registration to the competent authority, giving details of their experience, infrastructure and financial and manpower resources. No organisation shall hold eye camps in the community unless it has been duly registered with the competent authority. The registration may be withdrawn if the standards obtained are unsatisfactory.

3. PROCEDURES FOR PERMISSION TO HOLD EYE CAMPS

The permission to hold an eye camp shall be given on the application made on the prescribed proforma for this purpose (Appendix II.1).

4. FINANCIAL ASSISTANCE TO EYE CAMPS

4.1 Financial assistance from the Government is admissible only for such eye camps as organised in accordance with the guidelines laid down for the purpose and with the prior permission of the competent authority. In the camps the treatment of patients, including surgery, shall be free of cost.

4.2 Funds can be considered for release at the rate of Rs. 60/- per intraoccular operations subject to a maximum of Rs. 12,000/-. If the grantees are utilising the services of the mobile units provided by the Government financial assistance would be available at the rate of Rs. 40/- for per intraoccular operation. All Voluntary/Social Organisations are welcome to utilise the services of Government Mobile Unit.

4.3 The assistance under this scheme shall be offered in respect of the eye camps conducted in rural areas, towns with population not exceeding one lakh and in Metropolitan slums, subject to the following conditions:

a) Town with population between 50,000 and one lakh, where there is a Government Health Institution or mobile eye unit providing facilities for intraoccular operations under the National Programme for Control of Blindness, the services will continue to be provided by these institutions/units, and under the National Programme for Control of Blindness no voluntary organisation will be entitled to financial assistance for performing intraoccular operations in any eye camp organised by them in such areas.

b) In so far as the extension of the scheme to the metropolitan slums the authority sanctioning grant to voluntary organisations has to satisfy himself that the camp has actually been conducted in the slum area.

4.4 The Voluntary Organisations shall apply for assistance at the above rate on the prescribed proforma duly certified by the Ophthalmic Surgeon to the Chief Medical Officer of the District (Appendix II,2,3). The Scoial/Voluntary Organisation should certify that for the purpose of this camp for which financial assistance from the Government is being claimed, treatment of pateints, including surgery was done free of cost, and no financial assistance has been obtained or will be obtained from any other national or international agency.

A list of names and address of persons who were operated at the said camp for intraoccular operations is sent to C.M.O./Dy.C.M.O. alongwith the claim for financial assistance. The Chief Medical Officer/Dy. Chief Medical Officer will ensure that the eye camp was organised in accordance with the guidelines and follow-up of operated cases was done by the sponsors on ..... for examination, refraction and distribution of aphakik glasses. He should also record his recommendations with regard to the release of funds.

4.5 In cases of voluntary organisation drawing financial support from agencies other than the government, these agencies are required toensure that the organisers who approach them for assistance are cleared and certified by comptent authority in regard to the organisation of these camps.

5. RESPONSIBILITIES OF THE EYE SURGEON-INCHARGE OF THE CAMP

5.1 It is the professional responsibility of the Eye Surgeon to plan, implement and supervise the technical, component of the eye camp organisation; he must ensure that the required inputs are available for safe conduct of the camp.

5.2 The technique, drugs and instruments routinely used by the Surgeon at the base hospital should be used in the camps.

5.3 Informed constent should be obtained for all operations.

5.4 I.O.L., Keratoplasty and other major surgical procedures should not be performed in eye camps.

5.5 He shall inform the competent authority about any untoward happening in the camp and remedial measures taken by him.

5.6 He shall not be responsible for any untoward happenings which were not within his control.

5.7 He shall receive full protection from the government in the event of a mishap due to reasons beyond his control.

6. ADMINISTRATION, TECHNICAL SUPERVISION AND CONTROL

The Chief Medical Officer of the concerned district, as the competent authority, and other officers deputed for this purpose shall :

i) exercise administrative and technical supervision and control of the camp.

ii) allocate targets to the organisations, Mobile Ophthalmic Units and Ophthalmic Surgeons as a common responsibility.

iii) monitor atleast 20% of the camps held in his district and carry out surprise checks as may be considered necessary to ensure proper observance of guidelines.

iv) make the necessary arrangements for referal of all complicated eye cases which can not be treated in the eye camp, to the government hospitals.

v) recommend names for awards and other incentives as may be prescribed by the Central/ State Governments.

iv) have the power to investigate, pinpoint responsibility and take necessary action, as provided under the law in cases of complaints and mishaps.

vii) arrange for refresher/orientation training course for local eye surgeons and voluntary organisations wherever necessary.

