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SightReach®





International Eye Foundation

First Annual Report SightReach® Management

*Sustainability planning and
Capacity building for
Sustainable eye care services*

September, 1999 – December, 2000

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Acronyms

BCCEIO	British Columbia Centre for Epidemiologic and International Ophthalmology
BHR/PVC	Bureau for Humanitarian Response/Private and Voluntary Cooperation
CATOPS	Cataract Operations Post-operative Surveillance
CEA	Cost effective analysis
CORE	Cost and Revenue Analysis Tool
DOSA	Discussion-oriented Self Assessment
ECCE	Extra Capsular Cataract Extraction
ERC	Expert Review Committee
IAPB	International Agency for the Prevention of Blindness
INGDO	International Non-governmental Development Organization
IEF	International Eye Foundation
IOL	Intra-ocular Lens
LAICO	Lions Aravind Institute of Community Ophthalmology
LDC	Lesser Developed Countries
LSFEH	Lions SightFirst Eye Hospital
MDA	Management Development Assessment
MG	Matching Grant
MOHP	Ministry of Health and Population
MOST	Management and Organizational Sustainability Tool
NGO	Non-governmental Organization
OT	Operating theatre
PCINGO	Partnership Committee of International Non-governmental Organizations Dedicated to the Prevention of Blindness and Low Vision, Education and Rehabilitation Services for the Blind
QA	Quality Assurance
QAP	Quality Assurance Project
RFP	Request for Proposal
ROP	Retinopathy of Prematurity
SE	Social Enterprise
SR	SightReach SM
SRS	SightReach Surgical ^{FM}
SWOT	Strengths Weaknesses Opportunities Threats
USAID	United States Agency for International Development
WHO	World Health Organization

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Executive Summary

The First Annual Report represents activities under the International Eye Foundation's SightReach® program entitled "*SightReach Management: Sustainability planning and capacity building for sustainable eye care services*" supported by Cooperative Agreement No. FAO-A-00-99-00053-00, and with a project life from September 28, 1999 – September 27, 2004. The activities described include four components of the umbrella SightReach program:

1. SightReach® Management, eye hospital sustainability planning and the primary focus of the matching grant program,
2. IEF's Strategic/Business Plan,
3. SightReach Surgical®, IEF's social enterprise, and
4. "Seeing 2000" sub-grants to hospitals supporting pediatric eye care surgery,

The fourth component, "*Seeing 2000*" Revised and Expanded, IEF's pediatric surgery intervention is not included in this report as the current Cooperative Agreement supporting sub grants to non-governmental hospitals for pediatric surgery, Cooperative Agreement No. FAO-0158-A-00-5015-00, was extended until March 2002. "Seeing 2000" is reported separately in the documents produced during the November 2000 evaluation exercises.

In order to reduce confusion in reporting on the relevant three components, the primary focus of this report is the SightReach Management program supporting sustainability planning for eye hospitals. The associated Strategic/Business Plan and SightReach Surgical® are summarized briefly, and separate reports are submitted for each.

The report follows the reporting guidelines provided by U.S. Agency for International Development, BHR/PVC/ Matching Grant Division. However, modifications are made to the First Annual Report outline in order to provide additional detail on the SightReach Management partner in Malawi, as there is significant progress.

Finally, because submission of the report is delayed by three months, the reporting period extends up to December 2000, rather than to October 2000. Prior to and during the last quarter of 2000, there was the recruitment of three key staff persons, two major project evaluations ("Seeing 2000" and Child Survival, Ethiopia) and other major travel commitments, delaying submission.



I. Overview of Year One and Changes Subsequent to DIP

This reporting period represents significant planning, organizing, initiating new activities, and engaging the first eye care hospital partners.

A. Summary achievements

1. SightReach® Management

- a. Created a core team including one new full time staff and one part time staff.
- b. Developed, submitted, and reviewed the Detailed Implementation Plan.
- c. Refined the planning process and developed a web-based planning spreadsheet.
- d. Developed partnerships with two eye care hospitals and two collaborating organizations.
- e. Accelerated sustainability plans at the Lions SightFirst Eye Hospital resulting in:
 - Increased cataract surgery volume from 18 week to 80 week (450% increase).
 - Reduced the unit cost of cataract surgery from \$147 to \$59 (60%).
 - Improved quality of surgery by increasing the number of ECCE IOL surgery from 60% to 97%.
 - Reduced the cost of patients identified for surgery from outreach (>\$300 to <\$5).
 - Reduced hospital bed stay to < three days.
 - Redesigned all management, clinical and outreach systems.
 - Established standard protocols on all levels.
 - Created new management and administrative positions.
 - Established cost of surgery, identified expenditure, oriented staff to cost-recovery, and established multi-tiered pricing system including \$0.
 - Initiated plans for complementary and self-sustaining optical and food services.
- f. Initiated partnership arrangements with two other eye hospitals.

