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FINAL REPORT

MATCHING GRANT PDC 1078



HELEN KELLER INTERNATIONAL
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I. INTRODUCTION

45 million of the world's people are blind; approximately 36 million of those blind individuals live in Asia, Africa and South America, where cataract (clouding of the lens of the eye), trachoma (chronic inflammation and scarring of the conjunctiva and cornea), xerophthalmia (dry eye and ulceration of the cornea) and onchocerciasis (parasitic invasion of the eye) are the four major causes of blindness. Glaucoma (increased intraocular pressure that destroys the optic nerve) and a long list of other serious disorders can also destroy or limit sight.

The technology to prevent or treat most eye disease is available. Experts estimate that 60 to 80 percent of all blindness could be prevented by general public health measures and the application of readily available, simple, cost-effective treatment. But simple ophthalmic technologies and eye care delivery systems that are accessible to people in most of the developed world are, for the most part, still not available elsewhere. Thus, developing countries representing 80 percent of the world's population are engaged in what, to date, can only be seen as a losing battle against the ravages of blinding diseases. Technology transfer has been inappropriate and incomplete; their ophthalmic health care delivery systems have not been widely integrated into the existing health care delivery systems; and trained personnel and financial resources are insufficient to address the magnitude of the problem.

Helen Keller International's matching grant was designed to address these problems. Its stated purpose was "to plan, implement and evaluate over a three-year period...programs that demonstrate the degree to which preventive, treatment and restorative services can be integrated into the delivery of primary eye care." HKI's matching grant program operates in selected areas of four diverse countries--Peru, Sri Lanka, the Philippines and Tanzania--to demonstrate what is required if the number of blind people is to be kept from a predicted doubling by the end of the century.

II. SUMMARY OF GRANT ACTIVITIES (8/1/81 TO 1/31/85)

A. General

Its first matching grant with AID can now be described as a watershed in HKI's history. That grant made it possible for HKI to consolidate its first decade of blindness prevention experience in Indonesia, Bangladesh and Haiti (all of which focused principally on xerophthalmia) and to move to a more comprehensive response to the challenge of avoidable blindness in additional countries where widespread eye disease and blindness are significant problems.

HKI, along with the governments of the countries in which it works and indigenous NGOs, has gone far to prove a significant point: that essential blindness prevention services, along with economic opportunities for blind people can and should be brought to millions of underserved people at low cost through use of existing structures.

The integrated approach, combining the delivery of eye care into existing primary level structures, developed and tested in matching grant countries have become central to HKI's full range of activities, shaping program objectives and strategies in all countries in which the agency operates, including Indonesia, Fiji, Bangladesh, Haiti and Papua New Guinea. Furthermore, integrated approaches have had effects beyond the borders of these countries by encouraging many other organizations and agencies to consider such programs.

The matching grant has also permitted HKI to establish a definite programmatic momentum. As will be seen in later sections of this report, the programs it supports are all well advanced. Already, significant numbers of primary-level workers who care for people in remote areas have been trained and equipped to recognize, prevent or treat diseases that destroy vision. Already, an expanded logistical and referral eye-care structure, adapted by HKI and its private and governmental counterparts, is available to

the four countries. In three countries, pioneering rural rehabilitation programs for the blind are thriving, bringing services to handicapped people for the first time.

AID's matching grant has also strongly influenced HKI's financial and institutional structure and capacity. HKI's financial growth over the past four years clearly demonstrates and underscores the positive impact of a productive partnership between AID and a PVO. From 1980 through fiscal year 1984, HKI's total revenue has more than doubled to nearly \$3 million annually. Within this amount, HKI's non-AID cash income has increased by more than 100 percent, from \$867,000 to \$2,000,000 annually. Clearly, our expanded programs, made possible by the matching grant along with active fund raising efforts, have attracted increased contributions from all sources, particularly individual and corporate donors.

The matching grant also impelled organizational changes at HKI. Throughout the three-year-and-five-month life of the grant, HKI has continually reviewed and changed its own agency structure to meet the demands of field implementation in matching-grant countries as well as in countries with other HKI programs.

During the first year of matching grant implementation, in 1982, HKI instituted a number of organizational changes to effectively carry out the broad-based, integrated approach described in the grant agreement. Experts from the field of public health, ophthalmology, education and rehabilitation--who had formed the more categorical focus of HKI's previous efforts in prevention, education and rehabilitation--were organized into Country Planning and Implementation Teams, which did pre-implementation research and developed country-specific plans of operation. As a result, HKI was able to move expeditiously into four countries where it had not previously been involved in eye care activity.

An implementation plan and operational framework were ready for Peru in the summer of 1982, on the schedule put forth in HKI's grant agreement with AID.

Field implementation began in Peru in September, 1982. In Sri Lanka, all preparatory research and an operational framework were completed in December, 1982; field implementation began in April, only one month behind schedule. HKI's entry into a third country, projected originally in HKI's proposal to AID for the final months of the matching grant in 1984, was advanced a full year when implementation began in the Philippines in July, 1983. Finally, HKI's Tanzania implementation was scheduled to begin in April, 1983. Because of circumstances beyond HKI's control, it in fact got started six months behind schedule in November, 1983.

At the end of the second year of the matching grant, with actual program implementation under way in three countries and about to begin in the fourth, HKI's central matching grant effort moved from the realm of planning to direct support of field activity. Personnel were interviewed and assigned to field offices in Peru, Sri Lanka, the Philippines and Tanzania. At this point, HKI took a number of other significant actions at the central planning level. Two new program support officers, Susan McMahon (M.A. Medical Geography/African Studies) and Sonia Brown (M.S. Education) were added to the headquarters staff. The role of the Country Planning and Implementation Teams diminished in favor of a Matching Grant Management Team (MGMT) consisting of the Associate Director, a Senior Program Officer, HKI's Financial Officer, and the Program Support Officers. The MGMT took responsibility for the overall central management of the programs and developed procedures for monitoring and documenting progress toward project objectives and for financial accounting of project inputs.

Another significant institutional change was the addition to the HKI staff of a second medical advisor, Louis Pizzarello, M.D., M.P.H., a public health ophthalmologist on the faculty of Columbia University, who joined Alfred Sommer, M.D., M.S.P.H. of Johns Hopkins University. Drs. Pizzarello and Sommer worked with both central office and field staff in developing baseline assessments and translating this information into carefully targeted programs. Both men also met regularly with the MGMT to review reports from the

field as well as requests for drugs, supplies and equipment. These same reports and requests were also regularly sent to HKI's volunteer consultant ophthalmologists (recruited from the ranks of the American Academy of Ophthalmology). This review process ensures that multiple expert opinions were considered as policy and procurement decisions were made by headquarters staff.

Finally, an important need in primary eye care efforts was the development of appropriate education and training materials. A health education consultant (Jeannette Simmons, D.Sc. and Professor, Department of Community and Family Medicine, Dartmouth Medical School) with extensive experience in the development of curricula and training materials was recruited to work with HKI headquarters and field staff. Her initial reports guided a decision to hire a full time curricula/materials development expert. Victoria Sheffield, a Certified Ophthalmic Medical Technologist with 14 years experience in the design and implementation of blindness prevention training, was added to the HKI staff. Ms. Sheffield working with HKI field staff and local counterparts designed materials specifically for use in the matching grant countries. These are now being developed into generic prototypes that can be readily adapted for use in a wide variety of settings, both by HKI and other agencies involved in the development of primary eye health care.

B. Country-Specific Implementation: End of Grant Status

The elements of HKI's matching grant programs in each of the four countries were essentially the same. In each, the principal activities included:

- assessment of eye disease;
- development of curricula, training and public education materials;
- training of health and allied personnel;
- provision of curative and surgical services at secondary and tertiary level functions;
- logistical and administrative support, including appropriate equipment and supplies.

The purpose of the program in each country was to demonstrate a cost-effective, high-standard, primary eye care program integrated into the existing general health care structure at all levels (see Logical Framework, Attachment I). Sensitivity to local health care infrastructures necessitated varying approaches to accomplish this purpose. Also considered were the number of ophthalmologists and other specialists available in the system, the nature of prevalent eye diseases, population density and so forth.

The following is a summary of the eye care program and the status of project implementation in each of the four matching grant countries as the matching grant ended in January, 1985.

PERU

Field implementation began in Peru in September, 1982. John Lynch (M.Sc., Sociology and Education), who has teaching experience at Perkins School for the Blind, Gallaudet College and overseas experience in Fiji and Colombia, serves as HKI Country Director. He has been joined by Armando Becerra, a Peruvian physician with a specialty in administration and 19 years, experience with the Ministry of Health. HKI's Peru effort supports the programs of both the Ministry of Health, Center for Ophthalmology and that of a Peruvian non-profit agency, OPELUCE, to promote and strengthen the delivery of eye care and rehabilitation services.

HKI activities in support of the government's program concentrate on three diverse rural departments, one in each of Peru's three topographically distinct regions--jungle (San Martin), mountain (Puno) and Pacific Coast (Ancash).

Summary of Accomplishments

Assessment

A prevalence survey completed in Puno in the fall of 1983 identified definitively the eye diseases the joint HKI-Government program needed to address. The survey, designed with the assistance of Johns Hopkins University, Peru's National Institute of Statistics and IBM/Peru (which donated computer time), was the first in Peru to cover a scientifically selected sample of the rural population and the whole spectrum of eye diseases. The results were startling. Over 3 percent of the individuals examined had functional low vision (20/200 or less); 1.5 percent were blind. The assessment also found large-scale refractive errors in the area and a high rate of night blindness, a sign of vitamin A deficiency among children. The survey indicates that the chief causes of avoidable blindness are cataract, glaucoma, corneal opacities and infectious diseases.

Development of Curricula, Materials Development
and Public Education

Training courses using specially developed curriculum training modules for rural Peru were designed for health workers at all levels of the health structure and for rural teachers. Training was conducted by residents and staff ophthalmologists who traveled to all three areas for periods of three to five days. The duration of training for various categories of workers:

Primary School Teachers	1 day
Factory Auxiliaries	2 days
Health Auxiliaries	5 days
Nurse Supervisors	4 days
General Practitioners	3 days

The original HKI-developed manuals and materials were field tested and revised for use in the training programs. Those currently being used consist of the following:

- Primary Eye Care Manual - Sanitarios
- Primary Eye Care Manual - Health Auxiliaries in
Factories and Mines.
- Primary Eye Care Manual - Elementary School
Teachers
- Manual and Workbook for General Practitioners
and Pediatricians (Guide for Development of
Actions of Blindness Prevention)
- Color posters and charts
- Teaching slides for course participants.

