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FILE

PROJECT TITLE: IEF (International Eye Foundation)

INTRODUCTION

The International Eye Foundation (IEF), formerly known as the International Eye Bank, was founded in 1961 as a delivery system of ophthalmological care to developing countries. Since its inception the IEF has donated the expertise, eye tissue, surgical supplies, and equipment needed to perform more than 800 cornea transplants. In 1963, the IEF expanded its services to include all phases of eye health care and initiated a program of improving institutional capabilities of eye care centers in those LDCs where need was greatest and potential to utilize such technology existed. By 1970, eye care centers were in operation in five countries. Today, centers are operating in eight countries of Asia, Africa, and Latin America.

In 1970, the IEF established the Society of Eye Surgeons (SES), an international organization whose purpose is to promote the science of ophthalmic surgery among all people and nations. (Two international congresses on eye surgery have been held, one in 1971 and the other in 1973. A third one is planned for 1975.) The SES provides a large part of the medical talent that is used to run the IEF units in LDCs. In 1972, the IEF initiated the paramedical program called OATC (Ophthalmic Assistant Training Course). This program has become a success as a realistic response to disproportionate ratios of trained medical personnel available to treat overwhelming populations.

A primary reason for conducting the OATC activity is that this program becomes self-sustaining. The first two courses are taught by an IEF instructor. Two students, usually trained nurses, who are participants in the first course, are selected to receive special instruction and will participate in the second course as instructors. The paramedical program has now been conducted in three countries -- Indonesia, the Philippines, and Bangladesh. It is presently active in Barbados, West Indies, and a new program is scheduled for Pakistan in 1975.

Another important IEF activity is its Fellowships and Visiting Professors Program. Senior Ophthalmology residents from U.S. universities assist in eye care units in LDCs. Ophthalmology residents and eye surgeons from LDCs are trained in U.S. eye care centers. These exchange visits run about three months. In addition, senior surgeons and visiting professors spend two weeks to one month lecturing and performing demonstrative surgery at the LDC institutions where eye health care programs are being conducted, and to which eye tissue is sent by the Eye Foundation. To date, there have been a total of 482 such exchanges of medical experts and trainees working in 58 countries on three continents.

During the 14 years that the IEF has been in existence it has successfully expanded its program activities from a single activity in 1971 (eye bank), with an operational budget of \$3000, to a five-activity program in 1975 (International Eye Bank, Fellowships and Visiting Professors Program,

Paramedical Training, Volunteer Service, and the Society of Eye Surgeons). During this period the operational budget had increased to \$945,000 in 1974. The IEF seeks now to add a new capability to its on-going delivery system, and to the other existing health delivery activities of the LDCs, "Preventive Community Medicine Activity".

The IEF, over the 14 years of operation, sought to initiate and develop those delivery elements that would enhance involvement into an established and viable international organization. Additionally, the IEF demonstrated to LDC institutions its ability to successfully treat and cure eye diseases. At the same time, it influenced these institutions to develop and expand their own local resources for eye care delivery services. This track record strengthens IEF's confidence that it can successfully inaugurate a preventive community medicine activity for implementation in the LDCs.

To begin with, the IEF hopes to focus on two aspects of prevention, formal and informal education programs dealing with eye hygiene, and vitamin A. Strategy for the implementation of these activities will be designed to complement existing health care programs of any nature.

SUMMARY STATEMENT

The purpose of this proposed Development Program Grant (DPG) to IEF is to provide funding to institutionalize an in-depth program development and management capability -- which it does not now have -- within the IEF operations system, thereby reinforcing its ability to: a) effectively plan, design, implement, and evaluate low cost eye health care programs and projects in selected LDCs; and b) identify and develop existing resources, both public and private.

This grant will allow IEF to initiate, plan, and design needed programs and projects in selected LDCs which in the past have been designed largely by other institutions. Funding from this grant will enable IEF to acquire the skill and expertise to effectively respond to the many requests it receives each year to develop preventive and curative programs in developing countries.

Two additional staff members (Medical Program Coordinator and Program Development Officer) and a secretary will be provided under this grant. These additional key staffers will provide IEF headquarters and field staff with the ability to determine the capabilities of LDC institutions (both government and nongovernment) to utilize the technology which IEF can provide; and the ability to negotiate operational grants with USAID's and with other international organizations.