2. IEF Strategic and business plan

- a. Developed, submitted, and reviewed the Detailed Implementation Plan.
- b. Established new staff for child survival, SightReach Management, and SightReach Surgical.
- c. Established routine staff communication and quarterly program monitoring system.
- d. Increased involvement of Board of Directors in fundraising.
- e. Established proposal strategy.
- f. Completed revised staff job descriptions and evaluation format.
- g. Developed and presented six presentations and or articles.
- h. Redesigned the IEF web page.
- i. Established the registration (®) mark for SightReach.



3. SightReach Surgical®, IEF's social enterprise

- a. The Detailed Implementation Plan was developed, submitted, and reviewed.
- b. Replaced the previous back stopper by a new staff person.
- c. Developed marketing materials including a Sales Kit.
- d. Established a new computer accounting and inventory system.
- e. \$146,048 in sales and \$21,894 in gross profit.

B. Constraints, Unexpected Benefits, and Lessons Learned

1. Headquarters

The most pressing challenge faced at the headquarters was hiring new staff for three positions -- Child Survival/Vitamin A (replacement), SightReach Management (new), and SightReach Surgical (replacement). Departure of existing staff and the process of hiring new staff with the required qualifications, skills, and experience is disruptive in a small office environment. Additionally, the hiring of Mr. Raheem Rahmathullah, a National from the Republic of Indian, has required additional steps in order to allow him to stay in the USA. To base Mr. Rahmathullah in Bethesda, IEF applied for a H1B1 temporary employment visa. This application process is lengthy and still in process with no guarantee of being granted. In the interim, Mr. Rahmathullah is employed by IEF as a consultant and is based from his home of record.

2. Project level

a. SightReach Management --

The first year's experience with hospital sustainability planning has identified a number of general issues:

- 1) Level of effort: Greater time, effort and resources are needed per partner hospital than planned. The identification and development of a working agreement with a hospital is a lengthy process. Considerable advance time is needed to first develop sufficient awareness by the partner on the concept of sustainability, the extent of change needed, and the implications of changes. As the partner sustainability plan unfolds, the needs for specific resources are clarified requiring flexibility, transparency, and coordination.
- 2) Resources: The amount of IEF staff time has proven to require more and longer visits to the partner hospital in order to facilitate implementation and provide meaningful support.
- 3) Documentation: Due the complexity of the effort, documentation of activities requires additional resources in order to capture changes on multiple levels (process, output, outcome, impact). Obtaining 'baseline' data on expenditure, revenue, and organizational capacity are difficult and time consuming exercises.



- 4) Critical inputs on the partner level: At the hospital partner level, issues related to leadership, management, and lack of human resources are critical to the success of the hospital's productivity and financial sustainability.
- 5) Specific issues:
 - The project could not proceed in development and testing of standard quality outcome indicators as planned with the BBCEIO. During this period, other international NGOs organized a multi-center operational research exercise, including at the LSFEH, Malawi making IEF's planned efforts redundant.
 - During 2000 the Malawi Kwacha devalued 45% from MK55 to MK80. This devaluation affects the overall revenue projections and raises concerns on how to protect Mk earned at the hospital from future devaluation. The key issue of concern is that earnings are designated towards purchase of medical consumables that require payment in hard currency.

Greater detail on general lessons learned can be found in section C.1.d.

C. Changes in Project Design

There are no significant changes to the project design during this reporting period.

1. DIP review response

The IEF presented a four-part Detailed Implementation Plan to USAID on May 24th 2000. The following are general comments on the relevant advice provided from the external evaluator and USAID. The comment below reflects those related to SightReach Management and sustainability planning.

a. Feasibility of financial sustainability -

The reviewers' opening comments doubt the creation of financial self-reliance in poor countries. IEF's understanding regarding financial sustainability is not necessarily based on achieving self-earned revenue above all expenditure (true financial self-reliance). Although this might be desirable, SightReach Management goals are to achieve a level of financial self-sufficiency, defined on a case-by-case basis.

