

# Application of Juran Trilogy and Triple Helix System for Successful Implementation of Service Projects – A Case of Rotary Eye-care Project

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## Abstract

District 3190 is one of the 535 districts of Rotary International, a well-established service organization in the world, covering revenue districts of Bangalore Urban, Bangalore Rural, Chikkaballapur, Kolar, Mandya, Ramnagara, and Tumkuru of Karnataka and Chittoor of Andhra Pradesh. During the last two decades, Rotary clubs in district 3190 have successfully implemented several Eye-care Service projects.

Dr Joseph M Juran (1904-2008) was a charismatic figure, acknowledged worldwide for his extensive contribution to quality management. While often referred to as one of the leading figures of total quality management, much of Juran's work actually preceded the total quality concept. He became a legend in his own time, and has been instrumental in shaping many of our current ideas about quality. He has explained his model of quality improvement on the basis of three universal processes which have been popularly named a Juran Trilogy.

Triple Helix systems provide a fine-grained view of innovation actors, relationships between them and knowledge flows within the system, in a vision of a dynamic, boundary-spanning diachronic transition between the Knowledge, Innovation and Consensus Spaces. Triple Helix systems accommodate both institutional and individual roles in innovation, and explain variations in the innovative performance in relation to the existence and development stage of the three spaces, the strength of relationships between them and their capacity to integrate various regional development strategies.

The case that forms the core part of this paper enumerates how a member of Rotary club, within the framework of the organisation, develops and implements eye-care project for the benefit of economically down-trodden, using principles of Juran Trilogy and Triple Helix System that have been evolved over years for meeting the challenges faced by businesses and government.

**Key words:** Rotary, Juran Trilogy, Triple Helix System, Service project, Eye-care, NPOs

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## INTRODUCTION

Social entrepreneurship has emerged over the past several decades as a way to identify and bring about potentially transformative societal change. (Osberg & Martin, 2015). Some definitions limit social entrepreneurship to non-profit organizations (Lasprogata & Cotton, 2003), while others describe social entrepreneurship as for-profit companies operated by nonprofit organizations (Wallace, 1999). Still others equate social entrepreneurship to philanthropy (Ostrander, 2007), while some scholars embrace broader definitions that relate social entrepreneurship to individuals or organizations engaged in entrepreneurial activities with a social goal (Certo & Miller, 2008; Van de Ven, Sapienza & Villanueva, 2007). Social entrepreneurship can also be termed as a process that can provide viable solutions to address some of the existing social problems with the main objective of improving access to services to special groups like economically backward or physically / mentally challenged, in chosen regions at ‘no cost’ or ‘low cost’. The Rotary Foundation (TRF), philanthropic arm of Rotary international (RI) provides financial grants to its clubs for taking up humanitarian projects in broad focus areas to support special groups in their community, within the frame-work of its ‘Grant Programs’.

RI is a voluntary organization of business and professional leaders who provide humanitarian service, and help to build goodwill and peace in the world. Currently there are over 35,000 Rotary clubs spread in more than 200 countries with a membership of over 1.20 million. The philanthropic arm of RI, TRF was initiated in 1917 as ‘Rotary Endowment Fund’. It was renamed as Rotary Foundation in 1928 and became a distinct entity within RI. Since 1947, after the death of RI founder Mr. Paul Harris, TRF has been able to mobilize substantial donations and had evolved several programs over the last five decades to support Rotary clubs or districts that take up humanitarian projects for the benefit of their local community. As members of RI are successful business leaders and professionals, some of them adopt ‘best business practices’ in developing and implementing such humanitarian projects.

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## **RELEVANCE OF BEST BUSINESS PRACTICES FOR NPOS**

While there is no single definition of “best practices” for each and every NPOs, there are well recognized ethical standards and accountability practices. Due to several challenges faced by the NPOs, there is a constant evolution of best “management practices” to understand and resolve the issues arising out of challenges, for them to remain sustainable. Hence, it is important for NPOs to understand and adopt the best “business practices” to ensure sustainability and be relevant to the community by delivering services in the chosen area.

