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EVALUATION REPORT
WORLD REHABILITATION FUND
HONDURAN REHABILITATION
ASSOCIATION

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SUMMARY AND RECOMMENDATIONS

In response to the number of civilian victims of military action in Central America, an AID-financed program was begun in 1988 and expanded in 1990 to assist noncombatant victims needing prosthetic, orthotic or other rehabilitation services. The original universe of eligible recipients was 973 in 1988, and an additional 1018 in 1990 (the remaining number of recipients is approximately 900). This program was begun under the auspices of the Central American Task Force which operated outside normal USAID Mission channels. Since the end of military operations in Central America, priorities and politics have changed in Central America and in the United States. Rehabilitation is not a priority of USAID/Honduras, and recent staff cutbacks have forced the Mission to review its management workload.

The project has operated as a cooperative agreement with the World Rehabilitation Fund (WRF) which has (since 1990) worked with the Honduran Rehabilitation Association (AHR). The objective has been to create a self-sustaining Honduran capability to provide rehabilitation services to the general population, including the remaining needs of the original project recipients. The role of WRF has been decreasing by design as AHR becomes more mature. AHR has submitted a three year proposal designed to create a self-sustaining entity in that time period.

The evaluation team has reviewed the rehabilitative services available in Honduras and has found virtually no involvement by the Ministry of Health, token involvement of the Ministry of Labor, and nominal (but essentially unfunded) coordination by the Honduran Institute of Rehabilitation (IHRM). To the extent the Government finances rehabilitation at all, it is through the proceeds of the Lottery which earmarks 10% of PANI's social fund (approximately L400,000 annually) for patients 14 years of age or younger. The PANI Director mentioned that discussions had taken place with the Ministry of Social Welfare to include rehabilitation funding for persons over age 14. Any move to take more direct responsibility for the general population should be encouraged. The team was told repeatedly that rehabilitation is not a Government priority.

Private rehabilitative services are available for those who can pay, and subsidized services are available through centers operated by Teleton in Tegucigalpa, San Pedro Sula and Santa Rosa de Copan. Although there is some controversy about how much of the funds collected by Teleton actually reach potential recipients, the team did observe a very active prosthetics operation in San Pedro Sula funded by Rotary International of England and Rotary Bombay which is training seven local Teleton employees in the Jaipur system.

The team does not find the current AHR proposal worthy of further AID financing. AHR is attempting to continue a costly labor-intensive system of community-based rehabilitation (CBR) which is not sustainable without continuing external support. The social/moral objectives of the original program have been largely met, and the provision of replacement prosthetic/orthotic devices for the original

recipient population could be financed at a fraction of the cost through small project funds or a similar mechanism. Nonetheless, the team was very impressed with the dedication and hard work of AHR, and believes that the continuation of the organization is important for the future of Honduras. AHR is establishing production entities with products it sells in Honduras, and with potential for sale elsewhere in Central America. At this point in its maturation process, AHR does not need further technical input from WRF or the backstopping of a technical office in the Mission -- if it is to survive as a self-sustaining Honduran institution it needs business assistance.

If the Mission is prepared to have a direct relationship with AHR with management and assistance from small business advisors, the team believes there is a reasonable chance for viability. The current proposal would need to be completely redone with far lower costs and more attention to production, marketing and private investment. The 100% AID funding of the Executive Director would have to be scaled downward over the life of any new grant, and the cost of replacement prosthetic/orthotic devices for the original project recipients would have to be assumed by AHR. Funding would be from Mission small-business projects, possibly augmented by earmarked funds available for business assistance for the disabled (AHR is not only working with the disabled, it is one of the largest, if not the largest employer of disabled workers in Honduras). If these conditions are acceptable to the Mission, the team recommends:

the Mission small business office work with the AHR to develop a new proposal aimed at self-sufficiency within a 3 year AID grant period.

If these conditions are not acceptable to the Mission, or if the resulting new proposal does not indicate a viable organization in 3 years, and the Mission believes the commitment to the original recipients remains valid, the team recommends:

the Mission establish a small project fund (or similar mechanism such as a grant to PANI) to finance needed replacement prosthetic/orthotic devices on an as-needed basis for the remaining CASA recipients.