The manual for primary level workers includes sections designed to be used in conducting public education classes in schools and among villagers. These classes concern nutrition, preventive measures, the need for treatment of eye emergencies and encouraging adults with cataract to seek surgery.

Working with OPELUCE, HKI also developed public education messages for use in theatres and on television concerning eye safety, detection and

treatment of glaucoma, and promoting recognition of the abilities of the disabled. A weekly public education radio program was launched in Puno to advise the public, in Spanish and the two Indian languages, about eye care programs, how-to advice about prevention and information about where and when eye surgeons will be available for consultation.

Training of Health and Allied Personnel

As of January, 1985, a total of 1,356 personnel, at various levels of the health care and social services system, had been trained in eye care and were working in the three demonstration areas, which have a total population of 1.5 million.

Treatment and Referral Network

Secondary level ophthalmic care is now available in all three target areas. None had qualified eye surgeons or ophthalmic nurses three years ago. Two--Puno and Ancash--now have full-time ophthalmologists backed by trained technicians. All three areas are also regularly (once every two months) served by visiting teams of two or three surgeons and one or two nurses from Lima who run one-week eye care campaigns.

From February 1984 to January 1985 (the first period in Peru during which the data collection systems was fully operational) in the three rural areas served by the project 27,372 patients were received or served at the primary level. Rural teachers and health auxiliaries conducted 17,000 visual acuity screening examinations and the auxiliaries diagnosed, treated and/or referred over 2,600 cases of conjunctivitis, 560 foreign bodies in the eye, 120 cases of corneal luecoma, 180 cases of corneal scarring and erosion, 558 people with cataracts, 60 people with penetrating injuries, 98 cases of burns, 1,157 new born children with conjunctivits and 210 patients with trachoma.

People seen in the system, as delineated in the 11 month reports, consist of 1.5 percent of the

population of the target area. Of these, approximately 27,000 people were seen at the primary level, 4,895 received attention at the secondary level. Finally, at the regional hospitals in the three areas 2,012 people were referred from the rural network of trained personnel, including 440 who underwent surgery. Finally 221 patients with difficult diagnostic or treatment problems were transferred to Lima for specialized care.

Equipment and Supplies

Chapter No. 1
Trained Personnel Peru 1983-1984
by Occupational Groups

Occupational Groups	Until 1983	1984	TOTAL
General Doctors	61(1)	37	98
Supervisory Nurses	11	110	121
Health Auxiliaries	66	161	227
Factory Workers	--	80	80
Primary School Teachers	--	831	831
TOTAL	138	1,219	1,357

(1) Includes 52 General Practitioners who participated in the Course of Ophthalmology in Puno, 1982.

HKI provided in ophthalmic equipment and surgical instruments to the tertiary hospital in Lima, regional

hospitals in the three demonstration areas and clinics, as well as simple equipment--tweezers, magnifying glasses, eye shields--to trained paramedical workers. HKI has also provided 2,000 eyeglass frames to the project. This latter in-kind donation by a U.S. ophthalmic company will be used to provide spectacles at minimal cost to hundreds of indigent patients.

Evaluation

The Peru program was evaluated by a team consisting of Dr. Alfred Sommer of Johns Hopkins International Center for Epidemiology and Preventive Ophthalmology and Dr. Bjorn Thylefors, the Director of the WHO Blindness Prevention program, Geneva. This evaluation was submitted to AID in September, 1984.

Community-based Rehabilitation of the Rural Blind

In the Department of Ancash, HKI and OPELUCE are running a pioneering community-based rehabilitation program. Initial training of field workers was done in January, 1984. The program is staffed by an enthusiastic group of 11 workers who have identified 106 blind persons in need of rehabilitation services and are currently providing intensive rehabilitation services to 85 of these individuals.

Conclusion

In Peru, the program is fairly well advanced. The government, which does not yet have a specific blindness prevention priority reflected on its national plan, has encouraged its Center for Ophthalmology and OPELUCE, both supported by HKI, to demonstrate what can be done in terms of eye care. During the last year, the HKI program showed enough promise to encourage the Ministry of Health to form a National Committee to deal with eye care and develop a national plan for the prevention of blindness. The HKI-supported Peru program has, for the first time in Latin America, set up an eye health infrastructure in rural areas--the primary level backed by a referral

network, fully equipped and staffed by ophthalmologists able to deal with eye disease, prevention and treatment. At the terminal point of HKI's matching grant the Government of Peru, the Pan-American Health Organization, WHO, the Pan-American Congress of Ophthalmology and other Andean countries are beginning to recognize the full range of primary eye care possibilities.

PHILIPPINES

Jeffrey S. Watson (M.S., Health Education) serves as Country Director in the Philippines and has been responsible for guiding the implementation of a successful program in blindness prevention and rehabilitation activities in the Bicol region since July, 1983. Formerly a Peace Corps volunteer in the Philippines and a health education specialist on contract to USAID, Mr. Watson has effectively collaborated with regional health officials and with the Institute of Ophthalmology to provide primary eye care training to rural health workers and to bolster the existing referral system for treatment of eye disease.

HKI activities focus on two provinces in Bicol, with a combined population of 1,750,000. The program provides eye health training and an eye care referral network for the primary level network serving the Bicol Integrated Health, Nutrition and Population project, formerly supported by USAID.

Summary of Accomplishments

Assessment

A prevalence survey was conducted in 10 barangays from September through October, 1983. It revealed that cataract, infectious eye disease, vitamin A deficiency and low vision constituted significant conditions which the HKI primary eye care program needed to consider in planning future activities. Survey results highlighted a need in the Bicol region for more eye health education, increased curative facilities and better access to curative eye services to reduce higher than average prevalence rates--a rate of 2.75 percent using the U.S. standard of blindness equal or worse than 3/60 in the better eye. Of this overall rate cataract accounted for 4.35%, infectious eye disease 3.75 percent and vitamin A deficiency 3.25 percent. Additionally, plans were formulated to aid persons with low vision (4.75 percent) and to expedite the provision of spectacles for those with significant

error of refraction (22.3 percent)

Development of Curricula, Training and Public Education

Materials

Materials developed specifically for the Philippine setting with technical support from HKI include:

Teaching Aids

eye anatomy and function learning boards
anatomical eye models (made of coconut by handicapped individuals)
flannelboard eye disease chart
primary eye care slide show
transparency set
blindness simulation kit
case study cards
training evaluation forms
silk-screen vision screening charts
silk-screen community education flip charts
pre post tests and training-evaluation forms
skills monitoring checklist
case study cards
games and fun learning activities
training manuals for trainers, primary workers and nurses and general physicians

In the field of public education, health workers have been provided a monthly Eye Health Care newsletter, primary eye care pamphlet, posters and calendars to use among the general public. In addition, HKI has developed and broadcast by radio, songs and jingles conveying the importance of the abilities of primary care workers in treating conjunctivitis, nutritional blindness and other simple problems.

Training of Health and Allied Personnel

During the grant period, over 950 individuals have been trained as follows:

Regional Trainers	6
Provincial Trainers	15
Rural Health Physicians	54
Public Health Nurses	56
Barangay Health Aides (BHAs)	405
Rural Health Midwives	388
RRB Workers	17
Operating Room and Ward Nurses	7

In addition, HKI sponsored the participation of Dr. Evangeline Olivar Santos of the Philippine Institute of Ophthalmology in the Community Eye Health Course, University of London, from June through November, 1984, to broaden her knowledge of public health ophthalmology and community aspects of eye health care. With this global perspective, Dr. Santos will serve as a national link in the Philippines for future development of an institutionalized, country-wide program of eye care.

Treatment and Referral Network

Health and allied personnel have been trained to treat as well as refer cases (Figure 3). Barangay Health Aides (BHAs) and midwives work confidently in the community and are treating simple cases of infection, allergy and xerophthalmia as well as providing first aid for eye injuries. Patients with other conditions (e.g. cataracts, pterygia, trauma, painful red eye) are referred to the Rural Health Unit (RHU) for treatment by general physicians and nurses. Beyond this level of care is the hospital out-patient facility, staffed by physicians with ophthalmology training.

Since July, 1984, over 400 patients were treated at the barangay health clinics (cases of conjunctivitis, vitamin A deficiency, removal of foreign body); 252 were referred to the secondary, or RHU, level. Eighty cases were referred from the RHU to the hospital eye clinic. Cataracts accounted for two-thirds of the cases treated at hospital (N=56). In seven months, almost 1000 patients were seen and

treated or referred because of HKI involvement in the area. The success of project activities has influenced RHU and hospital based these doctors to become more involved with follow-up of post-operative cataract patients, even though they remain busy with private patients.

Since private physicians are only available a few hours a day at public hospitals to patients with cataract and other serious conditions who are referred from village and municipal health centers, HKI has arranged monthly clinics using the services of ophthalmic surgeons from Manila (Institute of Ophthalmology) to meet the needs of indigent cases. A total of 312 operations have been performed with 80 percent (n=91) being removal of cataracts.

Equipment and Supplies

At the primary level of care, eye care kits have been developed and made available to primary and first level referral workers. These contain diagnostic materials as well as vitamin A capsules and tetracycline eye ointment. To bolster the secondary and tertiary levels of the delivery system, HKI has furnished over \$55,000 worth of equipment and supplies including a slit lamp, three complete sets of cataract instruments, two ophthalmoscopes, tonometers, 80,000 vitamin A capsules, 11,000 tubes of tetracycline, sutures, medications and cryoprobes for cataract removal, 1,500 eyeglass frames and 200 sets of aphakic lenses.

Evaluation

Project activities were evaluated in September, 1984, by a team from Management Sciences for Health (MSH) and HKI. At that time, although conclusions concerning project impact could not be made since the project was still in the early stages of implementation, it was clear that the methods and materials employed to integrate primary eye care into primary health care training, services and referral had been successful and appropriate. The skills and status of community health workers have been

strengthened to provide care at the village and secondary clinic level. The MSH evaluation report was available for internal circulation in January, 1985.

