

PD-AAZ-100
12d 60597

ANNUAL REPORT

HELEN KELLER INTERNATIONAL

MATCHING GRANT ACTIVITY
PDC-0269-G-5024-00

REPORTING PERIOD
JANUARY 1, 1987 - DECEMBER 31, 1988.

CONTACT:

Dr. David French, Medical Director
Helen Keller International
15 West 16th Street
New York, New York 10011
212/807-5820

TABLE OF CONTENTS

	<u>PAGE #</u>
I. Executive Summary	1
II. Background to the Matching Grant and Project Context	1-2
III. Project Methodology	2-3
IV. Beneficiaries	3
V. Management Improvement Program and Strategic Planning	3-13
VI. Review and Analysis of Project Results by Country	13-14
Morocco	15-20
Peru	21-28
Philippines	29-37
Sri Lanka	38-44
Tanzania	45-50
VII. Management: Review and Analysis of Headquarters Support Functions	51-52
VIII. Monitoring and Evaluation	52-53
IX. Financial Report	54-61
X. Lessons Learned and Long-Term Project Implications	62-66
XI. Recommendations	67-68
XII. Attachments	

ANNUAL REPORT
HELEN KELLER INTERNATIONAL
MATCHING GRANT ACTIVITY
PDC-0269-G-5024-00

REPORTING PERIOD
JANUARY 1, 1987 - DECEMBER 31, 1988.

I. EXECUTIVE SUMMARY

1. This matching grant report differs from previous reports in several respects. Though lengthy, it includes more output and achievement reporting and much less general narrative. The present report is premised on the recognition that AID Project Managers have limited reading time, and are interested in knowing the specific activities PVOs have undertaken, when they were undertaken, how effective they have been, and what overall objectives have been achieved.

Little background material which has appeared in prior reports or documents is repeated here. Readers may obtain earlier information by contacting the cognizant AID Project Officer.

2. A section devoted to an HKI management and administrative improvement initiative, now actively under way, has been added to the report format. Recently, the AID Matching Grant Project Officer was supplied with HKI's five-year Strategic Plan (SP). The management improvement initiative is a product of the SP and should be reviewed in conjunction with it. The SP is one of several tangible products arising from an on-going HKI self-study process.

HKI believes that even effective PVOs have room to strengthen internal management. In this report, steps HKI is taking on the management front are detailed. These are the first of many actions to come. HKI is working to refine and improve what it does, while not losing sight of the substantial accomplishments that have been achieved.

II. BACKGROUND TO THE MATCHING GRANT AND PROJECT CONTEXT

There are 42 million blind persons in the world today and this number grows by 3 million per year. By the year 2000, there will be at least 75 million irreversibly blind persons in the world. More than 80% of those who are blind now live in the developing world. It is particularly tragic that more than 75% of this blindness is avoidable.

In 1981, Helen Keller International began demonstrating that proven low-cost preventive and curative interventions could be delivered to millions by means of simple additions to existing health systems. HKI is developing and refining economical vision-preserving health services as well as blindness prevention and control programs in the developing world within the primary health care framework.

III. PROJECT METHODOLOGY

HKI's methodology is conceptually straightforward:

- a) identify interested national colleagues in a representative sample of countries;
- b) select, with host country assistance, geographic areas in developing countries small enough to be manageable but large enough to prove that selected low cost intervention will make a difference; and
- c) attack the problem by:
 - i) assessing the prevalence of eye disease and the number of persons irreversibly blind in need of rehabilitation services;
 - ii) developing curricula, training and public education materials;
 - iii) training primary-level health and allied personnel in prevention, simple treatment and rehabilitation; and
 - iv) providing curative and surgical services at secondary and tertiary levels.

Blindness rates of populations in countries for which matching grant funds were originally sought were high -- Sri Lanka, 1.1%; Peru, 1.2%; The Philippines, 2.1%; Morocco, 0.9% and Tanzania, 1.6%. Known preventive and curative techniques can reduce blindness incidence by means of primary intervention and sight can be restored through secondary intervention. For the irreversibly blind, simple rehabilitation training can lead to more economically independent lives. Studies have shown that blind persons in the developing world require much assistance from those in economically productive age groups to attend to their needs. Consequently, the economic cost of blindness to the developing world is much greater than the loss of gainful employment of the sightless themselves.

HKI has had two continuing challenges associated with this matching grant:

- (1) to refine and adapt sustainability methodologies to meet specific country needs, and

(2) to find ways to inform and persuade national decision-makers of the utility and affordability of these interventions.

An important part of HKI's matching grant activities is the dissemination of project and program results and information. Such data is shared with ministries of health, colleagues in developing countries, national and international organizations of and for the blind, PVOs active in health care, and international private and multilateral agencies.

IV. BENEFICIARIES

HKI-assisted model eye care delivery programs within primary care contexts are being progressively extended to cover larger catchment or service areas in Peru, Sri Lanka, The Philippines, Morocco, and Tanzania. In Peru, the population to be covered is 1,800,000; in Tanzania, 600,000; in Sri Lanka, 1,500,000; in The Philippines, 2,500,000; and in Morocco, 600,000. More importantly, these programs are being incorporated into national public sector service activities and made permanent. As a result, they are becoming sustainable parts of each country's national health and social service structure.

Beneficiaries of HKI-catalized and -facilitated programs are helping other country persons afflicted by serious eye disease and blindness to develop. An estimated six million-plus people reside in the catchment areas of HKI's current demonstration projects. They are largely poor rural farmers, traders, fishermen and urban slum dwellers and their children. Over 125,000,000 more will eventually benefit through access to eye care and preventive services as these delivery programs are progressively incorporated within target countries.

V. MANAGEMENT IMPROVEMENT PROGRAM AND STRATEGIC PLANNING

A. Introduction and Background

In FY 1988, HKI initiated a management and administrative improvement program. It was not designed as a one-time effort, but as a continuing activity. The stimulus for this program has been the growth in HKI program and staff size. HKI is committed to this effort which is reflected in a number of important organizational plans and actions.

HKI's overall program has experienced significant change over the past five years. Executive management of the agency and the Board of Trustees are clearly aware that further reforms and refinements are necessary and desirable if HKI is to realize ambitious developmental goals outlined in its Five-Year Plan.

Active self-study, examination, review, and revision of the way HKI functions internally and externally is under way. "Quick fixes" for problems are not the goal. Rather, an orderly process is desired to develop and refine policies and procedures, reflecting the larger commitments to multiple constituencies. Such planning will benefit all who support HKI, and the organization will be strengthened in the process.

The management plan that has been developed articulates guidelines for change and evaluation. Additionally, the plan defines steps needed to carry out specific management improvements. These are designated as strategic objectives and priorities for the Fiscal Years 1989-1993.

B. Strategic Planning

There is an old American saying that "if you don't know where you want to go, you won't know whether you have arrived when you get there." HKI has embarked on its self-study and review, in order to ask questions about its mission and mandate as well as about present and future directions and opportunities. This process has, in part, taken the form of a strategic planning exercise and development of a Strategic Plan for FY 1989-93. The AID Project Officer for the Matching Grant has a copy of this Strategic Plan on file. The purpose in this report is not to reiterate its content, but to delineate its rationale and additional developments.

The Strategic Plan and the planning process are designed to introduce a discipline and consistency to HKI's management process. Thus, it becomes more feasible for HKI to play a proactive role in charting its direction. The alternative is to be reactive to grantors and granting agencies. The organization believes it is important for PVOs to develop a sense of what they would not be well advised to undertake as well as to be aware of those goals and objectives they should actively pursue.

The HKI Strategic Plan is uniquely adaptable; thus, long-serving. The introductory section of this document states:

"This will be a rolling plan, evaluated, reassessed and updated annually in conjunction with the annual budget process. Each annual budget and related program plan becomes the first year of an updated five year plan and projection."

Accordingly, it has been resolved that beginning FY 1990, the initial step in each annual budget process will be a reassessment and review of program and financial activities since the preceding budget, resulting in re-formulation and revision of the five-year strategic plan. This annual assessment will be the responsibility of the Executive Director. At his discretion, it will involve senior staff, agency advisors and invited input from other sources.

Steps in this annual process will include:

- Review and reaffirmation, or modification, of the basic underlying tenets of the agency (i.e., Mission Statement; Guiding Principles; Country Selection Criteria; and Research Statement);
- Assessment and updating of the overall agency strategic objectives and priorities, eliminating those already accomplished, extending time requirements where necessary, and adding additional points;
- Development of a financial budget for the new year and revision of financial prospects for an extended five-year period;
- Amendment of program, regional and management plans, using experience and new program developments to reorganize in accordance with financial projections.

Prior to the beginning of each annual budget cycle, the Executive Director and the Director of Finance will develop and publish a calendar outlining action steps, due dates and assignment of responsibilities to accomplish each update objective.

C. Management Guidelines

The executive staff devoted a substantial block of time during a retreat in January, 1988, to identifying elements of strategic planning that constitute hallmarks of good management in an agency such as HKI. From those sessions, criteria and principles emerged, which will further develop the management structure of the agency and include:

1. A clearly articulated mission, objectives and priorities;
2. Strong, knowledgeable, realistic, central leadership;
3. A code of agency ethics, both understood and adhered to;
4. Clearly articulated organization, responsibilities and accountabilities;
5. Effective information and evaluation systems;
6. Informed management at all levels, shaped by effective lateral communications and information feedback;
7. Delegation of authority to the lowest practical level;
8. Maximum local input and self reliance;
9. Accountability to donors, consumers and the public;
10. Well developed and communicated policies and procedures.

D. Specific Managerial Objectives and Schedules

Neither HKI Bylaws nor any other document now describes the responsibilities of the Board of Directors in detail, nor indicates the special expertise required for selection. The following draft of Board responsibilities is under review for Board consideration:

RESPONSIBILITIES OF THE BOARD OF DIRECTORS

1. Provision of basic central leadership of HKI through establishing and maintaining a purpose, philosophy and direction consistent with historic precedents.
2. Selection, monitoring and evaluation of the Executive Director, extending policy guidance, providing advice and supervision, but assigning full responsibility for program and fiscal administration.
3. Assurance of the financial integrity of HKI through providing for objective external audits and action on audit findings.
4. Discussion and approval of long-range program objectives and related financial strategies, annual budgets and any needed emergency or priority actions.
5. Receipt and review of regular financial statements and program reports.
6. Supervision of the development and distribution of a clear, full and honest report to the public annually, describing program activities, financial operations, and agency management.
7. Provision of active leadership (and direct participation by individual Board members) in fund-raising from corporations and foundations and in solicitation of major gifts; as well as monitoring of all fund-raising activities by the Board.
8. Provision for the orderly execution of Board responsibilities by the election of officers; appointment of committees; establishment of a schedule of meetings; and, maintenance of a procedure for the transaction of business.
9. Establishment of procedures for the selection of new Board members, assuring a balance of desirable expertise, and for appropriate orientation and training.

This draft outline of Board responsibilities is to be reviewed, revised as appropriate, and acted upon in FY 1989. Basic Board procedures will then be modified as needed.

E. Regional and Country Staff Resources and Organization

The success of HKI's mission depends in large part on the dedication and effectiveness of its country directors and staff. They must translate headquarters plans into on-site reality.

It is essential that these personnel be well-chosen, given clear objectives and adequate support, and that lines of communication be established and maintained.

To these ends, managerial attention is to be concentrated on the following procedures, all of which are currently being implemented in FY 1989:

1. Establishment of Positions of Regional Managers

To facilitate effective and efficient interaction between field and headquarters operations, Regional Managers have been appointed and located at the headquarters office. Regional Managers have the task of interfacing with and supporting the Country Directors.

When effective interface systems are in place and fully operational, the Regional Managers may become field based with the Regional Desk Officers assuming the headquarters support role.

2. Regional and Local Management Oversight and Communications Systems

Initially, Regional Managers will assist in establishing efficient systems, such as expenditure tracking (in line with approved budgets), field data collection reports and communication systems between the field and the headquarters office.

Simultaneously, Regional Managers will closely monitor and facilitate incoming correspondence from the field and coordinate responses that are made by headquarters. Periodic field trips will be taken to see, first hand, how systems are functioning, to monitor progress, and to keep abreast of in-country program activities.

Regional Managers will deal with all field related technical correspondence coming into the office and channel specific issues of a technical nature to the appropriate person(s) for

specific responses. One of a Regional Manager's primary responsibilities is to ensure that Country Directors receive prompt and appropriate responses to all queries.

3. Inter-country cooperation

Regional Managers have an on-going responsibility to assist in identifying appropriate and effective resources (human and material) within the region and facilitate the inter-country cooperation through providing logistical support to bring together those who need assistance in blindness-related matters. Periodic Regional conferences may be a good forum for such exchanges.

4. Reliance on beneficiary country resources and personnel

With HKI's goal of developing sustainable efforts in any given country, the Regional Managers will promote a steady and appropriate phasing-out of headquarters input while increasing efforts to promote policy level decisions that effect the in-country sustainability of the program.

Ideally, Country Representatives should be nationals in government positions where their influence can have an impact. HKI may continue to act as a support to fill in gaps as the system continues to develop.

It is also important to encourage the development of data collection and monitoring systems which can provide the necessary feedback and correct information to all concerned. The development and implementation of management information systems that can be sustained in the host country is an important objective.

5. Solicit input from country directors on initiatives for strengthening headquarters-field relationships and improving program delivery

Country Directors are being kept abreast of all managerial initiatives and their input and ideas will be utilized. Desk officers and regional managers regularly apprise field offices of the results of planning and operations research in their countries and around the world.

As a special initiative, a headquarters-field management conference is tentatively scheduled for September 1989. To be held in New York City, it is in the planning stage and funding is being sought.

This conference is proposed to bring headquarters and field staff together and to reinforce organizational progress in advancing and supporting HKI's strategic planning process by the entire team.

The agenda for this meeting will be discussed and developed at the semiannual headquarters senior staff conference on February 15, 16, 1989.

F. Core Headquarters Staff Development

An analysis of personnel contracts and employee turnover ratios revealed inconsistencies existed within policies and contracts. A lack of communication between professional and support staff was also noted.

To correct this situation and improve the capabilities and efficiency of the core headquarters professional staff, several steps are being taken:

- A Medical Director was appointed in November of 1988 to head the Program Division in response to the perceived need for a senior medical officer on the full-time staff;
- Regional Manager positions have been established to coordinate and manage country projects more efficiently;
- A Field Auditor position has been created to analyze field financial computer operations and assist in the setup of new programs;
- Employee contracts have been standardized in respect to salary, site, length, and job description;
- All personnel forms (evaluation, attendance, absence, etc.) have been standardized;
- Analyses of employee skills have been completed, (through discussions with employees and their supervisors and with upgraded curriculum vitae);
- Job openings are being posted within the agency before outside posting and employees are promoted from within whenever possible;
- Additional job-related training and/or schooling is actively encouraged;
- An open-door policy where staff can air grievances and/or concerns has been emphasized and implemented;
- Program Division support staff has been restructured to provide optimum secretarial and administrative program support to the professional staff;

- A program of annual merit performance evaluations and salary increases is in place;
- Staff meetings are held on a regular basis;
- FAX machines are being installed to facilitate communication with program officers overseas;
- Computer/modem links will be established with field offices, where practical.

These changes, and others, have already improved employee morale. Communication between support, professional, managerial and overseas staff has been strengthened by the creation of several new positions and improved managerial consistency.

The following projects are scheduled for FY 1990 to continue the management development program:

1. A system reflecting organizational changes and/or duties relative to job descriptions;
2. A system of grade and salary ranges reflecting the duties and skills required for each individual position;
3. An Office Procedures Manual and a Field Personnel Manual to further clarify policies;
4. Continued improvements in reducing costs in the health and benefits program;
5. Computerization of unsolicited curriculum vitae of prospective employees for rapid retrieval and referral.

G. Technical Advisory Resources, Structure and Utilization

HKI's program is developed and managed by a small, full-time, professional staff. To supplement this staff, an extensive network of technical advisors has been developed. Currently, however, few guidelines exist regarding how and when these resource persons should be utilized.

Available technical advisory resources include the following:

Medical Advisors: HKI retains three medical advisors, highly qualified and experienced in the agency's program. They are available regularly to counsel the full-time professional staff. The current medical advisors' focus is on the Vitamin A and Cataract Programs. Because of the differing nature of the Education and Rehabilitation program, one specific advisor is yet to be appointed. In the interim, several consultants have served.

U.S.- Based Technical Consultants: Over the years, HKI has developed relationships with a diverse cadre of ophthalmologists and technical specialists who can be called upon when appropriate. These individuals are available for program evaluation, technical review and other assignments. They have experience in specific regions and countries. An up-to-date roster of such individuals is maintained at HKI headquarters.

Developing Country-Based Technical and Professional Resource Persons: HKI Country Directors and Representatives are acquainted with technical and professional resource persons in developing countries where HKI sponsors programs. These individuals provide supportive information in such areas as health planning, ophthalmology, blind rehabilitation and education, social marketing, cost analysis, etc.

HKI Board members: The HKI Board includes members with background and technical expertise in finance, management, health planning, ophthalmology, public education and blind rehabilitation. Extensive and varied professional advice is thus available for consultation and for the assessment and decision-making process.

HKI Vitamin A and Cataract Advisory Committees: The Cataract Advisory Committee is composed of a multi-disciplinary group of professionals from international health, ophthalmology, management, sociology and operations research. Under formation, the Vitamin A Advisory Committee will consist of professionals in the fields of nutrition, public health, epidemiology and ophthalmology. Members from either of these committees may serve as technical resources or may be called upon to serve on task forces or subcommittees.

To utilize the above resources effectively and judiciously, the following initiatives will be researched and, if deemed appropriate, implemented:

1. A plan has been developed for coordinating the work of the Medical Director with Medical Advisors, Advisory Committees, and Technical Advisors (Objective: FY 1989).
2. A policy statement will be developed and submitted to the Board for review and approval, outlining circumstances under which non-staff assessment is required. Such circumstances will include USAID evaluations and outside review by technical consultants (Objective: FY 1989).

3. There will be regular participation by HKI Medical Advisors in planning and reviewing on-going grant-based proposals, assessments and evaluations (Objective: FY 1989).
4. A management memorandum will be circulated outlining procedures for selection and screening of non-staff consultants by a consultant review committee. The Executive Director and Personnel Director will make recommendations for consultant contracts (Objective: FY 1989).
5. A list of available advisors, consultants and other resource individuals, including qualifications and availability, will be developed and updated. Special attention will be paid to utilization of nationals of developing countries (Objective: FY 1989).
6. Assessment of a computer networking capability is planned, allowing "bulletin board" notification on the availability of key resource persons and data (Objective: FY 1990).
7. An implementation plan will be developed for the use of skilled and experienced volunteer ophthalmologists to serve as an HKI Cataract Corps where needed in the field (Objective: FY 1989).
8. Guidelines will be established for a volunteer "internship" program at HKI headquarters and overseas for student interns. Yale University, Cornell, Operation Crossroads and The School for International Training currently sponsor students for such overseas assignments (Objective: FY 1989).

H. Framework for Monitoring and Evaluation and for the Dissemination of Project and Program Results

HKI projects and programs invariably begin by defining objectives, inputs and outputs, and anticipated results. This documentation takes many forms and ranges from the highly structured and detailed to the less formal and general, depending upon the donor involved.

At present, there is no standard protocol for project or program design, monitoring and evaluation. All major components of such a system exist, but are applied is on a case-by-case basis.

Management is committed to developing a system that provides timely information on project/program performance, that regularly evaluates all major agency initiatives, and that clearly identifies responsibilities for these functions. Management also recognizes the need for improved dissemination of project and program results.

A program and project monitoring and evaluation plan will be designed and tested in 1989, with the objective of being fully operational by FY 1990. When this plan is completed, it will be applied to improve the dissemination of project and program results. This should be accomplished by FY 1991. The outline of the plan will address the following issues:

- reasons for monitoring/evaluating;
- individual/agency requiring information;
- components of HKI's approach;
- general questions to be addressed;
- means of gathering and applying information;
- responsibility for gathering/disseminating information;
- timeline and flowchart;
- long-term organizational perspective;
- modes of documentation and dissemination.

I. Strategic Plan Accomplishments

The 1989-1993 Strategic Plan was prepared in October, 1988. Progress has already been made in achieving many of the first year objectives. A "Monitoring and Evaluation Specialist" has been added to the HKI professional staff. As an initial assignment, he has developed a Monitoring and Evaluation Plan which is currently being refined.

The Strategic Plan was strengthened at its inception by encouraging input from all sectors of HKI. The result is a sense of "collective ownership," with objectives extending well beyond the executive office. This augurs well for its future viability. There is general consensus among staff concerning the utility and desirability of this effort and in the accompanying planning process which assists in its implementation. The Plan was not developed or conceived as a set of directives, but rather as a process and set of standards which are realistic, relevant and reasonable.

VI. REVIEW AND ANALYSIS OF PROJECT RESULTS BY COUNTRY

Project achievements are reflected in actions, events, number of persons trained, number of patients treated, meetings held and other such accomplishments. Inasmuch as achievement of planned project outputs is a major reason for their support, event reporting has been given priority.

In this section, an attempt is made to detail what has happened, where it happened, the numbers, and the impact.

After reading, the AID Project Officer should have information which answers the questions: "Is the matching grantee

undertaking and achieving the kinds of things that were agreed upon?" and, furthermore, "To what extent has the success or failure to produce outputs affected the Project's Purpose?"

A. Matching Grant Outputs Specified in the Logical Framework

Outputs specified in the Matching Grant logical framework and those specified in the Bridge Grant outputs are detailed in Attachment 4, Section XII. In the narrative which follows, outputs are reported by country. It will be noted that a series of coded letters and numbers follow each output (e.g., MG1, BG3). These codes refer to logical framework output indicators. Code letters have been developed to refer to the two respective grants, and the numbers following the letters refer to the specified output in the following manner:

MG = Matching Grant
BG = Bridge Grant
e.g., MG1 = 1st output specified by Matching Grant Log Frame
BG3 = 3rd output specified in Bridge Grant specified outputs

By their intrinsic nature, many achievements reported relate to more than one output. An example would be Output 1.4 for Morocco which is coded as (MG2/MG3)/(MG6/BG1) since it relates to several activities. This method permits a brief, efficient and time saving method of reviewing achievements and relating them to specified outputs.