A third alternative, not recommended by the team, would be to continue the present system of cooperative agreements with WRF. While the current overhead (about 20%) could presumably be negotiated downward, it remains a more costly option, and the independence of AHR would be compromised. Moreover, the type of assistance needed by AHR is in business fields, not technical rehabilitation assistance -- WRF is the wrong source. This option is included only because it was presented to the team in its initial briefing as the course of least resistance -- it is the easiest option which puts the least strain on Mission administrative resources.

There is always the ultimate option of ceasing funding after the current \$93,000 which is in process and will retroactively fund AHR from 6/1/93 through 9/30/93. The result would be the almost certain death of AHR, and the failure of an AID project with a great deal of investment at the point where it appears to be close to takeoff.

DISCUSSION

Under the Child Survival Assistance Program, WRF received an initial cooperative agreement in May 1988 to provide rehabilitation services, including prosthetics and orthotics, to injured civilian noncombatants aged 17 or younger at the time of their injury. The project continued until December 1990 and served 973 children and their families. The program was continued and expanded in 1990 under the Central American Survival Assistance program (CASA) which had broader definitions and no age limit. 1018 additional persons were treated under this expanded definition. WRF brought AHR into the operation in 1990 and has gradually transferred responsibility to the AHR. The AID funds have been channeled through WRF New York, and the Executive Director of AHR is an employee of WRF and is fully financed through the AID cooperative agreement. The team was satisfied with the technical and administrative operation of AHR, and believes that AHR is ready to pursue an independent self-sustaining status. WRF gave invaluable training, equipment and expertise at the start of the program, but any further assistance to the program must be direct with AHR to promote its independence. Any relationship between AHR and WRF in the future should be between the two organizations, with no additional funding or overhead to WRF from AID.

The project is more comprehensive and more costly than many other prosthetic/orthotic projects financed by AID. The community based rehabilitation system utilized by AHR includes vocational, social, and emotional rehabilitation needs as well as physical needs. The approach includes the establishment of community rehabilitation committees involving mayors, priests, local health workers and interested citizens. While costly, this program provides the only comprehensive service available on an outreach basis in small communities. In addition to servicing the needs of the CASA patients, AHR sells its services and products to those who can pay, and attempts to find sponsorship for those who cannot. Patients under 14 can be funded through lottery proceeds by PANI, and local committees and other sponsors are sought for other potential patients. AHR has done an effective job of linking potential recipients with other funding sources, and generating local community support. The only other prosthetic/orthotic services available in Honduras are from private clinics at commercial prices, or prostheses from the Rotary/Teleton program in San Pedro Sula. That program is sponsored by Rotary International/England and Rotary/Bombay and uses the somewhat crude, but inexpensive Jaipur system developed in India. Teleton in San Pedro Sula is building an addition to their current facility to house the prosthetic facility. In 1991 a visiting Indian technician (3 month TDY) fitted 180 patients at no cost to the patient. In 1992, 200 were fitted, and in 1993, the visiting technician is training seven Teleton technicians and brought materials to make 400 prostheses.

No hard data exist on the number of disabled persons or number of amputees in Honduras. Worldwide averages developed by the World Health Organization would put the approximate number of disabled in

Honduras at 450,000 (10% of the population) of whom 45,000 are amputees (10% of the disabled). The effective demand in Honduras is a small fraction of that, since most amputees and disabled persons do not have sponsorship and cannot afford treatment. Current supply appears to be meeting the effective demand without extending waiting times. Since the total production of prostheses in Honduras is a few hundred a year, many of which are needed as replacements, the supply will never come close to meeting the total demand. Orthotic devices are produced in much greater numbers because of a higher demand and generally lower prices. Other rehabilitation services (non-hardware) are available from other sources, including Teleton.

AHR records are exhaustive and appear to be complete with many types of reports generated by a computer-based system. The cost accounting, however, does not lend itself to easy use and shows the need for business-oriented technical assistance. The organization is dependent upon AID funding for its existence, as evidenced by the 9 month hiatus in AID funds in 1992 which forced AHR to fire many of its staff, and virtually cease operation. This hiatus, which ended with the receipt of AID funds in October 1992, largely halted any progress toward self-sustainability, and was a major setback to the project. The "benchmarks" provided by AID appear to be an arbitrary 50% increase per year in production and sales. These numbers appear to be overly optimistic and should be developed on a more realistic basis by AHR with business technical assistance. The board of AHR has considered the possibility of outside private investors in the production side of the operation which would have to be spun off as a for-profit corporation. The need for business technical assistance is crucial if this funding alternative is to be pursued.