7. MOBILISATION OF COMMUNITY RESOURCES AND SUPPORT FOR EYE CAMPS

A local eye camp committee should be formed in which persons interested in voluntary service and other officials and non-officials who can contribute to the success of the camp should be involved. The local committee shall be responsible for mobilisation of community resources and support and shall organise.

i) Fund collection
ii) Publicity
iii) Arrangements for Accommodation and food for patients
iv) Arrangements for the eye camp team of doctors and other
v) Volunteers and Social Workers
vi) Arrangement for the transport for carrying patients to and from the camp site.

2.4 It is not considered practicable to have medical or anaesthesia specialists in the camp situation. Cases needing general anaesthesia and special medical care should be referred to the base hospital.

3. DURATION OF THE CAMP

Eye camps should be held for a minimum duration of 10 days. Patients in the camps should be admitted at least 24-48 hours before the operations.

4. NUMBER OF OPERATIONS

Each surgeon must not perform more than 30 intraocular operations per day and not more than 50 intraocular operation should be carried out in a single day, in one O.T. set up. The surgical period may be phased over 4-5 days if so required. The patients should be kept for 4-5 days post-operatively. Special permission from the competent authority should be sought, with full justification, for handling more than 50 operations per day in the camp.

5. OPERATION THEATRE

5.1 For an eye operation camp, a minimum of one ophthalmic surgeon, 1 operation theatre assistant and 4 para-medical personnel are rquired.

5.2 It is advisable to have two eye surgeons and two operation theatre assistants.

5.3 The facilities of district hospital/district M.O.U./private practitioners, medical colleges and regional institutes in the form of more surgeons and para-medical personnel should be mobilised to provide better care to the patients.

5.4 The sterilisation of instruments, blunt as well as sharp is most crucial. It is ideal to use autoclaves for this purpose. Boiling of instruments may be carried out for sterilisation according to the prescribed norms.

6. STERILISATION IN OPERATION THEATRES

6.1 Sterilisation of operation theatre should be carried out as per standard techniques (Appendix II).

6.2 Strict asepsis of hands and isntruments must be adhered to. Masks, O.T. slippers and caps must be worn, by all people permitted inside the O.T. Excessive or unnecessary movement in the O.T. must be avoided. Unauthorised persons should not be permitted in the theatre.

6.3 Sterilisation of instruments should be done by an autoclave. If possible, resterilisation should be done by reautoclaving. Otherwise, by chemical sterilisation in Cidex for 10 min. followed by the instruments being dipped in rectified spirit and finally washed with boiling water in the steriliser. The spirit and boiling water should be changed after every 10 cases.

6.4 The number of sets of instruments should be atleast three times the number of operating tables. Details of sterilisation of operation theatres is given in Appendix III.

7. EMERGENCY SUPPORT

7.1 Arrangements to meet common emergencies should be available at the camp. For the management of serious emergencies, patients should be transferred to the nearest hospital.

7.2 The operation theatre should be equipped with life saving drugs and such equipment as can be provided at the eye camp for common emergencies (List enclosed Appendix IV).

7.3 A nursing station cum life saving and emergency unit should be established at a prominent place in the camp with provision for life saving drugs and equipments and electricity generator.

7.4 Fire fighting equipment should be made available at each camp.

8. STANDARDS FOR THE IN-PATIENT WARD

8.1 Separate wards are to be provided for male and female patients.

8.2 The beds should be numbered and regularly arranged.

8.3 Clean sheets should be provided for each bed.

8.4 Overcrowding should be avoided. A 25 sq. feet area should be allotted per patient.

8.5 Each ward should be kept under the charge of one worker. Other house keeping staff should help in catering and to provide other comforts to the patients.

9. CASE SELECTION FOR SURGERY IN EYE CAMPS

9.1 The camp surgeon should be very judicious in selection of cases. The nature of the surgery done at eye camps should be safe, simple and result oriented.

