



**PRIMARY EYE CARE/BLINDNESS PREVENTION
COMMUNITY BASED REHABILITATION OF RURAL BLIND**

**A COMPARATIVE ASSESSMENT OF
HELEN KELLER INTERNATIONAL
PROMOTED PROGRAMS IN SRI LANKA
AND THE PHILIPPINES**

Donald A. Swanson

NASPAA Management Consultant

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Views expressed here are those of the author and do not necessarily represent the views of NASPAA, Helen Keller International, or AID. This paper is part of an evaluation conducted by NASPAA for HKI on its individual programs in Sri Lanka and the Philippines May 25 - June 20, 1987. Those two evaluation case studies contain the data from which this comparative assessment is made. Dr. Henry Newland, a public health ophthalmologist consultant, was the co-evaluator of those individual projects.

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Background

Helen Keller International has been engaged in Primary Eye Care/Blindness Prevention (PEC/BP) and Community-Based Rehabilitation (CBR) of the rural blind for many years. Since 1981 it has received two matching grants from the U.S. Agency for International Development (AID) to further its work in these two program areas in different parts of the world. In particular, two leading countries are Sri Lanka and the Philippines, where programs have been operating for the past four years.

Primary Eye Care/Blindness Prevention is a specialized health area that includes prevention and treatment of eye injuries and infections, prevention of blindness due to vitamin A deficiency and other diseases, and cataract surgery to alleviate unnecessary and non-permanent blindness. PEC/BP programs are normally incorporated into the regular national government primary health care delivery system.

Community-Based Rehabilitation (CBR) is an innovative concept to provide orientation and mobility training, living skills, and income generating activities for permanently blind rural citizens in their homes and villages. All age levels from pre-school to the elderly can be engaged in this program which could eventually be incorporated into a national health, social welfare, or educational program.

HKI/New York has requested the National Association of Schools of Public Affairs and Administration (NASPAA) to evaluate the performance, effectiveness, and impact of its PEC/BP and CBR programs in Sri Lanka and the Philippines. NASPAA and an HKI public health ophthalmologist consultant conducted the individual case study evaluations in these two countries May 25 - June 20, 1987.

The evaluations assessed PEC/BP and CBR separately since these two projects have different historical roots, institutional relationships, and project activities. Overall assessments were made about delivery of services, field worker training, administration, institutionalization (sustainability, replicability, impact, spin-off effects), and strengths and weaknesses. Also included were recommendations to alleviate the identified constraints.

This comparative assessment is based on the findings of those evaluations, and its purpose is to search for common and divergent themes. The PEC/BP and CBR projects are first compared between Sri Lanka and the Philippines. Then a final overall comparison and conclusion is made about all four projects in the two countries. The assessment utilizes logical framework criteria found in the matching grant final report and the HKI matching grant proposal of 1985.

A. Primary Eye Care/Blindness Prevention Comparative Assessment

1. Overall Goal Achievement

Through the Ministry of Health (MOH) primary health care program the Sri Lanka PEC/BP program has a good delivery system in place in eight of twelve regions of Kurunegala district in the central highlands. About 2,000 government health workers have been trained to integrate PEC/BP activities into their regular work activities and have adequate equipment and supplies to do so. Coverage and identification of possible clients is still relatively low so that access to preventive, therapeutic and restorative services, particularly cataract surgery, is only moderately successful. Some bottlenecks still exist in referral and delivery systems. There is evidence that the government is taking over the project in the district and will expand to other districts, indicating a positive policy impact.

In the Philippines there is also a good PEC/BP delivery system put into place through the MOH primary health care system, in two of five provinces in Bicol Region V. Over 1,500 health workers have been trained and they are integrating PEC/BP as a part of regular service. Coverage is still moderately low due to inadequate outreach by workers, poor recording and monitoring, and some socio-cultural resistance to eye care. Some constraints in the cataract surgery component are due to lack of ophthalmologists working in the region; however, this is being resolved through HKI-sponsored residency training programs for ophthalmologists. A relatively low interest by MOH national-level officials in PEC means that it is doubtful that the demonstration program can be integrated into the national health system in the near future.