In the example of Malawi, the hospital began with no cost recovery mechanism and \$0 self-earned revenue to their first attempts ever to charge fees. As the amount of revenue is dependent on many fluid variables, (patient volume, reduction in fixed and variable costs, and prices acceptable to the public including the poor) forecasting the financial outcome is challenging. Additionally, other services are envisioned, such as optical services that will operate as a related but separate business and cost center. Necessarily, the business plan's revenue projections are only as accurate as the assumptions and



estimates made, and the ability of the institution to make needed changes to infrastructure, management, and service delivery. Continuous review and updating of projections will be necessary.

Secondly, one of the purpose of the SightReach management program is to pilot and measure the level of achievement different hospitals are able to achieve. IEF will continue to place increased emphasis on planning, monitoring and evaluation, and documentation.

b. Matrix and indicators –

A concern of the reviewer and USAID was clarification of baseline measures, indicators, and targets. IEF is in full agreement that additional efforts are needed in order to document effectiveness of SightReach sustainability strategies. There are several elements to establishing realistic indicators:

- 1) Financial -- A difficulty faced in establishing financial targets ‘in generic terms’ is first that all costs must be understood. IEF’s initial experience demonstrates the difficulty in obtaining accurate expenditure data from hospital records. Typically, the majority of data is not available even if there is an accounting system. This is further complicated by the fact that many expenses, e.g., staff salaries, pharmaceuticals, rent, and utility costs are not the responsibility of the hospital itself but the parent hospital and or the central government. Additionally, an important source of ‘revenue’ continues to be external NGDO donations subsidizing costs.
- 2) Organizational capacity -- Establishing a ‘baseline’ for organizational capacity is challenging. IEF itself has conducted several assessments of its own capacity. IEF also recognizes the relative value of these measures and the limitations of capacity measures as baseline indicators. Additional issues faced are adapting USA based tools to the specialized country level environment. In the case of the Malawi experience, many capacities were not existent such as an accounting and inventory system, basic protocols, and standard operating procedures and the first steps were to put these into place. In this sense, the baseline capacity begins at ‘zero’, in a similar fashion as the level of financial self-sufficiency.
- 3) Outcome indicators -- The realm of measuring outcomes and impact, presents another set of challenges. Separate activities are proposed in the SightReach program to address some of the relevant issues and are characterized as operational research. Measurement of surgical outcome results (vision and impact on daily life) are complex and entirely new to international eye care in developing nations.

Regardless, of the constraints above, a baseline for each partner is or will be established for monitoring and evaluation. It should be understood, however, SightReach Management hospital partner baselines are established on a case by case basis and are part of an emerging planning process.



IEF also recognizes the need to critically evaluate its own monitoring and evaluation capacities. As a result of the “Seeing 2000” evaluation recently completed, IEF is in full agreement to strengthen its own capacities for monitoring and evaluation. This capacity area will be a focus area for 2001. USAID also expressed the desire that IEF more fully integrate the IEF Sustainability/ Business plan with SightReach programming and express improvement indicators financially. IEF is considering further technical assistance in 2001 to develop an IEF ‘Results framework’ to address these concerns.

II. Review of Project Results - Headquarters and Country

A. SightReachSM Management HQ

1. Organization and planning

The major achievements completed over the reporting period are related to planning, organizing a team, further development of the planning process and tools, and developing initial hospital partnerships.

a. Development of detailed implementation plan

The Detailed Implementation Plan (DIP) was developed and submitted on March 31st. The “DIP” was composed of four distinct but interrelated components:

- 1) SightReach Management Eye Hospital Sustainability Planning
- 2) Seeing 2000 Pediatric Surgical Services (revised)
- 3) SightReach Surgical Business Plan
- 4) IEF Strategic and Operational Plan

A review of the Detailed Implementation Plans (DIP) was completed on June 13th at USAID BHR/PVC offices, in attendance by IEF and USAID. Additional feedback on the DIP and follow up on the review meeting took place at a meeting at IEF with Joy Pentecostes, AAA Fellow, USAID MG.

b. Building a team

A core team was organized for SightReach Management that includes the core IEF staff with additional support of David Green MPH, a part time consultant to IEF, Raheem Rahmathullah, a full time sustainability specialist, and Todd Robbin MHS, a part time intern working on special assignments.

The Director of Programs, John Barrows, worked with David Green to establish a scope of work and a schedule to formalize the working relationship. Mr. Green will provide twenty-five percent of his time towards SightReach Management. The primary duties are to assist the Director of Programs in organizing, planning, and specific technical assistance to partners. Mr. Green also provided advice on the



hiring of Mr. Raheem Rahmathullah to become a full time Sustainability Specialist at IEF headquarters.