If AID were to cease funding of AHR at this time, the organization would cease to exist in its present form. It is possible that it could continue to produce prosthetic/orthotic devices for sponsored patients on a greatly reduced scale. It does not appear that AHR could continue its outreach program, or provide any service to CASA patients unless they were able to secure funding from other sources. The staff which now does community organizing and linkages with sponsors would have to be virtually eliminated.

TECHNICAL ANALYSIS

The AHR workshops are located adjacent to the Hospital Escuela, on about 2 acres which belong to PANI and are leased to AHR for about \$50/month. The workshops consist of one large warehouse type building and several smaller buildings which were being remodeled at the time of the team visit. The buildings house a clinic, a physical therapy area, a prosthetics/orthotics laboratory, an industrial production unit and a carpentry shop. The industrial production and carpentry units produce items for sale (e.g., wheelchairs, crutches, prosthetic components, physical therapy equipment, school desks) -- the profits used to offset the costs of rehabilitation services. AHR also has a very small workshop in San Pedro Sula with one technician. The Director is Michael McGee, a US ex Peace Corps volunteer in Honduras, paid by WRF under the AID/WRF cooperative agreement. His input has been critical to whatever success AHR has had. He is an excellent technical leader, and appears to do well in the sometimes difficult bureaucratic political struggles to get things done. He desperately needs some good business assistance in marketing, sales and cost accounting.

Service quality is very good. Preparatory prostheses are provided for new amputees, who later may use this pylon prosthesis for outdoor work, to lengthen the life of their definitive prosthesis. The definitive prostheses are exoskeletal design with polyester resin lamination. Socket designs are conventional PTB for below knee, and quadrilateral above knee sockets.

Many more orthoses than prostheses are made (as is appropriate, but rarely seen in AID projects). Both metal and vacuum formed plastics are used.

AHR fits less than 200 prostheses per year (including replacements) of a total amputee population of perhaps 45,000. The number of employees of AHR (53) is heavily weighted to rehabilitation services and not to prosthetic production. AHR maintains that the number of prostheses is restricted by the ability to pay. While true, the breadth of rehabilitative services provided to a relatively small group of beneficiaries makes the cost per patient excessive.

AHR hopes to subsidize these high rehabilitative costs by the profits of the sale of prosthetic/orthotic components (inter alia). Knee joints, wrist units, valves etc., (sold under the trade name Biodynamics) appear to be of high quality and are priced below market prices for comparable quality.

The AHR wheelchair program was started with a visit by Ralph Hotchkiss several years ago. The most recent adaptation is a lightweight folding chair which is very well finished and painted in popular bright colors. The new model is designed to be sold in component parts in a box 24"x24"x12", with removable arm and foot rests for easy access at tables and for transfers. It will cost about \$90 to produce and will sell for between \$150-\$180. AHR expects the new chair to be a major product in Central America.

A November 1991 report, Market Estimate and Competitive Comparison, prepared for WRF by Catherine Rael did a creditable job of assessing market demand and competition in Central America:

"It is extremely important for WRF to first determine its capacity to produce product before entering the Central American market, A reputation for late delivery, lack of service and poor merchandise takes years to overcome."

"Marketing is essential. The cost of doing business is not just the production of the products. WRF need to build into its gross margin sufficient profit to cover advertising, promotion and other market related costs."

The team's assessment of the AHR sustainability plan has a list of positive and negative judgements:

POSITIVE:

- 1) quality products
- 2) low prices
- 3) local supplier
- 4) WRF name well-known in Central America
- 5) may find larger distributors
- 6) influential board of directors

NEGATIVE:

- 1) no mass production -- slow delivery on big orders
- 2) underestimated need for marketing
- 3) no marketing, fund raising or sales expertise on staff
- 4) questionable understanding of cost accounting
- 5) plan not being aggressively pursued by AHR -- priority?
- 6) insufficient capital -- outside investors?
- 7) unrealistic 50%/year AID growth targets -- couldn't handle it if it happened -- 20%/year more realistic

On balance, the team believes that AHR sustainability depends on aggressive marketing of the Biodynamics line -- too much time has lapsed with scant attention (due to hiatus in AID funding, according to AHR). Major input of business technical assistance is needed quickly, if this marketing plan is to get off the ground this year.