2. Outputs of Logical Framework

Standardized Assessments. HKI/Sri Lanka has only a very superficial eye survey that was conducted in 1981. This study was never finished, has unreliable data and is not used for a data base. Needs assessments, target population attitudes and behavior studies, and MOH feasibility studies have not been. Rather, decisions are made by informal channels.

In the Philippines there is a good eye survey conducted by the Institute of Ophthalmology of the University of the Philippines in 1983, in ten barangays (villages) in the two provinces of Bicol Region. Information from the survey is reliable and is used by HKI and the MOH. As in Sri Lanka, no needs assessments, attitude surveys, or feasibility studies have been made. Good preliminary informal groundwork by HKI staff is apparent.

Curricula, Manpower Education and Training Programs. The Sri Lanka program has a good PEC/BP curricula, developed for primary, secondary, and tertiary levels, with excellent training manuals in Sinhalese. Because all materials were pre-tested they demonstrate high relevance for Sri Lanka. They have all been published and are readily available for health workers. Over 2,000 health workers have participated in well-designed training programs lasting 2-6 days, with good follow-up, supervision, and monitoring. The Ministry of Health does its own training, which encourages institutional learning.

HKI/Philippines has assisted the MOH in putting into place a good curricula at all three levels. Training manuals have been written and are available at all levels. Excellent training materials, and especially adult or non-formal education methodology, are used. Over 1,600 health workers were trained by 25 MOH staff from the Bicol Region V Training Unit. This demonstrates definite signs of maturity.

Supplies and Equipment. The PEC/BP program in Sri Lanka has adequate supplies and equipment, which are provided by HKI in a low key manner. There is some evidence of dependence by MOH on these HKI-provided supplies, indicating possible future problems when HKI funding is terminated.

In the Philippines there are good vitamin A and tetracycline supplies. Excellent provision of equipment for cataract surgery and ophthalmologist training demonstrates HKI's visible presence for provision of supplies. HKI/Philippines has provided excellent PEC education and treatment packages for all health workers, which include eye charts, flip charts, eye supplies, and guidelines.

Delivery System: Initiation, Referral, and Treatment. The Sri Lanka program has about 6,000 patients identified in the past five years, in an area where there were no activities before this program began. However, only about 10-20% are referred up through the system and receive treatment. Evidence of good treatment by health aides at the village level indicates positive training and acceptance of the PEC/BP approach. The referral system is adequate but requires some adjustments and adaptations to ensure that it run more smoothly. Treatment at secondary and tertiary level is good based on five days of training for the health workers. A good school screening program is in effect,

with 112,000 school children screened, 7,000 referred, and 1,600 treated.

In the Philippines, roughly 4,000 patients with eye problems have been identified in four years. Only about 10% are referred for appropriate treatment. There is inadequate coverage because health workers are unable to identify and screen potential eye patients, which therefore results in a reactive rather than a proactive attitude. Treatment of vitamin A deficiency is good, with about 50,000 children receiving doses of vitamin A.

Cataract Surgery Services. The Sri Lanka program has an adequate delivery system for cataract surgery services. However the levels of coverage within the district are lower than they could be due to uneven distribution of ophthalmologists, lack of bed spaces, and limited patient response. The MOH is performing about 200 cataract surgery services per year. The system to deliver get aphakic lenses to cataract patients is somewhat inadequate and requires some revisions.

The existing cataract surgery system in the Philippine Bicol Region V is quite poor, with only one hospital offering services. Few ophthalmologists are willing to assist in the program. HKI and the Institute of Ophthalmology are making a monumental effort to resolve this problem through a modified residency training program for new ophthalmologists. However the results of this effort will not be known for the next three or four years. At present the resident trainees do some cataract surgery but this is a sporadic effort.

Public Education Strategies. The MOH in Sri Lanka has no systematic plan to educate the public about PEC/BP services. Screening of school children is the only effort being made to circulate information about eye care.