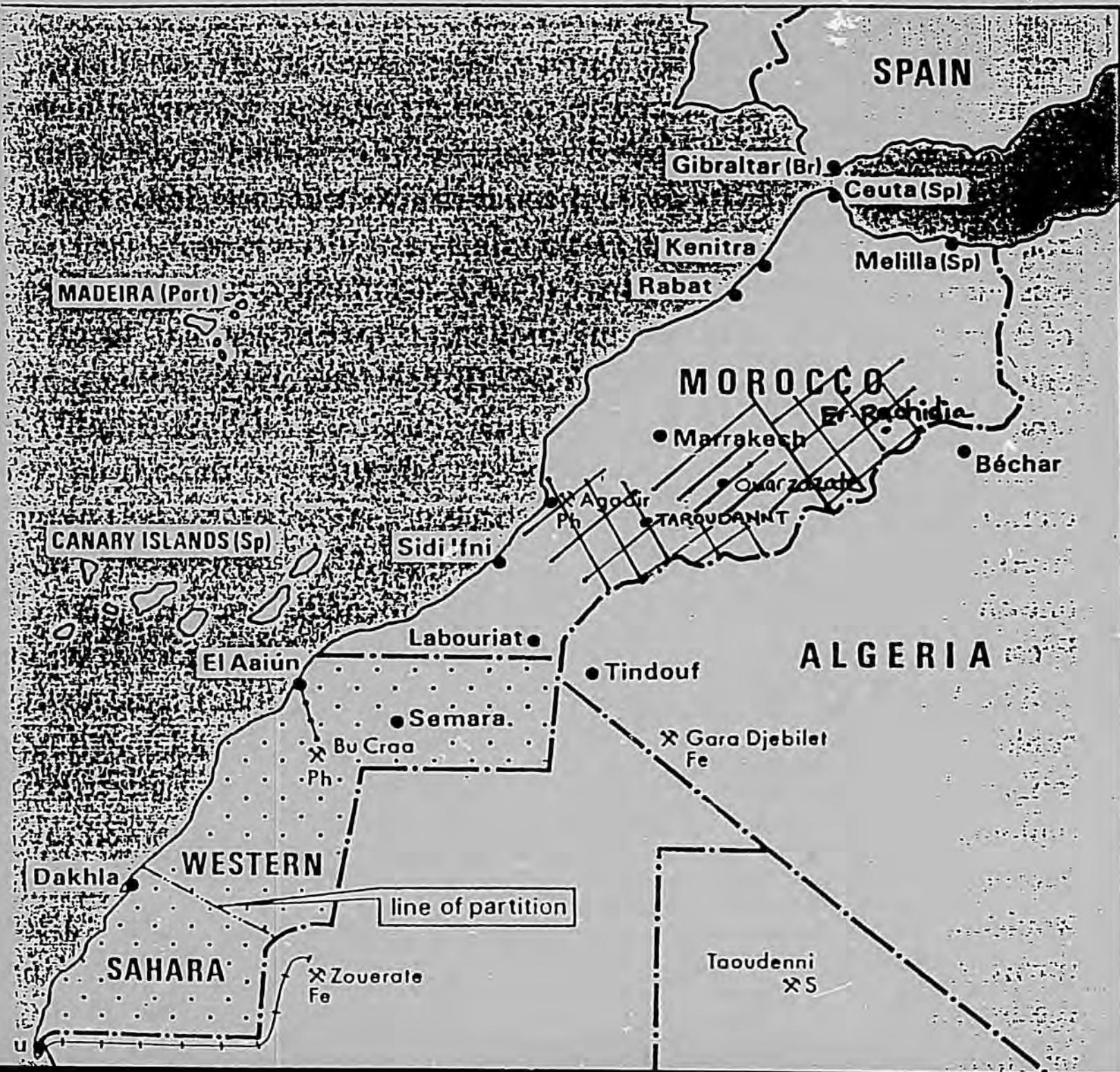
An overall summary reconciliation of outputs by country using the coding system described, is appended in Attachment 4, Section XII.

In this summary table, each output is coded as follows:

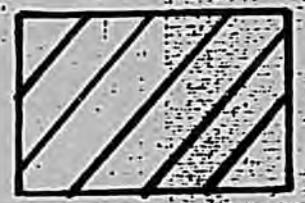
1. by grant (e.g., MG)
2. by output number (e.g., MG6)
3. by country (e.g., PERU)
4. by annual report item number (e.g., 1.27)

This cross referencing method permits the identification of particular outputs reflected in achievements in each country, and also indicates where to find the activities/achievements associated with any particular output in this report.

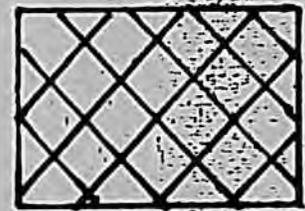
A variant of this method is under study as a conceptually simple project progress management review tool for monitoring, tracking, and internal and external reporting purposes with respect to objectives and outputs in several projects. The method has the value of being simple enough to be easily understood, yet makes it possible to conduct a systematic and flexible review of targets and achievements.



MOROCCO



PILOT SCHEME
1986-1989



REGIONAL
EXPANSION
1989-1993

B. Matching Grant Outputs Achieved - by Country

I. MOROCCO

a. Specific outputs achieved

- 1.01 February 1987: Anne Paxton, HKI Regional Manager for Africa, and consultant ophthalmologist James Sprague visited Rabat and Ouarzazate to further develop the project action plan. During this visit, information was gathered on available eye services in the region, ophthalmic equipment and supplies available, and interested counterparts (MG1).
- 1.02 April 1987: A team of ten (10) ophthalmologists from the national and military hospitals in Rabat visited Ouarzazate and provided one week of intensive ophthalmology services. The team was able to estimate the prevalence of various eye diseases in the area (MG1).
- 1.03 May/June 1987: Two (2) nurses from Ouarzazate were trained at the national hospital in Rabat in ophthalmology in methods to train other nurses in the province. Course curriculum included treatment of common eye diseases, minor surgery to correct trichiasis entropion (the blinding stage of trachoma), and training techniques. The nurse-trainers will be responsible for supervision of trained nurses and for providing treatment for referred patients at the secondary health care level (MG2/MG3)/(MG6).
- 1.04 April 1988: Thirteen (13) health center nurses, one from each health center in Ouarzazate, were trained in blindness prevention. The two-week course curriculum covered anatomy and physiology of the eye and treatment of common eye diseases. These nurses will provide direct services to people from rural areas and refer patients they cannot treat to the provincial hospital. (MG2/MG3)/(MG6/BG1 activity - completed before BG started).
- 1.05 April 1987 - June 1988 Summary: A total of 9,963 ophthalmic patients were seen. Of these patients, 246 had cataract operations and 248 received operations for trichiasis-entropion (MG3/MG6/MG8/MG9).
- April 1987 Detail: A team of ten (10) ophthalmologists from the national and military hospitals in Rabat visited Ouarzazate, saw 728 patients and performed 112 operations. Of the patients seen, 205 had cataracts, 25 trachoma, and 34 trichiasis and/or entropion. Of these operations, 54 were cataract extractions and 25 trichiasis/entropion.

-April 1988 Detail: A second team of ophthalmologists from Rabat and Agadir was organized by the Ministry of Health. 1,005 patients were examined, and 167 patients were operated upon during this one week mission.

-June 1988 Detail: An additional ophthalmology mission was undertaken which provided follow-up visits to those operated in April, as well as providing treatment and surgical services to additional patients. Eight (8) ophthalmologists saw 1,388 patients and operated on 223.

-Throughout the spring of 1988 ophthalmologists from the ophthalmology service in Agadir assisted the project, serving the population of Ouarzazate for periods of one to two weeks.

- 1.06 A training manual for nurses is under development by the MOH/Blindness Prevention Service with HKI technical assistance for use during initial training of nurses, and as a reference. This manual is to be used throughout southern Morocco (BG1/MG4).
- 1.07 Kits for ophthalmic nurses are being developed for distribution to all trained nurses (BG1/MG4).
- 1.08 A public education slide show on personal hygiene, sanitation and the prevention of eye infections was developed for viewing by patients in Moroccan "eye camps" (BG3/MG5) .
- 1.09 An illustrated booklet on eye care, personal hygiene, and sanitation is under development for distribution in primary schools for children and their families (BG3/MG5).
- 1.10 Several newspaper articles describing sight restoring achievements of the "eye camps" were promoted and appeared in national newspapers, resulting in greater public awareness about eye care (MG5).
- 1.11 September 1987: The following diagnostic and surgical equipment, drugs and supplies were supplied to the MOH and designated for the Provincial Hospital in Ouarzazate (MG7/BG4):
- | | | | |
|----------|----------------------------|------|------------|
| 1 | Marco Slit Lamp and Table | Lamp | US\$ 4,150 |
| 165 doz* | Silk Sutures | | 26,461 |
| 2 | Cataract sets | | 5,000 |
| 3 | Cryoextractors | | 5,000 |
| 1 | Zeis Loupe | | 1,200 |
| 1 | Topcon Trial Frame (Adult) | | 170 |
| 1 | Topcon Trial Frame (Child) | | 150 |
| 1 | Trial Lens Set | | 564 |

3	Tonometers	268
28*	Irrigation and Aspiration Kits	875
25	Acuity Charts	50
300*	Occluders	790
200*	Eye Pads	54
3 packs	Color Crayons	24
5	Flashlights	39
13	Golf Club Spuds	676
2	Da-Lite Overhead Tripod Screens	240
1	Da-Lite/Beseler Overhead Projector	330
1	Kodak Slide Projector	384
1	Dai System AF 2100 Slide Projector with Zoom Lens	257
1	Projector with brackets	700
4 packs	Transparencies	12
548 tubes	Neodecadron	1846
372 bottles*	Neodecadron	2638
480 bottles*	Decadron	3350
572 tubes*	Decadron	1687
326 bottles*	Timoptic	2995
260 bottles*	Ophtetic Solution	832
500 bottles*	Genoptic	2530
250 bottles	Pilocarpine	650
200 bottles	Cloramphenicol (Eye Drops)	579
200 tubes	Cloramphenicol	410
60 tubes*	Polypred	522
250 tubes	Gentamycin	825
300 bottles	Atropine 2cc (Eye Drops)	450
300 bottles	Maxitrol (Eye Drops)	960
200 bottles	Tropicamid 1%	560
300 bottles	Proparacaine 2CC	450
100 bottles	Cyclopentalate 1%	<u>1820</u>

Grand Total

US\$70,498

Of this amount HKI expended \$25,918 from AID matching grant funds and HKI gifts-in-kind (*) accounted for \$44,580 of the grand total.

In early 1988 the MOH, supported by HKI's work in the south, created a Blindness Prevention Service in the capital (Rabat) headed by a public health physician. (MG10).

Periodic supervisory visits were undertaken throughout 1987 and 1988 by the ophthalmology service of the national hospital, by HKI NY staff, the HKI country representative, and the Chief of the Blindness Prevention Service of the MOH (MG10).

July 1988: An AID project evaluation was performed. The evaluation team included an ophthalmologist, public health physician and an HKI representative (MG10).

- 1.15 November 1988: HKI's Country Representative visited HKI/New York for program review and action planning, following the "Preyecare" matching grant proposal submitted to AID (MG10).

b. Effects on target groups

- 1.16 Approximately 600,000 men, women and children live in Ouarzazate province. Until the HKI project began, there was virtually no access to blindness prevention services. The region has a high prevalence of trachoma and conjunctivitis and the common blinding conditions of cataract and glaucoma. The need for ophthalmic services was great.

HKI's experience in organizing teams of ophthalmologists to visit the province for one and two week missions, accompanied by MOH personnel, made evident how highly the population regarded this medical service. Over 10,000 people travelled to the provincial hospital from throughout the province to receive an eye examination. Of those 246 received Cataract surgery and 248 a trichiasis entropion operation.

c. Local resource linkages established

- 1.17 A significant linkage was made between ophthalmologists working outside of Ouarzazate in the southern region and the people of Ouarzazate. Ophthalmologists from other parts of the country participated in several training and service missions and gained a greater appreciation of the needs in underserved areas of the country. If the enthusiasm generated in these clinicians can be sustained, this may prove an invaluable source of assistance to people throughout southern Morocco.

d. Impact on local institutions, local policy, and people outside the project

- 1.18 In the GOM 1988-1995 National Health Plan, the Government acknowledged and commended HKI for its ability to provide paramedical training in ophthalmology to nurses and health workers.
- 1.19 In 1988, the MOH created a new service dedicated to prevention of blindness. The Blindness Prevention Service, staffed by a full-time public health physician and ophthalmic nurse, enhances coordination and communication between several governmental and nongovernmental partners in the fight against blindness. HKI served as a catalyst in the creation of this new Service.

- 1.20 GOM and MOH officials involved in the project and HKI staff have met on several occasions with the Governor of Ouarzazate. The Governor is enthusiastic about the project, and has agreed to set up a local blindness prevention committee composed of leaders from the business and public service communities to ensure that efforts begun by the project continue.
- 1.21 The MOH hopes to use the service delivery model refined in Ouarzazate -- which emphasizes the training of nurses in blindness prevention -- throughout the entire southern region. The ophthalmology service in Agadir, nominally providing referral services for the entire south but only effectively providing services to those in the immediate area, has become involved in the project in Ouarzazate.
- 1.22 Ophthalmologists from the Service in Agadir have participated in surgical missions to Ouarzazate. The head of the ophthalmology service, Dr. Medina, has become greatly involved in training project nursing staff in Ouarzazate. Plans are underway for project trainees from the ophthalmology services in Agadir to participate under Dr. Medina's supervision.

e. Unintended effects

- 1.23 Involvement of ophthalmologists from the ophthalmology service in Agadir in the project has been a surprising though unintended result of the project. MOH delay in posting an ophthalmologist full-time to the project stimulated this activity. While it would still be preferable to have a fulltime eye doctor, the fact that others from the region were inspired to go "beyond the call of duty" to assist a neighboring province could be extremely significant. The team from Agadir promised to continue to provide assistance to Ouarzazate even after a full-time ophthalmologist is posted.

f. Actual accomplishments compared with originally proposed activities:

- 1.24 The inability of the MOH to assign an ophthalmologist permanently to the region has temporarily impeded the ophthalmological referral point in the region. HKI, in its role as catalyst, has little power over these decisions, other than to ask repeatedly and remind the government to honor their commitment. In the future, HKI plans to write agreements with the GOM in such a manner that there is understanding of step-by-step conditions, requiring specific actions on the part of each party, before further development takes place. This will provide a financial or supply-tied incentive to the MOH to expedite actions agreed upon.

Peru



II. PERU

a. Specific outputs achieved

Diagnosis and Treatment:

- 2.01 In the first population-based study of its kind 23,929 persons 40 years or older were screened for cataracts in Chimbote, Peru in 1987 (MG8).
- 2.02 As a planned benefit of this study the following clinical services were provided to those participating in Chimbote (MG8):
- 1,172 received an ophthalmic examination,
 - 133 persons received successful outpatient cataract surgery.
- 2.03 An intensive service delivery campaign in outpatient cataract surgery was replicated without a costly house-to-house component in Ica, Peru from July through September 1988 (MG1,6,8,9,10,11/BG1,2).
- 2.04 The following clinical services were supported during the provided campaign in Ica, Peru:
- 1,048 persons over 50 years of age were screened;
 - 260 persons received an ophthalmic examination;
 - 48 patients received surgery for cataract.
- The above activities directly related to a number of project specified outputs (MG1,6,8,9,10,11/BG1,2).
- 2.05 February 1988: OPELUCE carried out a community ophthalmology outreach campaign in Tumbes, Peru with HKI support (MG6,7,8,9,10,11) and participation of 8 ophthalmologists under the supervision of its Board President:
- 814 patient consultations were provided;
 - 19 cataract operations were performed.

Educational materials:

- 2.06 July 1988: The following technical and administrative manuals used in the Chimbote service delivery study were reviewed and modified for the Ica service replication study (BG2):
- 1) Guide for visual acuity examination and social economic study;
 - 2) Manual for ophthalmological examination and surgical risks;
 - 3) Manual for efficient management of a surgical patient;
 - 4) Manuals of surgical procedures (2);
 - 5) Manual for post-operative evaluation of patients.
- 2.07 HKI assisted in developing curricula and related materials for CBR training courses (MG4).
- 2.08 An HKI CBR manual entitled "A Training Guide for Field Workers" has been adapted and translated into Spanish for distribution in Peru and the Latin American region (MG2,4).
- 2.09 Guidelines have been developed and are being written to teach mothers how to manage and stimulate blind preschool children (MG2).
- 2.10 In December 1988, a Cataract Free Zone procedure manual was developed for use in Peru and 9 other Latin American countries (MG4).

Personnel Trained:

- 2.11 During 1987 an ophthalmology resident from the National Institute of Ophthalmology, Lima, received the HKI/Labouisse award which supported training at a one-year (1987-1988) public health ophthalmology course at the International Center for Epidemiologic and Preventive Ophthalmology (ICEPO) at Johns Hopkins University in Baltimore (MG3,10).
- 2.12 Personnel trained in 1987 for the "Cataract Free Zone" project in Chimbote (MG2,3,6).
- 6 nurses trained in post-operative follow-up evaluation of cataract patients;
 - 37 fieldworkers trained for house-to-house survey to identify and refer cataract patients;
 - 750 community volunteers trained to assist fieldworkers.

- 2.13 Personnel trained (BG2) for the outpatient service replication study in Ica:
- 23 medical students to identify cataract patients;
 - 24 fieldworkers to disseminate information about the campaign;
 - 1 nurse;
 - 1 nurses aide.
- 2.14 February 1988: With HKI support, OPELUCE trained 6 nurses and 10 nurse auxiliaries during the community ophthalmology outreach campaign in Tumbes. (MG3,6,11).
- 2.15 January - June 1988: Primary eye care/prevention of blindness training courses given to (MG3,6):
- 574 primary school teachers;
 - 174 health auxiliaries;
 - 20 supervisory nurses;
 - 27 general practitioners.
- 2.16 July - September 1988: Training courses in primary eye care/prevention of blindness planned for training (MG3,6/BG1):
- 410 teachers;
 - 130 health auxiliaries;
 - 60 general practitioners.
- 2.17 A total of 20 CBR field workers have been trained in Puno and Ancash (MG3,6).
- Social Marketing:
- 2.18 Posters, radio spots and pamphlets were developed and produced for the "Cataract Free Zone" campaigns in Chimbote and Ica (MG5/BG2).
- 2.19 A videotape presentation describing the "Cataract Free Zone" project activities in Chimbote was developed and produced (in Spanish) as part of a regional public information activity (MG5).
- Equipment Supplied:
- 2.20 1987-88: Ophthalmic supplies and equipment supplied to the National Institute of Ophthalmology (NIO) Peru included cataract surgery sets and intraocular lenses (IOLs):

3	Cataract Sets	US\$ 15,000
100 sets	Intraocular Lenses	2,000

2.21 A computer, printer, and slide projector were sent the NIO to be used for eye health education. Thermoform equipment for Braille was also supplied:

1	COMPAQ 3 Computer	2,500
1	EPSON Printer	700
1*	Thermoform Braille Duplicator	2,000

2.22 The following miscellaneous equipment was supplied to the NIO during the reporting period:

1	Chargeable handle Welch-Allyn	65
1	Head, Direct Ophthalmoscope Welch-Allyn	48
1	Head of Retinoscope (Streak)	135
2	Forceps, Type Pierse, Colibri 0.1mm Katena	380
2	Westcott Tenotomy Scissors (medium size) Katena	340
1	Slide Projector	385

Pharmaceutical and Medications Supplied:

2.23 The following medications and pharmaceuticals were supplied to the NIO during the reporting period:

12.5 dozen*	Isopto Carpine 1%	836
100 dozen*	Isopto Carpine .5%	6,444
50 dozen*	Isopto Carpine 6%	3,900
90 dozen*	Isopto-Cetapred	7,500
100 dozen*	Isopto Tears 5%	6,060
10 dozen*	Naphcon Forte 1%	750
25 dozen*	Enconopred .5%	2,325
5 dozen*	Isopto-Cetamide	330
75 dozen*	Isopto Carbachol 3%	618
80 dozen*	Timoptic	3,993
1000 units*	Timoptic ocudose	<u>77,380</u>

Total US\$ 133,689

Of the total, HKI expended \$21,553 from AID matching grant funds and HKI gifts-in-kind (*) accounted for \$112,136 (MG7).

2.24 Work is underway to establish an eye glass assembly workshop at the Institute of Ophthalmology. This workshop will reduce the price of a pair of aphakic spectacles from over \$100 to approximately \$25 (MG8,9/BG1).

- 2.25 During 1988, an evaluation of ongoing CBR programs in Puno and Ancash was carried out. A revised CBR program plan was developed based on the evaluation results (MG10,11).
- 2.26 During 1988, Dr. Urcia, Executive Director of the Center for the Rehabilitation of the Blind in Lima (CERCIL) and HKI Rehabilitation Coordinator, began supervision of training programs for field workers in Huaraz and Puno (MG10,11/BG5).
- 2.27 The attendance of HKI counterpart, Dr. Francisco Contreras, Director of the National Institute of Ophthalmology (COLEB) and Chairman of the National Committee for the Prevention of Blindness, at American Academy of Ophthalmology (AAO) annual meetings in 1987 and 1988 was supported by HKI (BG1).
- 2.28 July 1987: Joint PAHO/HKI/WRF Andean sub-Regional meeting on CBR was held in Huaraz, site of an HKI community-based rehabilitation project (BG5).
- 2.29 April 1988: HKI sponsored and supported Dr. Fernando Urcia's attendance at the International Rehabilitation of the Blind Congress in Brazil (ULAC) where he made a presentation on the HKI community based rehabilitation service program model developed in Peru (BG5).
- 2.30 May 1988: Results of the population-based study to eliminate cataracts in Chimbote were presented (Dr. Campos) at the Annual Meeting of The Association for Research in Vision and Ophthalmology (ARVO) in Sarasota, Florida (BG1).
- 2.31 Oct-Nov 1988: An HKI consultant ophthalmologist presented a paper on blindness prevention and three papers on pediatric ophthalmology at the Second National Congress for the Prevention of Blindness and the XII Congress of the Peruvian Ophthalmological Society in Peru. Published results of the CFZ projects were also presented by HKI counterparts at these meetings (BG1,4).

b. Effects on target groups:

- 2.32 Despite problems in rural areas due to political disturbances, MOH statistics indicate 720 reporting sites are now providing results of visual examinations, identification, treatment and referral of cases to secondary or tertiary centers (Lima).