The technical assistance WRF has supplied to AHR has been of marginal use, with the exception of component production. The funding of Mike McGee has been the principal input. The most helpful technical assistance has come on a volunteer basis from a group of Texas prosthetist/orthotists who have paid their own way.

The procurement procedure through the WRF supply clerk may have been useful at the beginning of the project, but the suppliers are now well-known, and orders can be faxed directly without adding the time and expense of the WRF bureaucracy. No further AID funds should be used for WRF assistance unless specifically requested by AHR.

CASA RECIPIENTS

In a random review of CSAP/CASA patient files, (files organized by region, i.e. Morazan-Tegucigalpa, Olancho, Lempira, Choluteca and El Paraiso), the eligibility criteria most often cited was "any Central American noncombatant who is living in an area where the health care services have been suspended or depleted by the civil strife". The mean age treated was 19 years old. The majority of the sample required some type of orthotic device (shoes, braces) due to polio or apparent congenital birth defects. The next largest pathology cited was cerebral palsy. The smallest number of recipients in the sample were amputees (mean age of seventeen years old). No evidence of ineligibility was found.

The total number of CSAP/CASA beneficiaries as of March 31, 1993 is 1,991. Seventy-four (74%) are Honduran. Approximately twenty-six percent are Nicaraguan. A small percentage (00.30%) are Salvadoran. (WRF/HRA report to USAID Oct. 1992 - March 1993)

Since the program began in 1988, funds for eligible recipients have been used to provide medical care, immunizations, devices needed by the physically disabled i.e. prostheses, orthoses, wheel chairs, canes, walkers, pre and post prosthetic/orthotic medical care and therapy, physical therapy, occupational therapy/orientation and to a very limited extent (since approximately 1990), job placement services. More specifically, of the 1,991 recipients listed as having received some services under the CSAP/CASA program, approximately 623 are currently following some treatment plan.

The age range of the recipients is significant for certain follow-up services such as replacement and repair of prosthetic and orthotic devices. Fifty-six percent of the clients are under 17 years old, (31.20% male and 25.14 female). Depending on the type of disability treated (prosthetic/orthotic for example), they would require two to three times more attention than those in the 17 and older group) Forty-four percent of the beneficiaries are in the potentially productive (working age - 18 years old and above) group, (31% male, 12.66% female).

The outreach component of the program, couched in the context of community based rehabilitation, provides contact with the identified recipients approximately every three months. For example, an amputee measured for a prosthetic device in March, would not receive that device until June. In part, the barrier that distances present in Honduras can limit or make more rapid delivery difficult. In general, a three month waiting period for a prosthetic or orthotic device, unless for medical reasons, is too long. In that sense, the community based rehabilitation actions are not an efficient way to respond to clients' needs. Potential clients that do not meet CASA criteria, and who must seek sponsorship have between 60 and 90 days between request and delivery.

However, the majority of recipients who were available for testimony concerning the attention that the program has given them,

were extremely pleased with the services. The enormity of the task which the AHR staff has undertaken is apparent when reviewing their patient files. They are, in essence, trying to fill a huge gap for attention and services, which most Central American countries offer through the Ministries of Health and or Education.

Should AHR continue providing CBR services, the effort should focus on developing the ability of the existing committees to locate funding sources for members of their community who need services if the community or some other institution cannot provide them locally. This means going outside of the community and although this is in direct conflict with AHR established philosophy that rehabilitation should take place within the recipient's community in order to promote full integration into the community, it does not preclude "primary or secondary" integration. Many disabled people living in small towns in the United States, must leave their community and travel distances in order to have access to rehabilitation services. This implies that the recipient understands the need for these services and that a support network functions to provide economic or other assistance.

Under the present system of service delivery, there are eight departments that have participated in the community based programs since 1990. Although much consciousness raising has taken place and was apparent when talking to mayors, teachers, family members and the recipients themselves, the communities are still totally dependent on AHR staff to provide access to services.

Rather than expanding what AHR has established under the title of community based rehabilitation, the organization should focus on refining their philosophy in communities that have strong local committees such as San Marcos and El Paraiso. Identifying local sources of funding which would help a recipient with access to services not provided locally may actually speed the delivery of these services, which in turn speeds the "integration" of the recipient back into his/her community.