The Bicol Region V MOH Office in the Philippines has made no mass media efforts at present to promote PEC/BP but, with the direction of HKI/Philippines, there is a proposed social marketing strategy for promoting consumption of foods rich in vitamin A, as well as capsule for vitamin A deficiencies through easily-distributed capsules.

Program Supervision, Evaluation, and Planning. The PEC/BP program in Sri Lanka has a moderately adequate referral reporting system and an adequate cataract surgery record system. However, the MOH keeps minimal records and has an inadequate management system for project components that are already in place. No internal evaluation system is being used to monitor the project nor are formative evaluations made. No annual action plans and no specific behavioral objectives are being used. Few scopes of work for workers exist and there are no contracts for services.

In the Philippines the PEC/BP program has an adequate record keeping and referral system but the health workers do not use it well. HKI/Philippines demonstrates evidence of concern for management planning and of systemic management in practice, but there are no written evaluation systems, action plans, specific behavioral objectives, nor scopes of work. No contract with Institute of Ophthalmology exists, although it receives sizeable financial support from HKI.

Participation of Indigenous Organizations. In Sri Lanka there is some participation by the Sarvodaya Shramadama Movement in the PEC/BP program in Kurunegala district, but only through some referrals of screened clients to health clinics. Other Sri Lankan NGOs have their own eye care programs such as eye camps or limited cataract surgery in other districts.

There is limited NGO involvement in primary eye care in the Philippines and no NGO participation in PEC/BP program in Bicol Region V. Both the MOH and HKI/Philippines would welcome collaboration.

B. Community-Based Rehabilitation Comparative Assessment

CBR projects in both Sri Lanka and the Philippines have initiated what may be considered a revolutionary concept of training rural blind people in their homes in orientation and mobility, living skills, and some income generation or vocational skills. This approach attacked the fundamental problem of having rural blind people uprooted and sent to urban centers. The concept of training field workers to work one-on-one with a caseload of five blind clients in rural villages appeared in planning to make sense.

In both countries micro-project components such as worker training, case review, and rehabilitation plans function adequately. However, at the macro-outreach level of sustainable impact through assisting the largest number of clients possible, there are some constraints. If HKI and the host country agencies consciously elect to maintain a low level of outreach then the overall assessment is that the CBR projects function adequately. However, if the project goals are impact, sustainability, replicability, and expansion using this demonstration model, then there are some serious questions concerning coverage. In HKI's stated project goals for CBR it is emphasized that outreach, coverage, and integration of CBR into national health or welfare programs is important.

1. Overall Goal Achievement

As implementing institution the Sri Lankan NGO, the Sarvodaya Movement, has had 64 field workers train 250 rural blind clients in the past four years, and presently (as of mid-1987) has 42

field workers rehabilitating 150 clients. There is excellent training provided by HKI and an HKI/Indonesia training manual is used. The one-on-one approach limits coverage and outreach and makes impact minimal. A very credible initial effort is being made to assist with income generation activities for 50 adult rural blind in agricultural production and cottage industries. This component can go much further by having higher expectation levels of the clients and by increasing the capital revolving fund. There is a questionable policy level impact, as the project is implemented by an NGO that has not integrated CBR into its overall development strategy.

In the Philippines, the Department of Social Welfare Development (DSWD) has trained about 125 field workers who in turn have rehabilitated about 2,500 blind clients since mid-1978, in eight of the thirteen regions. By mid-1987 there were 25 field workers rehabilitating 125 clients in seven regions. Field worker training by DSWD staff and HKI international staff members is of a high quality. However, DSWD has several internal administrative problems which inhibit full use of field workers and have the potential to cause the program to come to a standstill. The one-on-one approach is also limiting coverage considerably. In mid-1987 a new multiplier effect strategy was being initiated for field workers to identify and train community volunteers to rehabilitate blind people. This approach, and others aimed at increasing coverage, are required to achieve the stated project goals.

2. Outputs of Logical Framework

Standardized Assessments. No standardized assessments were made in either country concerning perceived needs, approaches, community-level interest, attitudes and perceptions, or project feasibility. Strategies and approaches are based on previous HKI worldwide experience. Inadequate data for planning purposes is notable in both countries.