Mr. Raheem Rahmathullah, from Madurai India, was identified to be a new full time IEF staff specializing in hospital sustainability planning. Mr. Rahmathullah has considerable experience with the Aravind Eye Hospitals in Madurai, India in the development of new eye hospitals as well as experience in cornea eye bank management. The primary duties of Mr. Rahmathullah are to assist the Director of Programs and the “Seeing 2000” Coordinator providing direct technical assistance to the selected SightReach Management partner hospitals. Mr. Rahmathullah will provide short term (1-2 week) and longer term (2-8 week) visits at the partner hospitals. The longer stays allow additional time to assist partners in daily problem solving and implementation. Mr. Rahmathullah has already spent eight weeks at the Lions SightFirst Eye Hospital in Lilongwe, Malawi working to develop the in-country management capacity needed to support cost recovery.

IEF is applying for a H1B1 visa on behalf of Mr. Rahmathullah to work in the USA. This process was started in March 2000 and is still in process. To make best use of Mr. Rahmathullah’s time IEF has sent him to Malawi and a visit to the IEF headquarters in October is planned.

In addition to the above key staff, IEF has also retained Todd A. Robin, MSH as a part time intern (4 – 8 months) to work on specific products for SightReach Management. Mr. Robin has familiarity and previous experience in elements of eye care planning. Mr. Robin’s duties are to develop new versions of the planning spreadsheet and sustainability manual and assist IEF in documenting the Malawi LSFEH activities. Upon completion of these activities Mr. Robin will assist with other products for SightReach Management.

See Appendix: Resumes

c. Refinement of planning process and assessment tools

Central to the planning process is an assessment of the capacity and infrastructure of participating NGO hospitals to establish a “baseline” for planning and for monitoring changes over time. During the reporting period, the priorities determined were refinement of the existing tools central to this process. Mr. Todd Robin, MHS was engaged as a part-time intern to assist in reviewing earlier versions of the tools and refine them under direction from David Green and the Director of Programs.

The tools under review were the Facility Assessment Questionnaire and the Financial Planning Assessment spreadsheets presented in the DIP. Because both are related, the review and refinement process examined how to combine elements of both tools into one simplified and comprehensive tool to be accompanied by a manual.



The preliminary result is the “*Sustainability Planning Tool: A web based financial planning tool for eye hospitals throughout the world*”. The purpose of the tool is to provide a step by step guide for eye hospital managers to assess the capacity of their hospital, and develop plans for improvements in surgical productivity, cost and management efficiencies, and ultimately increased financial sustainability. The tool is envisioned to be made available free on a web-site (to be determined) to facilitate access by eye hospitals to sustainability planning.

The current version consists of one Excel spreadsheet file with multiple worksheets for entering data gathered by managers with assistance from IEF, other NGOs and consultants. The primary focus of the data is to identify all fixed and variable costs and all sources of revenue to determine unit costs. After costs are established other worksheets assist the manager in designing or revising fee structures and prices based on patients willingness to pay for services. From this basic data, unit costs analysis, break even analysis and other financial forecasting can be done. These reports become part of the jointly developed Action Plan and budget for SightReach Management partners.

The first draft of the tool was recently completed and will be distributed to several hospitals requesting them to pilot test the tool with real life data from their hospital. Based on this feedback further refinement is anticipated.

See appendix: Tools in development.

d. Developing selection criteria indicators

The core team is continuing to refine selection criteria for determining which eye hospitals become SightReach Management partners.

e. Developing partnerships with hospitals and collaborators

During the reporting period the first SightReach Management hospital partners and collaborators were initiated.

Malawi -- Lions SightFirst Eye Hospital (LSFEH): The first partner selected is the Lions SightFirst Eye Hospital (LSFEH) in Lilongwe, Malawi. Although SightReach Management activities were initiated during 1999 in the existing IEF “Seeing 2000” Cooperative Agreement (No. FAO-0158-A-00-5015-00) these activities are now officially under the umbrella of the SightReach Management Cooperative Agreement No. FAO-0158-A-00-5015-00.

Egypt – Al Noor Foundation, El-Magrabi Eye Hospital in Cairo, Egypt: Preparation was undertaken with the El-Magrabi Eye Hospital in Cairo, Egypt to become the second SightReach Management hospital partner. Through David Green and his contacts with the Al Noor Foundation, mutual agreement was developed to include this hospital into IEF’s program. A letter to Joy U. Pentecostes, PhD, MPH, USAID



BHR/PVC/MG was sent in July requesting that this hospital be accepted under the program.