Community Based Rehabilitation of the Rural Blind

In the Bicol region, 17 Rural Rehabilitation of the Blind workers have been working through the Ministry of Social Services and Development (MSSD) serving 42 clients. As a result of their further training in primary eye care during the past year, four of their clients were referred for successful cataract surgery. A spin-off of the primary eye care activities includes an interest on the part of MSSD to explore the use of the Intermediate Technology Lens Grinder to produce low-cost eyeglasses as a joint private sector/MSSD-HKI venture. Furthermore, RRB clients have been organized to produce eye shields, swabs and bandages for use in the eye care program.

Conclusion

In its Philippines program HKI has developed, and is now field testing, the most innovative materials, manuals and visual aids available anywhere in the world for eye care outreach programs. Of particular value has been a primary eye care kit for distribution to primary health workers as they leave basic training. The kit contains everything needed by the primary worker to serve and educate his or her patient population (didactic review information, medications, bandages and public education materials).

The program situation in the Philippines is similar to that in Peru, with one crucial difference. The Philippines has long had eye care incorporated in its national health planning documents but, until HKI arrived, had done little to implement such programs. Now, with HKI's stewardship and support, the Philippines has an active primary-level training program in one area, Bicol, soon to be extended to Panay. Also there is an active group in the Ministry of Health considering national eye care needs.

SRI LANKA

Field implementation began in Sri Lanka in April, 1983. Susan Eastman, (MPH Public Health and M.A. Communications) with sixteen years experience with World Bank, Michigan State University and HKI in health programming, serves as Country Director.

In Sri Lanka the venue for HKI's primary eye care and rehabilitation effort is in Kurunegala District, which has a population of 1.2 million.

The institutional umbrella and primary vehicle for HKI's Sri Lanka program is the Ministry of Health and the country's largest PVO, the pioneering Sarvodaya Shramadana Movement, with its network of community and district staff working in the field of education and public health. These are the focus of eye care training at the primary level, along with key Ministry of Health personnel--general practitioners, nurses, etc.--who staff Kurunegala clinics and regional hospitals. Some training for Sri Lankan Ayurvedic practitioners (traditional healers recognized by the government with their own Ministry) active in the project area is also being considered. Finally, the HKI project is continuing to support specialized employees of Sarvodaya working to rehabilitate blind individuals.

Summary of Accomplishments

Assessment

In September, 1983, a prevalence survey was conducted. It included 2,125 ocular examinations and 3,700 individual interviews to obtain social data. The overall blindness rate in the target area, based on WHO blindness standards, was 1.1 percent; using U.S. ophthalmological standards the rate was 2.2 percent. The principal etiology was cataract; other causes were glaucoma, uncorrected aphakia and macular degeneration, corneal opacity, retinal scar and refractive error.

Development of Curricula, Training Materials and Public Education

HKI's program in Sri Lanka has included training at many levels. Initially, the eye surgeons and nurses posted in Kurunegala's hospitals were given eight days of refresher training at the tertiary center in Colombo. This was followed by the training of medical health officers who were provided ten days of apprenticeship training with eye surgeons in Kurunegala's two hospitals. Three-day training sessions were then given to assistant medical practitioners using training manuals and slide sets developed by HKI. Thus, a complete set of hospital and clinic based personnel to staff the eye referral network and support the training of community-based workers has been provided.

These community-based workers were trained in three-day field sessions. Included were public health staff and special education teachers of the three MOH areas of the project. The central training aid was a thirty-page manual on blindness prevention and primary eye care developed by HKI. Finally, using a combination of the trained personnel listed above as trainers, community volunteers were trained in sessions lasting for two days. Instructors used a lesson guide, manual, flipchart and two posters developed by HKI. Volunteers, in turn, were provided charts for measuring visual acuity, distance measuring strings, training manuals, eye shields and tapes. They were also given flipcharts to use for public education.

Training of Health and Allied Personnel

Individuals Trained

<u>Category</u>	<u>Number</u>
Eye surgeons	2
Nurses	6
Medical Officer Health	5
Assistant Medical Practitioners	13
Public Health staff	130
Teachers	16
Family Health Workers	93
Community volunteers	<u>1,116</u>
Total	1,380

Treatment and Referral Network

Data on project effects were first collected during the last quarter of 1984, the period following completion of all the above training programs. The results were:

- a significant increase in patient attendance for eye problems following the training of public health staff and community volunteers at the Kuliypitiya Hospital, up from a 1983 monthly average of 547 to 744 each of the last three months of 1984.
- eye operations were significantly up, from a monthly average in 1983 of 19 to 41 in November, 1984.
- the overall referral system was easily able to absorb the additional 15 percent--October through December, 1984, 3,464 patients were seen at Kurunegala and Kuliypitiya eye clinics, 453 of whom were referrals from the project field staff.

Charts 1-9 of Attachment II give more detail on the statistical picture in the project area for October through December, 1984.

Eye specialist teams, two surgeons per team, from outside the project area will be brought in the project area monthly to assist the two surgeons permanently based in the project area. Arrangements for this regular support for hospital-based eye camps, principally to help clear the surgery backlog, estimated at about 3,000 people, in the area and allow for expansion, was set to begin in February, 1985, just as the present matching grant expired.

Community-Based Rehabilitation of the Rural Blind

Over the life of the matching grant, HKI and Sarvodaya, have trained 52 field workers, five field supervisors, and one central administrator for case review and project monitoring. Since April, 1984, with the full operating structure covering all of Kurunegala District, 360 individuals have been identified and 285 have entered into long-term rehabilitation training.

Conclusion

Sri Lanka, like the Philippines, has long had eye care as a priority in the national health plan, but had made little progress in its implementation. Again, HKI's presence has served as a catalyst to provide such services. Although program implementation was delayed because of civil disturbances and the flight of ophthalmologists in Kurunegala from the Tamil ethnic group, both the blindness prevention and rehabilitation programs are now moving along well.

The model for comprehensive preventive and curative action in the rural areas of Kurunegala district is already in place. In January, 1985, just before the end of the matching grant, HKI programs were the major subject at a National Conference of Blindness Prevention. These results were presented to the Ministry of Health by key Health Officials, the WHO Regional Representative and HKI's Associate Director. The conference concluded that the HKI project had good success; it provided a fertile ground for experimentation; should be expanded; and, finally, as further adjustments are made it will be used to form the basis for long-range blindness prevention planning in Sri Lanka.

TANZANIA

The Kongwa Primary Eye Care Project launched in January, 1984, was the last of HKI's matching grant programs to begin operation. Kongwa District covers an area of approximately 100,000 people. The program addresses the three major blinding diseases of central Tanzania--cataract, trachoma and xerophthalmia/measles-related blindness. It is part of an overall effort of the Ministry of Health, the National Prevention of Blindness Committee, and two major international PVO's: the Christoffel Blindenmission of Germany and the Royal Commonwealth Society for the Blind of the United Kingdom through its local affiliation, the Tanzanian Society for the Blind. HKI's component of the program serves the most basic level of the primary health care infrastructure: the Village Health Committee and Health Post levels.

HKI's Tanzania program involves a relatively modest flow of resources, a conscious decision on HKI's part in order to:

- perform cataract surgery that can be replicated where resources are extremely scarce;
- demonstrate a delivery system for control of trachoma and infectious diseases, including simple environmental interventions to reduce the incidence of these diseases; and
- recognize and provide early, inexpensive treatment of nutritional blindness associated with measles.

Summary of Accomplishments

Assessment

As elsewhere, a survey of the causes and prevalence of blindness in the Kongwa area was a first step in HKI's program. The survey, which took place in June and July, 1984, was preceded by a six-week advanced eye study course for nurses, doctors, ophthalmologists and others who learned how to conduct a survey as part of the Advanced Eye Course at Mvumi

Hospital. The students came from Zaire, Mali, Central African Republic, Uganda, Kenya, the U.S. and Canada as well as Tanzania. They joined the HKI staff and the village health workers as members of the survey teams.

The survey was conducted in five villages with a total population of 10,000. One-fifth of the people in each village were seen by the teams. The major cause of blindness was found to be cataract (38 percent), with corneal scarring, particularly that related to trachoma, second. Eighty percent of the children under five were found to have some form of trachoma, half of these had severe, potentially blinding signs. Nutritional blindness was confined to that related to measles. The latter disease appears to cause vision loss in about one-third of those afflicted.

Development of Curricula, Training and Public Education Materials

Village outreach is achieved through the ten health workers trained by HKI in basic eye care. Project activities include training and planning sessions for each village health committee and have intentionally been kept village specific and straightforward.

25 village health committee members from five villages have been oriented to the basics of program design and their responsibilities to the village. To create greater awareness of eye health problems public education and awareness materials such as T-shirts have been used to lend spirit, information and interest. These materials are given to those who have had cataract surgery and to the health workers on completion of training.

Training of Health and Allied Personnel

The Kongwa Project staff have used the traditional model of emulation/hands-on demonstration to train the ten village health workers (VHWs). For example, a

seminar was held prior to the cataract surgery; the VHWS viewed the cataract removal, and a follow-up lecture to answer questions was given. Thus, VHWS can answer villager queries on the surgery; who performs it, how, with what results, etc. A month or two before the cataract surgery began, VHWS received a basic course in primary eye care developed specifically for them by the consultant ophthalmologist. HKI staff make weekly visits to the villages where training is continued. Additionally, since the HKI ophthalmic nurse is one of the best in Tanzania, two other nurses have come to Kongwa for a week each for further training. This will continue throughout the life of the project.

Treatment and Referral Network

During and subsequent to the survey, patients found to have cataracts ready for surgery were referred to a district hospital for removal of the cataract and fitting with glasses. A landmark event occurred when 13 surgeries were done at the Kongwa Rural Health Center, where this type of surgery had never been performed. This was a first for cataract surgery. By the end of 1984, 25 cataract surgeries and 138 other operations (trachoma, trauma) had been performed and 929 people had attended the clinic, on referral from health workers. The village health workers are continuing their training, examining villagers, doing simple treatments and making referrals. Their work has been recognized and praised in meetings with regional and district policymakers and village health committee members. As a result, community support is strong.

Other Activities

- Research has gone forward on local herbal medicines used in the treatment of eye disease. A labeled collection of medicines reported to be used in treatment of eye conditions is being studied.
- An environmental sanitation survey of five villages was completed at the end of 1984. This record of factors implicated in the incidence

of trachoma has been shared with the villages and used at political party meetings. It identified the percentage of houses with animals indoors, access to water and pit latrines, families with vegetable gardens and refuse disposal.