- 2.33 More than 133 persons in Chimbote received cataract surgery. Because of popular demand and improvement in cataract surgical services in Chimbote and Ica, surgery is being provided at twice the previous rate. About one-third of those identified still refuse surgery and HKI is programming better public education techniques.
- 2.34 To reduce the high cost of aphakic spectacles, an assembly workshop will assemble frames and lenses. As a result, the cost of glasses can be lowered from \$100 to about \$25 per patient.
- 2.35 Training in rehabilitation in Puno and Ancash has had a positive effect on 34 blind persons who have been rehabilitated. Increased orientation and mobility has meant more self-confidence and involvement of the blind in community activities, including holding public office.

c. Local resource linkages established

- 2.36 Relationships between the Institute of Ophthalmology and the MOH, Social Services and Education has solidified. Dra. Adriana Rebaza has been a key supporter of the programs instituted.
- 2.37 With HKI's assistance, OPELUCE, an indigenous blindness prevention PVO, continues to conduct eye care outreach in rural areas.
- 2.38 MOH officials, including the Minister, have visited the cataract free zones. The National Eye Institute of the U.S. National Institutes of Health, HKI, and PAHO have worked on the CFZ. Local participation has included mothers' groups, chambers of commerce, churches, etc. in the public education campaign for CFZ.
- 2.39 On the rehabilitation front, several charitable institutions and the Ministry of Social Service are collaborating on the rehabilitation program. Interest by other Latin American countries in the community-based rehabilitation approach grows.

d. Impact on local institutions, local policy, and people outside the project

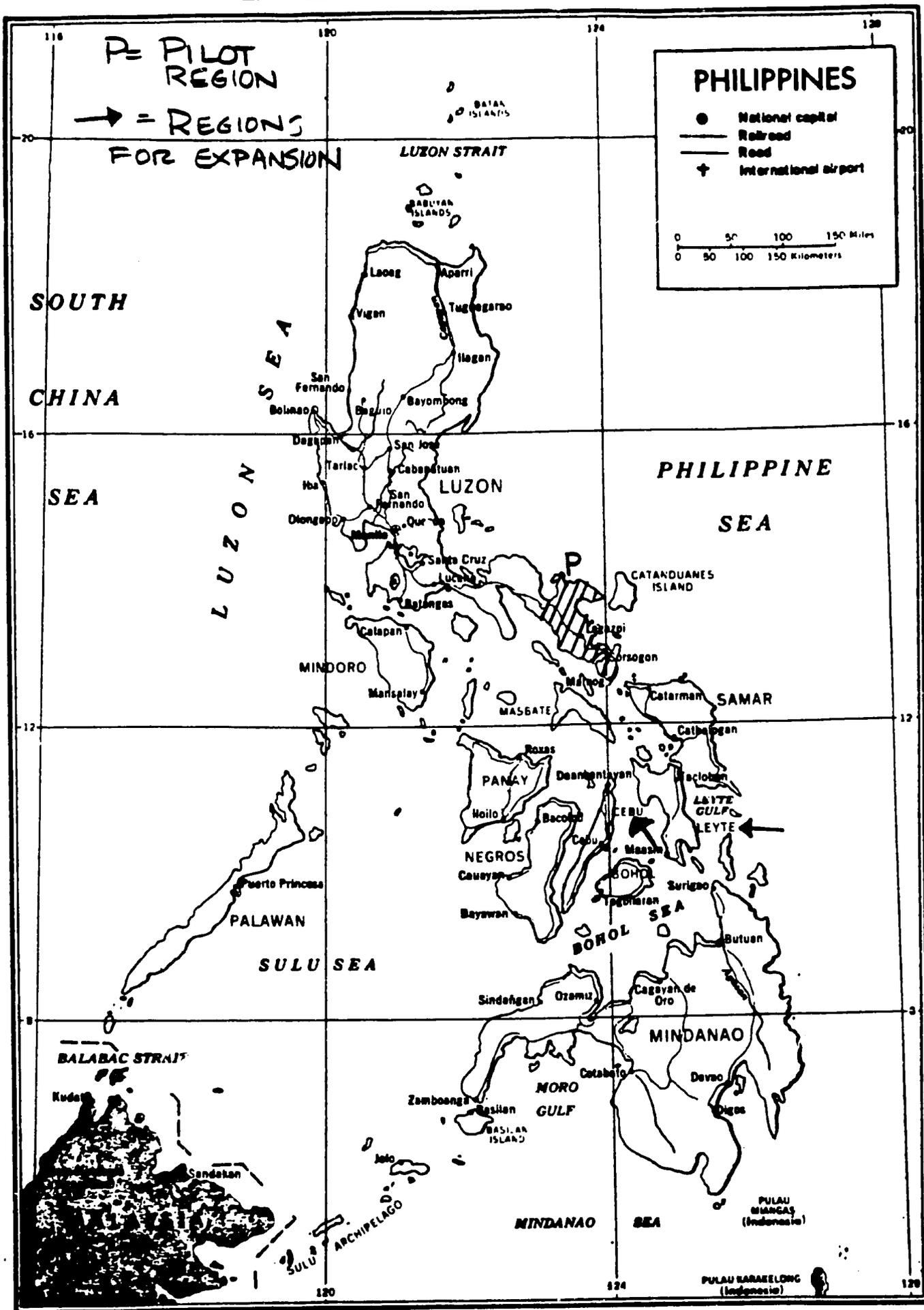
- 2.40 In 1987, the GOP created a new National Eye Institute which included rehabilitation as well as the promotion of preventive and curative aspects of blindness. CERCIL (Center for the Rehabilitation for the Blind in Lima) will assume the role of a national planning, development and training resource.

- 2.41 Although Cataract Free Zones are a U.S.-Peruvian effort, many other Latin American countries (Mexico, Bolivia, Venezuela, Ecuador, Uruguay, Chile) wish to join Peru and Brazil in implementing a Cataract Free Zone. The main impact of CFZ has been to motivate private ophthalmologists to do public ophthalmology and to increase an ophthalmologist's capacities to perform surgery. The cost of cataract surgery performed on an out-patient basis has reduced the \$100-per-night cost of in-patient surgery.
- 2.42 The GOP Minister of Health attended the Second National Congress for the Prevention of Blindness and the XII Congress of the Peruvian Ophthalmological Society in October/November 1988 and strongly endorsed PEC/Blindness Prevention activities being carried out by the Institute of Ophthalmology. These programs were cited as models for other medical activities.
- 2.43 The success of the project's effort to integrate eye care in Puno, Ancash and San Martin has encouraged the MOH to consider expansion of activities to other regions in the Amazonas, probably Iquitos.
- 2.44 The MOH is moving the Institute of Ophthalmology to larger headquarters in a 100-bed hospital which will permit genuine potential for expanding eye services to Limans and those in the surrounding catchment area.

e. Unintended Effects:

- 2.45 Return of a Peruvian ophthalmologist trained in public health ophthalmology in the U.S. has attracted donor support from other agencies, including Orbis and Sight Savers.
- 2.46 The move of the HKI office from Hospital Santo Toribio to the larger headquarters will result in a transition period while reorganization of office space and communications take place.

Map of the Philippines Bicol Region (Shaded)



III. PHILIPPINES

a. Specific Outputs Achieved

- 3.01 July 1987: The Philippine Institute of Ophthalmology and the Philippine Food and Nutrition Research Institute were assisted by HKI in carrying out a National Blindness Prevalence Survey. Results showed cataract to be the most frequent major blinding condition in adults and xerophthalmia the major cause of blindness in preschool children (MG 1,11).
- 3.02 A multisectoral Task Force for Intensified Primary Eye Care (IPEC) was formed. Action plans were developed to intensify and expand PEC services. The first step calls for detailed assessment of HKI project status, strengths and weaknesses, and recommendations for improvements (MG1,10).
- 3.03 July/August 1988: PEC Project Assessment was conducted by Bicol University in collaboration with HKI and the MOH. Assessment focused on PHC worker skills in providing eye care services, community awareness of PEC services, vitamin A and cataracts (MG1/BG2,4).
- 3.04 Two additional trainees were accepted in the Modified Eye Residency Training Program (MRTP) for a total of 5 residents in training (MG3,6).
- 3.05 3,073 patients with eye problems were served by the MRTP residents (MG3,6,7,8/BG2).
- 3.06 Upgrading of the Camarines Sur Regional Training Hospital through the MRTP Program was accomplished. Diagnostic equipment and supplies are being supplied by HKI as training progresses. The hospital staff is being trained on a daily basis to help screen and follow-up eye patients (MG3,6,7/BG1,2).
- 3.07 1987-88: 60 new health care workers were trained in primary eye care skills in Albay and Camarines Sur. Refresher courses focusing on cataracts and vitamin A deficiency were given to health workers at the RHU level (MG3,6).
- 3.08 March - April 1987: 79 Department of Health personnel in Bicol were trained in PEC (MG3,6).

- 3.09 With HKI assistance, The Philippines continues to develop and field-test innovative training materials - manuals, guidelines and visual aids (flipcharts, vision screening charts) for all levels of eye care health workers. The newest development is reconceptualizing and packaging PEC training topics into individual modules (Affective, Clinical Diagnosis, Clinical Procedures, Epidemiology, Office Procedures etc.), incorporating PEC assessment recommendations (MG4/BG2).
- 3.10 A documentary film on cataracts has been developed in collaboration with the Philippine Information Agency. The film depicts "before and after" case histories of cataract patients and encourages people who have relatives with cataracts to seek help for them. TV spots, posters and pamphlets were also utilized to support the cataract sponsorship program in Metro Manila (MG5/BG2).
- 3.11 Five cataract outreach missions serving 69 patients (44 of which were cataract patients) were carried out with collaboration of the Rotary Club of the Philippines, the Peace Corps and the Philippine Society of Ophthalmology (MG6,7,8,10,11).
- 3.12 Basic diagnostic and medical equipment was purchased by HKI for use by residents in the MRTTP in preparation for the postgraduate services they will provide when detailed to their respective provincial hospitals (MG7/BG1):
- 5 cataract sets
 - 3 minor surgical sets
 - 5 diagnostic sets
 - 3 loupes
 - 1 trial lens and frame set
 - 1 Ishihara color test chart
 - 2 tonometers
- 3.13 Ophthalmic supplies and equipment provided to the project are as follows: basic diagnostic and surgical equipment, including cataract sets given to all 5 residents in the MRTTP (as above); cataract instruments and surgical supplies provided to 4 government hospitals participating in the cataract sponsorship program; supplies, including tetracycline ointment and vitamin A capsules, provided to rural health units. Ophthalmology books and periodicals have also been provided (MG7/BG1,2).

3.14

Details and cost data on equipment and pharmaceuticals supplied to the Philippines follows: (MG7/BG1,2)

3 sets	Cataract set	US\$ 15,000
3 sets	Retinoscopes, ophthalmoscopes, Welch-Allyn	345
1 set	Retinoscope, ophthalmoscope, Heine	115
1 set	Loupe, Keeler	60
1 set	Ishihara color test chart	50
1 set	Trial lens set	564
1 set	Trial frame	170
3 pcs	Toothed forceps	222
3 pcs	Chalazion forceps	222
3 pcs	Enucleation scissors	144
3 pcs	Lid guard	39
4 pcs	Bard Parker blade handle	288
3 pcs	Cautery	66
3 pcs	Muscle hook	72
6 pcs	Lid retractor	174
3 pcs	Dilator Punctum	24
5 pcs	Currettes	210
3 pcs	Enucleation spoon	180
18 pcs	Lacrimal probes	324
1 pc	Tonometer, Schiottz	90
1 pc	Slit-ended forceps	74
1 pr	Scissors	200
1 pc	Caliper, Castroviejo	128
6 pcs	Serefine, curved	108
1 pc	Strabismus hook, Graefe	24
2 pcs	Air injection cannula	18
2 pcs	Troutmann Alpha-Chymar	24
2 pr	Scissors, Westcott	340
3 pcs	Tying forceps, McPherson	336
2 pcs	Castroviejo scleral scissors Right	412
2 pcs	Arruga capsular forceps	376
2 pcs	New Orleans lens loop	76
2 pcs	Schweiger capsular forceps	376
2 pcs	Harms tying forceps	224
2 pcs	Randolph Cyclodialysis Spatula	28
2 pcs	Castroviejo tying forceps	224
7 pcs	Jewelers forceps	105
2 pcs	Malleable retractor iris	48
2 pcs	Castroviejo Cyclodialysis spatula	136
4 pcs	Tenant Troutman forceps	584
2 pcs	Irrigator bulb	70
1 pc	Hemostats	11
1 pr	Iris scissors, curved	157
1 pc	Castroviejo colibri Forceps	128
1 pc	Needle holder	252

3.14 Equipment and pharmaceuticals supplied
(continued):

125	doz*	Isopto Carpine (different strengths)	8,390
15	doz*	Isopto-Carbachol (different strengths)	1,627
16	doz*	Isopto Cetamide 15%	1,047
2	doz*	Isopto Homatropine 2%	108
11	units*	Isopto Eserine .5%	83
14	doz*	Maxitrol Ointment	1,260
5	doz*	Maxitrol	480
70	doz*	Cetapred Ointment	2,904
30	doz*	Cyclogyl (diff.strengths)	3,240
12	doz*	Alcaine	828
5	doz*	Maxidex	1,269
2	doz*	Cetamide Ointment	132
50	doz*	Isopto Tears 5%	2,760
10	doz*	Naphcon Forte 1%	750
25	doz*	Mydriacycl 1%	3,225
120	doz*	Isopto Cetapred	9,840
4	boxes*	Steri Units	30
100	doz*	Zincfrin	6,300
4	boxes*	Pilocarpine	30
35	doz*	Isopto atropine 1%	1,851
13	doz*	Duratears ointment	563
16	doz*	Mydfin 2.5%	864
2	doz*	Mydrinyl	234
2	doz*	Isopto hyoscine	72
1	doz*	Tobrex	81
2	doz*	Gonioscopic	156
6	doz*	Alcaine .5%	414
50	doz*	Econochlor 5%	1,170
45	doz*	Isopto homatropine	2,430
50	doz*	Zolyse	10,680
20	doz*	Atropine sulfate	557
34	doz*	Tetracaine	1,840
6	doz*	Tetracaine hydrochloride	176
2	doz*	Sulfacetamide sodium	63
10	doz*	Fluoroscein sodium	294
20	doz*	Pilocarpine hydrochlde	587
6	doz*	Alcaine prop.	414
2	doz*	Balance salt solution	436
3	doz*	Timoptic	36,740
230	sets	Intraocular lenses	54,560
8	boxes*	Sutures	541
50	doz*	Eye shields	384
6	boxes*	Ophthalmology Books	2,200
	Ophthalmology	Periodicals	<u>1,011</u>

Grand Total

US\$ 185,439

Of the total expended, \$22,818 came from AID matching grant funds while HKI gifts-in-kind (*) accounted for \$162,621 of the grand total.

Cataract surgical supplies were also provided to the Rotary Club of Manila, Bataan Processing Zone, and FEU Hospital (MG7,11).

Cataract spectacles were provided for indigent patients who had cataract surgery under the cataract sponsorship program (MG8,9).

July 1988: an HKI consultant was sent to the Philippines to conduct a feasibility study on setting up an optical workshop to produce low-cost aphakic glasses to serve patients participating in the cataract sponsorship program and in outreach missions. In December 1989, the first such workshop is to begin service, reducing the cost of glasses from \$ 10. to \$ 4. U.S. (MG9/BG2,3).

September 1987: HKI sponsored a national blindness prevention meeting for key individuals and organizations concerned with the blindness problem in the Philippines. Meetings/seminars on blindness prevention were held during this period and directed toward NGOs and PVOs involved in some aspect of blindness prevention and rehabilitation (MG11).

July 1987: The HKI Country Director (Philippines) made a presentation on HKI's activities in Blindness Prevention and Rehabilitation at the International Lions Club convention in Taipei, Taiwan (BG2).

June 1987: An assessment of the performance and impact of the Philippines PEC and rural rehabilitation of the blind program was conducted by an HKI external evaluation team. The overall evaluation was positive. The project was found to be functioning well within the existing health care system. Recommendations from the evaluation have proven useful in subsequent project planning activities. (BG2).

An HKI in-depth evaluation of PEC training program/materials (including community eye health education materials) has been planned, the evaluation instrument developed and reviewed. The field phase is scheduled to take place in January 1989 (BG2,3).

Rehabilitation of the Blind (not funded by Matching Grant):

- 3.22 HKI sponsored training of 19 Department of Social Welfare and Development (DSWD) trainers from 4 regions of Mindanao in CBR skills. (HKI's CBR training manual for field workers was used as a reference.) HKI assisted training of RRB workers began in 1978. This latest phase represents expansion of the program within the DSWD.
- 3.23 Production and printing of a CBR reference manual for CBR workers within DSWD was supported.
- b. Effects on target groups
- 3.24 Increased awareness of the PEC program has been shown by requests for increased coverage and expansion of activities. For example, the Bicol Project has come to the attention of Deputy Health Minister Manuel Roxas who is presently encouraging replication of the Bicol model in Cebu Region. Requests from the Sorsogon Vitamin A project have also been received for PEC training.
- 3.25 Changes in attitudes of professionals and ophthalmologists toward primary eye care has been evidenced by inclusion of PEC in lectures, conferences and school curricula. Several prominent Manila ophthalmologists have accepted the fact of the magnitude of the cataract problem in the country and have begun encouraging cataract "eye missions" to be mounted for rural areas. (Note: Over 200 ophthalmologists are located in Manila, yet less than 10 do public health ophthalmology outside the capital).
- 3.26 Increased community awareness of curable cataract blindness is being shown in a growing demand for cataract services. Use of the Philippines Information Agency, national media, and local public education efforts by HKI and others have influenced this development.
- 3.27 Vitamin A deficiency is being viewed as a priority issue by the Department of Health, a reflection of the increased awareness of the problem.

- 3.28 Cataract patients, lacking the \$20 for medication and aphakic spectacles, were formerly turned away from Manila's main hospitals. They are now being served at a rate of about 1,000 per year through an HKI-stimulated Cataract Sponsorship Program.

c. Local resource linkages established

- 3.29 As a "first," with HKI's encouragement and brokering, the Philippines' Institute of Ophthalmology and the Ministry of Health met and agreed to join forces. This linkage provides a sharing of knowledge and programming in areas of vitamin A deficiency, Primary Eye Care, Cataract and Related Eye Surgery.
- 3.30 Linkages have been effected through cataract outreach missions conducted by HKI, US Peace Corps, the Philippine Society of Ophthalmology and the Rotary Club of Manila, in collaboration.
- 3.31 Recently, a new collaboration was established with the Australian Embassy to fund the low-cost cataract spectacle laboratory. It will serve indigent patients in the cataract sponsorship program and also function during outreach missions.

d. Impact on local institutions, local policy, and people outside the project

- 3.32 The Modified Residency Training Program (MRTP) has served as a training model. It demonstrates that:
- (1) high-quality ophthalmic training can be provided outside of Manila;
 - (2) DOH medical residents who come from areas lacking eye services can serve as a means to build up eye care services in rural areas;
 - (3) PVO planning and management expertise, when combined with local technical expertise (through the Institute of Ophthalmology), can implement innovative programs which might not otherwise have materialized.
- 3.33 Local eye care organizations and PVO's such as Rotary Club, Lions Club, the Philippines Society of Ophthalmology and the Philippines ophthalmological community have been networking with HKI stimulation to identify and refer cataract patients for surgery.

3.34 The concept of primary eye care integrated in the Barangay Health Worker (BHW) training program has become institutionalized and has long term potential for being replicated and sustained in the country.

e. Unintended effects

3.35 HKI programs have been slower in becoming institutionalized than desired since they are often viewed as "HKI projects." Every effort is being made to turn over planning, management and training aspects of the primary and secondary eye care program to regional public health officials.

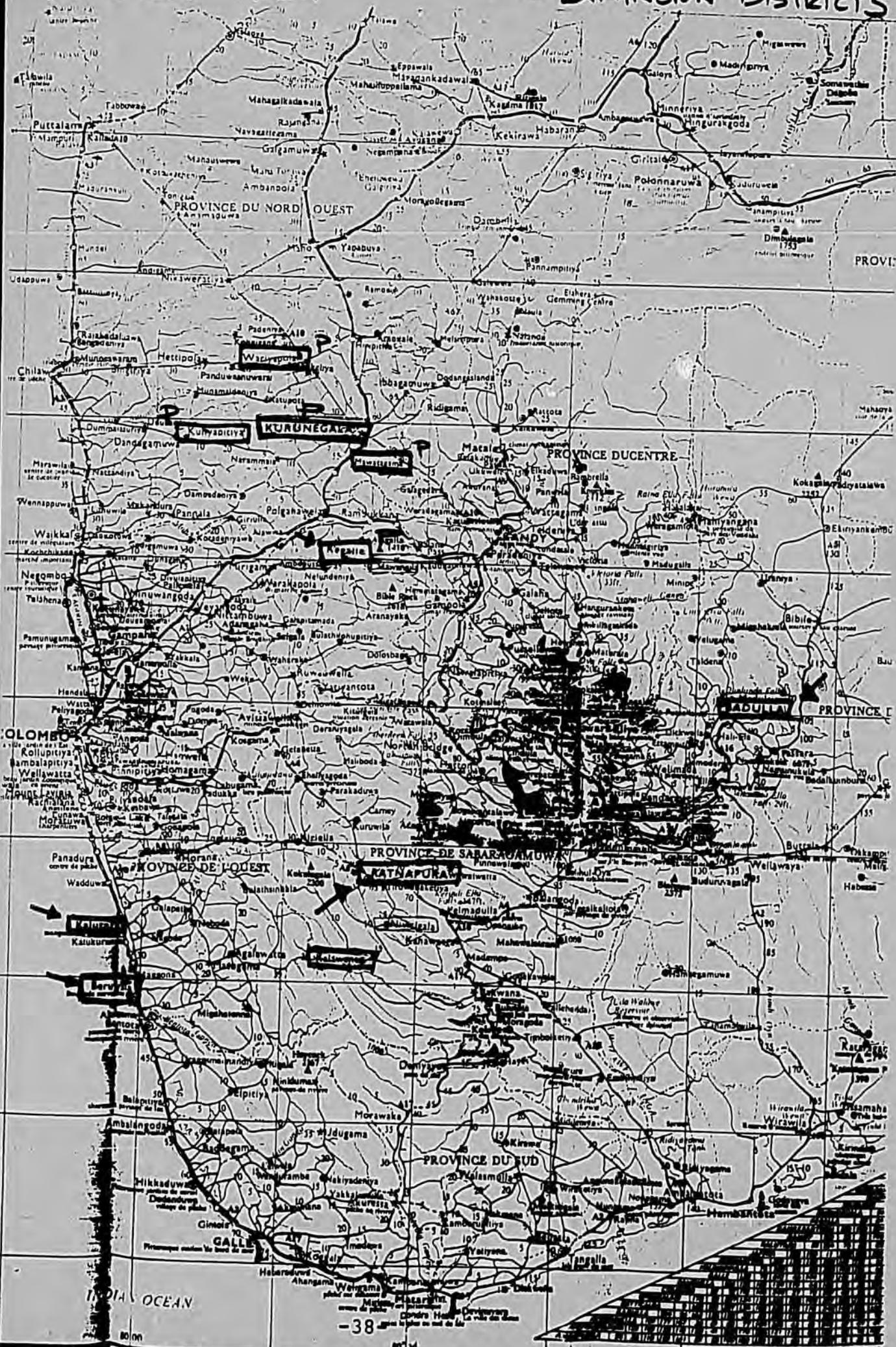
f. Actual accomplishments compared with originally proposed activities

There were large gaps in planned vs. accomplished activities, as a consequence of the following constraints:

- 3.36 Negative Political "Fallout" on HKI resulted from an interrupted Vitamin A and mortality study. This continues to tarnish PEC activities in Bicol;
- 3.37 The turn-over rate of previously trained PEC workers has been substantial;
- 3.38 Organizational changes in the DOH (beyond HKI's control) resulted in a loss of trained workers;
- 3.39 In June, 1988, HKI underwent an organizational transition with departure of HKI Country Director Jeff Watson who had played a key role in all PEC activities in Albay province;
- 3.40 Absence of a technical anchor person in the Regional Health DOH Office to coordinate PEC activities slowed progress;
- 3.41 A devastating typhoon ravaged the Bicol region, necessitating a focus on health relief interventions. Clinics, supplies and educational materials facilitating PEC service provision were badly damaged. Scars still remain almost one year later;
- 3.42 Cataract outreach missions in Albay were suspended in 1987 in order to concentrate on the medical residents who are trainees and to apportion surgical supplies more equitably to serve patients being treated at the Naga training hospital.