### **Key challenges that most of the NPOs normally face are:**

1. Risk of reliance on external funding
2. Creating a ‘brand’ for itself
3. Expectations of donors and partnering organizations
4. Demonstrating value and accountability to donors
5. Promoting community engagement and leadership.

RI is a well-established international service organization which has been in existence for over 111 years with TRF being an independent entity, though an integral part of RI for its nearly 100 years of existence. Hence, TRF is able to attract annually over US\$ 250 million in the form of donations and on an average support nearly US\$ 100 million towards various humanitarian projects initiated by clubs around the world. Thus, challenges 1 and 2 listed above may not apply to Rotary clubs who plan to undertake major service projects within the frame-work established by TRF. It is important that clubs adopt well-established business practices like Juran Trilogy and Triple Helix, more to address the other three challenges so that the projects can become sustainable on a long term basis.

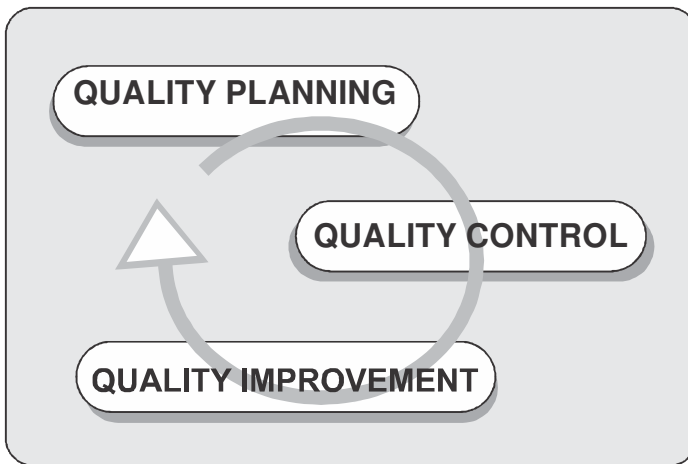
## **JURAN TRILOGY**

Joseph Moses Juran, (1904-2008), Romanian by birth, settled later in USA, was well known in the field of quality management for adding managerial dimension to quality. He adapted ‘Pareto Principle’ which is commonly referred to as the 80-20 principle. Its universal application makes it one of the most useful concepts and tools of modern-day management.

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Joseph Juran has explained his model of quality improvement on the basis of three universal processes – Quality planning, Quality control and Quality improvement which have been popularly named a Juran Trilogy. While the first two processes are self-explanatory, the third one is an approach which improves the level of performance of the process. This can be achieved by fresh ideas or innovation through technology or by bringing in new knowledge.

The three processes are seamlessly interconnected as shown in the schematic (Fig.1).



**Fig.1: Juran Trilogy**

## **SUSTAINABILITY AND TRIPLE HELIX SYSTEM**

Sustainability has to be approached within a perspective combining the environmental, economic and social dimensions. This thus implies that organizations, may it be business or NPO, should not only take into account traditional financial aspects, but environmental and social aspects for long term sustainability. This necessitates involving several experts from different domains to address varieties of issues to arrive at a cost-effective and optimal solutions. We are thus moving towards a new way of using knowledge in the economy – there is a shift from the ‘hands off’ linear method to an ‘assisted’ linear model of innovation with initiatives taken by triple helix coalitions (Ranga & Etzkowitz, 2013).

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**Triple Helix system can be defined as a set of**

1. Components (the institutional spheres like government, industry, NPOs with a wide array of actors)
2. Relationships between components (collaboration and conflict moderation, collaborative leadership, substitution and networking) and
3. Functions (processes taking place in what we label as ‘knowledge, Innovation and Consensus spaces)

Triple Helix systems accommodate both institutional and individual roles in innovation, and explain variations in the innovative performance in relation to the existence and development stage of the three spaces, the strength of relationships between them and their capacity to integrate various regional development strategies. Transcending sectoral or technology boundaries, Triple Helix systems focus on boundary permeability among the institutional spheres as an important source of organizational creativity, encouraging individuals to move within and in between the spheres and engage in recombination of elements to create new types of organizations. These effects are most relevant at the regional level, aiming to combine local resources for realising joint objectives and new institutional formats in any of the Knowledge, Innovation and Consensus spaces (Ranga & Etzkowitz, 2013). Thus, it is very important to look at resources, both monetary and knowledge, that are available from various sources and to apply them to solve specific social problems in an efficient way at the regional level.