Conclusion

To date, HKI's modest Tanzania effort has succeeded in identifying most, and treating some, of the cataract patients. In each village the total blind population has been identified. More importantly, the villagers have been given immediate information relating to blind people in other villages, what caused the blindness and how many came forth for surgery and with what results.

A base has been laid--work is in progress. Good participation from various agencies has been demonstrated. In addition, it is expected that the Tanzania program will be extremely important to a large number of African nations because it was designed carefully and systematically to address at least two major problems facing eye health care providers throughout East and Central Africa: first, how to mobilize community resources to persuade individuals to submit to simple sight-restoring surgical procedures; and, second, how to identify the one or two critical environmental variables which trachoma control efforts should address.

C. Other Matching Grant and Related Non-AID Funded Activities

During the life of the grant, HKI insured that the tenets of its programs were widely known (1) among agencies in the eye care field specifically charged with providing health care and education and (2) among agencies not in the eye health field, such as PVOs involved in nutrition, agriculture and development. In the last year of the grant, HKI joined PACT for just such reasons and has given presentations domestically and internationally to other PVO consortia such as CODEL and AVAB (in Bangladesh).

HKI has observed that its activities have evoked keen interest among the worldwide health and eye care communities, including WHO, UNICEF, Germany's Christoffel Blindenmission, Britain's Royal Commonwealth Society for the Blind, and national governments and indigenous private agencies. At major meetings in Lima, Manila, Dakar, Moshi (Tanzania), Geneva, London, Barbados, Caracas, Nairobi, Singapore, San Francisco and Colombo, HKI's matching grant efforts have been highlighted and examined in public sessions. Often (for example, in Lima and San Francisco) for the first time ever major ophthalmic associations (the Pan-American Congress of Ophthalmology and the International Academy of Ophthalmology, respectively) held symposia on primary eye care at HKI's urging and with the HKI programs as the major agenda items.

Blindness prevention and rehabilitation possibilities have also been made more vivid to ophthalmic and public health personnel throughout the world by matching grant activities so far carried out. For example, less expensive prevalence surveys of a shorter duration than heretofore available, such as those executed in the matching grant countries, have set new standards for such scientific assessment work. HKI's work in new types of materials and curricula (including, for example, innovative work with the author of Where There Is No Doctor to add new sections on eye care and blindness prevention), local production of eye glasses, HKI's pioneering study, Rehabilitation of the Rural Blind--An Economic Assessment of a Project in the Philippines, 1978-1983, and the HKI report, Research Priorities for Blindness Prevention in Developing Countries (both reports financed by HKI independently of the matching grant), are further examples of the leadership HKI has established. These activities, especially the research report, have resulted in the development of major new funding sources for the blindness prevention field at large.

III. Final Remarks

The matching grant has provided a new direction

and force to HKI's overall programs, programs that, as the report has shown, have been instrumental in demonstrating the degree to which preventive treatment and restorative services can be integrated into the delivery of primary health care. In turn, we believe the goals of the matching grant--to improve the quality of life and productivity of rural poor through insuring access to eye care, blindness prevention services and through the restoration of those already blind as productive members of the family and community--are being in large measure met in a beginning way in the four countries specifically targeted by the grant, and in many others where private citizens and governmental authorities are watching the progress of HKI matching grant activities.

The returns, of course, are not all in. Starting new programs in new countries over a three-year period, on a phased basis, did not allow the demonstration to proceed with full force in all countries until relatively recently. Yet, during the last year of the grant, in all four countries, the substance of the basic program has been solidly in place. The concept of integrating eye care and basic rehabilitation services into the existing health care and social welfare infrastructure has been accepted by local governments and institutions. The extent of the problem has been studied by means of scientific assessments. Training materials and curricula have been produced. Training has taken place. Equipment and supplies have been provided.

However, deficiencies still exist. The main shortfall, common to each, is the lack of full strength in local management capacities for supervision, reporting case referral, logistical support and evaluation. This requires additional attention. Also needed in each are actions to strengthen the preventive and rehabilitative aspects of the program and further work to increase overall awareness of the program through public education.

HKI is a changed organization, financially and technically stronger, as a result of its matching grant relationship with AID. It is in a position to finish the job started in the last three years.

III. FINANCES

The following Financial Status Report is illustrative and preliminary.

Helen Keller International expenditures for the period August 1, 1981 through January 31, 1985 are estimated to be \$1,563,980 plus in-kind donations totalling \$170,921 and local contributions of \$326,000. This compares with data indicating federal outlays of \$1,500,000. Thus, Helen Keller International's "match" for the entire grant period exceeded the federal share by more than \$560,901 on the basis of this data.

The final Financial Status Report for the project is attached as Attachment III. Country Information for AID-Supported PVO Projects forms for each of the countries included in the grant appear as Attachment IV.

III. LOGICAL FRAMEWORK MATRIX - PROP WORKSHEET

SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>A.1. Goal</p> <p>To improve the quality of life and productivity of the urban and rural poor in selected LDC's through the prevention and treatment of blindness; and through the restoration of those already blind to productive members of the family and community.</p>	<p>A.2.</p> <ol style="list-style-type: none"> 1. Number* of people screened and treated in clinics, schools, hospitals in countries selected. 2. Number of people who have gained access to preventive, therapeutic and restorative services. 3. Number of blind restored to productive and contributing members of their communities. 	<p>A.3.</p> <ol style="list-style-type: none"> 1. On-going follow-up joint evaluation and review. 2. IRII reports and records. 3. USAID reports and records. 4. Host Country reports. 5. Embassy reports. 	<p>A.4.</p> <ol style="list-style-type: none"> 1. The delivery of blindness preventive as well as education and rehabilitation services contributes to the productivity and well being of the poorest majority living in underserved areas. 2. Host governments recognize the priority to develop ongoing integrated systems to treat and prevent blindness. 3. Visual disability from preventable and/or treatable eye disease and trauma has a significantly greater social and economic impact in developing countries than in developed countries. 4. Integrated programs to deliver primary eye care significantly contribute to general health and development strategies.
	<p>*Given the fact that reliable statistics are unavailable at the program's outset, quantitative indicators only can be projected as estimates and data are gathered in the planned assessment studies.</p>		

10. LOGICAL FRAMEWORK MATRIX - PROP WORKSHEET

SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>B.1. Purpose</p> <p>Plan, implement, and evaluate over a three year period in four selected LDC's programs that demonstrate the degree to which preventive, treatment and restorative services can be integrated into the delivery of primary health care.</p>	<p>B.2. End of Project Status</p> <ol style="list-style-type: none"> 1. Blindness integrated into the existing health structures in 4 countries 2. Primary eye services available at each health care level, particularly at the primary level 3. Impact and cost of the integrated approach demonstrated 4. Host governments recognizing and supporting the employment of integrated strategies in other areas where blindness is identified as a problem 	<p>B.3.</p> <ol style="list-style-type: none"> 1. Ongoing joint evaluation 2. Evaluation Impact 3. Host Government reports and policy 4. Allocation of resources 5. USAID reports 6. HKI reports 	<p>B.4.</p> <ol style="list-style-type: none"> 1. Primary eye health care can complement the delivery of primary health care and contributes to the goal of health for all by the year 2000. 2. Ministries of Health in countries selected recognize the potential for delivering blindness services through existing or planned delivery systems. 3. HKI will maintain its momentum in planning and implementing expanded blindness programs. 4. Other PVO's, national and international organizations are interested and capable of integrating selected blindness components in their programs. 5. Host governments and institutions can and will assume responsibility to effectively carry on blindness programs

LOGICAL FRAMEWORK MATRIX - PROP WORKSHEET

SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
C.1. Outputs	C.2.	C.3.	C.4.
1. Integrated community level programs planned and initiated in 4 LDC's	1. 4 projects planned and underway in 4 countries	1. Ongoing joint evaluation	1. IRIKI has the management and financial expertise to plan and initiate integrated programs
2. Development of Assessment Methodologies	2. Assessments completed in 4 countries and baseline data available	2. Evaluation Impact	2. Governments will make financial and manpower resources available
3. Manpower education and training programs designed and in use	3. a. # personnel trained b. # trained at each level c. Lengths of training d. Examinations e. Retention f. Cost per worker trained	3. Host Government reports and policy	3. Personnel will complete training programs and remain in positions for which they are trained.
4. Professional, para-professional and community health workers delivering eye care services	4. a. # visits per day b. # treatments performed quarterly c. # treatments at each level d. # referrals e. Adequate record keeping f. Cost per treatment g. Cost per rehabilitation	4. Allocation of resources	
5. Operational planning manuals for governments and institutions produced and in use		5. USAID reports	
6. Increased planning and management capacity within host governments and institutions	5. 4 planning manuals produced and in use	6. IRIKI reports	
7. Development and IDC use of evaluation tools	6. # health workers trained at higher level to assume planning		
	7. Codification of assessment methodologies		

LOGICAL FRAMEWORK MATRIX - PROP WORKSHEET

4

SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
D.1. Inputs	D.2.	D.3.	D.4.
1. IKI Management and technical expertise. SEE BUDGET 2. IKI financial resources....\$1,500,000 AID financial resources....\$1,500,000		1. Ongoing joint evaluation and review 2. IKI reports and records 3. USAID reports and records 4. Host country reports 5. Embassy reports	1. USAID funding will be forthcoming 2. IKI will maintain and expand its technical and financial strengths.

January 1985

NATIONAL FORUM: BLINDNESS PREVENTION AND PRIMARY EYE CARE
MINISTRY OF HEALTH AND HELEN KELLER INTERNATIONAL

BACKGROUND STATEMENT: PROJECT IMPACT/ PRIMARY EYE CARE

Considerable data has been collected on possible project impact for the last quarter of 1984, October through December. This time period was selected since it was the first quarter following the completion of all training of public health and field staff in blindness prevention and primary eye care. During August and September, vision charts, notebooks and referral cards were distributed to field personnel. Hence, the complete system was in motion.

A number of charts or Tables have been developed to demonstrate the data. Following is a listing and summary of major points of interest.

CHART 1 Kuliyaipitia Eye Clinic
Total Patient Attendance
October - December 1983
October - December 1984

There was a significant increase in patient attendance following the training of public health staff and community volunteers--from a monthly average of 547 to 744.

CHART 2 Kuliyaipitiya Eye Clinic
Total Eye Operations
July - September 1984
October - December 1984

The number of eye operations rose dramatically following the training of public health staff and community volunteers--from a monthly average of 19 to 30.