The basic function of the two professionals that will be added to the IEF staff will include the following:

The Medical Program Coordinator will provide the necessary expertise to ensure that teaching and medical delivery aspects of each program are pertinent and of high caliber. (S)he will also fulfill the role of evaluating the medical impact of each program and will coordinate the plan, design, and implementation of these programs. This will include incorporation of evaluation measures into the initial design of new programs so that effective evaluation can take place.

The Program Development Officer will assist in developing survey criteria, evaluating local institutional capabilities, including local available resources. (S)he will work with host institutions, USAID Missions, and others in developing eye health care plans, incorporating an implementation strategy, and determining the skills necessary to ensure a desirable impact.

The two program professionals will work with the existing IEF staff, both headquarters and field, to strengthen overall management capabilities. They will provide the Program Director of IEF the in-depth skills to effectively design and manage the planning, implementation and evaluation components of its operation. Complementing the professional staff will be

the utilization of the consultative services of medical, management, and program planning experts, enabling the IEF to place a greater emphasis on impact planning and evaluation; as well as effecting an expanded concentration on preventive community medicine geared to integrating eye health care into existing health care delivery systems in selected LDCs.

Specifically, these consultants will assist in:

- A. Program planning and analysis,
- B. Assessing capabilities of host institutions,
- C. Selection of evaluation criteria,
- D. Collection of relative data concerning types, frequency, and impact of eye disease, and
- E. Design verifiable indicators to measure development impact.

A. PROJECT GOAL

1. To upgrade the delivery of eye health care in selected LDCs, measurably improving the day to day living of the LDCs poorest majority.
2. Measurement of the Goal Achievement
  - a. Percentage of each LDC's population who have access to and are reached by eye care centers.
  - b. Number of people screened.
  - c. Number of people treated or under treatment.
  - d. Number of professionals and paraprofessionals trained or in training.
  - e. Number eye diseases cured or prevented.
3. Means of verification
  - a. IEF reports
  - b. U.S. Government reports (USAID, AID/W and Embassies).
  - c. LDC reports

4. Basic Assumptions

- a. Institutionalized capability in eye care among selected LDCs importantly complements general health care programs in developing countries.
- b. That all echelons of LDC governments will fulfill their respective responsibilities to ensure success of the program.

B. PROJECT PURPOSE

1. Purpose Statement - To institutionalize in-depth program development and management capability within the IEF programming system.
2. End of Project Status
  - a. IEF is exhibiting strong capability in implementing, managing and evaluating eye health care projects in LDCs.
  - b. The IEF program staff has effectively programmed U.S. ophthalmology teaching centers, universities, and the ophthalmology professions as a whole, into preventive and curative eye health care programs in the LDCs.
    - Nine formal university affiliations
    - 36 university personnel participating
  - c. IEF is effectively assessing the immediate needs and potential effectiveness of specific eye care delivery systems in LDCs, both preventive and curative.
  - d. Potentially viable local institutions are being adequately developed to deliver low-cost eye health care services.
3. Means of Verification
  - a. IEF reports
  - b. U.S. Government agency reports
  - c. Review of LDC institution reports (public and private)
4. Basic Assumptions - LDCs, both the private and public sector, recognize the need for eye care programs, and collaborate for its success.

C. OUTPUTS

1. Outputs

- a. Recruitment, hiring and support of officials to be added to the IEF headquarters staff.
- b. In collaboration with LDC institutions, USAIDs, and other agencies, develop plans for low-cost preventive and curative treatment and training centers, both for auxiliary personnel and ophthalmologist.
- c. Design preventive educational programs geared to improving the daily existence of the poorest majority.
- d. Collect relative data concerning types, frequency of eye diseases and their social and economic impact.

2. Output Indicators

- a. Two program types added to the IEF headquarters staff.
- b. Eye care training and treatment centers functioning in six LDCs.
- c. Active in-service training of auxiliary personnel, in six blindness prevention programs.
- d. Eight surveys to collect data completed.

3. Means of Verification

- a. IEF reports
- b. Review of host country reports, both public and private institutions.
- c. U.S. Government agency reports.