9.2 One eyed patients must be given special care and should be operated upon by the senior surgeon.

9.3 Operations on both eyes at a time should not be done.

9.4 The following cases should not be operated at the camp but referred to Base Hospitals:—

i) Eye with discharge/congestion or other complications.

ii) Very tense and psychic patients.

iii) Children, if general anaesthesia is needed for operation.

iv) Cases of poor surgical risk (severe diabetes, severe hypertension and those with cardiac problems).

v) Cases with a definite history of urinary problems.

10. REFERRAL

For those cases who cannot be treated at the camp site and those who develop complications, following surgery, it must be ensured that the base hospital admits them on priority basis.

11. PRE-OPERATIVE INVESTIGATION CARE

11.1 On admission for surgery, the following investigations should be performed:

i) Blood pressure

ii) Urine analysis

iii) Intraocular pressure

iv) Lacrimal sac patency test.

11.2 The eye to be operated upon should be marked (on the forehead, with mercurochrome).

11.3 Local antibiotics drops must be instilled in the conjunctival cul de sac, 6-8 times before surgery.

11.4 The patient should be given instructions regarding the operation and post-operative care.

12. ANAESTHESIA IN EYE CAMP

Premedication and local Anaesthesia for surgery.

12.1 Premedication should be given. The Surgeon, may choose the premedication of his choice.

12.2 Standard methods of anaesthesia are to be used i.e. topical, facial and retrobulbar blocks.

13. STANDARDISATION OF OPERATION TECHNIQUES

13.1 Standard scientific techniques which give best results in the hands of the camp eye surgeon, who should be qualified and have adequate experience should be adopted.

13.2 A minimum of three corneo-scleral sutures must be given.

13.3 Sub-conjunctival injection of antibiotics must be given at the end of surgery.

13.4 The surgeon/surgeons shall describe the usual procedure and steps followed by them for the cataract operation (Proforma at appendix V).

14. POST OPERATIVE CARE

14.1 Atleast one eye surgeon should stay in the camp till all patients are discharged.

14.2 Post-operative dressing:

i) The bandaging of only one eye is preferred.
ii) Use of the caretella shield is advocated.
iii) The first dressing should be done after 24 hours, and subsequent daily dressings should be done by the ophthalmic surgeon.

14.3 Medication:

i) Daily instillation of local antibiotic drops and ointments.
ii) Systemic antibiotics or chemotherapeutic agents are ordinarily not necessary as a routine, but should be given wherever indicated.
iii) Local corticosteroid usage should depend on the local eye reaction.
iv) Cough and constipation should be adequately managed.

14.4 Mobility:

The patients can be mobilised ordinarily after 24 hours. This warrants the application of more sutures at the time of surgery.

15. DISCHARGE FROM CAMP

15.1 The patients must be advised about dos' and don'ts and the post operative instructions should be printed on the discharge slips.

15.2 Topical antibiotics/Steriods and atropine drops/ointments are prescribed depending on the need of the individual patient.

15.3 Temporary aphakic glasses may be dispensed at the time of discharge or at the follow up camp.

15.4 The follow up date should be announced at the time of discharge of the patients.

F. CODE OF ETHICS FOR VOLUNTARY ORGANISATIONS HOSTING THE EYE CAMP

For the success of an eye camp, it is essential that voluntary organisation should be involved in identifying the need for holding an eye camp in a particular locality. It shall ensure that the minimum standards laid in the recommendations and guidelines issued by the Government of India, would be followed both in letter and siprit. In fact, it should take all measures to optimise the facilities and just not be satisfied by fulfilling the minimum standards laid in the document. It shall coordinate its activities with the local representatives and other local agencies and the Government and non-government officials. In the first instance, an invitation will be extended to the Central/district mobile units created for organising comprehensive eye care camps. In the case of their non-availability, it shall invite private doctors who have requisite expertise and are willing to abide by the guidelines issued by the Government. Additional help would be mobilised from the local medical officers and ophthalmic surgeons of the district.

The voluntary organisation shall take permission in advance from the competent authority as laid in these guidelines and shall depute some of its office bearers to be available at the camp-site round the clock till the last date of closing of the camp.

The voluntary organisation shall raise funds ethically and shall use them for the purpose of the eye camp only.