P = PILOT AREA

→ = EXPANSION DISTRICTS



IV. SRI LANKA

a. Specific Outputs Achieved:

Geographic Project Coverage:

- 4.01 The PEC/cataract services pilot project service delivery model in Kurunegala District has been expanded to four additional districts. Program expansion includes training primary health care workers to recognize and treat basic eye diseases and encourage and support the ophthalmologists in the area to serve the public (MG1,10).
- 4.02 The new districts chosen by the MOH are: Kalutara, Ratnapura, Badulla, and Kegalle (MG1,10).

Health Personnel Trained (MG3)

- 4.03 75 field staff from 10 MOH project areas were trained in PEC interventions at Kurunegala in 1987.
- 4.04 2 medical officers were trained in primary eye care at Kurunegala General Hospital Eye Clinic.
- 4.05 86 field workers were provided refresher training in vision testing and first aid for eye injuries arising from accidents.
- 4.06 18 medical officers were provided with a refresher course which reviewed blindness epidemiology in Sri Lanka.
- 4.07 25 assistant medical practitioners and registered medical practitioners were trained in diagnosis and management of simple eye conditions at the Eye Unit of Kandy General Hospital.
- 4.08 22 field workers were provided with a health education refresher course on strengthening eye care education activities.
- 4.09 14 medical officers from three new districts were trained in PEC (October - December 1987). Training strategies adopted were those used in Kurunegala.
- 4.10 27 medical officers, 18 medical practitioners and 88 field health workers received training in PEC in the three new health areas (MG3,6,7,8,9).

- 4.11 5 supervisors and 3 selected field workers were given a CBR "training of trainers" residential training course. (MG2,3,6).
- 4.12 36 field workers were trained by 8 HKI-prepared trainers in a course for field workers in CBR (MG3,6).
- Training Courses and Workshops Provided (MG3):
- 4.13 Training sessions for Medical officers from three of the new districts were held in PEC intervention approaches from October through December, 1987, in light of HKI expansion of PEC/BP activities to four additional districts. (See 4.09) (MG3,6,7,8,9)
- 4.14 In the three new health areas, PEC training was provided to medical officers, medical practitioners and field health workers. (MG3,6,7,8,9).
- 4.15 Three 3-day PEC training courses for field staff from 10 MOH project areas were held at Kurunegala (See 4.03)
- 4.16 Two 1-day refresher courses were held for 54 and 32 field workers respectively on a practical skills review, including vision testing and first aid for eye injuries arising from accidents (See 4.04).
- 4.17 A refresher course was conducted for medical officers reviewing the epidemiologic situation of blindness in Sri Lanka (See 4.06).
- 4.18 One 1-day refresher seminar on diagnosis and management of simple eye conditions for assistant medical practitioners and registered medical practitioners was conducted at Kandy General Hospital (See 4.07).
- 4.19 One 1-day health education refresher course was held for field workers to promote eye care education activities. (See also 4.08)
- 4.20 One 3-day CBR "training of trainers" residential training course was provided for supervisors and selected field workers. A suitable curriculum outline for training field workers was developed during this course (MG2,3,6).

- 4.21 Two 2-week training courses were developed and the 8 HKI-trained CBR trainers were used for training of field workers in CBR (MG3,6).

Seminar/Workshop/Publication/Meeting Activity:

- 4.22 A workshop was held in association with the Faculty of the NIHS Kalutara to develop a curriculum based on the Kurunegala experience in order to ensure uniformity in training PEHC workers in the 4 new districts. Since 1984 HKI has assisted Sri Lanka in development of standardized training curricula and manuals for assistant medical practitioners, registered medical practitioners, public health midwives, public health inspectors, and village volunteers. (MG2/BG4).
- 4.23 February 1987: A seminar co-sponsored by WHO and HKI was held for media people working in Kurunegala District to promote public awareness of the PHC/PEC program (MG5).
- 4.24 May 1987: A 3-day National Meeting, jointly sponsored by HKI and WHO, was held in Colombo to formulate a national plan for prevention of blindness. HKI's efforts were highlighted, as the Kurunegala program is being used as the national model for primary eye care (MG10,11).
- 4.25 HKI Country Director, Dr. Tilak Munasinghe, has been appointed National Blindness Prevention coordinator. He convened a national planning meeting on cataract surgery on June 14, 1988. The government has taken the lead in blindness prevention efforts and has identified targets of 15,000 cataract extractions in 1988 and 19,000 per year until 1992. The program will eventually be expanded to all 23 districts (MG10,11).
- 4.26 HKI's Country Director participated in a Ministry of Education training program for special education teachers, focusing on the epidemiology and prevention of blindness and community-based rehabilitation, with special reference to the rehabilitation of blind preschool children (MG3,6/BG8).
- 4.27 HKI's Country Director participated in a WHO Regional Intercountry Workshop on PEC in Thailand (MG10/BG9).

- 4.28 A paper entitled "Identification of the Blind and Visually Impaired in Sri Lanka" was written and published by HKI staff. It indicated that key informants identified more functionally blind persons with less cost and fewer manpower hours than house-to-house surveys. Based on these findings, key informants will be used in future program activities (MG1,10).

Education and Training Materials Developed/Utilized:

- 4.29 A video on the CBR project is in final stages of development as part for a national public information program (MG5/BG6).
- 4.30 HKI's CBR manual, "A Training Guide for Field Workers," is being used as a resource for the CBR project field supervisor and administrator (MG4)

Equipment, Supplies and Medication Provided:

- 4.31 HKI provided ophthalmic equipment and medications to the project area as follows (MG7):

53	doz*	Cetrapred ointment	US\$ 4,134
5	doz*	Isopto homatopine 2%	270
2	doz*	Mydriacyl .5%	234
2	doz*	Isopto hyoscine	144
3	doz*	Gonioscopic	234
65	doz*	Isopto atropine	3,474
52	doz*	Isopto cetapred	4,056
12	doz*	Dura tears	562
34	doz*	Mydfrin	1,836
50	doz*	Zolyse	10,680
736	doz*	Timoptic	36,740
50	doz*	Eye Shields	384
48	sets*	Intraocular Lenses	<u>11,040</u>
Grand total			US\$ 73,788

Materials donated in the amount of US \$73,788 were from HKI's gifts-in-kind (*) program.

- 4.32 Together with WHO, sets of cataract surgical instruments were provided for hospitals in Kurunegala District (MG7/BG1).
- 4.33 Availability and suitability of low-cost cataract surgical instruments from China for use in the Sri Lanka program is under investigation by HKI (MG7).

Monitoring/Reporting/Evaluation:

- 4.34 David Korten, an external consultant, evaluated the PEC/Cataract and CBR efforts in Sri Lanka. He emphasized, among other things, performance-oriented management as a major need to properly utilize trained manpower and resources to maximize the capacity of the health system which has been stimulated by HKI's efforts (MG10).
- 4.35 Dr. Norval Christy, noted ophthalmologist, and Dorothy Christy, operating room nurse, evaluated the cataract and nursing aspects of the Sri Lankan program. Their assessment indicated that Sri Lanka has succeeded in stimulating ophthalmologists and public health officials to address the problem of blindness in Sri Lanka. They recommended several appropriate technological innovations that could be used in Sri Lanka, which would reduce the overall cost per patient and increase the efficiency of the system (MG7,10).
- 4.36 An HKI in-depth evaluation of the primary eye care training program/materials, including the use of community eye health education materials, is in process. The evaluation instrument has been developed and is presently being reviewed. The field work is scheduled to take place in January 1988 (MG10/BG4).
- 4.37 A reporting system for the community based rehabilitation efforts was introduced and data was submitted to each district supervisor (MG10/BG2).
- 4.38 Self-evaluation was introduced in the community based rehabilitation program in relation to skills achievement; it proved less objective than outside evaluation (MG10).

b. Effects on target groups

- 4.39 Satisfactory levels of primary eye care services at the community level were maintained in the pilot district. While the total number of cataract surgeries increased during the second quarter of 1988 by a factor of two, certain surgical centers have not been holding sessions due to lack of manpower or an infection in the hospital.
- 4.40 The number of hospital beds for eye patients have been increased in Kaliyapitiya due to the good results and energy of the ophthalmologist, Dr. Mallikarachi.
- 4.41 Korten implies that the rural population served is quite sophisticated and that a major problem exists with unqualified practitioners and Ayurvedic treatment. The transition from traditional healing to prevention and clinic healing is noticeable as patients come for "western medicine" after the failure of the traditional techniques.

- 4.42 Increased awareness of availability of services in Kurunegala district has occurred. There is an increased demand in new districts and a waiting list for cataract surgery.
- 4.43 Community based rehabilitation has not met expectations for widespread impact due to limitations of the HKI-Sarvodaya partnership. HKI needs to include the Ministry of Social Services.

c. Local resource linkages established

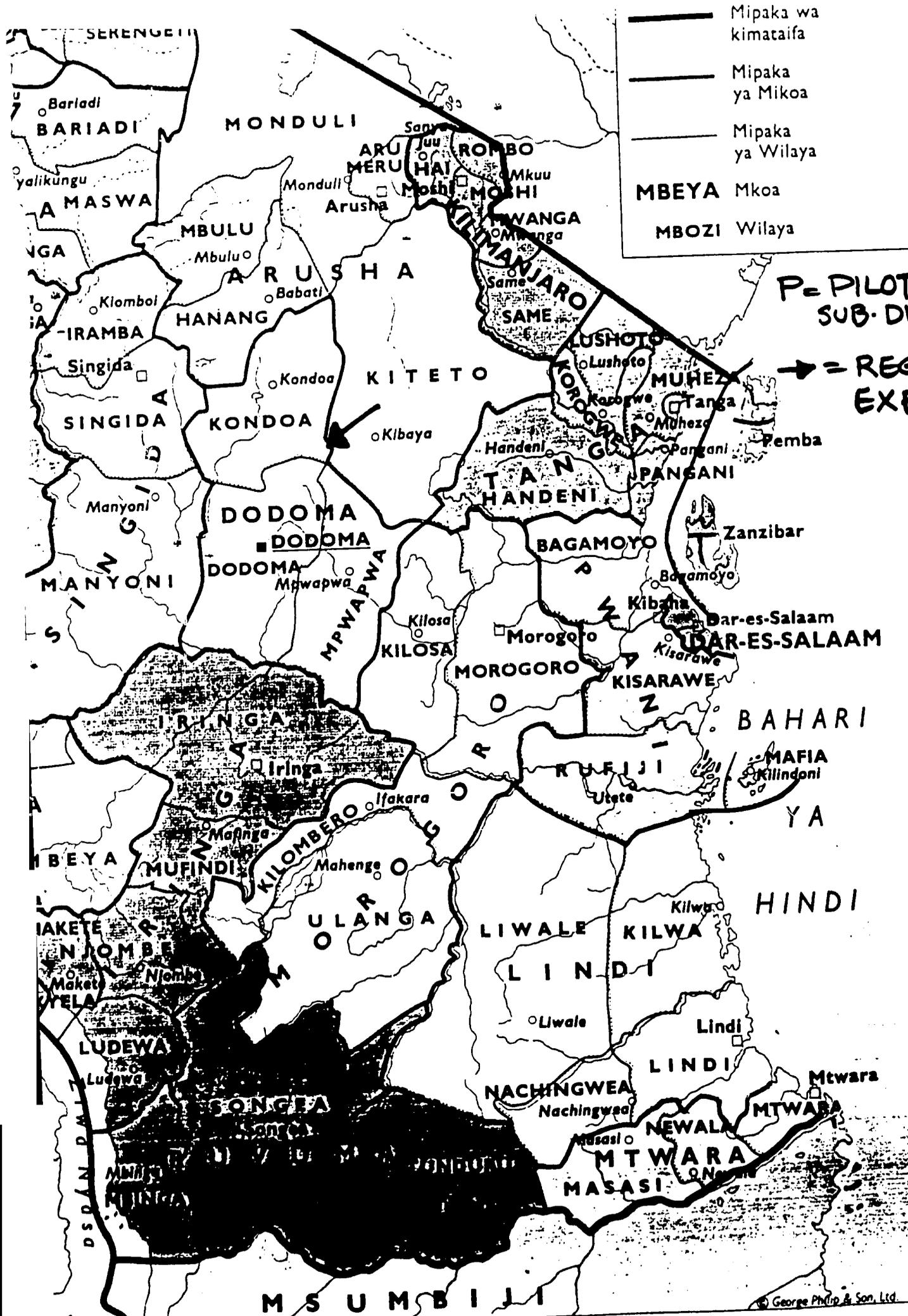
- 4.44 Expansion has resulted in the cooperative services of four new ophthalmologists. The activities in Kurunegala district have served as a model and a laboratory for the expansion.
- 4.45 Lions Clubs have assisted in construction of an operating theater in Rathnapura.
- 4.46 Integration of the Swedish Handicapped International Agency (SHIA) program has been accomplished for the Rehabilitation Program.
- 4.47 UNDP is assisting the program (through a \$75,000 grant to Eye Care Activities).
- 4.48 Relations with the Ministry of Social Services and the Director General of Health Services have been solidified.

d. Impact on local institutions, local policy, and people outside the project

- 4.49 The program has expanded to four new districts.
- 4.50 An attempt is being made to integrate activities with SHIA in CBR.
- 4.51 The support of Lions Clubs has been positive.
- 4.52 Dr. Reggie Pereira and Dr. Seimon have cooperated to accomplish training.

e. Unintended effects

- 4.53 Korten's report reveals two weaknesses: performance management and failure to integrate CBR services. A recalculation of strategy prompts HKI HQ to reassess its role and add a monitoring and evaluation specialist to address these problems.
- 4.54 HKI looks to SHIA and agencies in addition to Sarvodaya to cooperate on the Rehabilitation Program.



- Mipaka wa kimataifa
- Mipaka ya Mikoa
- Mipaka ya Wilaya
- MBEYA** Mkoa
- MBOZI** Wilaya

P = PILOT SUB-DISTRICT
→ = REGIONAL EXPANSION

V. TANZANIA

a. Specific outputs achieved

- 5.01 Ten (10) village health workers, trained in primary eye care and cataract referral during the previous reporting period, continue to promote blindness prevention basic treatment of common eye diseases in their villages. Health workers rotate through the district health center periodically to upgrade their skills (MG3/MG6/BG1).
- 5.02 The Kongwa Eye Care and Surgical Clinic, developed under the project in 1984, continues to provide services weekly to patients referred from their villages by the village health worker. In the initial five project villages; an estimated
- 6,000 people have been treated at the Kongwa clinic;
 - 120 patients have had cataract extractions;
 - 1,500 lid rotations have been performed (MG6,8,9/BG1,2).
- 5.03 May 1988: 15 nurse auxiliaries (13 from district level health centers and 2 from district hospitals in Dodoma Region) were trained to detect, refer, follow-up, and motivate cataract patients, to treat other common eye conditions, and to schedule and keep records of eye care services. Reporting forms and teaching posters were given to each of the participants in the training seminar (MG2,3,4,6/BG1).
- 5.04 August 1988: 12 village health workers were trained to detect and refer cataract patients, treat communicable eye diseases, and teach personal hygiene and environmental sanitation (MG2,3,6/BG1).
- 5.05 Cataract surgical equipment and supplies, as well as equipment, materials and supplies for the primary eye care project, were provided by HKI as follows (MG7/BG1):

2	Cataract Sets	US\$ 10,370
12	Cryoextractors	120
2	Toyota Hilux vehicles	32,414
1	Photocopier	1,307
1	Camera	127
2	Sleeping Bags and	
3 pairs	Boots	172
1	Megaphone	165
1	Calculator	20
600 dozen*	Sutures	6,000
100 bottles*	Ophthalmic	520
50 tubes*	Polypred	520
300 bottles*	Genoptic	1,482
100 bottles*	Atropine Sulfate	<u>281</u>
	Total	US\$ 53,498

HKI funds used for Tanzania project since last reporting period (Dec. 1986) until June 1987:

The total contribution made by HKI to Tanzania amounts to \$53,498. Of this amount HKI gifts-in-kind (*) account for \$8,803 of total.

5.06 AID matching grant funds (Bridge Grant) used as of July 1988 for materials for program in Tanzania (MG7/BG1).

2000 tubes	Tetracycline eye ointment	380
1	IBM Computer/hard disc	1,083
	Motorcycle spare parts	<u>118</u>
	Total	US \$ 1,581

Through the combined HKI/USAID resources, the project in Tanzania has received equipment, supplies, and medications totalling US\$ 55,079 during this reporting period.

5.07 March 1988: A trachoma intervention research and development study began as a cooperative venture between HKI, the Government of Tanzania and Johns Hopkins University (the International Center for Epidemiologic and Preventive Ophthalmology). This study proceeds from an earlier trachoma study undertaken with the same groups in 1984; namely, a trachoma risk factor survey. The current study hopes to provide useful information on community-based trachoma intervention for future program development. The study will focus on improving hygiene -- especially face-washing of children -- and fly control, as these interventions seem to address the risk factors shown to correlate most strongly with trachoma transmission (MG1/BG6).

- 5.08 HKI's consultant in community-based rehabilitation visited Tanzania in August 1988 to begin implementation activities for a rehabilitation program. Data was collected in 1986 on the needs of the irrevocably blind, and referrals of children to schools for the blind were made. In this intervention, a community development specialist, identified and seconded by the government to the project in August 1988, will receive training in rehabilitation. He will then work directly with the blind in their homes, training them in mobility, life skills, and income-generating activities such as farming (MG1).
- 5.09 In 1988, the primary eye care project was expanded to 5 new villages in the Dodoma Region (MG1/MG10/BG5).
- 5.10 Tanzania was one site of the USAID evaluation visit in July 1988. A team composed of an ophthalmologist, public health physician, HKI representative and USAID representative spent a week in Tanzania, reviewing activities to date and recommending modifications (MG10).

b. Effects on target groups:

- 5.11 To date, the HKI primary eye care program has concentrated on five villages in the Kongwa subdistrict, serving approximately 200,000 people. In these five villages:
- 6,000 people have been treated at the Kongwa clinic;
 - all 120 with operable cataracts have had their cataracts removed, and
 - 1,500 lid rotations to prevent blindness from advanced trachoma have been performed.

The village health workers provide more to the villages than simply eye care. They have been active in community sanitation efforts such as the building of pit latrines and the encouragement of sweeping in front of doorways. This has had an effect on curtailing the transmission of many communicable diseases, including, of course, trachoma. A vehicle provided by HKI to the project is used to transport immunization teams to the villages.

The village health workers have joined with forestry personnel, missionaries and community groups in the planting of trees; 1,600 trees have been planted in this fashion. The effect of the project on the men, women and children of the five target villages cannot be measured through service statistics alone.

HKI's primary eye care project has been a catalyst for improved primary health care in the villages through the mobilization of village health workers and community members.

- 5.12 The current trachoma intervention study will yield information on the reduction of this infectious eye disease through the participation of community groups, particularly women. The data from this study will have an impact not only on program design in Tanzania, but will be disseminated world-wide throughout those countries with a significant trachoma problem.
- 5.13 The new initiatives undertaken in 1988 -- the cataract initiative, the community-based rehabilitation of the blind, and the expansion of the primary eye care project into five more villages -- will increase the number of beneficiaries twofold. HKI intends to prove to the public health community of Tanzania that the lessons learned during the first three years of the project are replicable.

c. Local resource linkages established

- 5.14 The primary eye care project in Tanzania relies on local leadership and direction, local health workers and clinicians from the Ministry of Health system, and villagers themselves in the fight against blinding eye disease. This unique link between the Tanzanian community and an outside PVO allows for the kind of community-based experience and research, such as the research in trachoma intervention, to be undertaken. The people of the five villages of the initial project site have come to rely on the services the project has established. At the same time, local government health resources and community participation in economic terms and in personnel have been invested for sustained impact.
- 5.15 Strong cooperative bonds have been created between HKI and the local government of the Dodoma region. In 1988, HKI's Country Director was given responsibility for blindness prevention throughout the five northern regions of Tanzania. This attests to the respect and support he has earned from the local authorities.

d. Impact on local institutions, etc.

e. Unintended effects

5.16 Locally, in Dodoma, Dr. B.B.O. Mmbaga, Assistant Medical Officer - Ophthalmology and HKI's Country Director, is developing an organization to further strengthen cooperation and communication among interested groups. He is developing a national foundation, the Central Eye Foundation, which can receive grants from various organizations to implement unified programs. Many details remain to be worked out, but the principle is actively supported by HKI; namely, encouraging local management and planning of blindness prevention activities.