### **EYE-CARE SERVICES TO THE RURAL AREAS AND URBAN SLUMS**

The problem of avoidable blindness rapidly escalating remained a major cause of concern in the Indian healthcare scenario for some time now. In a developing country the government alone cannot meet the health needs of all, owing to a number of challenges like growing population, inadequate infrastructure, low per capita income, aging population, diseases in epidemic proportions and illiteracy.

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Blindness has been recognised as an important public health issue in India. More than 12 million Indians are blind as against world blind population of 45 million. More than 80% of the blind can be treated as the major causes for blindness are Cataract, Refraction and Glaucoma (Exhibit 1).

Realizing this, Dr. Venkataswamy (1918- 2006) established an alternate health-care model- Arvind Eye-care system that could supplement the efforts of the government and also be selfsupporting. In 1976 he established in Madurai, Tamilnadu, a 11-bed eye hospital with 4 medical officers. Today it has grown into a nearly 3,600 bed operations spread over five cities in South India. The hospital works on Juran's 'Pareto Principal' of 80-20, which translates to 80% of the patients treated are poor, who cannot afford to pay or can pay very limited amount for their treatment, as against 20% of normal paying patients who can afford to pay as per prevailing market prices. On a similar basis, few more eye hospitals - Sankara Eye Hospital, Coimbatore, L.V. Prasad Eye Institute, Hyderabad have been established. During the last 25 years, these hospitals have received financial support, though in a limited way, for capital equipment or in the form of subsidy for the treatment of poor patients from local Rotary clubs through 'grants program' of TRF.

### **ROLE OF ROTARY IN AVOIDABLE BLINDNESS (AB) PROJECTS**

RI being an international service organization, operates in a systematic and structured manner like a corporate entity. An annual membership subscription is collected from its 1.20 million members who are part of one of 35,000+ clubs situated in communities spread over 200+ countries in the world. The organizational structure of RI is given at Exhibit 2. 535 Rotary districts are distributed across 34 zones based on geographical regions, while ensuring number of members is more or less equal in each zone. Each district has many clubs, varying from 60 to 150, representing generally a particular area in the city / region, with different membership strength and is headed by a Governor who represents RI. The Rotary club is the functioning unit through which RI implements all its programs.

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The club is headed by President, supported with a board consisting of a Secretary, a Vice- President, a Treasurer, a Joint Secretary and an administrator called as Sergeant at Arms and five directors representing five avenues of service – club service, vocational service,

community service, new-gen and international service. A Club has its own by-laws to determine the size of the board, weekly meeting day place, frequency of meeting, subscription, etc., generally developed to align with Manual of Procedures (MOP) established by RI.

TRF, the philanthropic arm of RI is an independent entity, having a well-structured system for raising funds from its members and others. TRF also has established a standardized framework to give grants to humanitarian projects initiated by the clubs in any of the focus areas. The six focus areas of TRF for supporting clubs through its ‘grant program’ are:

1. Disease Prevention and Treatment,
2. Basic education and Literacy,
3. Maternal and Childcare,
4. Water and Sanitation,
5. Economic and Community Development and
6. Peace and Conflict Prevention / Resolution.

As per the statistics available for our district (D 3190), in the last 25 years nearly 40% of the service projects undertaken by the clubs are under ‘disease prevention and treatment’ among the focus areas (Exhibit 3) and in that area, majority of the projects have been in the area of ‘Avoidable Blindness’ and ‘Children Heart Surgeries’. Rotary Club of Bangalore Koramangala (RCBK) is one of the 149 clubs in district 3190 and was established in 1986. Currently it has 52 members drawn from different vocations. The club has also established a trust in 2003 with the main objective of humanitarian service projects through raising funds from the club members, community and grants from TRF in compliance with Income Tax Act. The trust has six trustees, who manage the trust. Members who volunteer to develop and implement humanitarian projects that are beneficial to the community, propose the project highlighting the main objective, budgetary details and how funds will be raised to the

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trust and the same is also endorsed by the board of the club. A committee consisting of three members, headed by a senior member is formed to develop the project by assessing the needs of the community, identify and firm up donors (including applying for TRF grant) and right service partners for implementation of the project.