It shall provide all necessary drugs and other items including sharp instruments, suture material, aphakic spectacles or in lieu thereof provide lumpsum money for the purpose of the above items to the camp leader. It shall report the conduct of the camp to the competent authority within one week of its conclusion.

It shall immediately report any serious complication occuring in an epidemic form or any death to the competent authority. It shall mobilise and provide all possible help in case of any acute emergency in relation to the organisation and running of the eye camp.

It shall seek additional funds from the Government of India/State Governments or other established funding agencies like Royal Commonwealth Society for the Blind only in case they run short of money in mobilising their own resources for the conduction of such a camp. They shall submit a certificate to this effect when requesting additional funds.

Incentives, such as blanket etc. shall not be given to patients to attract them to the camps. Hygienic and light food such as milk and khichri only should be served to the patients in the eye camp.

DISTRICT CO-ORDINATION COMMITTEE

District Co-ordination Committee is formed for arranging and programming of eye camps in each of the Districts, with the full participation of thepeople, social and voluntary agencies. The composition of the Committee suggested in this Ministry's letter No. T.12020/8/77-Ophth. dated the 8th Feb., 1977 is reproduced below, with additions shown as(XX)

1. District Magistrate/Dy. Commissioner	Chairman
2. Chief Medical Officer/Civil Surgeons	Vice-Chairman
3. Representative of Rotary International	Member
4. Representative of Lions International	Member
5. Representative of the National Society for Prevention of Blindness, District Branch, if any	Member
6. Representative of the Indian Medical Association, District Branch	Member
7. Any other member(s) of the State Government – the Chairman may like to include	Member(s)
8. Any other voluntary organisation(s) institution(s), CONDUCTING EYE CAMPS and/or running eye hospitals	Member(s)
9. Professor and Head of the Department of Ophthalmology, of the local Medical College, if any, in the District	Member
10. Ophthalmic Surgeon of the District Hospital	Member-Secretary
(XX)	
11. Ophthalmic Surgeon of the Central/District Ophthalmic Unit	Invitees
12. Motivated social workers, philanthropists from the district by invitation	Invitees

Appendix-II.1

APPLICATION FOR PERMISSION TO HOLD EYE CAMPS

1. Name of the Voluntary Organisation/Hospital/Institution holding eye camp. If registered body under Societies Act of 1860 or similar enactment give Registration No. and State where registered.
2. Places, dates and duration of proposed eye camps

   Place : Village _____ Site _____

   District _____ Date from _____ to _____
3. Name of the Institution/Organisation, collaborating in the Camp.
4. Whether any financial assistance is being received from the State Govt./International Organisation like RCSB. OXFAM, Christofel Blinden Mission etc. for organising the proposed camp. If so, indicate the source and amount.

5. i) Funds proposed to be raised locally by the sponsoring authority for organising the camp

   ii) Financial assistance expected from the Central Government for the Camp.

6. i) Name and qualifications of the Senior Surgeon Incharge.

   ii) Names and qualifications of Additional Ophthalmic Surgeons attending the proposed camp.

   a)
   b)
   c)
   d)

7. Number of days the Ophthalmic Surgeons would be available in the Camp.

8. Appropriate number of the intra-ocular operations likely to be performed in each camp for which arrangements will be made.

9. Whether arrangement will be made for refraction and prescribing glasses.

10. Will the examination of school children be conducted in the areas where the camp is being performed.

11. Will the survey of the community be taken up for early detection of visual defects?

12. Record of the previous 5 eye camps organised with their duration and details of costs and number of intra-ocular (Cataract & Glaucoma) operations performed in each of the camp.

Place	*Date from*	*to*	*No. of Operations*	*Total Cost*
1.				
2.				
3.				
4.				
5.				

Signature and address
of the applicant.

SEAL

Dated

Permission Order No.

The _____ Institute/organisation is permitted to hold Eye Camps as applied with the specific condition that the camp will be organised in rural areas and supervised by Senior Ophthalmic Surgeon and the operations will be performed by the qualified Ophthalmic Surgeon and staff and that competent Ophthalmic Surgeon(s) would remain at the camp site throughout the duration of the camp till the last patient is discharged.

Place :

Date :

Signature
Chief Medical Officer/Dy. C.M.O.