4. Basic Assumptions - That host governments will follow through with commitments to establish local treatment and training centers.

That local institutions cooperate fully in assigning auxiliary personnel for in-service training.

That LDC governments will participate in data collection surveys.

D. PROJECT INPUTS

1. AID

a. Funding

2. IEF

a. Funding

b. Administrative skills

c. Technical skills

E. BUDGET SCHEDULE (\$000)

|     | FY | <u>75</u> | <u>76</u> | <u>77</u> |
|-----|----|-----------|-----------|-----------|
| AID |    | 145       | 138       | 137       |

IEF

|  | <u>1st Year</u>  | <u>2nd Year</u>  | <u>3rd Year</u>  | <u>Total</u>     |
|--|------------------|------------------|------------------|------------------|
| I. Salaries                                |                  |                  |                  |                  |
| A. Medical Program Coordinator (Part-time) | \$ 10,000        | \$ 11,000        | \$ 12,100        | \$ 33,100        |
| B. Program Development Officer - 100%      | 19,500           | 21,000           | 22,500           | 63,000           |
| C. Secretary - 100%                        | 9,000            | 9,900            | 10,300           | 29,200           |
|  | <u>\$ 38,500</u> | <u>\$ 41,900</u> | <u>\$ 44,900</u> | <u>\$125,300</u> |
| II. Fringe Benefits (14%)                  | \$ 5,390         | \$ 5,866         | \$ 6,286         | \$ 17,542        |
| III. Other Direct Costs                    |                  |                  |                  |                  |
| A. Materials and Supplies                  | \$ 2,199         | \$ 2,020         | \$ 1,840         | \$ 6,059         |
| B. Telephone and Telegraph                 | 2,400            | 2,154            | 1,963            | 6,517            |
| C. Printing, Postage and Repo              | 3,318            | 2,896            | 2,689            | 8,903            |
| D. Equipment                               | 2,199            | 2,020            | 1,840            | 6,059            |
|  | <u>\$ 10,116</u> | <u>\$ 9,090</u>  | <u>\$ 8,332</u>  | <u>\$ 27,538</u> |
| IV. Travel and Per Diem (Staff)            |                  |                  |                  |                  |
| A. Domestic                                | \$ 9,000         | \$ 9,500         | \$ 6,000         | \$ 24,500        |
| B. International                           | 22,000           | 18,000           | 15,000           | 55,000           |
|  | <u>\$ 31,000</u> | <u>\$ 27,500</u> | <u>\$ 21,000</u> | <u>\$ 79,500</u> |
| V. Consultants                             |                  |                  |                  |                  |
| A. Travel and Per Diem                     | \$ 25,830        | \$ 22,413        | \$ 18,104        | \$ 66,347        |
| B. Salaries                                | 25,830           | 19,913           | 13,104           | 63,847           |
|  | <u>\$ 51,660</u> | <u>\$ 42,326</u> | <u>\$ 36,208</u> | <u>\$130,194</u> |
| VI. Information Exchange                   | \$ 10,000        | \$ 8,000         | \$ 6,000         | \$ 24,000        |
|  | <u>\$146,666</u> | <u>\$134,682</u> | <u>\$122,726</u> | <u>\$404,074</u> |

## RATIONALE

For the past 13 years the IEF has successfully demonstrated to AID its ability to plan and implement eye health care programs in selected LDCs, mobilizing limited resources to achieve measurable results.

The fact that the incidence of eye disease and the lack of localized treatment centers staffed by trained personnel to provide treatment has a substantial impact on the social and economic development of LDCs is rapidly becoming recognized. The need for rural eye care is real and acute. In most LDCs the IEF's programs are created to act meaningfully on critical social and economic problems at hand and are intended to involve participation of national, regional, and community institutions in solving their mutual problems.

As an example, at the request of the Ministry of Health of Kenya, the IEF is currently developing a program of blindness prevention and health education in rural Kenya. In that country, as in other LDCs, the incidence of blindness and ocular disability is alarmingly high, approximately ten times that in America, and visual disability has a much greater social and economic impact than in developed nations. The large number either blind or disabled from ocular disease in Kenya is estimated at more than one-half million people, the majority of whom are the very young or those who are in their productive years and who, therefore, are unable to contribute to the social and economic well being of the community.