### **THE CASE**

Having worked in the Research and Development department of a premier Public Sector Undertaking for 11 years (1973-1984) after completing my graduation in Electronics and Communication, I ventured to become an entrepreneur. As part of business networking, I subscribed to become member of several industry associations. During May 1988 I was invited to become member of RCBK by one of my MBA class-mates, who was then employed with a major corporate. Thus, I joined RCBK in July 1988. Over a period of time, having served as member of the board in different positions, I was elevated to the position of President of the club in 2000-01.

During 2000-01, then RI President had announced a special scheme, by which any club in the world can partner with TRF by contributing a minimum amount of US\$ 1000 and it would be matched equally by TRF to enable the club to take up AB project for supporting Cataract surgeries of poor people at the rate of US\$ 20 per surgery. I visited a practising Ophthalmologist in the Koramangala community and checked with him about the feasibility of implementing such a project, as I just then had paid Rs. 10,000/- for the cataract surgery of my mother. Ophthalmologist said that it would be possible, as all his services and his hospital infrastructure would be free and the type of Inter Ocular Lens (IOL) that would be used will be less expensive compared to the one used for paying patients. He also suggested that eye screening camps in rural areas or urban slums should be organized to identify patients for cataract surgeries.

Our club's board discussed this and decided to conduct 2 camps – one in Chembenhalli village situated 18 Kms from Koramangala and the other in the Rajendranagar slums situated in Koramangala itself. After finalizing the dates, permissions from District Medical Officer was obtained to conduct Eye Screening camps. We engaged an auto with Public address



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system to announce about the screening camp in the village two days before the camp. Posters announcing the details of the camp were displayed at important public places and involved local village panchayat officials to motivate all the villagers to participate.

Typically on the camp day, the rural people who have come for screening are initially registered to collect the details like name, gender, age, address and type of job they do. After registration, the eyes of the person are checked by an experienced para-medical staff for possible eye-related problems. If any problem is identified, then the person is referred to an Ophthalmologist who in turn checks the person thoroughly with equipment for specific problem – cataract, glaucoma, retinopathy or any other problem. Once diagnosed with such problem, the patient is checked for general health conditions like Blood pressure to evaluate whether the he / she can undergo surgery. If their general health is normal, they are advised to come the camp location on a particular day so that they can be taken to the Eye hospital for surgery. At the eye hospital the patient is again checked for general health conditions like Blood pressure, Blood sugar, etc., to ensure that they are fit to take up surgery. After surgery, they stay at the hospital for a day or two depending on their condition and they are dropped back to their location by the hospital.

The camps were successful as we could attract over 1000 poor people to participate in screening and 102 cataract patients were identified and successfully operated at a very nominal cost of Rs.900/- cataract surgery. Few members of our club volunteered to make all the logistics arrangements for the screening camps, transporting the patients from the village to the hospital and back as well as arranging for another visit of ophthalmologist for post-operative check-up. The experience was very satisfying for all those who had participated.

During 2002-03, the District Governor nominated me as the Chairman for District AB committee. With the experience that I had gathered while organizing AB project as President of the club and with the availability of technology (internet and mobile), it was possible to motivate several club presidents to take up AB projects as well as to guide them. This resulted in more clubs in our district (nearly 30) supporting nearly 4000 cataract surgeries during that year.