Dr. Mmbaga has active affiliation and involvement with several international blindness prevention organizations. The Royal Commonwealth Society for the Blind and Christoffel Blindenmission are among them. Representatives from all groups in Tanzania (both national and international) concerned with blindness prevention are members of the National Blindness Prevention Committee.

f. Actual accomplishments compared with originally proposed activities:

5.17 Delays were experienced in implementation of a community-based rehabilitation program in Tanzania. These delays have been due to Education and Rehabilitation staff over-commitments. Concrete plans for this aspect of the project are in the final design phase. Further delays are not anticipated.

VII. MANAGEMENT: REVIEW AND ANALYSIS OF HEADQUARTERS SUPPORT FUNCTIONS

HKI has undertaken an extensive and far-reaching strategic planning analysis described in a previous section. Much of what evolved from that ongoing process was detailed in Section V of this report.

Headquarters support capabilities have been greatly expanded since the last reporting period. A full-time senior level Medical Director (Dr. David French) has been added to the staff. Also added are a full-time monitoring and evaluation specialist, a new Director of Education and Rehabilitation, and additional secretarial staff. For the physical plant, square footage of floor space and additional computer capability have been acquired.

Most significant from an operations standpoint has been the reorganization of HKI staff into technical, geographical and administrative branches with specific designation of regional managers and program support officers to backstop field and country programs and activities. Given the fact that HKI senior staff must engage in mission-related travel overseas frequently, this new organizational configuration will ensure timely headquarters backstopping. Field support functions will be greatly enhanced and turn-around time for headquarters actions will be reduced. Field-to-headquarters and headquarters-to-field communications have begun to experience less lag-time due to faxes and improved telecommunication.

In the Finance Department, a total overhaul has been completed of the existing Chart of Accounts and a customized report writer for General Ledger has been installed. This was necessitated by an increase in the type, number and frequency of financial reports required, both from the perspective of the requirements of regulatory agencies as well as a diversified group of HKI funding sources.

Each donor requires unique reporting. It must meet each particular detail. The creation of a revised cost center system, revision of the Chart of Accounts, and a new object coding system (flexible enough to satisfy reporting requirements for each donor) have demanded considerable effort on the part of the Finance Department. The new system will have an increased capacity to generate reports which satisfy each private, corporate, and federal funding source. Every PVO funded by multiple sources must eventually develop mechanisms to deal with this problem. There are standard accounting conventions, but there are few or no standardized reporting conventions or formats acceptable to the public, private, foundation and corporate donor communities. While the new accounting system is being established, the old system is running in parallel so as not to change accounting definitions in mid-course, and to ensure data integrity.

Award of funding support in several related program areas, notably Vitamin A, has permitted overall strengthening of headquarters support capabilities in general. It has also permitted reallocation and reprogramming of unrestricted funding raised from the general public and corporations to activities which will improve the overall effectiveness of program operations. AID funding has been important but is by no means the sole source of an expanded institutional base. An active fund raising program using experienced fund raisers has been undertaken in order to develop corporate and foundation solicitations.

VIII. MONITORING AND EVALUATION

The 1984 Matching Grant Proposal referred to the importance of documenting program inputs, outputs, costs and impact indicators. In September 1988, HKI added a professional Monitoring and Evaluation Specialist to its staff to focus and coordinate agency activities in these areas. An initial assignment was given to this staffer to develop a Monitoring and Evaluation Plan. This plan is currently being refined. [A copy of the draft plan is attached as Attachment 3 in Section XII.]

The Monitoring and Evaluation Plan requires development of an agency-wide integrated system of surveillance and tracking of service statistics and regular periodic program review. Where possible, appropriate baseline studies will be undertaken, and a midterm evaluation and final review of each project performed, with standardization of regular, quarterly reporting of data from the field to the greatest degree feasible.

Examples of specific process and impact indicators are envisioned as follows:

- * Number of personnel (M.D.s, nurses, health workers, community members, etc.) trained and the number of trainers in programs related to cataract and/or rehabilitation;
- * Number of people completing a rehabilitation program;
- * Number of patients examined, referred, refracted and recommended for surgery in a cataract program;
- * Number of cataract surgeries performed;
- * Number of spectacles produced and/or distributed;
- * Availability of surgical equipment and other materials (this includes consistency of supply, storage and/or transport);
- * Quantity, quality and dollar value of surgical equipment, medications and other materials supplied;

- * Quantity and quality of educational activities including training materials (manuals, curricula, etc.) and public education campaigns (radio, TV, posters, comics and other media);
- * Documentation and expansion of project activities into new districts and/or additional health facilities;
- * Contacts made with key persons and/or institutions (governmental and NGOs), coordination of efforts, coalitions developed for the strengthening of the program;
- * Policy changes on the regional, national or local level; new attention and/or services developed as a result of program activities.

As detailed in the Monitoring and Evaluation Plan, a long-term goal of HKI is to develop the capacity to collect, tabulate and analyze data on-site for most projects. To this end, greater emphasis will be placed on training and skills-transfer in these technical areas.

While this capability is being developed, outside experts will be consulted continuously for monitoring and evaluation. As an example, a two-part assessment of HKI's program in Sri Lanka was completed in August 1987 by Dr. Donald Swanson and Mr. David C. Korten of the National Association of Schools of Public Affairs and Administration. Their conclusions were that HKI could effectively continue as a catalyst for policy change but that management systems in the national program should be strengthened. Further training and cost analysis evaluation is scheduled (by HKI staff and consultants) for January-May 1989 for projects in Sri Lanka and in the Philippines.

In some cases, specific studies will be conducted as part of an evaluation procedure. For example, demographic studies and/or prevalence studies may be required as part of the baseline information; KAP (Knowledge, Attitude and Practice) studies are useful for assessing a community's approach to eye care. Alternative delivery systems or screening methods might be tested as part of another project.

Finally, project cost analysis will be given greater attention. Analysis of the sum of appropriate inputs (supplies, educational materials, personnel, etc.) will permit analysis of cost-effectiveness. Program "expansion of benefits" studies with comparison of pilot districts to added districts will dramatize the most efficient models.

IX.1. FINANCIAL REPORTS

A. BUDGET VERSUS ACTUAL EXPENDITURES

(Year 1)
2-1-85 to 1-31-86

<u>Project Elements</u>	<u>USAID</u>		<u>PVO</u>	
	<u>Budget</u>	<u>Expenses</u>	<u>Budget</u>	<u>Expenses</u>
1. Technical Assistance	225,000	242,534	25,000	35,378
2. Materials & Development	28,000	31,467	75,000	78,323
3. Assessments	9,400	3,181	- 0 -	- 0 -
4. Project Management	20,300	21,607	- 0 -	- 0 -
5. Dissemination of Experience	22,000	22,661	- 0 -	- 0 -
6. Training	267,000	265,145	75,000	82,903
7. Equipment Supplies	29,000	27,957	150,000	152,341
8. Indirect Costs	<u>49,300</u>	<u>50,392</u>	<u>300,000</u>	<u>427,638</u>
<u>TOTAL PROJECT</u>	<u>650,000</u>	<u>664,944</u>	<u>625,000</u>	<u>765,583</u>

FINANCIAL PROFILE OF THE PROJECT

(Year 1)
2-1-85 to 1-31-86

<u>B. SOURCES OF FUNDS</u>	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>
1. USAID Matching Grant	525,630	594,521	355,595
2. Private Contributions:			
Cash	2,045,762	3,256,441	3,604,243
In-Kind	463,000	287,681	885,612
3. Other USAID Grants:			
G492-1687 South Pacific/RDO	72,000	9,261	- 0 -
PDC-0506-5096 Child Survival	35,000	658,389	510,017
G-83-14 Indonesia	48,350	39,000	34,693
GR-493-0342-6031 Thailand	- 0 -	125,428	126,331
DAN-0045-6069 Child Survival #2 Haiti	- 0 -	41,982	84,250
DAN-0045-6068 Child Survival #2 Philippines	- 0 -	182,954	141,986
PDC-0284-6131 Child Survival #2 Operational Assistance/Niger	- 0 -	381,079	449,106
DAN-0045-6011 Sudan	- 0 -	132,629	160,294
879-0001-6012 South Pacific MSP	- 0 -	54,499	156,204
879-0001-4001 Papua New Guinea 497-0336-G-SS-7092	127,000	49,922	- 0 -
Indonesia Fortification DAN-0045-G-SS-7115 Bangladesh Fortification	- 0 -	- 0 -	39,597
DAN-0045-G-SS-7116 Indonesia Fortification	- 0 -	- 0 -	33,634
DAN-0045-G-SS-7117 Bangladesh Social Marketing	- 0 -	- 0 -	103,643
DAN-0045-G-SS-6066 Bangladesh Mortality Study	- 0 -	- 0 -	16,169
	<u>- 0 -</u>	<u>- 0 -</u>	<u>147,639</u>
 TOTAL PROJECT SOURCE FUNDS	 <u>3,316,742</u>	 <u>5,813,786</u>	 <u>6,849,013</u>

FINANCIAL PROFILE OF THE PROJECT

A. BUDGET VERSUS ACTUAL EXPENDITURES

(Year 2)
2-1-86 to 1-31-87

<u>Project Elements</u>	<u>USAID</u>		<u>FVO</u>	
	<u>Budget</u>	<u>Expenses</u>	<u>Budget</u>	<u>Expenses</u>
1. Technical Assistance	207,500	234,821	25,000	25,107
2. Materials & Development	25,750	58,751	75,000	76,907
3. Assessments	8,100	8,969	- 0 -	- 0 -
4. Project Management	18,450	11,427	- 0 -	- 0 -
5. Dissemination of Experience	19,250	15,147	- 0 -	- 0 -
6. Training	250,500	170,436	55,000	60,104
7. Equipment Supplies	26,000	35,519	200,000	178,928
8. Indirect Costs	<u>44,450</u>	<u>43,876</u>	<u>350,000</u>	<u>473,125</u>
<u>TOTAL PROJECT</u>	<u>600,000</u>	<u>578,946</u>	<u>705,000</u>	<u>814,171</u>

FINANCIAL PROFILE OF THE PROJECT

(Year 2)
2-1-86 to 1-31-87

<u>B. SOURCES OF FUNDS</u>	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>
1. USAID Matching Grant	525,630	594,521	355,595
2. Private Contributions:			
Cash	2,045,762	3,256,441	3,604,243
In-Kind	463,000	287,681	885,612
3. Other USAID Grants:			
G492-1687 South Pacific/RDO	72,000	9,261	- 0 -
PDC-0506-5096 Child Survival	35,000	658,389	510,017
G-83-14 Indonesia	48,350	39,000	34,693
GR-493-0342-6031 Thailand	- 0 -	125,428	126,331
DAN-0045-6069 Child Survival			
#2 Haiti	- 0 -	41,982	84,250
DAN-0045-6068 Child Survival			
#2 Philippines	- 0 -	182,954	141,986
PDC-0284-6131 Child Survival			
#2 Operational Assistance/Niger	- 0 -	381,079	449,106
DAN-0045-6011 Sudan	- 0 -	132,629	160,294
879-0001-6012 South Pacific MSP	- 0 -	54,499	156,204
879-0001-4001 Papua New Guinea	127,000	49,922	- 0 -
497-0336-G-SS-7092			
Indonesia Fortification	- 0 -	- 0 -	39,597
DAN-0045-G-SS-7115 Bangladesh			
Fortification	- 0 -	- 0 -	33,634
DAN-0045-G-SS-7116 Indonesia			
Fortification	- 0 -	- 0 -	103,643
DAN-0045-G-SS-7117 Bangladesh			
Social Marketing	- 0 -	- 0 -	16,169
DAN-0045-G-SS-6066 Bangladesh			
Mortality Study	- 0 -	- 0 -	147,639
	<u>3,316,742</u>	<u>5,813,786</u>	<u>6,849,013</u>
TOTAL PROJECT SOURCE FUNDS			

FINANCIAL PROFILE OF THE PROJECT

A. BUDGET VERSUS ACTUAL EXPENDITURES

(Year 3)
2-1-87 to 6-30-88

<u>Project Elements</u>	<u>USAID</u>		<u>FVO</u>	
	<u>Budget</u>	<u>Expenses</u>	<u>Budget</u>	<u>Expenses</u>
1. Technical Assistance	207,600	235,235	25,000	28,725
2. Materials & Development	25,800	12,243	75,000	89,044
3. Assessments	8,400	13,229	1,000	1,112
4. Project Management	18,600	7,841	0	0
5. Dissemination of Experience	19,800	5,436	0	0
6. Training	248,400	252,333	45,000	35,661
7. Equipment Supplies	26,400	33,860	150,000	196,640
8. Indirect Costs	<u>45,000</u>	<u>45,933</u>	<u>224,000</u>	<u>294,856</u>
<u>TOTAL PROJECT</u>	<u>600,000</u>	<u>606,110</u>	<u>520,000</u>	<u>646,038</u>

FINANCIAL PROFILE OF THE PROJECT

(Year 3)
2-1-87 to 6-30-88

B. <u>SOURCES OF FUNDS</u>	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>
1. USAID Matching Grant	525,630	594,521	355,595
2. Private Contributions:			
Cash	2,045,762	3,256,441	3,604,243
In-Kind	463,000	287,681	885,612
3. Other USAID Grants:			
G492-1687 South Pacific/RDO	72,000	9,261	- 0 -
PDC-0506-5096 Child Survival	35,000	658,389	510,017
G-83-14 Indonesia	48,350	39,000	34,693
GR-493-0342-6031 Thailand	- 0 -	125,428	126,331
DAN-0045-6069 Child Survival #2 Haiti	- 0 -	41,982	84,250
DAN-0045-6068 Child Survival #2 Philippines	- 0 -	182,954	141,986
PDC-0284-6131 Child Survival #2 Operational Assistance/Niger	- 0 -	381,079	449,106
DAN-0045-6011 Sudan	- 0 -	132,629	160,294
879-0001-6012 South Pacific MSP	- 0 -	54,499	156,204
879-0001-4001 Papua New Guinea 497-0336-G-SS-7092	127,000	49,922	- 0 -
Indonesia Fortification	- 0 -	- 0 -	39,597
DAN-0045-G-SS-7115 Bangladesh Fortification	- 0 -	- 0 -	33,634
DAN-0045-G-SS-7116 Indonesia Fortification	- 0 -	- 0 -	103,643
DAN-0045-G-SS-7117 Bangladesh Social Marketing	- 0 -	- 0 -	16,169
DAN-0045-G-SS-6066 Bangladesh Mortality Study	- 0 -	- 0 -	147,639
	<u>3,316,742</u>	<u>5,813,786</u>	<u>6,849,013</u>
TOTAL PROJECT SOURCE FUNDS			

FINANCIAL PROFILE OF THE PROJECT

FINANCIAL PROFILE OF THE PVO

<u>A. PROGRAM EXPENDITURES</u>	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>
1. Blindness Prevention, Rehabilitation and Cataract Programs	2,734,216	4,736,179	5,144,150
2. Indirect Costs Agency-wide	<u>260,495</u>	<u>697,432</u>	<u>1,034,787</u>
<u>TOTAL WORLDWIDE PROGRAM</u>	<u>2,994,711</u>	<u>5,433,611</u>	<u>6,178,937</u>
<u>B. SOURCES OF FUNDS</u>			
1. USAID Matching Grant	525,630	594,521	355,595
2. Private Contributions:			
Cash	2,045,762	3,256,441	3,604,243
In-Kind	463,000	287,681	885,612
3. Other USAID Grants:			
G492-1687 South Pacific/RDO	72,000	9,261	- 0 -
PDC-0506-5096 Child Survival	35,000	658,389	510,017
G-83-14 Indonesia	48,350	39,000	34,693
GR-493-0342-6031 Thailand	- 0 -	125,428	126,331
DAN-0045-6069 Child Survival #2 Haiti	- 0 -	41,982	84,250
DAN-0045-6068 Child Survival #2 Philippines	- 0 -	182,954	141,986
PDC-0284-6131 Child Survival #2 Operational Assistance/Niger	- 0 -	381,079	449,106
DAN-0045-6011 Sudan	- 0 -	132,629	160,294
879-0001-6012 South Pacific MSP	- 0 -	54,499	156,204
879-0001-4001 Papua New Guinea	127,000	49,922	- 0 -
497-0336-G-SS-7092 Indonesia Fortification	- 0 -	- 0 -	39,597
DAN-0045-G-SS-7115 Bangladesh Fortification	- 0 -	- 0 -	33,634
DAN-0045-G-SS-7116 Indonesia Fortification	- 0 -	- 0 -	103,643
DAN-0045-G-SS-7117 Bangladesh Social Marketing	- 0 -	- 0 -	16,169
DAN-0045-G-SS-6066 Bangladesh Mortality Study	<u>- 0 -</u>	<u>- 0 -</u>	<u>147,639</u>
 <u>TOTAL PROJECT SOURCE FUNDS</u>	 <u>3,316,742</u>	 <u>5,813,786</u>	 <u>6,849,013</u>

IX.2. FINANCIAL REPORTS (continued)

2. Since the project has essentially been completed, we will make no comment on further years for this grant. No variances are applicable.

3. The drawdown is done on a thirty-day cycle through Federal Reserve Letter of Credit No. 1481. We do not anticipate any changes from the rate of drawdown at present nor any cost overruns above the normal annualization over the project monthly budget.

4. HKI has embarked on a heavy corporate foundation solicitation campaign, in addition to ongoing fund-raising through direct mail, direct response marketing and the combined federal campaign.

5. HKI does not anticipate any present or future problems in its cost-sharing obligation to USAID. In anticipation of this, HKI has been motivated to develop a more accurate budget process in order to meet the specific spending requirements of the USAID cost-sharing budgets.

X. LESSONS LEARNED AND LONG TERM PROJECT IMPLICATIONS

A. Replication and Policy Impact

Over the life of the Matching Grant (1983-1988), integrated eye care programs of minimal cost have been introduced by HKI in Sri Lanka, the Philippines, Peru, Morocco and Tanzania. In Sri Lanka, the spontaneous expansion of the pilot project in Kurunegala District into five additional districts has occurred. At the initiative of the Ministry of Health, the public health community and the ophthalmologists, HKI Country Director, Dr. Tilak Munasinghe has been appointed National Coordinator to implement the National Plan to Prevent Blindness and Visual Impairment. Success in Sri Lanka is being analyzed and adapted for application to the programs of the other countries.

The Philippines model program is ready for replication upon gaining the reflections of an economic assessment to determine where, how and when that government should proceed.

In Tanzania, the model eye care program and rehabilitation services have received the endorsement of the Government of Tanzania and its ruling party Chama Cha Mapinduzi (CCM). Involvement at the village level in community-based rehabilitation and an extension of the activities in primary eye care has been planned for the Dodoma Region. The MOH covers expenses, the salaries of eye care workers and primary eye care training. HKI was supported by external evaluators (Messrs. Copp and Moore) in its belief that infrastructure development in Tanzania was essential before more eye care services would be available in the Dodoma Region.

In Morocco, The Ministry of Health created a Service of Blindness Prevention in 1988 and has hired a full-time physician to coordinate blindness prevention activities. This policy change was a direct result of HKI's role in the country. The infrastructure in Morocco, while well-developed, needs to be utilized in a constructive public health oriented fashion.

A fundamental point highlighting the importance of firm commitments between host country governments and HKI was apparent early in the program. Zambia made a commitment in principle to the integration of eye care in its health scheme. However, due to the lack of firm accord with HKI, an agreement was never signed. Conversely, Morocco had the commitment to a model blindness prevention program ready for funding and was ready to sign an agreement. HKI's willingness to follow the Moroccan government's lead with regard to implementation of the program had much to do with the ease of signing of the agreement. Even so, constant pressure on the Ministry of Health was necessary before an ophthalmologist was permanently assigned in the pilot region. In the future, HKI plans to write agreements with governments in such a way that there is a step-by-step procedure with specific actions to be taken by both parties. This will provide some financial incentive to the government to expedite their actions.

In Peru, The National Institute of Ophthalmology has achieved national recognition as the "eye" branch of the MOH. The Minister of Health has visited all HKI Cataract Free Zones. Municipal Hospitals are providing equipment, transportation and manpower to be at the disposal of eye care service delivery. Vice Minister Adriana Rebaza Flores, representing the Consejo Nacional para La Integracion de Impedido (CONAII), is a staunch advocate of the community based rehabilitation and cataract free zone approach. The Peruvian National Institute of Ophthalmology is moving into a large hospital complex from its small, cramped headquarters at the MOH. The commitment of funds from the government has been agreed upon for the restoration of these buildings. Though hampered by political and economic malaise, Peruvian demonstration projects have expanded from Puno and Ancash to include Loreto and Huancayo Regions.

B. Costs and Benefits

Initial costs of developing model eye care programs may be high due to the expenses of providing equipment and training a cadre of field workers. In contrast, the marginal cost of providing cataract surgery for roughly \$20 a patient, the cost per copy (\$.20) of a diagnostic eye chart for primary health care workers, or the income generated by a fully-rehabilitated blind person is of exceptional value in relieving the unnecessary effects of disabling blindness. By May 31, 1989 a complete economic assessment of the Philippine and Sri Lankan programs will detail total investment costs of eye care and rehabilitation services and forecast future replicability and expansion.

An evaluation of the training techniques, materials and trainers will be published in March, 1989. In the Philippines, integrating eye care training into existing health training workshops is more effective and less expensive than designing an extracurricular workshop on eye care. Knowledge presented at such seminars should be clear and concise so as not to overwhelm the student. For example, focusing on knowing the signs of vitamin A and cataract in the workshops is preferable to a lengthy study of their etiology. Using the current model in Bicol Region as a base, HKI now plans to bring barangay health workers from other districts to be trained in Bicol. HKI learned training evaluations should be conducted early in the health worker's assignments so as to monitor effectiveness and provide valuable feedback.

C. Sustainability

According to Korten, the great success toward integration of the program in Sri Lanka has been due to the demonstration effect of the pilot program. The Country Director, Dr. Tilak Munasinghe, an insider in the public health system, has been a stabilizing and quietly influential presence. Korten stressed the importance of assuring the availability of eye care services and their performance in terms of efficiency. With this in mind, HKI began to effect a plan to support the government's replication of the pilot in four new districts in 1988. HKI HQ learned that service statistics have to be analyzed and performance weaknesses corrected in order to assure efficient replication.

In the role of catalyst, not service provider, HKI has learned to stand behind the scenes, while at the same time defining the substance and timing of many of the pilot activities. Of particular importance is the effort required for enabling local data collection, monitoring and analysis. For real progress to be made in performance management, HKI has taught health care providers to make do with minimal resources and at the same time, to maximize the services provided by equipped hospitals, trained personnel and health systems.