Guatemala – Unidada Nacional de Oftalmologia (formally Roosevelt Hospital): Follow up was made to the Unidada Nacional de Oftalmologia, formally the Eye Department of the Roosevelt Hospital in Guatemala City, to determine whether this hospital was an appropriate SightReach Management partner hospital. A joint IEF visit was made to the hospital in May for information gathering and discussion with key officials. It remains undecided to officially include the UNO at this time.

Lions Aravind Institute of Community Ophthalmology (LAICO): The Lions Aravind Institute of Community Ophthalmology (LAICO) of the Aravind Eye Hospitals, Madurai, India is proposed as a collaborating organization in the DIP. Detail of the collaboration are currently under review for support in 2001.

The British Columbia Centre for Epidemiologic and International Ophthalmology (BCCEIO): The British Columbia Centre for Epidemiologic and International Ophthalmology (BCCEIO) is proposed as a collaborating organization in the DIP. Detail of the collaboration are currently under review for support beginning in 2001.

See trip report, Guatemala attached.



B. SightReach® Management Countries

1. Malawi – Lions SightFirst Eye Hospital, Lilongwe

a. Background

Significant progress has been made at the Lions SightFirst Eye Hospital of the Lilongwe Central Hospital, Malawi. Although activities were initiated under the existing IEF “Seeing 2000” Cooperative Agreement No. FAO-0158-A-00-5015-00, activities are reported under this SightReach Management Cooperative Agreement No.FAO-0158-A-00-5015-00.¹

During 1998, IEF made the decision to develop a partnership relationship with one eye hospital in order to begin a learning process on sustainability planning. Through an email letter sent to a list of eye hospitals and NGOs worldwide, IEF identified the LSFEH and developed a mutual agreement to redesign their eye care services.

Two joint visits were made by John Barrows, Director of Programs and David Green, consultant, in April and September 1998, to consult with Dr. Moses Chirambo, Director of LSFEH. The purpose of the visits were to assess the LSFEH leadership, commitment for cost recovery, management capacity, and infrastructure. The result from these visits was a basic two-phase approach for improved services and establishing measures to achieve sustainability:

- 1) Demonstrate that high volume cataract surgery (ECCE and IOL) and improved quality and service delivery with a patient focus is feasible.
- 2) Demonstrate that cost-recovery based on user fees is feasible and desirable once increased productivity and improved quality are achieved.

A two phased approach was determined necessary because of the skepticism and sometimes opposition many stakeholders expressed regarding the effort. During IEF’s initial meetings and throughout the planning period, there was a constant need to explain, persuade, and reassure stakeholders that the purpose was not a ‘cost recovery project’ for ‘paying vs. free services’; but rather the effort was to redesign services to be more productive, efficient and of better quality so that they were valued by patients. Although Malawi has an ‘official’ policy embracing cost recovery, the Ministry of Health is overly cautious and uncertain how to implement their own ‘hospital autonomy’ policy. However, permission was provided by the Principal Secretary to proceed.

¹ Partial reporting on these activities were also provided to USAID during the recent “Seeing 2000” evaluation, November, 2000.



The Objectives and Outcomes defined were:

- 1) Reduce unit cost per surgery to < \$35.
- 2) Increase surgical productivity (from 500 to 2,500 to 3,800 per year).
- 3) Improve surgical quality and patient satisfaction outcomes.
- 4) Demonstrate options for improved patient identification/outreach strategies.
- 5) Research and recommend cost recovery options/ pricing and implement.
- 6) Strengthen coalition and consensus among stakeholders to implement cost-recovery.

After basic plans and commitments were established, IEF re-oriented already committed funding from the “Seeing 2000” program (prior to this Cooperative Agreement) to support initiation of the plan.

c. Describe outputs/ achievements

- 1) Total immersion, orientation, training, and redesign

Essentially, the effort was a basic re-design of the hospital services and required an intensive orientation and training effort. The strategy to transfer skills and technology to the LSFEH was support by exchange visits between the LSFEH of the Lilongwe Central Hospital, and the Lions Aravind Institute of Community Ophthalmology (LAICO). There were multiple purposes of the “south to south” exchange:

- IEF needed a manageable and affordable way to provide the technical assistance to LSFEH.
- LSFEH required an intense orientation in hospital cost recovery planning. The fact that LAICO was known by the LSFEH leadership as a leader in this field added trust to the partnership.
- The experience was also a first for LAICO in providing an intensive technical team exchange outside of India. The exposure and experience also contributed to building LAICO’s capacity for ‘consulting’.