CHART 3 Kurunegala Eye Clinic
Total Patient Attendance
September - December 1984

Patient attendance at the Kurunegala Eye Clinic steadily declined since the departure of the eye surgeon in early October 1984.

CHART 4 Kurunegala and Kuliyaipitia Eye Clinics
Total Patient Attendance
Project Referrals
October - December 1984

The system was able to absorb an additional 15% patient load, comprised of referrals from the project field staff.

CHART 5 Kurunegala and Kuliyaipitiya Eye Clinics
Project Referrals
October - December 1984

Substantial number of patients seen.

CHART 6 Pannala M.O.H. Area
Project Referrals
October - December 1984

Substantial number of patients identified and referred.

CHART 7 Kurunegala and Kuliyaipitiya Eye Clinics
Project Referrals
Cataracts by Age Groups
October - December 1984

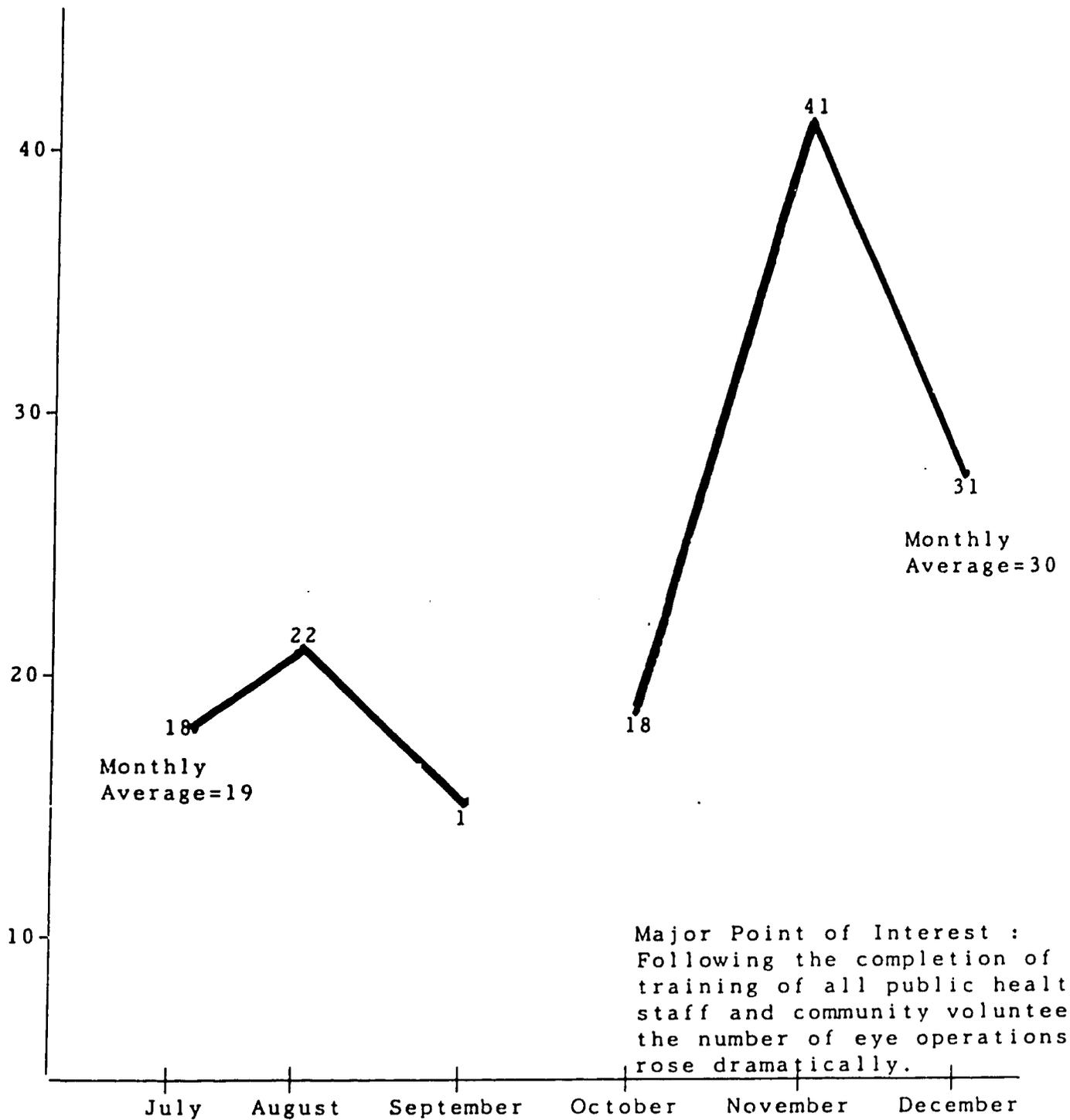
Patients identified and referred by field personnel
for cataract condition later presented at eye clinic.

CHART 8 Pannala M.O.H. Area
Project Referrals
Reasons for Cataract Patients Not Attending Eye Clinic

Economic considerations was the first and foremost reason
for person not attending eye clinic following cataract
identification.

CHART 9 Kuliyaipitiya Eye Clinic and Pannala M.O.H. Area
Project Referrals
Refractive Errors
October-November 1984

More than double the number of women than men were seen
with refractive errors in both the eye clinic and field
work.



1 9 8 4

KURUNEGALA EYE CLINIC

Total Patients Attendance

September through December 1984

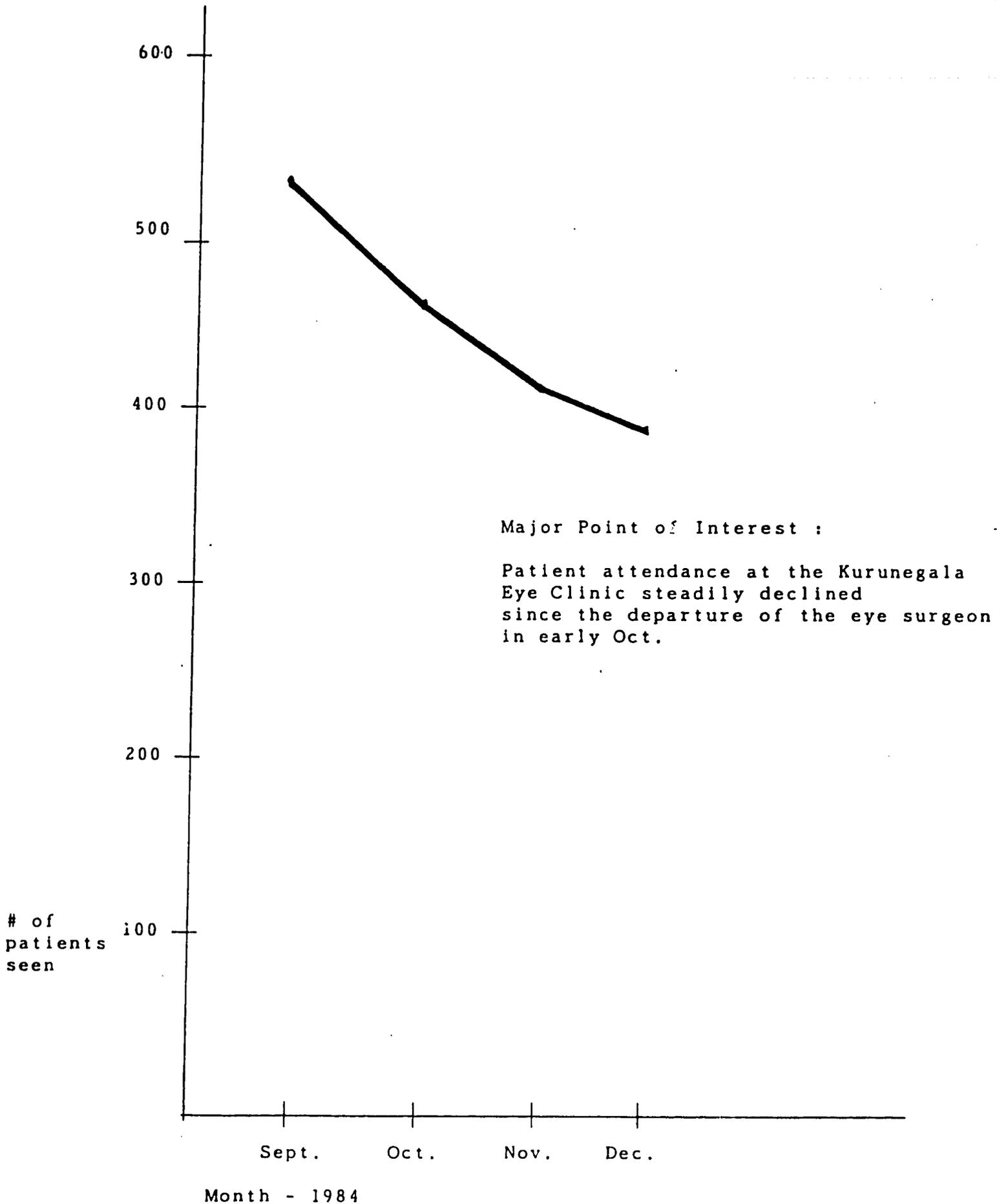
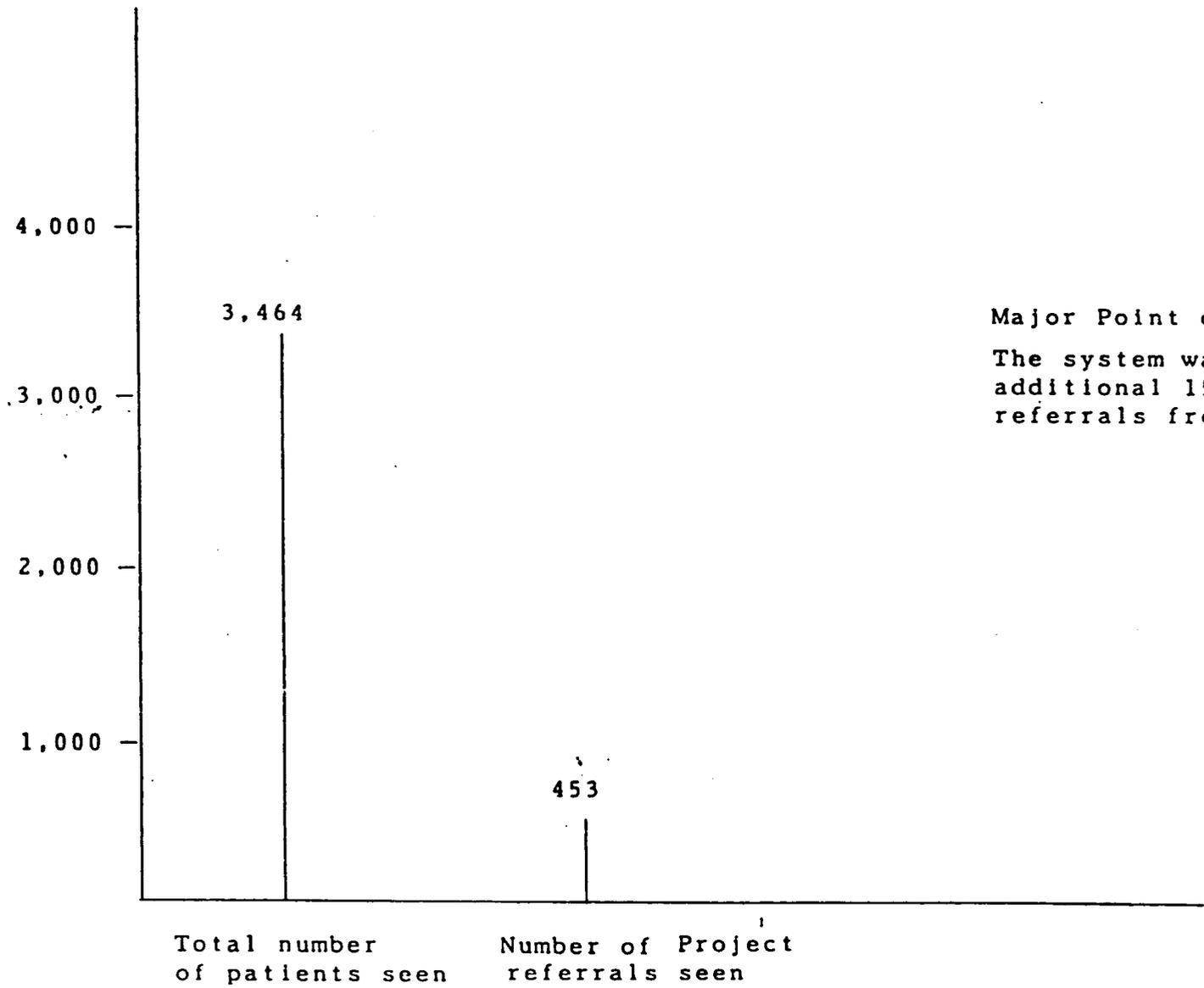