Curricula, Manpower Education, and Training Programs. In Sri Lanka a good curriculum was developed by CBR specialists from HKI and pre-tested with blind clients. The training manual used is from the HKI/Indonesia CBR program. Training of field workers is of high quality, and field workers therefore demonstrate good client training as a result.

In the Philippines there is a good curriculum developed by the DSWD and CBR specialists from HKI. A training manual has been written that covers most orientation and mobility and living skills curricula and it is supported in part with the HKI/Indonesia training manual. DSWD field workers have received excellent training from DSWD trainers and HKI staff.

Supplies and Equipment. There are no major supplies or equipment provided for these projects in either country.

Delivery System. The Sarvodaya workers in Sri Lanka identify clients by going from house to house. There is little screening and the general policy is that interested parties are accepted with only minimal entry requirements. Field workers spend 50% of their time on CBR and have roughly five clients each. Of the actual CBR time, about 45% is spent on case review and making initial adjustments, and approximately 25% for actual rehabilitation. About one-third of the clients are school children, another one-third are adults in living skills rehabilitation, and the remaining one-third are in the income generation program. All three sub-projects work well in their present manner. The one-on-one (client/field worker) approach is somewhat inefficient because Sarvodaya workers are only contracted on a half-time basis, and spend 25% of that time traveling to homes.

In the Philippines clients are identified by the community-based DSWD workers (primarily out-of-school youth) who carry out good assessments of all clients. Client rehabilitation ensues according to well-established plans. Almost all present clients are in the orientation and mobility or living skills rehabilitation programs. Workers spend 75% in rehabilitation time and only 25% time in case review. Case closures are made by DSWD supervisors. There are only a few cases of income generation clients in their program. The most significant problem is the underpaid DSWD workers who are not full civil service employees and thus have high attrition rates and problems of low morale.

Public Education Strategies. There are no CBR public education strategies in either country. If there were to be considerable changes in the CBR program, as recommended, then a communication development strategy could be used effectively in both countries.

Program Supervision, Evaluation, and Planning. In the Sri Lanka CBR program there is good supervision of rehabilitation through the case review process and internal evaluation process. There is disregard for contractual arrangements, management processes, or scopes of work. There is no contract with Sarvodaya, although it receives a sizeable financial expenditure and contracts about 50 field workers.

In the Philippines there is also good supervision by the DSWD of the limited number of rehabilitation clients. There are no internal evaluations or systemic planning, but there is high quality DSWD management which keeps the program going in its limited fashion.

Participation of Indigenous Organizations. The Sarvodaya Movement is the leading NGO in Sri Lanka and has a good worldwide reputation. As a respected private institution, it could have considerable policy impact on the government, as it has had with other integrated rural development programs, if the CBR program expands.

Several Filipino NGOs have blind rehabilitation programs in Manila which have been very successful. To our knowledge, DSWD has not solicited NGO assistance or collaboration for this CBR program.

C. Summary of Findings

1. Sustainability/Replicability

The PEC/BP programs in both countries have initiated positive steps toward introducing PEC/BP into the national health systems. In over four years of effort it is possible to see the beginnings of an integration of PEC/BP concepts where they did not exist before. Both programs have roughly the same degree of success in terms of effectiveness of project components, with minor bottlenecks and constraints that are different in each country. However, in Sri Lanka there is much more acceptance by the MOH to incorporate the PEC/BP model than in the Philippines. This does not detract from the HKI/Philippines effort, but is merely a statement of level of acceptance by the MOH.

Both PEC/BP programs most likely will be integrated into the MOH health care systems within the next few years. This is a major accomplishment in such a short period of time. Two crucial factors leading to this accomplishment are that considerable learning through trial and error has already occurred in both countries and HKI interventions are within the realistic possibilities of the respective ministries of health.