D. Leadership Development

Country Directors (nationals or expatriates) with skills in supportive roles are essential. The Philippines' HKI staff now knows the advantages of maintaining a low profile. This has been a dynamic process due to the volatility of working in a region such as Bicol where civil strife has politicized eye care. Similarly, the typhoon which struck in 1987 caused unexpected turmoil, negating the economic gains of the people. Yet even during political turmoil, HKI learned health workers can maintain their services if they are supported and encouraged in their work.

Critical equipment and public recognition for achievement are potential incentives necessary for negotiating and achieving project enhancements. HKI has provided on-site experience at other projects for some colleagues, resulting in policy change and the creative solutions to problems in their "home" projects. Further formal training, both locally and internationally, has been made possible by HKI for ophthalmologists, eye nurses and primary health workers from each of the Matching Grant countries. Such training has been in the areas of community ophthalmology, epidemiology and surgical technique.

Recently, at the American Academy of Ophthalmology (the North American national convention for ophthalmologists and eye health suppliers), HKI's consultant ophthalmologist, Dra. Eva Santos, from the Philippines was able to solicit gifts-in-kind from various U.S. equipment manufacturers and suppliers. In addition, Dra. Santos aroused interest through two breakfast presentations to Philippine/American ophthalmologists. HKI plans to develop innovative activities such as local production of ophthalmic solutions, purchase of low-cost instruments from China, and other cost-abatement programs.

E. Technology Transfer

In 1988, the publication of the WHO report on the Production of Spectacles at Low Cost and Kortten's report on Sri Lanka disclosed the need to provide corrective lenses for school children and persons with refractive errors in the demonstration schemes. As a result, HKI tested the feasibility of integration of spectacles production in its projects. A report on the cost effectiveness of spectacles production for aphakic patients in the Philippines was written in 1988. The integration of a workshop into East Avenue Medical Center in Manila will provide a five-hospital sponsorship program for aphakic spectacles necessary for post-surgery cataract patients. The low-cost approach will bring the price of aphakic spectacles from \$10 to \$4 per pair.

Dramatic lessons learned in Peru and Brazil will be applied to eight other Latin American countries (Ecuador, Mexico, Uruguay, Chile, Bolivia, Colombia, Argentina and Venezuela). Outpatient surgery for cataract patients (modeled after the United States' ambulatory system) can be done safely and at a cost saving in contrast to \$100 or more per night in the hospital. In the first-ever "cataract free zone" in Chimbote, Peru, HKI worked with local counterparts on operations research to find the most efficient means of motivating cataract blind. HKI learned that expensive house-to-house surveys and persuasive attempts to bring forth the cataract blind are inefficient and costly. In addition, lessons learned in social marketing of vitamin A can be adapted and applied to the effort to stimulate services for the cataract blind.

In integrating services for the blind, knowledge was gained concerning the practicability of working with indigenous NGO's to achieve national integration of their rehabilitation programs. In the Sri Lankan program, the training of rural rehabilitation workers through the Sarvodaya movement did not achieve the national integration expected. This was in part because the Sarvodaya health care workers were seconded to HKI for rehabilitation training and were not part of the social system. To correct this situation, HKI is working to involve the Ministry of Social Service, the community leaders and the blind themselves in the training. The integration of the blind in Sarvodaya's ongoing income-generating activities is in process. HKI learned it is imperative to avoid the perception and practice of rehabilitation of the blind as "charity."

F. Local Participation and Networking

HKI works with a number of non-governmental agencies in Matching Grant countries. In Peru, the work of the National Institute of Ophthalmology is funded by Alcon Industries (a pharmaceutical company), the International Foundation, and Project Orbis. In the Philippines, the work of the Institute of Ophthalmology is supported by groups and agencies ranging from the U.S. Peace Corps to the Philippine American Ophthalmological Society, Rotary Club, General Electric and the Australian Direct Action Fund. Many of these relationships were developed by HKI in an effort to promote sustainability. The Tanzania Eye Health Project under the Ministry of Health is supported by groups ranging from Edna McConnell Clark and the Christoffel-Blindenmission to the Roman Catholic Mission Societies. One could go on to cite Sri Lanka and UNDP, Niger, Morocco, and USA for Africa. However, collaborative funding alone is not enough. HKI plans to develop innovative activities such as local production of ophthalmic solutions, purchase of low-cost instruments from China, and other cost-abatement programs. In all Matching Grant countries, extra effort is made to develop and nurture cooperative relationships with other NGOs. This may take the form of the Sarvodaya-HKI partnership and more recently, the collaboration with the Swedish Handicap International Agency as in Sri Lanka.

G. Summary

The lessons learned and the long-term implications revealed in the Matching Grant countries will provide important information regarding the integration of eye care, the efficiency of training programs, and cost efficiency of eye care and rehabilitation services for the blind. Sustainability of the model programs in these countries will be documented by June 30, 1989 and brought to national and regional attention. This reporting period has brought many important issues to HKI's attention. Significant among these issues is the continuing importance of listening to local counterparts, leaders and beneficiaries with respect to the development of eye care programs and rehabilitation and education of the blind.

XI. RECOMMENDATIONS

The recommendations made in this section reflect both internal assessments of program progress as well as future activities planned under the "Preyecare" proposal submitted and accepted by USAID FVA/PVC:

We recommend that:

1. On March 21, 1989, the Program Directors meet to establish: a) program activities scheduled for completion under the "Bridge Grant;" b) a timetable for the drafting of the detailed implementation plans; and c) correspondence and responses from each matching grant country with regards to inputs, outputs and budget for the matching grant "Preyecare."

2. HKI headquarters plan and develop internal mechanisms for regular weekly review of matching grant country programs. These meetings shall cover:

A. Integrated strategies for the delivery of services for prevention, sight restoration and rehabilitation and education of the blind. There shall also be a forum for the cross-fertilization of country program information and the monitoring and evaluation of program progress;

B. A bimonthly regional review to assess program performance, to initiate problem-solving and performance corrections and to plan program evaluation, travel and networking with host country PVO's and AID missions, and;

C. Performance monitoring (critical feedback) and responsive actions to be taken based upon quarterly project reports, data collection and financial information

3. HKI Country Directors and national health authorities be given adequate information with regard to concrete examples of the development, evaluation, maintenance and cost of establishing and sustaining eye care programs.

4. HKI Country Directors and project counterparts take more of an active role in soliciting local help from private industry and community organizations in the financing and support of model eye care programs.

5. HKI take steps to develop a technical assistance capability in the area of training in the provision of eye care, and rehabilitation services for the blind and the development, field testing and distribution of eye care training devices and materials. The forthcoming "training evaluation" to be published this Spring shall be widely disseminated to developing country health authorities and interested PVOs.

6. The USAID and PACT "Cost Assessment" of HKI Programs in Sri Lanka and the Philippines be disseminated to developing country authorities and interested PVO's to provide examples of the implementation of model eye care programs, their integration into existing health care and expansion/replication to new areas. This example of PVO effectiveness in being a catalyst for sustainable development should be of interest to all persons concerned with "third generational" development strategies.

XII. ATTACHMENTS

XII.1. COUNTRY DATA SHEETS

ON AID SUPPORTED PVO PROJECTS

PROJECT INFORMATION

Name of Organization

HELEN KELLER INTERNATIONAL, INCORPORATED

Project Number

Grant/Contract Number

PDC-0269-G-SS-5024-00

Start Date (MM/DD/YY)
2/1/85

End Date (MM/DD/YY)
1/31/88

AID Project Officer's Name
McEnaney

AID OBLIGATION BY AID-FY (5000)

FY	AMOUNT	FY	AMOUNT
1985-86	\$ 650,000	1987-88	\$ 600,000
1986-87	\$ 600,000		\$
	\$		\$
	\$		\$

Project Purpose

To demonstrate a cost-effective, high-standard primary eye health care program and rehabilitation services integrated at all levels into the existing primary health care and social service infrastructures.

COUNTRY INFORMATION

Country

MOROCCO

Location in Country (Region, District, Village)

Ouarzazate and Agadir provinces

PVO Representative's Name

Madame Fatima-Zohra Akalay

Local Counterpart/Host Country Agency

Dr. M. Aidi, Chef, Ministry of Health
Service of Blindness Prevention

COUNTRY FUNDING INFORMATION

YEAR	1985-86	1986-87	1987-88		
AIDS	26,394	38,733	71,289		
PVOS	15,000	21,000	26,000		
INKIND	3,500	2,000	4,000		
LOCAL	- 0 -	- 0 -	- 0 -		
TOTAL	44,894	61,733	101,289		

Purpose (if other than project purpose)

N/A

Status

FOR OFFICIAL USE ONLY

PVOTYPE

SUBPROJ

APPN

FUNDTYPE

CNTRY CODE

TECHCODE

PRO/OFFC

NONADD1

NONADD2

AID 1550-11 1B-85.

ON AID SUPPORTED PVO PROJECTS

PROJECT INFORMATION

Project Organization: HELEN KELLER INTERNATIONAL, INCORPORATED

Project Number: _____ Grant/Contract Number: PDC-0269-G-SS-5024-00

Start Date (MM/DD/YY): 1/2/85 End Date (MM/DD/YY): 1/31/88 AID Project Officer's Name: McEnaney

AID OBLIGATION BY AID-FY (5000)			
FY	AMOUNT	FY	AMOUNT
1985-86	\$ 650,000	1987-88	\$ 600,000
1986-87	\$ 600,000		\$
	\$		\$
	\$		\$

Project Purpose

To demonstrate a cost-effective, high-standard primary eye health care program and rehabilitation services integrated at all levels into the existing primary health care and social service infrastructures.

COUNTRY INFORMATION

Country: PERU Location in Country (Region, District, Village): Lima, Puno, San Martin, Ancash, Ica, Iquitos Departments

PVO Representative's Name: Armando Becerra, M.D. Local Counterpart/Host Country Agency: Dr. Francisco Contreras, Director, Instituto Nacional de Oftalmología Jr. Miro Quesada

COUNTRY FUNDING INFORMATION Lima (1) Peru

YEAR	1985-86	1986-87	1987-88
AIDS	220,523	146,227	138,025
PVOS	120,450	135,220	141,206
INKIND	85,750	102,000	120,000
LOCAL	- 0 -	- 0 -	- 0 -
TOTAL	426,723	383,447	399,231

Purpose (if other than project purpose)

N/A

Status

FOR OFFICIAL USE ONLY

PVOTYPE: _____ SUBPROJ: _____

APPN: _____ FUNDTYPE: _____

CNTRY CODE: _____ TECHCODE: _____

PROJOFFC: _____ WONADDI: _____ NONADDI: _____

PVO PROJECT REPORTING INFORMATION
ON AID SUPPORTED PVO PROJECTS

PROJECT INFORMATION

HELEN KELLER INTERNATIONAL, INCORPORATED

Project Number

Grant/Contract Number

PDC-0269-G-SS-5024-00

Start Date (MM/DD/YY)

2/1/85

End Date (MM/DD/YY)

1/31/88

AID Project Officer's Name

McEnaney

AID OBLIGATION BY AID-FY (\$000)

FY	AMOUNT	FY	AMOUNT
1985-86	\$ 650,000	1987-88	\$600,000
1986-87	\$ 600,000		\$
	\$		\$
	\$		\$

Project Purpose

To demonstrate a cost-effective, high-standard primary eye health care program and rehabilitation services integrated at all levels into the existing primary health care and social service infrastructures.

COUNTRY INFORMATION

Country

PHILIPPINES

Location in Country (Region, District, Village)

BICOL, MANILA

PVO Representative's Name

Rolf Sabres Klëmm

Local Counterpart/Host Country Agency

Dr. Eva Santos
Institute of Ophthalmology

COUNTRY FUNDING INFORMATION

YEAR	1985-86	1986-87	1987-88		
AIDS	192,753	168,336	204,765		
PVOS	102,000	128,350	136,000		
INKIND	15,000	95,000	45,000		
LOCAL	- 0 -	- 0 -	- 0 -		
TOTAL	309,753	391,686	385,765		

Purpose (If other than project purpose)

N/A

Status

FOR OFFICIAL USE ONLY

PVOTYPE

SUBPROJ

APPN

FUNDTYPE

CNTRY CODE

TECHCODE

PROJOFFC

NONADD1

NONADD2

AID 1550-11 (8-85)

13

PVO PROJECT REPORTING INFORMATION
ON AID SUPPORTED PVO PROJECTS

PROJECT INFORMATION

Organization

HELEN KELLER INTERNATIONAL, INCORPORATED

Project Number

Grant/Contract Number

PDC-0269-G-SS-5024-00

Start Date (MM/DD/YY)

2/1/85

End Date (MM/DD/YY)

1/31/88

AID Project Officer's Name

McEnaney

AID OBLIGATION BY AID-FY (\$000)

FY	AMOUNT	FY	AMOUNT
1985-86	\$ 650,000	1987-88	\$ 600,000
1986-87	\$ 600,000		\$
	\$		\$
	\$		\$

Project Purpose

To demonstrate a cost-effective, high-standard primary eye health care program and rehabilitation services integrated at all levels into the existing primary health care and social service infrastructures.

COUNTRY INFORMATION

Country

SRI LANKA

Location in Country (Region, District, Village)

Kurunegala, Kalutare, Ratnapura, Badulla, Kegalle

PVO Representative's Name

Dr. Tilak Munasinghe

Local Counterpart/Host Country Agency

Dr. Abeysinghe

COUNTRY FUNDING INFORMATION

YEAR	1985-86	1986-87	1987-88		
AIDS	198,452	160,427	192,631		
PVOS	226,250	175,350	264,540		
INKIND	15,000	35,000	42,000		
LOCAL	- 0 -	- 0 -	- 0 -		
TOTAL	439,702	370,777	499,171		

Purpose (if other than project purpose)

N/A

Status

FOR OFFICIAL USE ONLY

PVOTYPE

SUBPROJ

APPN

FUNDTYPE

CNTRY CODE

TECHCODE

PROJOFFC

NONADD1

NONADD2

AID 1550-11 (8-85)

PVO PROJECT REPORTING INFORMATION
ON AID SUPPORTED PVO PROJECTS

PROJECT INFORMATION

Name of Organization: **HELEN KELLER INTERNATIONAL, INCORPORATED**

Project Number: _____ Grant/Contract Number: **PDC-0269-G-SS-5024-00**

Start Date (MM/DD/YY): **2/1/85** End Date (MM/DD/YY): **1/31/88** AID Project Officer's Name: **McEnaney**

AID OBLIGATION BY AID FY (5000)			
FY	AMOUNT	FY	AMOUNT
1985-86	\$650,000	1987-88	\$600,000
1986-87	\$600,000		\$
	\$		\$
	\$		\$

Project Purpose
To demonstrate a cost-effective, high-standard primary eye health care program and rehabilitation services integrated at all levels into the existing primary health care and social service infrastructures.

COUNTRY INFORMATION

Country: **TANZANIA** Location in Country (Region, District, Village): **Kongwa SubDistrict, Mpwapwa District, Dodoma Region**

PVO Representative's Name: **Dr. B.E.C. imbaga** Local Counterpart/Host Country Agency: **Dr. G. Upunda, Ministry of Health**

COUNTRY FUNDING INFORMATION

YEAR	1985-86	1986-87	1987-88
AIDS	- 0 -	- 0 -	- 0 -
PVOS	34,000	22,000	15,150
INKIND	7,000	4,000	3,275
LOCAL	- 0 -	- 0 -	- 0 -
TOTAL	41,000	26,000	18,425

Purpose (If other than project purpose)

N/A

Status

FOR OFFICIAL USE ONLY

PVOTYPE	SUBPROJ
APPN	FUNDTYPE
CNTRY CODE	TECHCODE
PROJOFFC	NONADD1

75

ON AID SUPPORTED PVO PROJECTS

PROJECT INFORMATION

Project Organization

HELEN KELLER INTERNATIONAL, INCORPORATED

Project Number

Grant/Contract Number

PDC-0269-G-SS-5024-00

Start Date (MM/DD/YY)

2/1/85

End Date (MM/DD/YY)

1/31/88

AID Project Officer's Name

McEnaney

AID OBLIGATION BY AID-FY (5000)

FY	AMOUNT	FY	AMOUNT
1985-86	\$ 650,000	1987-88	\$600,000
1986-87	\$ 600,000		\$
	\$		\$
	\$		\$

Project Purpose

To demonstrate a cost-effective, high-standard primary eye health care program and rehabilitation services integrated at all levels into the existing primary health care and social service infrastructures.

COUNTRY INFORMATION

Country

ZAMBIA/KENYA

Location in Country (Region, District, Village)

NDOLA/NAIROBI

PVO Representative's Name

Anne Paxton

Local Counterpart/Host Country Agency

Dr. Chelemu

COUNTRY FUNDING INFORMATION

YEAR	1985-86	1986-87	1987-88		
AIDS	26,823	65,223	- 0 -		
PVOS	- 0 -	67,750	- 0 -		
INKIND	- 0 -	15,000	- 0 -		
LOCAL	- 0 -	- 0 -	- 0 -		
TOTAL	26,823	147,973	- 0 -		

Purpose (If other than project purpose)

N/A

Status

FOR OFFICIAL USE ONLY

PVOTYPE

SUBPROJ

APPA

FUNDTYPE

CNTRY CODE

TECHCODE

PROJOFFC

NONADD1

NONADD2

AID 1550-11 (8-85)

XII.2. LOGICAL FRAMEWORK AND SPECIFIED OUTPUTS

LOGICAL FRAMEWORK MATRIX

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 who have gained access to preventive, therapeutic and restorative services. 2. 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. HKI 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 prevention 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>2. Sub-goal</p> <p>To have the preventive, curative rehabilitative aspects integrated into national health and social welfare policy in countries where eye disease and blindness is a widespread public health problem.</p>	<ol style="list-style-type: none"> 1. Number of countries with conscious priorities and policy and active programming designed to integrate blindness services into National health social welfare systems. 		

JP

LOGICAL FRAMEWORK MATRIX

SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>B.1. Purpose</p> <p>To continue HKI's progress and momentum in designing, implementing and disseminating innovative strategies to reduce blindness and eye disease and the delivery of services to those already blind.</p>	<p>B.2. End of Project Status</p> <ol style="list-style-type: none"> 1. Blindness prevention and services to the blind integrated into existing health/social welfare infrastructures in 6 countries 2. Percentage of people in need of services who have gained access to preventive, therapeutic and restorative services. 3. Impact and cost of integrated approach demonstrated. 	<p>B.3.</p> <ol style="list-style-type: none"> 1. Ongoing joint evaluation 2. Evaluation Impact 3. Host Government reports and 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 contribute 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 PYO'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 programs designed.

LOGICAL FRAMEWORK MATRIX

SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
C.1 Outputs	C.2.	C.3.	C.4.
1. Apply Standardized assessment methodology developed by HKI in expanding the existing country programs and in new programs	1. Standardized Assessment	1. Ongoing joint evaluation	1. HKI has the management and financial expertise to plan and initiate integrated programs.
2. Manpower education and training programs developed and in use	2. Curricula developed field tested, revised and applied	2. Evaluation Impact	2. Governments will make financial and manpower resources available
3. Professional, paraprofessional and community level personnel trained and delivering eye care and rehabilitation services	3. Number of individuals in health and rehabilitation trained and active in the field	3. Host Government reports and policy	3. Personnel will complete training programs and remain in positions for which they are trained.
4. Specialized eye care training curricula/materials available and being used in general health care delivery structure	4. Curricula /training aids and manuals developed and published	4. Allocation of resources	
5. Public education strategies developed and in use	5. Radio, TV posters, illustrated comics etc. produced	5. USAID reports	
6. Logistical and referral system in place in target areas	6. Appropriate specialized personnel on the job	6. HKI reports	
7. Specialized cataract extraction programs in place	7. Supplies and equipment available	7. Reports from NGO's and interview with key staff	
8. Adequate supply of aphakic lenses available	8. Reduced backlog of cataracts		

50

LOGICAL FRAMEWORK MATRIX

SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>C.1. Outputs (Cont'd.)</p> <p>9. Widespread dissemination of training curricula and materials related to eye health care and rehabilitation</p> <p>10. Local capacity to supervise, manage and evaluate program results</p> <p>11. Active participation of indigenous organizations of and for the blind and those delivering eye care in the demonstration programs</p>	<p>C.2.</p> <p>9. Patients fitted with appropriate aphakic lenses</p> <p>10. Supervising systems, evaluation plans and clear replanning rationale available</p> <p>11. Documented involvement of NGO's</p>	<p>C.3.</p>	<p>C.4.</p>

LOGICAL FRAMEWORK MATRIX

<u>SUMMARY</u>	<u>OBJECTIVELY VERIFIABLE INDICATORS</u>	<u>MEANS OF VERIFICATION</u>	<u>IMPORTANT ASSUMPTIONS</u>
D.1. Inputs	D.2.	D.3.	D.4.
1. HKI Management and technical expertise.		1. Ongoing joint evaluation and review	1. Continuing "matching" funding will be forthcoming
2. HKI financial AID financial		2. HKI reports and records	2. HKI will maintain and expand its technical and financial strengths.
		3. USAID reports and records	
		4. Host country reports	
		5. Embassy reports	

29

XII.3. ADDENDA: MONITORING & EVALUATION PLAN

MONITORING AND EVALUATION PLAN

I. INTRODUCTION

"Monitoring" and "evaluation" are distinct but interrelated activities. These terms should not be used interchangeably, but because of their complementary nature we will discuss both simultaneously in this conceptual framework. Monitoring is a regular and on-going part of project/program development. It is meant to take a systematic measure of short-term activities (including effectiveness) for internal oversight. Service statistics or process indicators are routinely used for this purpose.

Evaluation, on the other hand, is a periodic activity which may involve monitoring but usually also involves special research and reports. Its purpose is to aid in long-term decisions and judgments regarding projects and programs. Both monitoring and evaluation should be integral to the overall project/program design and planning.

The terms "project" and "program" are also often used interchangeably, although they actually involve different levels of review. Most monitoring and evaluation that is required by external agencies takes place at the level of the individual project (i.e., a single focus in a specific location). However, for internal as well as external purposes, it is sometimes necessary to review actions on a wider scale. The programmatic level refers to multiple projects with a shared focus, spread out over a larger geographic area. In addition to this type of "vertical" analysis (of a single project or combination of similar projects), it may also be prudent to conduct periodic "horizontal" reviews of HKI activities (i.e., projects of different types in the same country or region).

II. WHY MONITOR/EVALUATE? FOR WHOM? FOR WHAT PURPOSE?

The question of the target audience is critical and must be addressed before the process of monitoring/evaluation can begin. The reasons for monitoring and/or conducting an evaluation will vary depending on the interested parties.