CHART 4

Comparison between the total number of patients and the number of Project referrals, seen at the Kurunegala and Kuliypitiya Eye Clinics October through December 1984



Major Point of Interest :
The system was able to absorb an additional 15%, comprised of referrals from the project field staf.

Kurunegala and Kuliyaipitiya Eye Clinics
October, November, and December 1984

Project Referrals

1. Number of patients seen in the clinic with a project referral chit	453
2. Number of cataract patients identified	90
3. Number of cataract patients requiring surgery and given date for surgery	43
4. Number of cataract patients operated on	8
5. Number of cataract patients who refused surgery	1
6. Backlog of cataract patients	81
7. Number of spectacles prescribed for refractive errors	187
8. Number of other eye problems	154

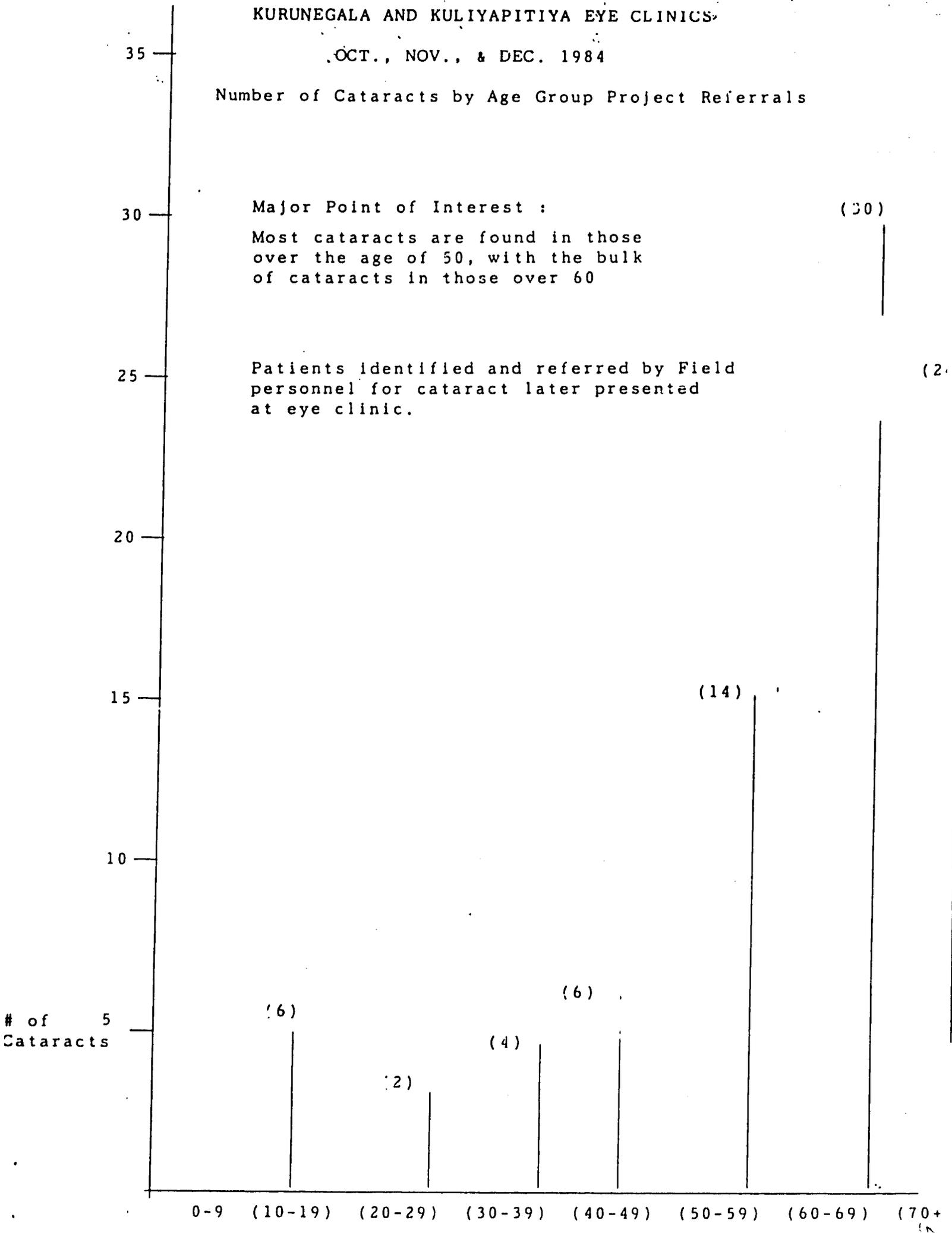
PANNALA M.O.H. AREA
PROJECT REFERRALS
OCTOBER THROUGH DECEMBER 1984

	<u>OCTOBER</u>	<u>NOVEMBER</u>	<u>DECEMBER</u>	<u>TOTAL</u>
1. Examined	600	403	653	1656
2. Cataract	11	66	36	113
3. Vision Defects	188	236	274	698
4. Other Eye Problems	401	101	343	845
5. Referrals to Eye Surgeon	561	381	338	1280
6. Treated by M.O.H.	36	14	05	55

KURUNEGALA AND KULIYAPITIYA EYE CLINICS

OCT., NOV., & DEC. 1984

Number of Cataracts by Age Group Project Referrals



Major Point of Interest :

(30)

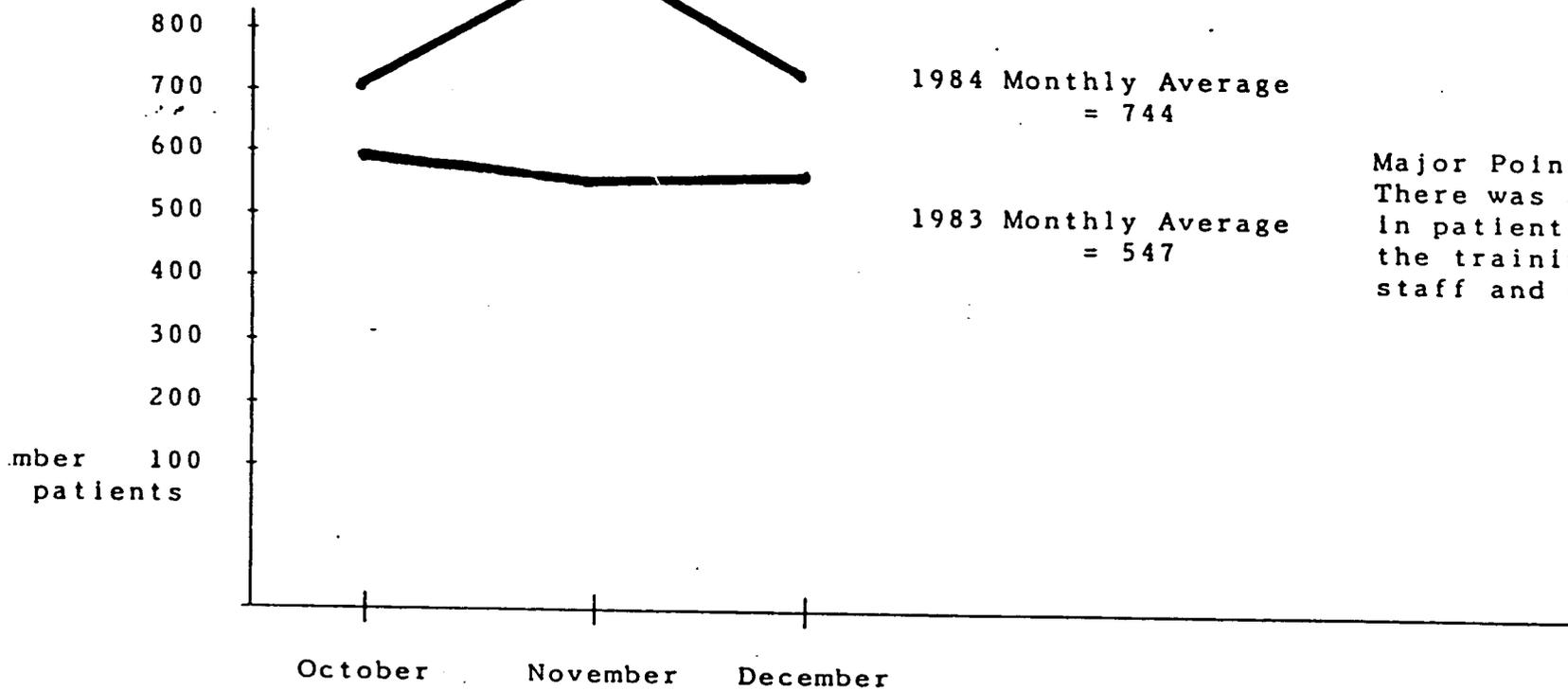
Most cataracts are found in those over the age of 50, with the bulk of cataracts in those over 60

Patients identified and referred by Field personnel for cataract later presented at eye clinic.