The IEF's approach to the eye health care deficiencies in Kenya have been well received because it is a practical one. It delivers health education and badly needed eye care to people who would otherwise do without and does it with a minimal capital input, a minimal cost per patient seen (over 200,000 patients screened per year at a cost of roughly one dollar per patient) and a major emphasis on disease prevention and health education. Equipment and medicines are kept as simple as possible, and central to the whole program is the training and supervision of teams of Africans to work among their own people.

Current IEF units in LDCs are providing treatment and preventive care for hundreds of thousands. The following are estimates of the number of patients physically seen and treated at IEF facilities yearly:

|                       |                |
|-----------------------|----------------|
| Bangladesh            | 50,000         |
| El Salvador           | 15,000         |
| Ethiopia: Addis Ababa | 30,000         |
| Harar                 | 25,000         |
| Haiti                 | 13,000         |
| Honduras              | 20,000         |
| Kenya                 | 200,000        |
| Peru                  | 13,000         |
| Indonesia             | 62,000         |
| Barbados              | 18,000         |
|                       | <u>446,000</u> |

It is important to note that these figures do not include the numbers who have access to eye care through the existence of these programs. More often than not the IEF units provide the only eye care available to millions. As an example, the Mobile Eye Unit program in Kenya is the only eye care available to more than 11 million people.

In addition, in Ethiopia the IEF conducts programs in Harar and Addis Ababa and is responsible for five of the seven ophthalmologists available to provide eye care to a population of over 25 million. The desire for the IEF's assistance in this country has been so great that the people of the Harar Province raised among themselves the \$45,000 U.S. dollars necessary to equip their clinic which has been operating for more than one year and is now one of the finest in Africa. These IEF eye health care programs represent the only source of modern eye care available to the entire population of Ethiopia.

It can be pointed out that the need for eye care and blindness prevention programs has been recognized by other multilateral organizations as well. In a recent study published by WHO, the Director General estimated that the number of blind in the world will rise to over 30,000,000 unless active measures are taken. In the same report, the Director General estimated that over 400 million people suffer from blindness-inducing trachoma.

Indeed, the impact is so great that a recent report of national priorities published by the World Bank placed trachoma at the number four level in Asia and at the number six level in Africa.

The IEF has demonstrated to AID since the approval of its first program grant in 1972 its ability to carry out effective, low-cost programs in selected LDCs. In addition, the IEF has demonstrated its managerial capabilities to the Auditor General through on-site management audits conducted by AID at IEF headquarters. Further, the IEF Program Development Director, who will have implementation and management responsibility of this grant, has been working with ASHA and PVC since 1972 and has completed the AID course in Program Design and Management. However, the demands for broader assistance and the need for comprehensive impact planning dictate the need for additional planning and management skills, and to develop the capabilities of local staff and field personnel. The new professionals that will be added to the staff will provide the additional skills needed and will also design activities to upgrade the management capacities of appropriate host country personnel, and IEF field personnel.

As stated earlier, the IEF is finalizing an OPG for Kenya of which the initial acceptance has been favorable. Also, other OPGs are scheduled to be developed for Ethiopia, Malawi, Guatemala, Colombia, Pakistan, Tanzania, El Salvador, and Bangladesh.

In addition, the IEF has completed a successful mission funded project in Bangladesh and is currently discussing with AID/Dacca programs for further assistance.

This grant will enable the IEF to channel its energies to continue to direct itself to a most urgent need to bring about meaningful improvements in the well being and productiveness of the lowest income groups who are beyond the reach of current public services.

#### INVOLVEMENT OF WOMEN

The programs of the IEF are intended to bring about changes in the quality of life of women. Beyond just being the recipients of improved eye health care and the subsequent betterment of their daily existence, women are active participants themselves. The majority of those trained to be Ophthalmic Assistants are women. The IEF also involves women at the professional staff level and avails itself of the services of ophthalmic technicians, nurses, and ophthalmologists, many of whom are women.

#### FUTURE FUNDING CAPABILITIES

The IEF has demonstrated its abilities to identify and utilize funding from sources other than AID will will continue to expand and redefine its fund-raising strategy with a major emphasis of gearing its growth in this area to program expansion.