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During November 2003 Rtn. Dr. Gabriel Minder, member of Rotary Club of Ferney-Voltaire, France who was appointed by then RI President to coordinate AB projects with World Health Organisation (WHO) on behalf of RI, visited Bangalore. He was keen in supporting AB projects in our district through his club as well as another club in Portugal in which he was an honorary member. This motivated me to understand details of 'Grant Program' of TRF. As per the frame-work established by TRF, the project hosting club should necessarily identify one or more International club(s), outside the host country to partner in the project with their contribution. TRF shall then contribute 50% of the contributions made by the clubs and 100% of the contribution given by the district from its designated fund\*, subject to a minimum of US\$ 15,000 and maximum of 200,000. I coordinated with 10 clubs in the district to collect funds, as well as with the two international partnering clubs. The whole process of eveloping the project proposal, application for TRF grant and obtaining the approval took nearly 5 months. Completed application for the grant was submitted to TRF in April 2004 and the same was approved in May and the amount was received in July 2004. The project was completed during March 2005 and the completion report was filed by May 2005.

During this process, I learnt to work with clubs outside the country, different eye hospitals for conducting out-reach screening camps, logistics of transporting the patients and treatment for cataract surgeries at the base hospital, understood cost involved for each of the processes and reporting to TRF as per their compliance norms. This project opened the window of opportunities for me to network with more clubs in Europe, UK and USA and seek their support for similar AB projects. Having been an entrepreneur did help me to apply 'best business practices' for developing and managing such AB projects. List of various AB projects initiated during 2003-16 in which I was either involved directly in developing and implementation or indirectly in getting required support for the project is at Exhibit 4.

While most of the AB projects were to support treatment of eye-related problems of poor patients, some of them were to fund capital equipment for the eye hospitals to improve the quality / efficiency of treatment. Thus, I learnt about emerging technologies for eye-care, that are cost effective as well as efficient. Being a researcher in the area of

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entrepreneurship and an entrepreneur, I was motivated to write case-studies about start-ups in the eye-health care in association with academics and this developed stronger association with equipment manufacturers and service providers.

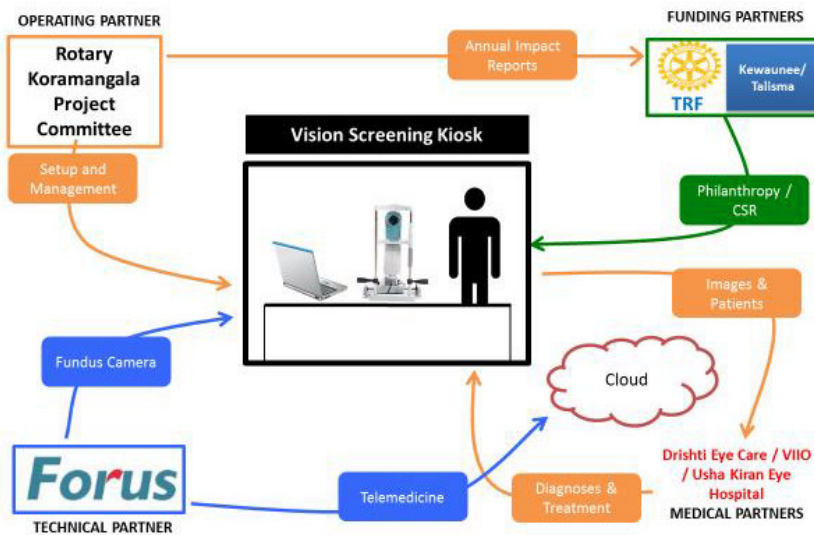
The process of identifying patients through screening camps involved lot of logistics management and availability of Ophthalmologist and paramedical staff who were busy otherwise in the hospitals was difficult. Having done several projects in this area for over 12 years and developed a network of Equipment suppliers, Technology Start-ups, Eye hospitals and Corporates, I could apply principles as enumerated in Triple Helix system. During 2015- 16, I developed a grant proposal with the support of six Rotary clubs in Europe and five Rotary clubs in my district to establish four Vision Screening Kiosks for rural areas where there was no eye-care facility. The project envisaged each Vision Screening Kiosk to be equipped with the required Screening equipment and accessories and all required infrastructure support for registration, storage of data / information and connectivity with the eye hospital.