A. Funding sources and donor agencies will be primarily interested in documentation of performance and progress towards the

stated goals of the project. As an example of this reporting requirement, the USAID Child Survival guidelines call for indicators to be stratified into three "tiers" which differ in their level of functions measured, data collection source, and the cost and complexity of data collection process:

1. Tier I - Routine process indicators which primarily include project/program inputs and outputs (eg., budget, expenditures, number of persons trained or vitamin A capsules delivered).

2. Tier II - Indicators which are useful for local project/program management, sensitive to changes over time, reliably and reproducibly measurable, consistent with indicators used by other donor agencies, and which require a sample size and data collection methodology which is consistent with that of other indicators (eg., percent of bilaterally blind adults over 40 years of age who have received cataract surgery).

3. Tier III - Indicators of overall project/program impact (eg., changes in prevalence of xerophthalmia or other forms of preventable blindness). These indicators generally necessitate special studies and are only expected of those projects/programs with relatively large resources designated for evaluation.

Other funding sources, including in-country sources, have similar reporting requirements. These are useful generic categories which distinguish between process and impact, management and evaluation.

B. HKI headquarters makes use of such assessments for the purposes of decision-making, policy-making and strategic planning. For these purposes, it is important to document not only the anticipated results of program activity, but also any unexpected outcomes which might lead to a new design or a new approach in the future.

C. Field operatives must be kept up-to-date with information that will aid them in short-term planning, implementation and operational efficiency. This information will not only be derived from the field and forwarded to headquarters, but will also be fed back from headquarters to the field in the form of periodic, regional and/or programmatic summaries and assessments which will serve as a useful basis for dialogue between headquarters and the field for joint decisions and supervision of programs.

D. The general public should be supplied with a few key indicators which describe and quantify past accomplishments of the

organization. These should be translated into lay terminology for educational and solicitation purposes. An example would be the number of children which HKI's work has prevented from going blind in the past year.

E. Other PVOs and host country collaborators should be kept informed of the progress of HKI activities. The sharing of this information will facilitate the coordination of efforts of all parties involved in the treatment and prevention of blindness and will enable the host country to effectively move towards eventual assumption of the responsibility for the programs.

III. FEATURES OF MONITORING AND EVALUATION

There is a tendency to think of monitoring and evaluation as highly technical tasks which involve complex statistical analyses and overwhelming reams of data. Because of this misconception, they are often treated as an undesirable burden or avoided altogether. However, HKI plans to minimize the amount and type of data required through a systematic approach utilizing standardized protocols. Other features of the monitoring and evaluation system include the following:

A. Use both quantitative and qualitative measurements in a variety of formal and informal ways. In other words, collect "objective" data as well as "subjective" impressions and descriptions.

B. Measure both outcome and process; look at the end results, intermediate results and also the means to those ends, where appropriate.

C. Integrate the review system into the program design; it must be part of the planning process if it is to be carried out at all, let alone in a timely manner, and if results of past performance are to effectively impact on future program design.

D. Be selective and simple; do not overload the system with unneeded or unusable data. Rather than collecting as much information as possible, always ask What information is needed? By whom? For what? Will it be useful in the analysis?

E. Create a "dialogue of information". This should be dynamic and participatory not only within the headquarters, but also between headquarters and the field. Feedback loops must be created so that the information does not proceed in only one

direction. This will encourage production as well as digestion of information.

F. Be flexible enough to be able to profit from lessons learned. The information system should be able to flag performance problems for attention and possible further study.

G. Use operational research methods rather than a strictly experimental study design, unless a special epidemiological component is included and the scope of the program allows for such. [Refer to the Research Statement]

IV. WHAT TYPES OF QUESTIONS SHOULD BE ADDRESSED THROUGH MONITORING? THROUGH EVALUATION?

Each project/program requires its own set of specific questions, tailored to its particular circumstances. Because of funding and management arrangements, HKI's programs are divided into the categories of vitamin A, rehabilitation and education, cataract and integrated eye care. However, these are often operationally linked and need not be treated as wholly separate entities for monitoring and evaluation purposes (unless required for reports to funding sources).

A core set of questions can be arranged so as to be easily applied to each type of program. These "modular components" can build upon one another as needed when programs interact or overlap. They will be designed to satisfy the minimum reporting requirements of donor agencies and also fulfill internal HKI needs regarding program review and oversight.

A. Monitoring is often referred to as "tracking" or "surveillance" because of its reliance on regular data from the field. The most common means of collecting this information is in the form of service statistics or impact indicators such as the following:

- * Which/how many personnel have been trained for the project?
- * What supplies and equipment are needed/have been used?
- * How many cases/clients have been identified as needing attention?
- * How many cases/clients have received attention recently?

- * What percentage of the cases/clients treated have had satisfactory results?

B. Evaluation begins with questions on a general level, then advancing to the more specific. At a minimum, the design should address the following general categories:

- * Was the target population reached?
Describe their size, demographics, needs and problems
- * What are the objectives of the intervention?
HKI's perspective and that of the local population
- * How effective and efficient has the intervention been?
Regarding the unmet need and the capacity to meet that need
- * Is the intervention appropriate for the setting?
Realistic and timely
- * How sustainable is the intervention beyond the life of the project/program?
Institutions in place; policy changes; coalitions built
- * Any unexpected results?
Positive or negative
- * Other means of achieving the objectives?
Lessons learned from previous experience

A major objective of HKI's monitoring and evaluation plan is to define and incorporate a series of questions to be addressed into all proposals for funding by the beginning of the next fiscal year. By June 1989, at least one project will be field tested with a complete set of service statistics and specific evaluation questions.

V. EXAMPLE: EVALUATING AN EDUCATION AND REHABILITATION PROJECT

The following are categories of indicators to be measured in an evaluation. Note that they include input, process and output indicators and that they are both quantitative and qualitative.

A. Target Population:

1. Total population in catchment area
2. # blind in catchment area
3. % irrevocably blind out of total blind population
4. Age, place of residence (urban/rural) and general socio-economic status (low/middle/high income) of all of the above

B. Training of Workers:

1. # workshops conducted and planned for teachers
2. # teachers trained for special education (primary and secondary levels); # currently working
3. # support staff trained; # currently working
4. # health workers (rehabilitators, CBR field workers) trained; # currently working
5. % of rehabilitators who are themselves blind
6. Rate of turnover of rehabilitators (i.e., months on the job)

C. Promotional Material:

1. New publications developed
2. Translations/adaptations developed
3. Training materials/educational activities (eg., training manuals, curricula, etc.)
4. Public education campaigns (eg., radio, TV, posters, comics and other media)
5. Increased awareness of the availability of services offered (possibly conduct pre-post KAP surveys)

D. Rehabilitation Component:

1. # receiving rehabilitation prior to start of project
2. # active cases (client-months)
3. # completing rehabilitation programs (quarterly, annually and total numbers)
4. % who have died since completing rehabilitation program
5. # waiting to enter rehabilitation programs
6. Age, place of residence and socioeconomic status of all of the above groups
7. Increased activity, orientation, self-confidence, mobility and participation of the blind in community activities (eg., public office, vocational skills, income-generating activities, etc.)

E. School Component:

1. # schools participating in integrated education prior to the start of the project

2. # schools currently participating in integrated education
3. # students attending integrated education prior to the start of the project
4. # students currently attending integrated education
5. # students waiting to enter integrated education
6. # students currently attending 'special' schools
7. Cost per child in regular schools versus 'special' schools (possibly conduct a cost-benefit analysis)

F. Management/Administration:

1. Reporting system for data; adequacy and efficiency
2. Referral system for potential patients to rehabilitation (including those from cataract programs) and for blind children to schools
3. # supervisors in place for the education and rehabilitation components
4. Existence of a 'Case Review Committee'

G. Sustainability:

1. Acceptance of CBR services in areas where operational
2. Expansion of project activities into new districts
3. Transfer of management and training aspects to local workers
4. Potential for maintenance of funding beyond the project

H. Policy Impact:

1. New attention paid and/or services developed by the local and/or national government as a result of project activities (eg., higher priority within the MOH and/or MOE)
2. Contacts made with key persons and/or institutions (gov't or NGOs); coalitions built; coordination of efforts with other organizations
3. Interest expressed by other governments

VI. HOW TO GATHER INFORMATION?

A variety of formal and informal methods are employed. Where appropriate, any combination of the following monitoring and evaluation tools can be used:

A. Questionnaires and surveys. These usually include fixed-choice questions but can also make creative use of rankings, ratings and scales. Answers are coded to aid in computer input-

ting and data analysis. The design and distribution can be at the level of the individual, household, community or district. However, because of the expense involved, few large-scale surveys are conducted.

B. Interviews. These can be formal or informal but should always allow for open-ended and frank answers. The term "interviewer" is often applied to the person(s) conducting a survey, although it need not be restricted to this. However, an interview guide can be written and the questions pre-tested so as to avoid trivial responses. Less formality can be used in discussions with the senior people involved with the project.

C. Records and registration data kept by health workers, clinics, hospitals, etc. This is the typical source of service statistics for a project. Where an adequate record-keeping system already exists (eg., "Road to Health" cards), it is usually preferable to use it. Otherwise, a separate method for data gathering will have to be devised for use during a transitional period (eg., "Postcard" records to be mailed directly from the health workers). When relying on existing records for crucial impact data, it is sometimes advisable to set up an external or secondary system in order to check for accuracy.

D. Documents from headquarters and/or field offices that are relevant to the project/program.

E. Observation. This is a more passive and non-intrusive technique than those above and can only be effective when done by someone who is familiar with the working environment and the people involved. The person(s) chosen to conduct this type of review requires a combination of expertise and impartiality.

VII. WHO IS RESPONSIBLE FOR MONITORING AND EVALUATION?

In September 1988, a new position of Monitoring and Evaluation Specialist was created at HKI headquarters. The duties of this position include coordinating the collection and analysis of service statistics from the field, providing technical assistance to the country projects and advising in the design and conduct of all monitoring and evaluation activities.

The monitoring and evaluation process is collaborative. The staff specialist works with the following resources:

A. Outside consultants are employed on a regular basis for

their expertise in clinical and epidemiological matters, for their familiarity with the goals and activities of HKI, and for their working knowledge of the key players. They will continue to be brought in for consultation on the design and conduct of research studies and review activities.

B. Field staff must be an integral part of the review procedures. They constitute the "front line" and are in the best position to monitor the progress of local projects. Although they can request the help of the staff specialist and/or outside consultants, an objective of HKI is to develop the capacity to collect, enter and analyze data on-site for most projects. To this end, we will place a greater emphasis on training and skills-transfer in these technical areas.

C. Host country personnel in government and in collaborating agencies must be involved in the design of project review since their opinions about the needs of the population and of the country are critical when formulating the appropriate questions to be addressed. Recognizing that a long-term goal is to transfer responsibility for programs to the host country personnel, HKI will actively seek their participation in the review process.

D. Program and Regional Directors at HKI headquarters have been involved with monitoring and evaluation on a case by case basis in the past. The intent is to systematize this process and to make it part of the planning of all programs. Generally, this will take place during the writing of new grant proposals, implementation plans and/or revisions to the plans.

E. Advisory groups are being formed within each program area. These groups will also serve as a resource to review projects and programs.

VIII. WHEN AND HOW OFTEN? TIMELINE FOR MONITORING AND EVALUATION

A. Monitoring of projects is an on-going activity which involves frequent communication between headquarters and the field in the form of telexed or faxed memos, phone calls, letters and field trips. For most programs and projects, regular reporting should be maintained on the following schedule:

1. Quarterly reports from the field should include the service statistics and any relevant observations about the progress of the project. Data received in headquarters will be tabulated; regional summaries can be sent back to the field offices as

part of the feedback loop.

2. Annual reports for donors, the Board of Directors and the general public must be generated with the collaboration of staff at headquarters and in the field offices.

B. Evaluation of projects occurs periodically and should optimally include the following three elements: [Refer to the Flow-chart on the following page]

1. Baseline study of the population and the problem, if time and funds permit. This is important if a rigorous evaluation of impact or a scientific study is to be undertaken. Otherwise, existing baseline information of a more general nature or, in some cases, "rapid assessment surveys" will be used. Obviously, baseline information is gathered before the implementation and monitoring of the project has begun.

2. Midterm evaluation of the results and the process by which these results have been obtained. This enables the field operators to alter their programmatic strategy, if necessary, so as to increase efficiency and effectiveness. However, unless required and provided for in a project grant, midterm evaluation is usually minimal due to cost constraints.

3. Final evaluation occurs within a few weeks or months of the completion of the project. Time and cost factors generally necessitate starting the final evaluation before rather than after the end of the project implementation.

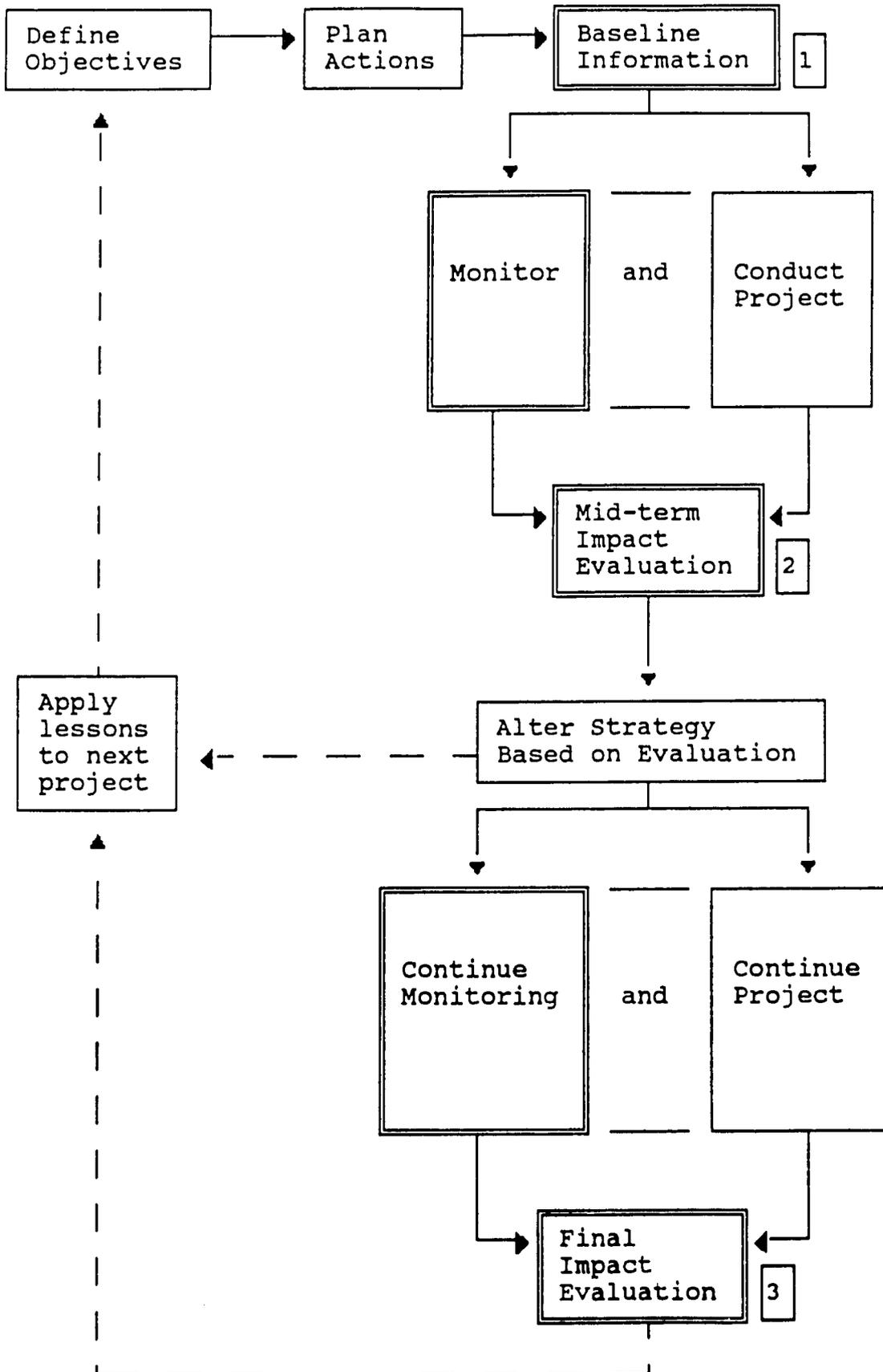
IX. LONG-TERM PERSPECTIVE

HKI defines itself more along the lines of a "third generation" development agency than a "first generation" relief agency. As a result, organization accomplishments are measured against such criteria as long-term sustainability of projects and programs, impact on policies and institutions in the host country (both governmental and private), and the building of coalitions for the above purposes.

In short, monitoring and evaluation is designed to measure not only our direct impact through projects and programs, but also our success as a catalyst for more profound, although possibly more subtle, change in the developing countries.

99

FLOWCHART FOR PROJECT MONITORING AND EVALUATION:



How is all of this to be used? Its immediate use is in offering feedback toward project management and operations. In addition, project monitoring is used for project evaluation and both are used in the assessment of our programs. In turn, all of these should be used to gain a wider perspective as to where we are going as an organization. Toward this end, we can focus on the following levels:

A. Regional assessment of achievements. This can either focus on the country level or on a larger geographic area. Include all programs in a given region, look at the integration of programs, decide which to maintain, what to add and what to change. [Refer to the Country Selection Criteria]

B. Five-Year follow-up to projects. Long after HKI's active involvement in a project, it is instructive to look at the lasting effects of our activity, including the degree of success in transferring programs to the control of the local players and/or phasing them out. Specific attention should be given to the impact these programs have had on policy in the host country.

C. Agency-wide review of materials development and training, cutting across all program activities.

X. DOCUMENTATION AND DISSEMINATION OF RESULTS

In order to create a useful flow of information, the results of the monitoring and evaluation activities must be accessible to the appropriate parties. Who produce and who receives what information depends on their roles in the project.

A. Internal to HKI and/or the project:

1. Headquarters develops and distributes full project reports, the Annual Report, monographs, Technical Reports and newsletters as well as some of the other items mentioned below.

2. The Board of Directors receives a short summary of the results of each project.

3. Country Directors and the field offices have an active role in the writing of the final reports; in addition to receiving a copy of the final reports, they are debriefed by the evaluation team, receive quarterly reports from headquarters and are encouraged to produce newsletters documenting their work.

4. Project participants in the host country are debriefed by the Country Director verbally and/or in the form of newsletters.

B. External to HKI:

1. Donor agencies receive summary reports of each project which are tailored to their specifications, in addition to on-going consultation in the form of meetings and presentations.

2. The general public has access to the HKI's Annual Report, the organizational newsletter ("Insight") as well as the program-specific newsletters (eg., "Vitamin A News Notes"), periodic monographs and Technical Reports focusing on broad aspects of HKI's work.

3. Local government agencies with an interest in specific projects receive summary reports and briefings on those activities from HKI staff in the field and at headquarters.

4. Community members not directly involved in the project should be kept informed and encouraged to make use of the services resulting from HKI programs through such means as radio announcements, newsletters, educational campaigns and the media.

XII.4. PROJECT ACHIEVEMENTS BY OUTPUT,
COUNTRY & REPORT NUMBER

XII.4. ATTACHMENT

PROJECT ACHIEVEMENTS BY OUTPUT, COUNTRY AND REPORT NUMBER

GRANT CODES

PROJECT DESCRIPTION REPORTS

<u>OUTPUT CODE</u>	<u>COUNTRY</u>	<u>REPORT NUMBER</u>
MG1	MOROCCO	1.01
	MOROCCO	1.02
	PERU	2.03
	PERU	2.04
	PHILIPPINES	3.01
	PHILIPPINES	3.02
	PHILIPPINES	3.03
	SRI LANKA	4.01
	SRI LANKA	4.02
	SRI LANKA	4.28
	TANZANIA	5.07
	TANZANIA	5.08
TANZANIA	5.09	
MG2	MOROCCO	1.03
	MOROCCO	1.04
	PERU	2.08
	PERU	2.09
	PERU	2.12
	SRI LANKA	4.11
	SRI LANKA	4.20
	SRI LANKA	4.22
	TANZANIA	5.03
	TANZANIA	5.04

CS

PROJECT ACHIEVEMENTS BY OUTPUT, COUNTRY AND REPORT NUMBER

GRANT CODES

PROJECT DESCRIPTION REPORTS

<u>OUTPUT CODE</u>	<u>COUNTRY</u>	<u>REPORT NUMBER</u>
MG5	MOROCCO	1.08
	MOROCCO	1.09
	MOROCCO	1.10
	PERU	2.18
	PERU	2.19
	PHILIPPINES	3.10
	SRI LANKA	4.23
	SRI LANKA	4.29
MG6	MOROCCO	1.03
	MOROCCO	1.04
	MOROCCO	1.05
	PERU	2.03
	PERU	2.04
	PERU	2.05
	PERU	2.06
	PERU	2.12
	PERU	2.14
	PERU	2.15
	PERU	2.16
	PERU	2.17
	PHILIPPINES	3.04
	PHILIPPINES	3.05
	PHILIPPINES	3.06
	PHILIPPINES	3.07
	PHILIPPINES	3.08
	PHILIPPINES	3.11
	SRI LANKA	4.10
	SRI LANKA	4.11
	SRI LANKA	4.12
	SRI LANKA	4.13
	SRI LANKA	4.14
	SRI LANKA	4.20
SRI LANKA	4.21	
SRI LANKA	4.26	
TANZANIA	5.01	
TANZANIA	5.02	
TANZANIA	5.03	
TANZANIA	5.04	

PROJECT ACHIEVEMENTS BY OUTPUT, COUNTRY AND REPORT NUMBER

GRANT CODES

PROJECT DESCRIPTION REPORTS

<u>OUTPUT CODE</u>	<u>COUNTRY</u>	<u>REPORT NUMBER</u>
BG4	MOROCCO	1.11
	PERU	2.31
	PHILIPPINES	3.03
	SRI LANKA	4.22
	SRI LANKA	4.36
BG5	PERU	2.26
	PERU	2.28
	PERU	2.29
	TANZANIA	5.09
BG6	SRI LANKA	4.29
	TANZANIA	5.07
BG8	SRI LANKA	4.26
BG9	SRI LANKA	4.27