It is significant to note that the IEF funding from private sources (i.e., Foundations, industry, and individuals), despite current economic conditions, continues to show growth. This year's estimate will approach over a quarter million in cash and is estimated to top the 20% growth of last year.

The IEF is currently undertaking steps to ensure and expand its ability to maintain its growth in this area to meet its financial obligations that will be created by the successful implementation of this Grant.

Of primary importance in continuing to meet this objective will be the successful identification and utilization of resources that may be available at the local level. This is closely aligned with the purpose of this grant, that is to effectively plan, design, implement, and evaluate low cost eye health care and prevention programs and projects

in LDCs. The IEF intends to strengthen its already demonstrated capability to create a consortium resource formulated from local institutions, both public and private. It should be pointed out that well over one-third of the IEF's total budget currently comes from resources available at the local level. The primary example of this can be found in the IEF's program located in Harar, Ethiopia. It is most significant to point out that the IEF's contribution to this project both above and beyond the volunteer manpower represents less than one-third the cost of the total project. The local Ministry of Health provides transportation, housing, housing allowance, drugs and supplies, and physical facilities. It can also be noted that the 45,000 U.S. dollars necessary to equip this teaching and treatment center was contributed by the people of Harar. The utilization of available resources at the local level is a basic aspect of each IEF program and one that can be demonstratively continued.

Complementing these continuing endeavors to strengthen the IEF's funding resources will be a continually expanding effort here in the U.S. Currently, one of the very successful IEF fund-raising projects is the annual Eye Ball Dinner Dance, a Black Tie affair usually held here in Washington and sponsored through one of the local embassies. From an initial event at which \$5,000 was realized, the Eye Ball has grown to the extent that last year's dance contributed over \$46,000 after expenses. Plans are now being implemented to establish an annual Eye Ball fund-raising dance which is organized through the socially prominent Board members and friends of the IEF in Palm Springs, California, Palm Beach, Florida, and New York City. One location will be added each year. It is estimated that these functions will provide an annual resource of a minimum of \$250,000.

The IEF will continue to branch into other social functions. Last year it held its first Wine Tasting event which this year will become an annual event.

The IEF will also expand its staff and has hired a full-time professional to work with Foundations, industry, and private individuals to increase the resources in this area. The IEF will continue its direct mail campaigns. Its continuing campaign to build its donor list will yield increased results.

The Latin American Regional Office of the International Eye Foundation is being established in Mexico City this year. The primary function of this office will be to identify and utilize local resources, that is, industry, individuals, institutions--U.S. or otherwise--that can provide the ingredients necessary to plan and implement eye health care and preventive programs in Latin America. Complementing this particular program will be an increased effort in this country working with the embassies here in Washington. The IEF has appointed to its Advisory Council The Honorable Sevilla-Sacasa, Dean of the Diplomatic corps, who will act

as Diplomatic Consultant to the IEF. Ambassador Sevilla-Sacasa will work with his colleagues from various other countries to contact U.S. industry and other institutions which have programs in developing countries in an effort to involve them in providing resources to the IEF.

These proposed programs and areas of expansion are being firmly planned. It is the IEF's sincere wish that once the purposes of this and other grants have been achieved it will have the strong institutional capabilities to do without AID's funding.

## COURSE OF ACTION

The International Eye Foundation seeks AID's assistance in enabling it to strengthen its capabilities to plan, design, implement, and evaluate eye health care programs in selected LDCs.

Specifically, the IEF seeks to:

Strengthen its capabilities to create an in-depth management structure enabling it to keep pace with program expansion, reinforce its capacity to identify and develop its inherent resources, both public and private, to effectively implement and carry out eye health care programs in selected LDCs.

Make for more effective utilization of U.S. technological resources (Ophthalmology) by establishing a closer working liaison with leading U.S. Ophthalmology teaching centers and the ophthalmology profession as a whole.

Strengthen its ability to assess the immediate needs and potential effectiveness of specific eye care delivery systems in selected LDCs.

## IMPLEMENTATION PLAN

Working toward achievement of these objectives to strengthen a particular program will involve a five-step process which will enable the IEF to make significant strides in working with local LDC education and community health institutions to increase the effectiveness and capability of ophthalmic teaching programs, at both the auxiliary and physician level.