Replication implies repeating a project or program in another location under similar conditions, and for the most part the PEC/BP programs could be replicated. Both are in healthy shape, but at the same time require fine tuning and adaptations. Constraints which presently are considered to be insignificant, can become monumental barriers with expansion and growth. The fine tuning required is in the areas of referral mechanisms, reporting systems, and in-service training for health workers. More detailed adaptations are required by the cataract surgery programs before bottlenecks become a serious problem.

Both CBR programs are limited and provide rehabilitation to a rather small number of blind clients. In both countries there are concerns about whether the programs could exist without the presence of HKI. In Sri Lanka there is minimal evidence of sustainability by the implementing agency, and even less evidence

of interest by government organizations. In the Philippines the program is at a standstill despite motivated leadership.

Both CBR programs could be replicated in their present form with no major problems. However, it is not recommended that they do so until there is evidence of more support from government agencies.

2. Policy Impact

Both PEC/BP efforts are the leading demonstration models in these two countries and have the respect of the ophthalmology community and government agencies. The Sri Lankan government is ready to implement major changes based on the effectiveness of the PEC/BP approach in Kurunegala district. MOH officials at the Bicol Region V level in the Philippines affirm positive interest and acceptance of the PEC/BP model but, through no fault of HKI/Philippines, there is less interest at the MOH in Manila. However, this could change within the next year, due to the increased interest in primary health care by the new administration.

Outside of government channels, there is good evidence in both countries that the ophthalmological communities support the PEC/BP approach. In Sri Lanka ophthalmologists praise the PEC/BP project and recommend its expansion to other districts. In the Philippines the Institute of Ophthalmology and the Council on Blindness have written policy papers on PEC/BP based on the Bicol Region V demonstration model.

The CBR program in Sri Lanka is implemented by a non-governmental organization and there is no evidence of government interest in taking this program over in the near future. In the Philippines the DSWD is a government agency and the program operates in eight regions. Yet it is viewed as a limited effort within the Bureau of Rehabilitation, and there is no expectation of expansion in its present form.

The most promising policy impact that has come out of the CBR program is acceptance by the Government of the Philippines that blind rehabilitation can be done in rural areas. This may help to change the long tradition of removing the blind client from the home environment.

3. Strategies and Approaches

Both countries receive overall project guidance from HKI/New York, while having considerable freedom to operate independently. This means that individual decisions are made locally, based on the assessment of the nature of the problem and the capacity of the staff to accomplish the tasks. Thus decision-making is not based on a carefully worked out systematic strategy but rather on

the staff preferences for types of interventions. This seems to work fairly well with the PEC/BP programs but less well with the CBR programs.

HKI/New York has considerable experience in implementing development projects in the Third World. Therefore, it is somewhat surprising that their corporate experiences are not always transferred to individual countries in the form of guidelines, directives, implementation strategies, and staff training.

In both countries HKI strategies exclude activities that are extravagant or in which they can expect limited results. There is little desire by HKI to undertake activities that appear to go beyond their unwritten scope of work. This approach wins the respect of their colleagues since HKI is viewed as an institution that can be trusted. The tasks are quite definable though not in specific behavioral terms.

HKI views their role in development as either a charitable provider of relief and welfare or as a catalyst for small-scale local development. Rarely does their approach deal with the issue of sustainable development. From the relief and welfare perspective the projects are viewed as missions to direct delivery of goods and services. This is apparent, for example, in providing vitamin A capsules in the Philippines or cataract surgery supplies in Sri Lanka. Project staff members become very involved operationally in directing outputs. In small-scale local development HKI works more often through the governmental institutions but still performs direct interventions. This can be seen in both countries by the active involvement of HKI in organizing training courses, initiating new projects such as the Metro Manila cataract surgery program, or promoting vitamin A consumption through media campaigns.

4. Spin-Off Effects

There is some evidence that the PEC/BP training model has affected other training programs within both ministries of health. Also the reporting and monitoring systems of PEC/BP are much better than the primary health care systems in both countries, which could affect the latter. HKI support of health workers is viewed positively in both countries and it is possible that similar support could be forthcoming in other specialized primary health care services.