A three-stage approach was planned beginning in 1999:

Table 1. Schedule for LAICO/ LSFEH technical exchange visits

Stages	Activities 1999	Dates
1.	Planning and needs assessment	March 9 th – 20 th
2.	Systems development and training - Aravind training and exposure	April 4 th – May 10 th
3.	On-site implementation, training & technical support	September 15 th – October 23 rd



-
- Ongoing volunteer skills transfer
 - Surgical/clinical training
 - Systems implementation
-

During stage one, a four person team from LAICO visited the LSFEH for orientation and assessment.

During stage two, a six person team from LSFEH visited LAICO to attend a “Vision Building Workshop”, and developed an Action Plan outlining strategies in three broad areas including:

- Generating Demand -- how to attract more patients,
- Improving Quality – how to improve processes and quality of services,
- Improving Self-sufficiency – how to improve cost effectiveness, management and financial self-sufficiency.

During stage three, the six person LAICO team returned to LSFEH to provide on-site implementation of the LSFEH Action Plan established during stage two. Work concentrated on improving or establishing systems, policies, standards, and practices needed to support high volume cataract surgery. The areas of focus and review were in four broad areas including 1) Clinical management, 2) Human resources management, 3) Information systems management, and 4) Outreach services. The specific areas examined were the following:

Table 2. Areas of systems review, improvement and redesign.

Areas of Assessment, Improvement, Redesign, and Implementation
<ol style="list-style-type: none">1. Staffing and organizational structure2. Personnel practices3. Review of hospital departments and systems<ul style="list-style-type: none">- Registration,- Patient flow,- Examination processes,- Clinical services,- Medical records,- Admission, discharge process and inpatient stay,- Operating theatre,- Surgical processes,- Stores and inventory practices,- Maintenance,- Other services (optical, pharmacy, food services),- Management practices (book keeping and information management)4. Patient opinion of services5. Outreach practices



Table 3, below summarizes the primary activities during the LAICO exchange visits. Due to the size of the reports and their submission during the recent “Seeing 2000” evaluation, these reports are not included as attachments, but are available upon request.



Table 3: Accomplishments 1999/2000

A. Clinical management		
Objective/ Activity	Accomplished	Constraint
1. Demonstrate high volume cataract surgery.	<ul style="list-style-type: none">Over 5 weeks 500 cataract surgeries were performed (representing an increase from 18 to 100 week (455%).Performance targets set for 60-80 cataract surgeries per week.	Increased volume highlighted management, medical supply, and coordination gaps in the hospital.
2. Improve micro surgery skills.	<ul style="list-style-type: none">High volume micro surgical practices demonstrated and practiced by LSFEH surgeons (65% of surgeries completed by staff).Established wet lab.	Increased volume highlighted basic shortage of surgeons.
3. Strengthen case management.	<ul style="list-style-type: none">Reviewed current OT, ward & OPD practices.Rearranged OT for better patient flow.Established standard protocols for (preoperative surgery, Cataract surgery, Operating theatre, Management of uncomplicated cases, Management of complicated cases)Established standard protocols for wards and OPD.Reorganized OPD and wards to accommodate more patients.	
4. Improve patient satisfaction.	<ul style="list-style-type: none">Establish patient counseling services.Established ECCE surgery with IOL as standard practice.Established patient satisfaction monitoring system for routine reporting.	



B. Quality improvement and redesign of services		
Objective/ Activity	Accomplished	Remarks
1. Strengthen human resource management.	<ul style="list-style-type: none">Analyzed and proposed reorganization of department clarifying lines of authority and job functionsCompleted HRD Assessment reviewing (Capacity, Planning, Policy, Practices & Training).Created job descriptions for 11 categories of staff.Revised organization structure.Identified staff recruiting needs.Reassigned nurses to counseling.Created new positions for Manager, bookkeeper.	<p>The new position of Hospital Manager was identified but is not an official MOH position.</p> <p>Donor support is required to support this position for the next 2 years.</p>
2. Strengthen management and use of information.	<ul style="list-style-type: none">Review existing MIS and record keeping system.Redesigned MIS and reporting system for:<ul style="list-style-type: none">out patient registrationmedical records (inpatients & out patients)Admission, ward, dischargeOperating theatreOutreach campsInventory, materials and procurementAccountingQuality assurance patient satisfactionOPD/ Inpatient feedback interviewsImplement mo./qtr. summary reporting.Introduce computers	<p>The existing MOH system cannot be replaced; thus the new system runs parallel to the MOH system.</p> <p>The number of and skills of clerical staff needs strengthening to support the system.</p>