1. Providing adequate consultative services to the LDCs to assist in the development of information patterns for the exchange of ideas, potential solutions for development and establishment of low cost, effective training and treatment programs both for the auxiliaries and the ophthalmologists. This aspect will be undertaken to better determine what the most urgent needs are to insure that meaningful improvements in eye health care can be accomplished -- reaching the greatest number of people at the lowest per capita cost.
2. A direct result of Phase I will lead to the collection of information concerning the types, frequency, and distribution of eye disease, which is Phase II. It might be pointed out that there is no realistic base of information enabling any organization to measure the social and economic impact of eye diseases in LDCs. In fact, the 15-16 million estimate used by WHO is based

on information that is five years old. The IEF has been using the figure of 16 million since 1970. The most recent study published by WHO states that it is imperative that up-to-date data on blindness be established.

3. Phase III will involve the implementation of specific training programs of auxiliary health workers in the diagnosis and treatment of eye diseases (or at least training for screening for the identification of treatable diseases), which will be done through the utilization of local institutions. Where training programs exist for Ophthalmic Aides, it will be necessary to strengthen these programs, as well as provide for the expansion of local health care centers to provide minimal eye care needs, i.e., simple refraction, minor treatment, and screening for referral. IEF program professionals will design implementation strategy for these training activities.
4. Phase IV will be to facilitate the establishment of referral centers for surgical treatment or for treatment too sophisticated to be handled by the rural centers. In many instances, this may be the regional center such as those in Kenya or Ethiopia. These sites would also serve as centers for advanced education or training, i.e., specialized surgical techniques.
5. Key to the functioning of the centers will be emphasis placed on formal and informal health education geared to blindness prevention, specifically focusing on hygiene and Vitamin A, two leading factors that are the cause of blindness to millions. The program will, structurally, be planned to complement capabilities currently non-existent in most LDC health care delivery systems.
6. Phase V will provide IEF with the capability to undertake a meaningful evaluation to be presented to the LDC government and USAID of the efficiency, impact and future needs of each LDC where a program has been established. As in most development programs, there comes a point at which assistance can be reduced, however, many programs have failed because assistance is withdrawn before an evaluation is made, or as in some cases, when assistance is terminated rather than being slowly phased out.

This grant will provide the IEF with strengthened competence in the areas of program development and management. Facilitating an accelerated implementation of the activities provided for under this grant is the fact that the development and management functions will be under the direction of

the current Director of Program Development, an experienced IEF staffer who has been responsible for negotiating all AID-IEF grants since the first grant was initiated in 1971. In addition to also having a strong background in negotiating with local MOHs, this officer, as mentioned in the Rationale, has broadened his knowledge and understanding of AID's planning and evaluation methodology through his participation in AID Program Design and Management Seminars.

The Medical Program Coordinator, in collaboration with the Director of Program Development, will identify eye health care needs in LDCs, assisting in design and evaluation of medical training programs and will schedule volunteer surgeons and technicians as priorities dictate.

The Program Development Officer will assist in program design and management activities in addition to collaborating on development priorities and evaluation.

With the consummation of this grant, the IEF is set to begin immediate implementation. The rate of travel of IEF personnel and field activities at the beginning of this program will be in accordance with the progress of program development in LDCs.

**PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK**

Life of Project: \_\_\_\_\_  
 From FY \_\_\_\_\_ to FY \_\_\_\_\_  
 Total U. S. Funding \_\_\_\_\_  
 Date Prepared: \_\_\_\_\_

Project Title & Number: International Eye Foundation (IEF)