PROJECT ACHIEVEMENTS BY OUTPUT, COUNTRY AND REPORT NUMBER

GRANT CODES

BRIDGE GRANT OUTPUTS SPECIFIED

BG1	MOROCCO	1.04
	MOROCCO	1.06
	MOROCCO	1.07
	PERU	2.03
	PERU	2.04
	PERU	2.16
	PERU	2.24
	PERU	2.27
	PERU	2.30
	PERU	2.31
	PHILIPPINES	3.06
	PHILIPPINES	3.12
	PHILIPPINES	3.13
	PHILIPPINES	3.14
	SRI LANKA	4.32
	TANZANIA	5.01
	TANZANIA	5.02
	TANZANIA	5.03
	TANZANIA	5.04
	TANZANIA	5.05
	TANZANIA	5.06
BG2	PERU	2.03
	PERU	2.04
	PERU	2.06
	PERU	2.13
	PERU	2.18
	PHILIPPINES	3.03
	PHILIPPINES	3.05
	PHILIPPINES	3.06
	PHILIPPINES	3.09
	PHILIPPINES	3.10
	PHILIPPINES	3.13
	PHILIPPINES	3.14
	PHILIPPINES	3.17
	PHILIPPINES	3.19
	PHILIPPINES	3.20
	PHILIPPINES	3.21
	SRI LANKA	4.37
	TANZANIA	5.02
BG3	MOROCCO	1.08
	MOROCCO	1.09
	PHILIPPINES	3.17
	PHILIPPINES	3.21

PROJECT ACHIEVEMENTS BY OUTPUT, COUNTRY AND REPORT NUMBER

GRANT CODES

PROJECT DESCRIPTION REPORTS

<u>OUTPUT CODE</u>	<u>COUNTRY</u>	<u>REPORT NUMBER</u>
MG10	MOROCCO	1.12
	MOROCCO	1.13
	MOROCCO	1.14
	MOROCCO	1.15
	PERU	2.03
	PERU	2.04
	PERU	2.05
	PERU	2.11
	PHILIPPINES	2.25
	PHILIPPINES	2.26
	PHILIPPINES	3.02
	PHILIPPINES	3.11
	SRI LANKA	4.01
	SRI LANKA	4.02
	SRI LANKA	4.24
	SRI LANKA	4.25
	SRI LANKA	4.27
	SRI LANKA	4.28
	SRI LANKA	4.34
	SRI LANKA	4.35
SRI LANKA	4.36	
SRI LANKA	4.37	
SRI LANKA	4.38	
TANZANIA	5.09	
TANZANIA	5.10	
MG11	PERU	2.03
	PERU	2.04
	PERU	2.05
	PERU	2.14
	PERU	2.25
	PERU	2.26
	PHILIPPINES	3.01
	PHILIPPINES	3.11
	PHILIPPINES	3.15
	PHILIPPINES	3.18
	SRI LANKA	4.24
	SRI LANKA	4.25

102

PROJECT ACHIEVEMENTS BY OUTPUT, COUNTRY AND REPORT NUMBER

GRANT CODESPROJECT DESCRIPTION REPORTS

<u>OUTPUT CODE</u>	<u>COUNTRY</u>	<u>REPORT NUMBER</u>
MG7	MOROCCO	1.11
	PERU	2.05
	PERU	2.23
	PHILIPPINES	3.05
	PHILIPPINES	3.06
	PHILIPPINES	3.11
	PHILIPPINES	3.12
	PHILIPPINES	3.13
	PHILIPPINES	3.14
	PHILIPPINES	3.15
	SRI LANKA	4.10
	SRI LANKA	4.13
	SRI LANKA	4.14
	SRI LANKA	4.31
	SRI LANKA	4.32
	SRI LANKA	4.33
	SRI LANKA	4.35
	TANZANIA	5.05
	TANZANIA	5.06
MG8	MOROCCO	1.05
	PERU	2.01
	PERU	2.02
	PERU	2.03
	PERU	2.04
	PERU	2.05
	PERU	2.24
	PHILIPPINES	3.05
	PHILIPPINES	3.11
	PHILIPPINES	3.16
	SRI LANKA	4.10
	SRI LANKA	4.13
	SRI LANKA	4.14
	TANZANIA	5.02
MG9	MOROCCO	1.05
	PERU	2.03
	PERU	2.04
	PERU	2.05
	PERU	2.24
	PHILIPPINES	3.16
	PHILIPPINES	3.17
	SRI LANKA	4.10
	SRI LANKA	4.13
	SRI LANKA	4.14
TANZANIA	5.02	

PROJECT ACHIEVEMENTS BY OUTPUT, COUNTRY AND REPORT NUMBER

GRANT CODES

PROJECT DESCRIPTION REPORTS

<u>OUTPUT CODE</u>	<u>COUNTRY</u>	<u>REPORT NUMBER</u>
MG3	MOROCCO	1.03
	MOROCCO	1.04
	MOROCCO	1.05
	PERU	2.11
	PERU	2.12
	PERU	2.14
	PERU	2.15
	PERU	2.16
	PERU	2.17
	PHILIPPINES	3.04
	PHILIPPINES	3.05
	PHILIPPINES	3.06
	PHILIPPINES	3.07
	PHILIPPINES	3.08
	SRI LANKA	4.03
	SRI LANKA	4.04
	SRI LANKA	4.05
	SRI LANKA	4.06
	SRI LANKA	4.07
	SRI LANKA	4.08
	SRI LANKA	4.09
	SRI LANKA	4.10
	SRI LANKA	4.11
	SRI LANKA	4.12
	SRI LANKA	4.13
	SRI LANKA	4.14
	SRI LANKA	4.20
	SRI LANKA	4.21
	SRI LANKA	4.26
	TANZANIA	5.01
TANZANIA	5.03	
TANZANIA	5.04	
MG4	MOROCCO	1.06
	MOROCCO	1.07
	PERU	2.07
	PERU	2.08
	PERU	2.10
	PHILIPPINES	3.09
	SRI LANKA	4.30
	TANZANIA	5.03

114

PROJECT ACHIEVEMENTS BY COUNTRY

GRANT CODES

PROJECT DESCRIPTION REPORTS

<u>COUNTRY</u>	<u>OUTPUT CODE</u>	<u>REPORT NUMBER</u>
PERU	MG1	2.03
PERU	MG2	2.08
PERU	MG2	2.09
PERU	MG2	2.12
PERU	MG3	2.11
PERU	MG3	2.12
PERU	MG3	2.14
PERU	MG3	2.15
PERU	MG3	2.16
PERU	MG3	2.17
PERU	MG4	2.07
PERU	MG4	2.08
PERU	MG4	2.10
PERU	MG5	2.18
PERU	MG5	2.19
PERU	MG6	2.03
PERU	MG6	2.04
PERU	MG6	2.05
PERU	MG6	2.12
PERU	MG6	2.14
PERU	MG6	2.15
PERU	MG6	2.16
PERU	MG6	2.17
PERU	MG7	2.05
PERU	MG7	2.23
PERU	MG8	2.01
PERU	MG8	2.02
PERU	MG8	2.03
PERU	MG8	2.04
PERU	MG8	2.05
PERU	MG8	2.24
PERU	MG9	2.03
PERU	MG9	2.04
PERU	MG9	2.05
PERU	MG9	2.24
PERU	MG10	2.03
PERU	MG10	2.04
PERU	MG10	2.05
PERU	MG10	2.11
PERU	MG10	2.14
PERU	MG10	2.25
PERU	MG10	2.26
PERU	MG11	2.03
PERU	MG11	2.04
PERU	MG11	2.05
PERU	MG11	2.14
PERU	MG11	2.25
PERU	MG11	2.26

PROJECT ACHIEVEMENTS BY COUNTRY

GRANT CODES

PROJECT DESCRIPTION REPORTS

<u>COUNTRY</u>	<u>OUTPUT CODE</u>	<u>REPORT NUMBER</u>
MOROCCO	MG1	1.01
MOROCCO	MG1	1.02
MOROCCO	MG2	1.03
MOROCCO	MG2	1.04
MOROCCO	MG3	1.03
MOROCCO	MG3	1.04
MOROCCO	MG3	1.05
MOROCCO	MG4	1.06
MOROCCO	MG4	1.07
MOROCCO	MG5	1.08
MOROCCO	MG5	1.09
MOROCCO	MG5	1.10
MOROCCO	MG6	1.03
MOROCCO	MG6	1.04
MOROCCO	MG6	1.05
MOROCCO	MG7	1.11
MOROCCO	MG8	1.05
MOROCCO	MG9	1.05
MOROCCO	MG10	1.12
MOROCCO	MG10	1.13
MOROCCO	MG10	1.14
MOROCCO	MG10	1.15
MOROCCO	BG1	1.04
MOROCCO	BG1	1.06
MOROCCO	BG1	1.07
MOROCCO	BG3	1.08
MOROCCO	BG3	1.09
MOROCCO	BG4	1.11

PROJECT ACHIEVEMENTS BY COUNTRY

GRANT CODES

PROJECT DESCRIPTION REPORTS

<u>COUNTRY</u>	<u>OUTPUT CODE</u>	<u>REPORT NUMBER</u>
PHILIPPINES	MG11	3.01
PHILIPPINES	MG11	3.11
PHILIPPINES	MG11	3.15
PHILIPPINES	MG11	3.18
PHILIPPINES	BG1	3.06
PHILIPPINES	BG1	3.12
PHILIPPINES	BG1	3.13
PHILIPPINES	BG1	3.14
PHILIPPINES	BG2	3.03
PHILIPPINES	BG2	3.05
PHILIPPINES	BG2	3.06
PHILIPPINES	BG2	3.09
PHILIPPINES	BG2	3.10
PHILIPPINES	BG2	3.13
PHILIPPINES	BG2	3.14
PHILIPPINES	BG2	3.17
PHILIPPINES	BG2	3.19
PHILIPPINES	BG2	3.20
PHILIPPINES	BG2	3.21
PHILIPPINES	BG3	3.17
PHILIPPINES	BG3	3.21
PHILIPPINES	BG4	3.03
SRI LANKA	MG1	4.01
SRI LANKA	MG1	4.02
SRI LANKA	MG1	4.28
SRI LANKA	MG2	4.11
SRI LANKA	MG2	4.20
SRI LANKA	MG2	4.22
SRI LANKA	MG3	4.03
SRI LANKA	MG3	4.04
SRI LANKA	MG3	4.05
SRI LANKA	MG3	4.06
SRI LANKA	MG3	4.07
SRI LANKA	MG3	4.08
SRI LANKA	MG3	4.09
SRI LANKA	MG3	4.10
SRI LANKA	MG3	4.11
SRI LANKA	MG3	4.12
SRI LANKA	MG3	4.13
SRI LANKA	MG3	4.14
SRI LANKA	MG3	4.20
SRI LANKA	MG3	4.21
SRI LANKA	MG3	4.26
SRI LANKA	MG4	4.30
SRI LANKA	MG5	4.23
SRI LANKA	MG5	4.29

PROJECT ACHIEVEMENTS BY COUNTRY

GRANT CODES

PROJECT DESCRIPTION REPORTS

<u>COUNTRY</u>	<u>OUTPUT CODE</u>	<u>REPORT NUMBER</u>
PERU	BG1	2.03
PERU	BG1	2.04
PERU	BG1	2.16
PERU	BG1	2.24
PERU	BG1	2.27
PERU	BG1	2.30
PERU	BG1	2.31
PERU	BG2	2.03
PERU	BG2	2.04
PERU	BG2	2.06
PERU	BG2	2.13
PERU	BG2	2.18
PERU	BG4	2.31
PERU	BG5	2.26
PERU	BG5	2.28
PERU	BG5	2.29
PHILIPPINES	MG1	3.01
PHILIPPINES	MG1	3.02
PHILIPPINES	MG1	3.03
PHILIPPINES	MG3	3.04
PHILIPPINES	MG3	3.05
PHILIPPINES	MG3	3.06
PHILIPPINES	MG3	3.07
PHILIPPINES	MG3	3.08
PHILIPPINES	MG4	3.09
PHILIPPINES	MG5	3.10
PHILIPPINES	MG6	3.04
PHILIPPINES	MG6	3.05
PHILIPPINES	MG6	3.06
PHILIPPINES	MG6	3.07
PHILIPPINES	MG6	3.08
PHILIPPINES	MG6	3.11
PHILIPPINES	MG7	3.05
PHILIPPINES	MG7	3.06
PHILIPPINES	MG7	3.11
PHILIPPINES	MG7	3.12
PHILIPPINES	MG7	3.13
PHILIPPINES	MG7	3.14
PHILIPPINES	MG7	3.15
PHILIPPINES	MG8	3.05
PHILIPPINES	MG8	3.11
PHILIPPINES	MG8	3.16
PHILIPPINES	MG9	3.16
PHILIPPINES	MG9	3.17
PHILIPPINES	MG10	3.11
PHILIPPINES	MG10	3.02

PROJECT ACHIEVEMENTS BY COUNTRY

GRANT CODES

PROJECT DESCRIPTION REPORTS

<u>COUNTRY</u>	<u>OUTPUT CODE</u>	<u>REPORT NUMBER</u>
SRI LANKA	MG6	4.10
SRI LANKA	MG6	4.11
SRI LANKA	MG6	4.12
SRI LANKA	MG6	4.13
SRI LANKA	MG6	4.14
SRI LANKA	MG6	4.20
SRI LANKA	MG6	4.21
SRI LANKA	MG6	4.26
SRI LANKA	MG7	4.10
SRI LANKA	MG7	4.13
SRI LANKA	MG7	4.14
SRI LANKA	MG7	4.31
SRI LANKA	MG7	4.32
SRI LANKA	MG7	4.33
SRI LANKA	MG7	4.35
SRI LANKA	MG8	4.10
SRI LANKA	MG8	4.13
SRI LANKA	MG8	4.14
SRI LANKA	MG9	4.10
SRI LANKA	MG9	4.13
SRI LANKA	MG9	4.14
SRI LANKA	MG10	4.24
SRI LANKA	MG10	4.01
SRI LANKA	MG10	4.02
SRI LANKA	MG10	4.25
SRI LANKA	MG10	4.27
SRI LANKA	MG10	4.28
SRI LANKA	MG10	4.34
SRI LANKA	MG10	4.35
SRI LANKA	MG10	4.36
SRI LANKA	MG10	4.37
SRI LANKA	MG10	4.38
SRI LANKA	MG11	4.24
SRI LANKA	MG11	4.25
SRI LANKA	BG1	4.32
SRI LANKA	BG2	4.37
SRI LANKA	BG4	4.22
SRI LANKA	BG4	4.36
SRI LANKA	BG6	4.29
SRI LANKA	BG8	4.26
SRI LANKA	BG9	4.27

PROJECT ACHIEVEMENTS BY COUNTRY

GRANT CODES

PROJECT DESCRIPTION REPORTS

<u>COUNTRY</u>	<u>OUTPUT CODE</u>	<u>REPORT NUMBER</u>
TANZANIA	MG1	5.07
TANZANIA	MG1	5.08
TANZANIA	MG1	5.09
TANZANIA	MG2	5.03
TANZANIA	MG2	5.04
TANZANIA	MG3	5.01
TANZANIA	MG3	5.03
TANZANIA	MG3	5.04
TANZANIA	MG4	5.03
TANZANIA	MG6	5.01
TANZANIA	MG6	5.02
TANZANIA	MG6	5.03
TANZANIA	MG6	5.04
TANZANIA	MG7	5.05
TANZANIA	MG7	5.06
TANZANIA	MG8	5.02
TANZANIA	MG9	5.02
TANZANIA	MG10	5.09
TANZANIA	MG10	5.10
TANZANIA	BG1	5.01
TANZANIA	BG1	5.02
TANZANIA	BG1	5.03
TANZANIA	BG1	5.04
TANZANIA	BG1	5.05
TANZANIA	BG1	5.06
TANZANIA	BG2	5.02
TANZANIA	BG5	5.09
TANZANIA	BG6	5.07

BRIDGE GRANT OUTPUTS SPECIFIED - 1988 - 1989

MOROCCO

Extension Period Activities

Using the accomplishments in Ouarzazate as a base, during the one year extension HKI will:

1. use the trainer-clinicians to train one nurse in each of 13 clinics and 25 rural dispensaries throughout the province to identify, treat and refer, as appropriate, cases to the regional hospitals. The trainer-clinicians will also be instrumental in the provision of secondary care to patients referred to the regional hospital for eye conditions.
2. evaluate the region-wide school-based trachoma control program which includes specially trained school nurses who administer 1% tetracycline ointment to all students in April and November each year. Active infections will be carefully monitored. Based on government's request, the evaluation of this activity will be used to strengthen the program in the coming year.
3. supplement the trachoma control effort and the entire Ouarzazate program with public education activities. This initiative will include posters on blindness prevention for all health centers and schools, an illustrated booklet for schoolchildren and slide sets for use in schools and clinics and dispensaries where womens' groups have been formed.
4. continue to supply the regional hospital with essential ophthalmic equipment and supplies. A newly appointed ophthalmologist will handle all eye complications referred from the rural clinics, as well as perform intraocular surgery. The ophthalmologist will also supervise all eye care services in the region.
5. work with colleagues from the Ministry of Health to develop a system for the collection of service statistics for the project. This, in turn, can serve as a model for the collection of eye care service information throughout Morocco. Data on other diseases such as tuberculosis, diarrhea, malaria, etc., are routinely collected by health care personnel, so there is a precedent for this activity. These data will provide the opportunity for periodic review and modification of program to increase program efficiency.

6. further encourage the government's new interest in blindness prevention and promote the formation of a National Blindness Prevention Committee. This will serve as a forum for discussions among Ministry of Health and Service of Ophthalmology officials, representatives of HKI and other PVOs active in blindness prevention in the country, and regional Chefs de Medicins where appropriate.

PERU

Extension Period Activities

Using the strong base already established in Peru, during the one year extension, HKI will:

1. continue to support its indigenous technical staff, supplemented by key outside consultants;
2. support the National Institute of Ophthalmology in the use of its existing management, technical and training capacity to insure the continuation of statistical monitoring in seven sentinel villages and logistical support for the referral system in Puno, Ancash and San Martin; support refresher and replacement training for approximately half of primary and secondary level health workers in these same areas; evaluate and document the performance and costs of the overall demonstration program; complete the second-phase cataract service delivery study in Ica; and implement a six-month follow-up cataract campaign in an additional provincial city;
3. continue support for the community ophthalmology outreach campaigns program of OPELUCE; five campaigns which involve between 8-12 private surgeons, nurses and rehabilitation specialists are planned;
4. present published results of the Institute of Ophthalmology and OPELUCE findings to the National Blindness Prevention Committee and selected Ministry of Health officials;
5. complete the evaluation of the existing Ancash and Puno Community-Based Rehabilitation (CBR) program to determine the elements which need to be further strengthened; develop a National Training and Monitoring Team from the staff of CERCIL (the National Rehabilitation Institute) for continued support of activities in the outreach areas and for training of trainers from other countries in the Andean region (supported by German and Spanish donors and the Pan American Health Office (PAHO)).

PHILIPPINES

Extension Period Activities

During the period July 1, 1988 through June 30, 1989, HKI will concentrate on perfecting and evaluating the existing structure in the Bicol region, and insuring that the National Department of Health Primary Health Care Task Force is fully informed of the achievements. Specifically, HKI will:

1. continue to support its indigenous technical and managerial staff, supplemented by key outside consultants;
2. support the Philippine Institute of Ophthalmology in the use of its existing monitoring, technical and training capacity and;
 - continue support of the modified ophthalmology residency program;
 - conduct follow-up surveys in 10 sentinel barangays in order to assess performance of existing eye care services;
 - provide training of at least 70 replacements for health personnel who have resigned and refresher training for one-half of previously trained primary and secondary level health staff;
 - continue work on HKI's Japanese-financed operational research on cataract surgery in the project area and the underserved urban areas of Manila;
 - complete revisions in existing training materials; and
 - use local media to support the primary health workers by making people more aware of the services available.
3. collect data on all costs associated with the program and analyze these data preparatory to an upcoming AID evaluation of the program. (An outside consultant will assist this effort).
4. present final documentation on program performance, including the program evaluation, cost-effectiveness analysis, training program and materials, etc., to the National Department of Health.

SRI LANKA

Extension Period Activities

Using the experience from the pilot program in Kurunegala, during the one year extension HKI will:

1. continue to support its indigenous technical and managerial staff, supplemented by key outside consultants;
2. renew efforts to develop standardized medical forms and statistical tracking through the referral system and monitor and evaluate the performance of the overall system including both eye care and rehabilitation services;
3. focus on perfecting the system for providing refraction services to schoolchildren with vision problems; and aphakic spectacles for cataract patients;
4. update and revise training manuals and materials for the program and insure these are tested in refresher and replacement training of 600 health workers;
5. mount a major public education and community awareness campaign using public meetings, posters, and public address announcements during the Blindness Prevention Week to inform as many individuals as possible about the eye care and rehabilitation services available;
6. continue to assist the Sarvodaya Movement in Kurunegala with technical and materials resources for rehabilitation of the blind. (Sarvodaya will absorb into its budget the costs of rehabilitating all blind people in the district. The Swedish International Development Association/the Swedish Handicapped International Aid Foundation will broaden the base of this program from a single disability initiative to a multidisability approach which utilizes community-based workers to stimulate a more family-centered approach).:
7. systematically review the expectations of blind clients with regard to income generation, increase the capital revolving fund and support worker training in management of cooperatives;
8. describe and disseminate, at regional and national levels, actions required for any community to undertake a Community-Based Rehabilitation program;
9. encourage the adoption of a national eye care and rehabilitation program through regional and national seminars.

TANZANIA

Extension Period Activities

Using the Kongwa District program as a base, HKI will:

1. continue to support its indigenous technical staff;
2. continue its weekly village clinics which the people in the Kongwa District have come to rely upon. At the same time, HKI's ophthalmic nursing office will train another replacement on-the-job so that he is free to begin work in other blindness prevention efforts in the region;
3. work with its Tanzania colleagues to standardize the type of service statistics currently being gathered in the project site. Weekly meetings will be convened to review and act upon performance data;
4. engage the services of a Community-Based Rehabilitation trainer of trainers for a six-week workshop for community leaders in Kongwa District. Income-generation and community-development skills will be the focus of the training;
5. expand the cataract relief services throughout the Dodoma Region; and
6. collaborate with Johns Hopkins International Center for Epidemiology and Preventive Ophthalmology on a study to determine the most appropriate community sanitation and health measures for the eradication of endemic trachoma.

In addition, HKI's Country Director, Dr. B.B.O. Mmbaga, who sits on the National Blindness Prevention Committee will continue to showcase the Dodoma program in that forum and will disseminate results to influence policymakers by representing the Tanzania experience at a number of East and Southern African Blindness Prevention meetings which will occur during the upcoming year.