B. Quality improvement and redesign of services		
Objective/ Activity	Accomplished	Remarks
3. Improve patient environment.	<ul style="list-style-type: none">• Rearranged wards.• Rearranged OPD.• Reduced length of stay (by increased OT days and transport).• Improved catering services by opening new kitchen services.• Provide patient counseling.• Increased attention to maintenance and security.	Patient counseling is considered key to improving patient acceptance of surgery. Currently, there are not MOH position of 'counselor'.
4. Strengthen quality improvement.	<ul style="list-style-type: none">• Introduced QA concepts.• Established review committee process.• Established patient feedback system.• Established staff code of conduct.•	Formal organized QA training is needed to support CQI activities.
5. Strengthen support services	<ul style="list-style-type: none">• One staff sent for equipment maintenance course.• Standardized purchasing and inventory control systems.• Developed list of basic consumables and suppliers.• Created mini-business cafeteria serving patient guardians and staff.• Identified specific role for future optical services.	<p>Current procurement practices are complicated due to numerous suppliers and donors. The hospital pharmacy has inadequate supplies of medications.</p> <p>The cafeteria business was he initiative of staff with a small loan from the Lions Club.</p>



C. Cost effectiveness and financial self-sufficiency		
Objective/ Activity	Accomplished	Remarks
1. Maximize efficiency in current operations.	<ul style="list-style-type: none">• Completed review of all fixed and variable costs and revenue sources.• Increased hours of the existing one day paying services.• Introduced concept of outreach camp sponsorship.	There was considerable difficulty in establishing costs of medical consumables and other fixed costs as there is a limited record keeping system.
2. Create new sources of revenue	<ul style="list-style-type: none">• Developed financial sustainability plan and established prices for services:<ul style="list-style-type: none">- general, semiprivate, day surgery- OPD• Tested patient willingness to pay for services.• Planned new optical service business.• Proposed development of local fund raising strategy.	Full implementation of the plan is dependent on completion of renovations of the day surgery center (space below kitchen). Optical services will be essential to the financial sustainability plan.
3. Strengthen preparations for cost recovery.	<ul style="list-style-type: none">• Negotiate use of funds with central hospital.• Orient staff to daily expectations supporting cost recovery.• Establish accounting systems.• Educate staff on economic use of resources and accountability.• Drafted renovation plans for day surgery center.	Accounting and control of funding will be dependent on hiring the new manager.



D. Outreach services		
Objective/ Activity	Accomplished	Remarks
1. Strengthen community outreach system.	<ul style="list-style-type: none">• Redesigned entire outreach strategy and procedures.• Established curriculum and training program. Adopted comprehensive diagnostic team approach.• Clarified schedules and targets per district.	
2. Improve efficiency.	<ul style="list-style-type: none">• Established detailed protocols.• Adopted policy to screen, identify and transport patients to base hospital on same day.• Revised patient selection criteria (VA<= 6/60).• Initiated patient counseling.• Reduced unit cost per patient accepting surgery from >\$100 to <8 per acceptor.• Create referral networks.	Limited vehicles available. OMAs required further training in case selection. Remains to be accomplished.
3. Create awareness for new services.	<ul style="list-style-type: none">• Developed radio advertisement, poster and megaphone publicity strategy.• Increased number of patients mobilized and cataract patients identified (30 per session).• Identified other new strategies (use of OMAs and traditional authorities).	
4. Increase understanding of patient expectation, behavior and needs.	<ul style="list-style-type: none">• Conducted interviews and focus groups with patients.	Completed during October.



Table 4, below summarizes some of the performance statistics of both the Lions SightFirst Eye Hospital and also the Eye Department of the Queen Elizabeth Central Hospital in the southern region of the country.

Table 4: Performance of Malawi Eye Care Program 1997 – 2000

	1997				1998			
	TOTAL	LSFEH	QECH	MOOP	TOTAL	LSFEH	QECH	MOOP
Out-patient								
Children	16,336	5,306	11,030		32,919	8,969	23,950	
Adults	37,849	11,329	26,520		56,540	22,969	33,571	
Total outpatient visit	54,185	16,635	37,550		89,459	31,938	57,521	
Admissions						1,208		
Operations								
<i>Cataract</i>								
ICCE	235	176	59		328	210	118	
ECCE	72	47	25		84	61	23	
ECCE – IOL	301	226	75		382	218	164	
Total cataract operations	608	449	159		794	489	305	
Glaucoma								
Corneal surgery	53	41	12		65	38	27	
Other Minor operations	82	49	33		98	57	41	
Total Operations	412	301	111		857	510	347	
Total Operations	2,015	840	315	860	3,215	1,094	720	1,401
<i>Percent +/-</i>					60%	23%	129%	