5. Lessons Learned

There is a high degree of trial and error and reactive rather than proactive interventions in both countries. This means that in most cases immediate solutions are sought for problems, rather than looking for long term systemic solutions. In both countries

HKI staff members prefer to get a specific component operational and to think about the long term consequences later. This seems to work very well at this stage of their programs when outreach is still limited. A problem may develop later when current minor mistakes will expand with a larger program. In Sri Lanka, a classic example is the increased provision of cataract surgery. There was sufficient demand for this service, but there was the unanticipated problem of inadequate bed space and proper post operative care in some hospitals. In the Philippines the project staff has had to struggle to convince ophthalmologists to perform cataract surgery in order to have a well-rounded program.

Acceptance of additional responsibilities outside of the immediate scope of work, without taking into account possible negative consequences, has been a good learning experience for HKI/Philippines. The Vitamin A research project of the Johns Hopkins University backfired and has caused unnecessary negative repercussions for the HKI project in the Philippines.

6. Management

In both countries HKI staff members perform well with a low level of expenditures. They appear to maximize their limited budgets through creative, though often time-consuming, efforts. At the same time, however, in both countries there is an almost total disregard for contracting services. In Sri Lanka there is no contract with Sarvodaya and no specific scope of work. Likewise, HKI/Philippines has no contract with the Institute of Ophthalmology and has little apparent monitoring of scopes of work, travel and per diem, and services performed.

Another related issue is with cost effectiveness and cost efficiencies. It was not possible to do a cost effectiveness review of these programs due to inadequate data collection in terms of both costs and outputs. In project planning, neither country program keeps records of government costs, in-kind costs, and opportunity costs. Only actual costs, for example printing of manuals, are kept in some fashion. (Parenthetically, there is little awareness in the field of HKI/New York program expenditures for equipment and supplies.) This means, from a management perspective, that decisions are made based on only partial information. This will have considerable implications when expansion occurs, in terms of sustainability and replication of these demonstration projects.

7. Recommendations

Previous individual evaluations have indicated strengths, weaknesses, and recommendations. They are based on careful analysis of the projects from outside as non-participant observers. To the degree possible much care has been taken to assure objectivity and to assure that the evaluation flows from

analysis to recommendations in a scientific fashion. Those recommendations should be reviewed so that the comparative assessment made here can be viewed alongside them. The following are summaries of those recommendations.

PEC/BP:

- * Assume a more catalytic role as a development institution and move away from the service delivery role, so as to begin capacity building among the local implementing institutions.
- * Adopt a systemic approach to increase coverage and services.
- * Establish guidelines for an eye care program that establish a management system for action planning based on realistic and achievable objectives.
- * Improve data accuracy, monitoring, and collection to facilitate future planning activities.
- * Address the backlog of clients who are blind due to cataract by initiating alternative strategies to those used presently, so as to obtain more significant coverage.
- * Utilize communication development strategies to educate the public concerning availability of eye care facilities and to promote specific issues such as vitamin A promotion.

CBR:

- * Conduct several studies that appraise the needs and aspirations of rural blind people, the types of services required by them, family member interest and availability to participate in CBR, and feasibility of alternative strategies.
- * Engage in systemic review of CBR programs to decide on specific goals and objectives that will transform CBR from a limited effort to a sustained development program.
- * Initiate a series of activities that places the responsibility of blind rehabilitation on family members and supports that philosophy through action programs. These would include: 1) training family members as client trainers; 2) family training manuals and guidelines; and 3) communication development strategies that enhance public awareness, change attitudes, and affect behavior of rural blind members.
- * Start action plans in the income generation component that upgrade the low-level income expectations with better employment opportunities.

- * Negotiate action plans and sign contracts with host country institutions for program implementation based on the above series of activities, so that the CBR program can be replicated and sustained.

Special Comments

Helen Keller International provides meaningful services on a worldwide level. It must work within the given environment of each country so that its programs can be adapted to those countries in the most effective manner. Both Sri Lanka and the Philippines were going through considerable political turmoil in mid-1987 with insurgent activities and civil war. It is to the organization's credit that it can work well in this environment.