4. Name & Qualification of the Operating Surgeon/Surgeons :

5. Total Number of patients,

   a) examined and treated :
   b) operated for Cataract :
   c) operated for Glaucoma :
   d) surgical operations other than those above :

6. Number of days on which operations were performed :

7. Were scalero corneal stitches applied for cataract operations? :
   If so, give average in each case. : 1 3 5

8. Was a follow-up clinic organised?
   If so, how many weeks after closing the camp date of follow-up. :

9. Whether glasses were prescribed and given, if so, whether on payment or free of charge. :

10. Whether Government-sponsored mobile unit was utilised for the conduction of this camp. :

11. The camp was organised in one of the area specified under the guidelines :

12. The treatment including surgery was rendered free of cost. :

Signature

Name and qualification of the Ophthalmic Surgeon in-charge of the Eye Camp

Seal and Date

Appendix-III

LIST OF LIFE SAVING DURGS AND EQUIPMENT

A. Life Saving Drugs

1. Inj. Avil 5 Amps.
2. Inj. Deriphyline 10 Amps.
3. Inj. Aminophyline 5 Amps.
4. Inj. Coramine 10 Amps.
5. Inj. Mephentine (10 Ml.) 5 Amps.
6. Inj. Noradernalin 10 Amps.
7. Inj. Adrenaline 10 Amps.
8. Inj. Atropine 10 Amps.
9. Inj. Soda Bicarb 5 Amps.
10. Inj. Calcium gluconate 5 Amps.

B. Life Saving Equipments

- Fire extinguisher
- Generator set
- Oxygen cylinder with regulator
- Suction apparatus
- B.P. Instrument
- Stethoscope
- Endotracheal tubes
- Laryngoscope
- Ambu bag
- Mouth gag
- Face mask for oxygen delivery
- Tracheostomy Tray.

Appendix-VI

PROFORMA

UNTOWARD HAPPENINGS AND COMPLICATIONS ENCOUNTERED IN THE EYE CAMP HELD AT_____ON_____

1. Cases in which surgery was postponed due to
   a) Retrobulbar haemorrhage –
   b) Severe reaction to pre-medication/anaesthesia –
   c) Serious drug reaction –

2. a) Number of patients who developed vitreous loss during surgery –
   b) Number of patients who developed haemorrhage during surgery –

3. Number of patients who developed post-operative

   a) Hyphaema –
   b) Iris prolapse –
   c) Iridocyclutis –
   d) Shallow Anterior Chamber –
   e) Bullous Keratopathy –
   f) Fetinal Detachment –
   g) Malignant Glaucoma –
   h) Endophthalmitis –

4. Number of patients who failed to regain vision due to other causes/complications –

Detailed List Enclosed

Sl. No.	*Name*	*Son of*	*Village*	*Complication*	*Ramarks*

Appendix-VII

REPORT OF THE OPHTHALMIC SURGEON INCHARGE OF THE EYE CAMP

No. of patients examined –
No. of refractions done –
No. of cases admitted –
No. of operations done –
   a) Cataract
   b) Glaucoma
   c) Other Intraocular (specify)
   d) Minor surgical procedures
      Entropion
      Pterygium

OPERATION THEATRE STERILISATION

Routine Method of O.T. Sterilisation

Routinely the operation theatre is sterilised in three steps.

1. Copious washing with water.
2. Fumigation with formalin vapours (30 ml. of 40% formalin dissolved in 90 ml. of clean water for 1000 cubic feet by aerosol spray). Keep the room closed for 6 hours.
3. Carbolisation with 2% carbolic acid.
   The disadvantage of this method is that it takes about 24 hours for the pungent smell of formalin and carbolic acid to go off.

Modern method for O.T. Sterilisation (R.P.Centre)

A new solution 'Aldekol' which contains 6% of formaldehyde, 6% Glutaraldehyde and 5% of Benzalkonium Chloride can be used for O.T. fumigation. For an average OT of 20' x 20' x 10' (4000 cubic feet) 325 ml. of Aldekol dissolved in 150 ml. of water and sprayed by aerosol for 30 minutes and keeping the room closed for 2 hours is enough for making the O.T.Sterile. Switching the fan/ aircondition/exhaust fan on for 1 hour clears the smell of the solution. O.T. is ready for use after 3 hours. This method is especially useful for O.T.Sterilisation in camps.