Each of the kiosks shall be managed by an established eye hospital with their technical staff and an assistant. This kiosk shall also be connected through internet to the eye hospital so that tele-consultation can also be done with the ophthalmologist. The patients identified through these screening kiosks shall be transported by the hospital with their own bus or van to provide the required treatment either 'free-of-cost' for poor patient as it is subsidized by Rotary or as against any of the existing government schemes. The main objective of the project is to reach eye care services to the unreached, nearer to their homes. Thus, on any day, anyone can walk in to the Vision Screening kiosk to get their eyes tested without any charge.

To achieve this in a cost-effective manner, I had to identify the right stake-holders – Technology Start-up, Companies who are ready support the project through their CSR fund, Eye hospital who are ready to manage the vision screening centres at their cost and do treatment for a subsidized fee, to become partners of the project to make it a win-win-win proposition. As the project outlay was fairly big and TRF can fund only up to a maximum of 50% of the project cost, I had to also identify the

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right International partnering Rotary clubs outside India, apart from identifying local Rotary clubs / NGOs who can help in increasing the foot-falls for the Vision Screening Centres. This required not just ‘quality planning’ and ‘quality control’ but ‘quality improvement’ as explained in Juran Trilogy. This also involved connecting various institutions and resources for solving specific issue (providing free eye-care services) in a particular region, the principles as explained in ‘Triple Helix’ system have to be adopted. A schematic depicting the connectivity among various stake-holders is given in Figure 2.



**Fig. 2: Stake-holders Connectivity Schematic**

The four Vision Screening Kiosks are likely to be fully operational from January 2017 and can expect an average foot-fall of 15 - 25 persons every day. Thus, in a year each kiosk is likely to screen nearly 6,000 people and overall about 25,000. Apart from this, school children in the nearby areas shall also be screened in the centre, thus catering to 25,000 children. Based on the past statistics it is observed that nearly 10% of the adults above 50 years have cataract or some other eye-related problems and 4% of the children in the age group of 5 – 15 years screened, have some eye-related problem or other. Through this project Rotary will be

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supporting treatment of 3000 poor adults and 1100 poor children, free of cost.

An independent website giving all the details of the project and the reports of number of people screened, treated, type of problems for which they were treated, kiosk-wise and hospital-wise will be available for the donors and the clubs to view at any point of time. This should motivate more Rotary clubs and corporates to come forward in supporting the future treatment of poor patients, thus ensuring sustainability.

## CONCLUSION

Based on the above case, we can infer NPOs have as much responsibilities as companies to perform, adopting 'innovative' and 'best business practices' if they have to be sustainable. While companies have to continuously satisfy its investors and customers within the framework of government regulations, even NPOs have to continuously satisfy donors (CSR / TRF) on one side and beneficiaries (poor population) on the other side within the regulatory framework. Hence, it has become important to understand the best management practices of industry, so as to adopt them suitably for managing NPOs to ensure projects are sustainable on long term basis.

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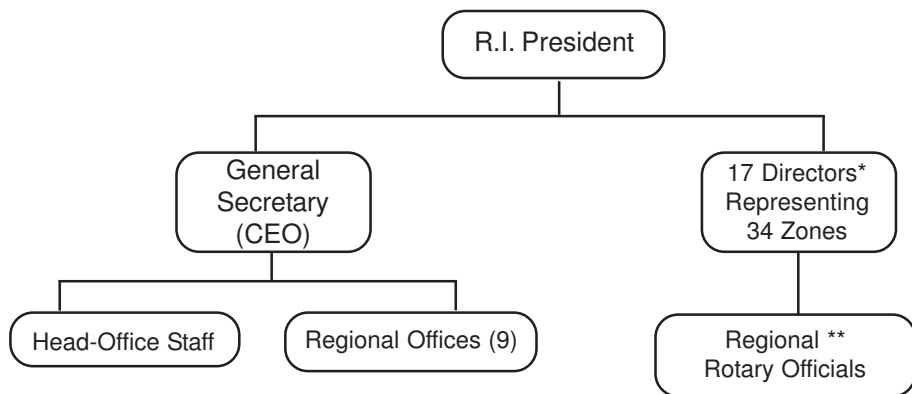
**EXHIBIT 1 TABLE GIVING DETAILS OF CAUSES OF BLINDNESS IN INDIA**