(2)

CHART 1

KULIYAPITIYA EYE CLINIC - TOTAL PATIENT ATTENDANCE
1983 COMPARED WITH 1984
OCTOBER THROUGH DECEMBER OCTOBER THROUGH DECEMBER



Major Point of Interest:
There was a significant increase
in patient attendance following
the training of public health
staff and community volunteers.

CHART 8

PANNALA M.O.H. AREA

Reasons for cataract patients
not attending eye clinic

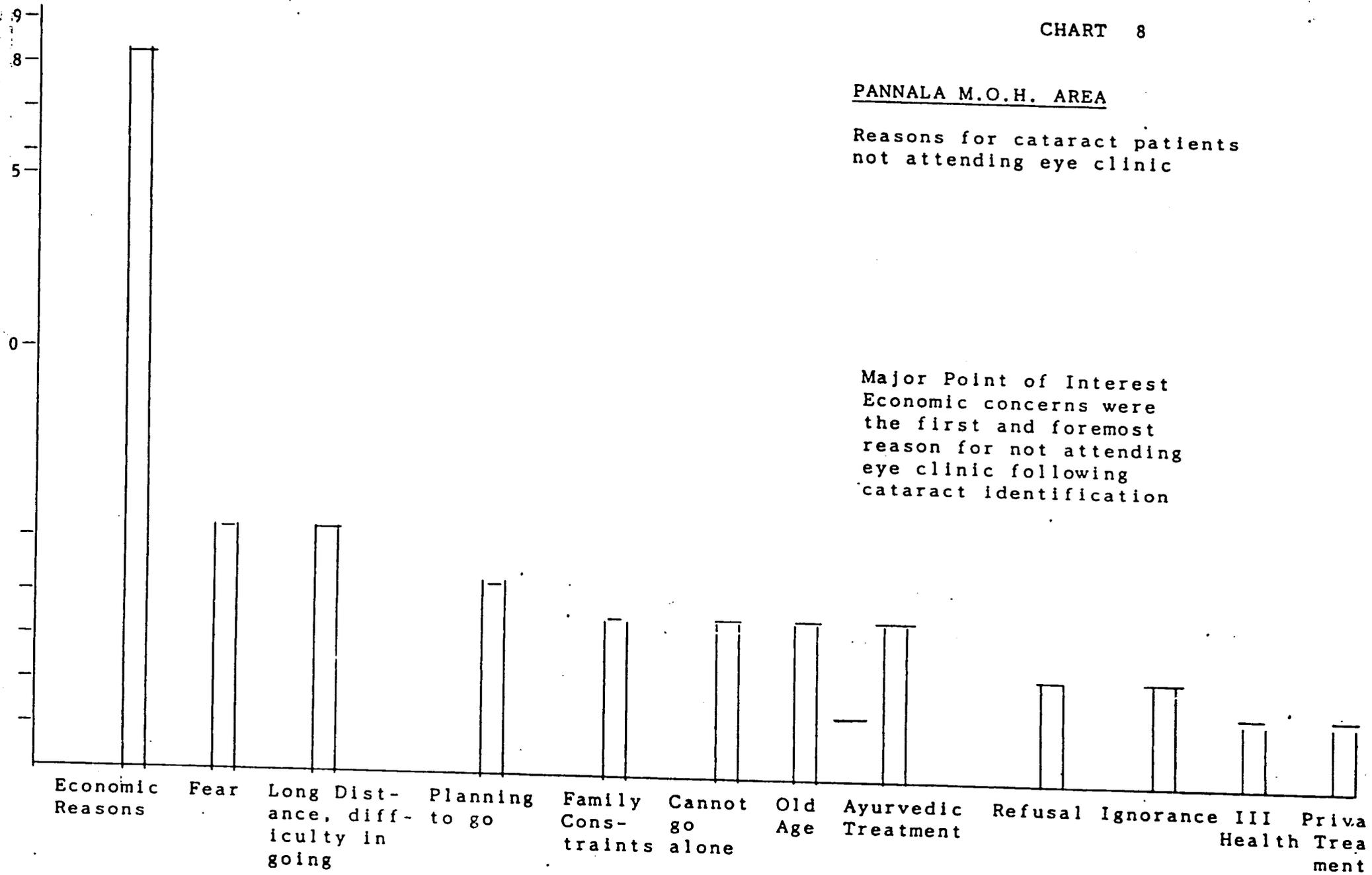
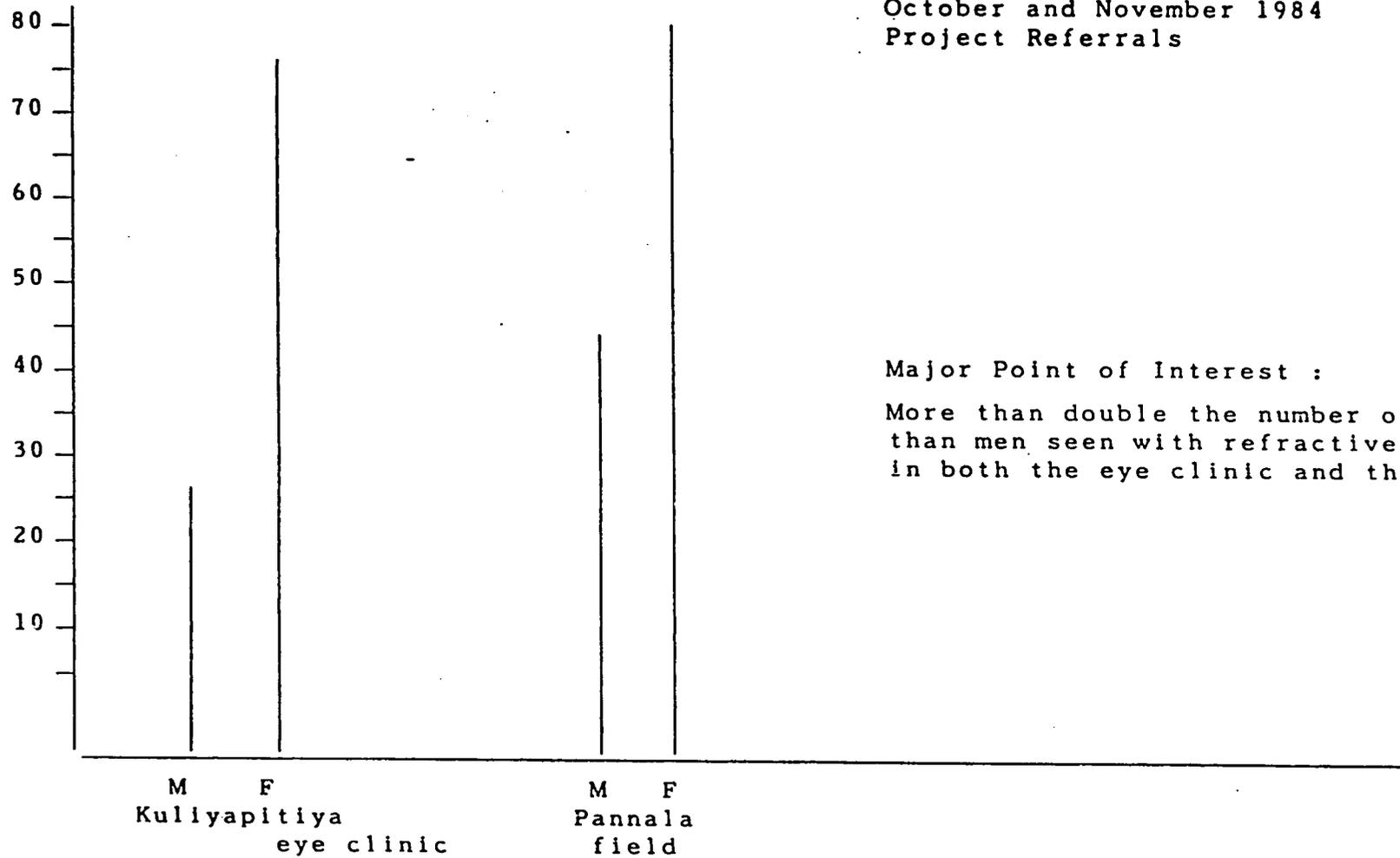


CHART 9

KULIYAPITIYA EYE CLINIC & PANNALA MOH-FIELD
Refractive Errors
October and November 1984
Project Referrals



Major Point of Interest :

More than double the number of women than men seen with refractive errors in both the eye clinic and the field.