Cost of Oticare aerosol disinfactor	= Rs. 5500/-
Cost of Aldekol solution required for 4000 cubic feet O.T.Sterilisation	= Rs. 25/-

O.T.STERILISATION WITH OTICARE*/AUTOMIST**

By Aerosol Disinfection:

1. Principal of Aerosol disinfection: Disinfectants are most effective in their aerosol form. They have aerodynamic stability, hence they coagulate and falls only after several hours of emission. They permeate cracks and crevices of rooms and dissipate instantly and spread evently in the atmosphere. Formaldehyde (formalin) is highly lethal to all kinds of microbes and spores (air containing 2ppm of formalin produces 100% kill of all organisms in 180 minutes). It is economical and non-injurious to cloth, fabrics, wood, rubber, paints and metals.

*OTICARE : Climate Control Services Ltd.,
38, Sarojini Devi Road,
Secunderabad.

**AUTOMIST
Hatchwell Incubators,
5-9-42/A, 1st Floor,
Basheer Bagh, Hyderabad.

2. Methods of sterilisation using 'Aerosol disinfector' :
   i) ALDEKOL (R) : Contains (6% formaldehyde+6% glutaraldehyde + 5% Benzalkonium chloride). It is sprayed and room closed for 2 hours. An O.T. of area 4000 cuft. is finally ready *after 6 hours* i.e. after the fumes clear, and no neutralisation agent required.
   ii) Sterilisation technique using formalin : 90 cc of formalin + 100 cc H20 is atomised using 'OTICARE' atomiser. O.T. is closed for 6 hours and then the formalin is neutralised using Ammonia Liquid (90 cc) sprayed through the same machine. The O.T. is ready in 10 hours.
   Cost of formalin for 4000 cuft = Rs. 12.50 p.
   Cost liquid ammonia for 4000 cubic feet = Rs. 5.20 p.
   iii) Old technique for sterilisation formalin (2000 cc) is poured into a bowl containing 500 gms. KKNO4 crystals. The O.T. is closed for 24-48 hours. Additional 24 hours required for fumes to clear. Therefore O.T. ready in 72 hours approx.
   Cost of formalin = Rs. 102 for 4000 cuft.

PROFORMA TO BE FILLED BY THE EYE SURGEON REGARDING THE ROUTINE FOLLOWED IN GENERAL IN THE EYE CAMP

(Please tick the relevant clause)

1. No. of cases operated daily
   - Less than 25/25-50/more than 50
   - If more than 50, specify number _____

2. Pre-operative investigations
   - i) B.P. Yes/No
   - ii) I.O.P. Yes/No
   - iii) Test bandage Yes/No
   - iv) Urine albumin Yes/No
   - v) Urine sugar Yes/No
   - vi) Other (specify) _____

3. **Pre-operative preparation**
   - **i) Bath/wash face withsoap & water Yes/No**
   - ii) Cutting of eyelashes Yes/No
   - iii) Preparation of local area
     - a) On night preceding surgery Yes/No
     - b) Pre-operatively Yes/No
   - iv) Agent used
     - a) Mercurochrome Yes/No
     - b) Betadine Yes/No
     - c) Spirit Yes/No
     - d) Other (specify) _____
   - v) Pre-operative antibiotics (Local) Yes/No
     - if yes, mention name _____
     - frequency of drops _____
     - duration of treatment _____
   - vi) Pre-operative systemic antibiotics Yes/No
   - vii) Pre-operative pupillary dilatation Yes/No
   - viii) Other (specify) _____

4. Routine Premedication
   - i) Oral (specify) _____
   - ii) Injectable (specify) _____
     _____
   - iii) Glycerol Yes/No
   - iv) Mannitol Yes/No
   - v) Others (specify) _____

5. Anaesthesia
   - i) Xylocaine Plain/with adrenaline
   - ii) Marcain (bupivacaine)
     - a) Topical Yes/No
     - b) Retrobulbar Yes/No
       If yes, amount _____

c) Facial — Yes/No
If yes, amount _____
Site of Inj. _____
d) Ocular (digital) massage — Yes/No
if yes, duration _____
e) I.O.P. lowering device — Yes/No
if yes, specify _____