| NARRATIVE SUMMARY  | OBJECTIVELY VERIFIABLE INDICATORS   | MEANS OF VERIFICATION   | IMPORTANT ASSUMPTIONS  |
|--|---|---|--|
| <p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p><u>PROJECT GOAL</u><br/>           To upgrade the delivery of eye health care in selected LDCs, measurably improving the day-to-day living of the LDC's poorest majority.</p> | <p>Measures of Goal Achievement:</p> <ol style="list-style-type: none"> <li>1. Percentage of each LDC's population who have access to and are reached by eye care centers.</li> <li>2. Number of people screened.</li> <li>3. Number of people treated or under treatment.</li> <li>4. Number of professionals and para-professionals trained or in training.</li> <li>5. Number eye diseases cured or prevented.</li> </ol>  | <ol style="list-style-type: none"> <li>1. IEF reports.</li> <li>2. U.S. Government reports (USAID, AID/W and Embassies).</li> <li>3. LDC reports.</li> </ol>                      | <p>Assumptions for achieving goal targets:</p> <ol style="list-style-type: none"> <li>1. Institutionalized capability in eye care among selected LDCs importantly complements general health care programs in developing countries.</li> <li>2. That all echelons of LDC governments will fulfill their respective responsibilities to insure success of the program.</li> </ol> |
| <p>Project Purpose:</p> <p>To institutionalize in-depth program development and management capability within the IEF programming system.</p>   | <p>Conditions that will indicate purpose has been achieved: End of project status.</p> <ol style="list-style-type: none"> <li>1. IEF is exhibiting strong capability in implementing managing and evaluating eye health care projects in LDCs.</li> <li>2. The IEF program staff has effectively programmed U.S. ophthalmology teaching centers, universities and the ophthalmology profession as a whole, into preventive and curative eye health care programs in the LDCs.               <ul style="list-style-type: none"> <li>- Nine formal university affiliations.</li> <li>- 36 university personnel participating.</li> </ul> </li> <li>3. IEF is effectively assessing the immediate needs and potential effectiveness of specific eye care delivery systems in LDCs, both preventive and curative.</li> <li>4. Potentially viable local institutions are being adequately developed to deliver low-cost eye health care services.</li> </ol> | <ol style="list-style-type: none"> <li>1. IEF reports.</li> <li>2. U.S. Government agency reports.</li> <li>3. Review of LDC institution reports (public and private).</li> </ol> | <p>Assumptions for achieving purpose:</p> <p>LDCs, both the private and public sector, recognize the need for eye care programs, and collaborate for its success.</p>  |

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

From FY \_\_\_\_\_ to FY \_\_\_\_\_  
Total U. S. Funding \_\_\_\_\_  
Date Prepared: \_\_\_\_\_

Project Title & Number: INTERNATIONAL EYE FOUNDATION (IEF)

| NARRATIVE SUMMARY  | OBJECTIVELY VERIFIABLE INDICATORS  | MEANS OF VERIFICATION  | IMPORTANT ASSUMPTIONS  |
|--|--|--|--|
|  |  |  |  |
| <p>Outputs: 1. Recruitment, hiring and support of officials to be added to the IEF headquarters staff. 2. In collaboration with LDC institutions, USAID's and other agencies, develop plans for low cost preventive and curative treatment and training centers, both for auxiliary personnel and ophthalmologist. 3. Design preventive educational programs geared to improving the daily existence of the poorest majority. 4. Collect relative data concerning types, frequency of eye diseases and their social and economic impact.</p> | <p>Magnitude of Outputs: <u>Output Indicators:</u><br/>1. Two program types added to the IEF headquarters staff. 2. Eye care training and treatment centers functioning in six LDC's. 3. Active in-service training of auxiliary personnel in six blindness prevention programs. 4. Eight surveys to collect data completed.</p> | <p>1. IEF reports.<br/>2. Review of host country reports, both public and private institutions.<br/>3. U.S. Government Agency reports.</p> | <p>Assumptions for achieving outputs:<br/>1. That host governments will follow through with commitments to establish local treatment and training centers.<br/>2. That local institutions cooperate fully in assigning auxiliary personnel for in-service training.<br/>3. That LDC governments will participate in data collection surveys.</p> |
| <p>Inputs:<br/>1. A.I.D. - funding.<br/>2. I.E.F. - a. Funding<br/>          b. Administrative Skills<br/>          c. Technical Skills</p>  | <p>Implementation Target (Type and Quantity)<br/><u>FY-75</u> <u>FY-76</u> <u>FY-77</u><br/>A.I.D.     145    138    137<br/>I.E.F.</p>  | <p>1. Fiscal reports<br/>2. Vouchers<br/>3. Audits</p>   | <p>Assumptions for providing inputs:<br/>1. That A.I.D. funding will be at the level anticipated.<br/>2. That I.E.F. funding will be at the level anticipated.</p>   |