(presenting vision 6<60 in better eye)

Cause of Blindness	Percentage of Population
Cataract	62.40
Refractive errors	19.65
Glaucoma	5.83
Posterior segment causes	4.72
Corneal opacity	0.89
Posterior capsular opacification	0.89
Surgical complications	1.15
Others including phthisis/absent globe/amblyopia, etc.	4.47

(Source: British Journal of Ophthalmology, 2005, Vol.89, pp 257-260)

**Exhibit 2 Rotary International Organizational Chart**



(Source : www.rotary.org)

\* R.I.President is nominated for a period of one year by a nominating committee comprising of 17 Past R.I. Directors from the 34 zones, alternating every year.

\* There are 34 zones and 17 directors are nominated for a period of 2 years by a nominating committee comprising of Past District Governors representing each of the districts in that zone. Each zone shall be represented alternately in the board and in the nominating committee.

\*\* Regional Rotary Officials who shall be in-charge of certain functions like Membership Development, Public Image Building, Rotary Foundation will be nominated by R.I President in consultation with Zone Director from the pool of Past District Governors in that Zone.

**Exhibit 3 Service Projects implemented by clubs in  
Rotary District 3190 during 1991-2015**

Focus Area	Within D3190	Outside D 3190 (with in India)	TOTAL
Disease Prevention & Treatment	180	06	186
Water & Sanitation	72	01	73
Maternal & Child Health	34	02	36
Basic Education & Literacy	91	01	92
Economic & Community Development	80	15	95
<b>TOTAL</b>	<b>457</b>	<b>25</b>	<b>482</b>

(Source: Rotary Foundation of India, New Delhi)

**Exhibit 4**  
**List of AB Rotary Projects which were developed / supported by Dr. Ravikumar during 2003-2016**

Project Plan Rotary Year	Month & Year of completion	MG/ GG# or Partner	Purpose	Remarks
2003-04	May 2005	51695	1000 Cataract surgeries	1060 surgeries done
2004-05	June 2006	54210	900 Cataract surgeries	930 surgeries done
2004-05	Aug 2006	55300	2000 Cataract surgeries	2100 surgeries done
2005-06	Sept 2009	7061	6400 Cataract surgeries	6500 surgeries done
2005-06	March 2007	58385	Laser Equipment	Capital equipment
2005-06	March 2010	59138	1500 Cataract surgeries + 1000 Spectacles	1770 Surgeries done & 900 Spectacles given
2005-06	June 2006	59493	1100 Cataract surgeries	1144 surgeries done
2006-07	Aug 2009	63339	1000 Cataract surgeries	1060 surgeries done
2007-08	June 2008	65831	Retinopathy Equipment	Capital equipment
2007-08	June 2009	66303	2000 Cataract surgeries	2200 surgeries done
2008-09	June 2010	70652	3 Vision Screening Equipments	To support 3 Eye Hospitals Capital equipment
2008-09	June 2011	70901	2570 cataract surgeries	2650 surgeries done
2009-10	Aug 2011	SAP Labs	2000 Cataract surgeries	Gift of Vision Program (CSR)
2010-11	March 2012	SAP/NJ	1000 Cataract surgeries	Gift of Vision Program (CSR)
2011-12	Dec 2012	NJ	300 Cataract surgeries	Collaborated with NGO
2012-13	Nov 2013	CBI/NJ	225 Cataract surgeries	Central Bank of India (CSR)
2014-15	Jan 2016	14-18651	1600 Cataract surgeries + Screening Equipment	Capital Equipment + 1730 surgeries done
2014-15	Nov 2014	KSCI	Donation of SUV	Van to Support Out-reach Program of Eye Hospital
2015-16	Dec. 2015	NJ	25 Children Eye Surgeries	Completed in 5 months
2015-16	-	16-39012	3000 cataract surgeries + 100 Children Surgeries + Capital equipments for 4 Vision Centres	Under implementation