6. Visual aids used in surgery
i) Operating glasses/loupe — Yes/No
if yes, magnification _____
ii) Operating microscope — Yes/No

7. Conjunctival flap — Yes/No
if yes, — Limbl based/fornix based

8. Incision
a) Von Graefes' knife — Yes/No
b) Keratome – Scissor — Yes/No
c) Blade – Scissor — Yes/No
d) Others (specify) _____

9. Iridectomy — Yes/No
if yes, — Sectoral/peripheral

10. Lens delivery — Intracapsular/extracapsular
if intracapsular, — Cryo/Forceps/tunsbling
Others (specify) _____

11. Sutures Preplaced — Yes/No if yes, number
Postplaced — Yes/No if yes, number
if yes, material used
a) Absorbable/silk/nylon
– if absorbable (specify) _____
b) 6-0/7-0/8-0/9-0/10-0 _____
c) Eye ball/atraumatic _____
d) Exposed/buried knots _____
e) Interrupted/continuous _____
f) Conj. flap suture — Yes/No/Not applicable

12. Anterior chamber reformation — Yes/No
– if yes, air/saline/other (specify) _____

13. Subconjunctival injection — Yes/No
if yes — Antibiotic/antibiotic + steroid/steroid
Cycloplegic — Yes/No
Name and amount of antibiotic _____
_____
Name and amount of steriod _____

14. Local application
Antibiotic drops/ointment — Yes/No
Steriod — Yes/No
Cycloplegia — Yes/No

15. Bandage
    a) Unicular/binocular
    b) Number of days (specify) _____
    c) Others _____

16. Post-operative management
    a) Systemic antibiotic — Yes/No
        if yes, specify _____
    b) Local antibiotics — Yes/No
    Local sterioids — Yes/No
        if yes, frequency _____
    d) Atropine — Yes/No
    e) Pilocarpine — Yes/No
    f) Others (specify) _____
    g) dressings
        daily/alternate days (specify) _____

17. No. of days patient kept in camps following surgery _____

18. Medication at discharge
    a) Medicines issued — Yes/No
        if yes, mention name & amount _____
    b) Other medicines prescribed if any _____

19. Follow up — Yes/No
    if yes
    a) number od weeks after the camp _____
    b) Number of follow up visit _____

20. Suture removal — Yes/No/Not applicable
    if yes
    a) How many weeks post-Oper _____

21. Aphakic glasses
    a) temporary, issued at discharge — Yes/No
    b) temporary, prescribed at discharge — Yes/No
    c) issued at follow up visit — Yes/No
    d) prescribed + 10.0 (Not issued) — Yes/No
    e) prescribed as per refraction — Yes/No
    f) Others (specify) _____

22. Comments/Remarks

Signatures _____

Name _____

Qualification _____

Address _____

Chalazion
Foreign body removal
Others (Specify)

Procedures/routinely adopted for Cataract Operation
Appendix V

No. of Cases in which pre-operative, operative post-operative complications encountered
Appendix VI

Appendix-VIII

CHIEF MEDICAL OFFICER'S REPORT ON EYE CAMPS

District_____

State _____

Name/Place of the Camp
Taluka/P'H.C./Village

Number of Operations done
Intraocular
Extraocular
Total

Name of the Sr. Eye Surgeon/
I/c of the Eye Camps. Is he in
i) Private Practice
ii) Govt. Service
iii) Charitable Hospital
iv) Others (Specify)

Name and address of the hosting/
Collaborating Voluntary Organisation

Name of the funding agency
i) Local Voluntary Organisation
ii) State Government/Central Govt.
iii) R.C.S.B.
iv) Others (specify)

Eye camp inspection done — Yes/No
If yes by:
i) C.M.O.
ii) Distt. Ophth. Surgeon
iii) State Programme Officer
iv) Others (specify)

Report of the inspecting
Officer be appended

Mobile Unit used — Yes/No

Mobile Unit used Yes/No

If yes mark:

Central State Distt. Ophth.

Others (specify)

Total amount recommended as financial assistance Rs._____

SIGNATURE
State Programme Officer Control of Blindness

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