FINANCIAL STATUS REPORT

(Follow instructions on the back)

ATTACHMENT III

3. RECIPIENT ORGANIZATION (Name and complete address, including ZIP code)

HELEN KELLER INTERNATIONAL, INCORPORATED
15 West 16th Street
New York, New York 10011

1. FEDERAL AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH REPORT IS SUBMITTED
USAID/WASHINGTON, D.C.

7. FEDERAL GRANT OR OTHER IDENTIFYING NUMBER
PDC 1078

DMH Approved
No. HHS RO1HO

4. EMPLOYER IDENTIFICATION NUMBER
13-5562162

5. RECIPIENT ACCOUNT NUMBER OR IDENTIFYING NUMBER
FRLC #72-OC-1481

6. FINAL REPORT
 YES NO

7. BASIS
 CASH OTHER

8. PROJECT/GRANT PERIOD (See instructions)

FROM (Month, day, year)
8/1/81

TO (Month, day, year)
1/31/85

9. PERIOD COVERED BY THIS REPORT
FROM (Month, day, year)
1/1/85

TO (Month, day, year)
1/31/85

STATUS OF FUNDS

PROGRAMS/FUNCTIONS/ACTIVITIES ▶	STATUS OF FUNDS							TOTAL (g)
	(a) Personnel	(b) Development	(c) Consultants	(d) Travel	(e) Other Direct Costs	(f) Indirect		
a. Net outlays previously reported	\$ 499,522	\$ 172,318	\$ 80,213	\$ 272,054	\$ 302,910	\$ 112,815	\$ 1,439,832	
b. Total outlays this report period	28,045	5,535	5,973	16,485	8,731	5,311	70,080	
c. Less: Program income credits	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	
d. Net outlays this report period (Line b minus line c)	28,045	5,535	5,973	16,485	8,731	5,311	70,080	
e. Net outlays to date (Line a plus line d)	527,567	177,853	86,186	288,539	311,641	118,126	1,509,912	
f. Less: Non-Federal share of outlays	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	
g. Total Federal share of outlays (Line e minus line f)	527,567	177,853	86,186	288,539	311,641	118,126	1,509,912	
h. Total unliquidated obligations	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	
i. Less: Non-Federal share of unliquidated obligations shown on line h	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	
j. Federal share of unliquidated obligations	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	
k. Total Federal share of outlays and unliquidated obligations	527,567	177,853	86,186	288,539	311,641	118,126	1,509,912	
l. Total cumulative amount of Federal funds authorized	277,000	150,000	225,000	410,000	310,000	128,000	1,500,000	
m. Unobligated balance of Federal funds	(250,567)	(27,853)	138,814	121,461	(1,641)	9,874	(9,912)	

11. INDIRECT EXPENSE

a. TYPE OF RATE (Place "X" in appropriate box) PROVISIONAL PREDETERMINED FINAL FIXED

b. RATE * c. BASE d. TOTAL AMOUNT e. FEDERAL SHARE

13. CERTIFICATION

I certify to the best of my knowledge and belief that this report is correct and complete and that all outlays and unliquidated obligations are for the purposes set forth in the award documents.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL

Jack W. Swartwood

TYPED OR PRINTED NAME AND TITLE
Jack W. Swartwood
Director, Operations Division

DATE REPORT SUBMITTED
4/23/85

TELEPHONE (Area code, number and extension)
(212) 620-2169

12. REMARKS: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation.

269-101 * 8/1/81 to 6/30/82 15.0% Final Rate on \$ 58,830 = \$ 8,825
7/1/82 Thereafter 8.2% Provisional Rate on 1,332,956 = 109,301
\$ 118,126

STANDARD FORM 269 (7-76)
Prescribed by Office of Management and Budget
Cir. No. A-110

ATTACHMENT III

COUNTRY INFORMATION FOR
AID-SUPPORTED PVO PROJECTS

Organization: Helen Keller International, Inc.
 Project/Grant No. PDC-1078
 Grant Dates 08/01/81-01/31/85
 Funding Mechanism MG
 (i.e., MG, OPG, Contract, CA, Etc.)

COUNTRY PHILIPPINES

Project Purpose: (limit to 40 words or less)

To demonstrate a cost-effective, high-standard primary eye health care program integrated at all levels into the existing general health care structure.

Project Implementation

Start Date: July 1983 Estimated Completion Date: January, 1985
 Status: (limit to 25 words or less)

Phase I completed January, 1985. Phase II begun February 1, 1985.

Project Funding Information

Year <u>1981-82</u>	Year <u>1982-83</u>	Year <u>1983-84</u>	Year <u>1984-85</u>
AID\$ <u>0</u>	AID\$ <u>23,700</u>	AID\$ <u>91,053</u>	AID\$ <u>38,867</u>
PVO\$ <u>40,000</u>	PVO\$ <u>12,000</u>	PVO\$ <u>52,000</u>	PVO\$ <u>41,000</u>
INKIND <u> </u>	INKIND <u> </u>	INKIND <u>2,865</u>	INKIND <u>46,669</u>
LOCAL <u> </u>	LOCAL <u>6,000</u>	LOCAL <u>23,000</u>	LOCAL <u>10,000</u>
TOTAL <u>40,000</u>	TOTAL <u>41,700</u>	TOTAL <u>168,916</u>	TOTAL <u>136,536</u>

Location in Country (Region, District, Village - Be Specific)

PVO Representative in Country (if any)

(name) Jeffrey L. Watson
 (address) PO Box 191, Legaspi City
 (phone)

Local Counterpart/Host Country Agency (If no PVO representative)

*Complete separate sheet for each project/activity in a country

**COUNTRY INFORMATION FOR
AID-SUPPORTED PVO PROJECTS**

Organization: Helen Keller International, Inc.
 Project/Grant No. PDC - 1078
 Grant Dates 08/01/81 - 01/31/85
 Funding Mechanism Matching Grant
 (i.e., MG, OPG, Contract, CA, Etc.)

COUNTRY PERU

Project Purpose: (limit to 40 words or less)

To demonstrate a cost-effective, high-standard primary eye health care program integrated at all levels into the existing general health care structure.

Project Implementation

Start Date: September 1982 Estimated Completion Date: January 1985
 Status: (limit to 25 words or less)

Phase I completed January 1985. Phase II begun February 1, 1985.

Project Funding Information

<u>Year 1981-82</u>	<u>Year 1982-83</u>	<u>Year 1983-84</u>	<u>Year 1984-85</u>
AID\$ <u>19,169</u>	AID\$ <u>187,500</u>	AID\$ <u>218,087</u>	AID\$ <u>108,327</u>
PVO\$ <u>20,000</u>	PVO\$ <u>48,000</u>	PVO\$ <u>198,250</u>	PVO\$ <u>116,000</u>
INKIND <u> </u>	INKIND <u>1,200</u>	INKIND <u>2,200</u>	INKIND <u>41,600</u>
LOCAL <u>40,000</u>	LOCAL <u>60,000</u>	LOCAL <u>70,000</u>	LOCAL <u>35,000</u>
TOTAL <u>79,169</u>	TOTAL <u>296,700</u>	TOTAL <u>488,537</u>	TOTAL <u>300,927</u>

Location in Country (Region, District, Village - Be Specific)

Lima; Puno; San Martin; Ancash Departments

PVO Representative in Country (if any)

(name) John Lynch
 (address) Prolongacion Arenales, San Isidro, Lima, Peru
 (phone) 40-56-86

Local Counterpart/Host Country Agency (If no PVO representative)

*Complete separate sheet for each project/activity in a country

**COUNTRY INFORMATION FOR
AID-SUPPORTED PVO PROJECTS**

Organization: Helen Keller International, Inc.
 Project/Grant No: PDC - 1078
 Grant Dates 08/01/81 - 01/31/85
 Funding Mechanism MG
 (i.e., MG, OPG, Contract, CA, Etc.)

COUNTRY SRI LANKA

Project Purpose: (limit to 40 words or less)

To demonstrate a cost-effective, high-standard primary eye health care program integrated at all levels into the existing general health care structure.

Project Implementation

Start Date: April 1983 Estimated Completion Date: January 31, 1985
 Status: (limit to 25 words or less)

Phase I completed January, 1985. Phase II begun February 1, 1985.

Project Funding Information

<u>Year 1981-82</u>	<u>Year 1982-83</u>	<u>Year 1983-84</u>	<u>Year 1984-85</u>
AID\$ <u>5,260</u>	AID\$ <u>76,500</u>	AID\$ <u>91,217</u>	AID\$ <u>62,863</u>
PVO\$ <u> </u>	PVO\$ <u>17,000</u>	PVO\$ <u>78,000</u>	PVO\$ <u>45,630</u>
INKIND <u> </u>	INKIND <u> </u>	INKIND <u>4,718</u>	INKIND <u>50,164</u>
LOCAL <u> </u>	LOCAL <u>20,000</u>	LOCAL <u>25,000</u>	LOCAL <u>15,000</u>
TOTAL <u>5,260</u>	TOTAL <u>113,500</u>	TOTAL <u>198,935</u>	TOTAL <u>173,657</u>

Location in Country (Region, District, Village - Be Specific)

Kurunegala District

PVO Representative in Country (if any)

(name) Susan J. Eastman
 (address) 410/85 Baudhaloka Mawatha, Colombo
 (phone) 598331

Local Counterpart/Host Country Agency (If no PVO representative)

*Complete separate sheet for each project/activity in a country

**COUNTRY INFORMATION FOR
AID-SUPPORTED PVO PROJECTS**

Organization: Helen Keller International, Inc.
 Project/Grant No. PDC - 1078
 Grant Dates 08/01/81 - 01/31/85
 Funding Mechanism MG
 (i.e., MG, OPG, Contract, CA, Etc.)

COUNTRY TANZANIA

Project Purpose: (limit to 40 words or less)

To demonstrate a cost-effective, high-standard primary eye health care program integrated at all levels into the existing general health care structure.

Project Implementation

Start Date: November 1983 Estimated Completion Date: January 31, 1985
 Status: (limit to 25 words or less)

Phase I completed. No further USAID input after completion date per State Department guidelines.

Project Funding Information

<u>Year 1982-82</u>	<u>Year 1982-83</u>	<u>Year 1983-84</u>	<u>Year 1984-85</u>
AID\$ <u>2,136</u>	AID\$ <u>20,400</u>	AID\$ <u>32,000</u>	AID\$ <u>17,591</u>
PVO\$ _____	PVO\$ <u>32,000</u>	PVO\$ <u>45,500</u>	PVO\$ <u>26,600</u>
INKIND _____	INKIND _____	INKIND <u>765</u>	INKIND <u>20,740</u>
LOCAL _____	LOCAL <u>5,000</u>	LOCAL <u>12,000</u>	LOCAL <u>5,000</u>
TOTAL <u>2,136</u>	TOTAL <u>57,400</u>	TOTAL <u>103,050</u>	TOTAL <u>69,931</u>

Location in Country (Region, District, Village - Be Specific)

Kongwa subdistrict, Mpwapwa District, Dodoma Region.

PVO Representative in Country (if any)

(name) Dr. Dorothy Prentice
 (address) PO Box 192, Kongwa Tanzania
 (phone) Kongwa 19

Local Counterpart/Host Country Agency (If no PVO representative)

Dr. B.B.O. Mmbaga
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*Complete separate sheet for each project/activity in a country