	1999				2000 (incomplete)			
	TOTAL	LSFEH	QECH	MOOP	TOTAL	LSFEH	QECH	MOOP
					2Q	3Q		
Outpatient								
Children			13,890			5,611		
Adults			24,530			11,201		
Total outpatient visit	66,991		38,420					
		28,571			13,370	16,812		
Admissions	2,731		819					



Operations	1,912		961 1,013	
<i>Cataract</i>				
ICCE		34	39	17
ECCE		17	124	4
ECCE – IOL		378	1,428	809
			619	
<i>Total cataract operations</i>	1,826	429	830	
	1,397		761	
Glaucoma	47	17	27	8
	30		19	
Corneal surgery	63	39	43	27
	24		16	
Other Minor operations	825	401	771	470
	424		301	
<i>Total other surgeries</i>	935	457	841	505
	478		336	
Total Operations	2,761	886	2,432	1,335
	1,875		1,097	
<i>Percent +/-</i>	- 16%	23%	-12%	51%
			Goal --	
			->	2,500

Notes: Year 2000 data is incomplete. As of January 2001, the total cataract surgery reported by LSFEH for year 2000 was 1,600, and the above table has not been updated.



2) Reflection, and follow up support

The intense team exchanges accomplished fundamental change to the LSFEH services. As a result, during the five week period (third visit) over 500 cataract operations were performed (representing an increase >450% from average baseline surgery rate); new systems were designed; gaps in the management structure identified; and patient willingness to pay for surgery demonstrated.

However, it was apparent that institutionalizing many of the changes were dependent on completing several critical inputs: 1) creating new staff positions and hiring a manager, accountant, stores clerk; 2) completing renovations to accommodate high pay patients; 3) further reduction in cost of outreach sessions; and 4) guaranteeing a supply of all surgical and medical consumables; and 5) establishing optical services.

Follow up activities --

April – A follow up visit to LSFEH took place by the IEF Director of Programs in April 2000. The purpose of the visit was to review progress since the departure of the LAICO team exchanges. It was apparent that the LSFEH/ LAICO team exchanges provided the hospital staff with concrete orientation, re-deployed systems, and established clear plans to continue work.

July/August – Dr. Marty H. Spencer, a Seva Foundation volunteer, provided a two week surgical training at the LSFEH from July 23rd through August 20th. The purpose of the visit was to provide continuing surgical training (small incision sutureless cataract surgical procedure) to Malawi and visiting ophthalmologists from Egypt and Tanzania. Additionally, the training also served as an opportunity to ‘test’ the ability of the hospital to coordinate outreach services, patient flow, and surgical production.

July – A team from IEF consisting of Mr. David Green, Ms. Lori Carruthers, and Mr. Raheem Rahmathullah visited during July 8th – 20th to provide continuing assistance in planning for the second phase introducing cost recovery. Mr. Rahmathullah stayed in Malawi after the others departed to provide continuing support through September 10th. As a result of Mr. Rahmathullah’s visit a number of outstanding activities and issues were resolved:

- Tabulated performance reports (number patients, surgery etc.),
- Established consensus for the fee structure for paying and non-paying patients sliding scales at the OPD, ward, and surgery),
- Investigated patient willingness to pay for services by focus groups,



- Clarified staff expectations, roles and responsibilities for launching the fee structure,
- Clarified hospital expenditure and project revenue,
- Further reduced outreach costs (cost per patient acceptor),
- Established job descriptions for new staff (manager, bookkeeper), and,
- Established final plans for renovations to accommodate a day surgery paying section. (January 2nd 2001 was accepted as the official date that ‘cost recovery’ would begin).

3) Developing the business and sustainability plan

The major objective of Phase I was to establish the foundations for implementing a cost recovery plan. During this reporting period (1999/2000) this objective was completed by providing the awareness, orientation, training, establishing systems, and through analysis of expenditure and revenue. Through further research, negotiation and some educated guessing regarding patient’s willingness to pay for services, a fee structure was established. Although still incomplete, IEF and the LSFEH have a level of comfort that the prices, services, and targets are reasonable.

The final plans for the paying sections were to limit investing in the mid-level semi-private rooms. As there were few of these rooms available (2 with 4 beds each) and no separate toilet facilities there would be little difference in service between the free service in the general ward and the paying service in the semi-private rooms.

The alternative was to renovate an unused space adjacent to the main building as a ‘day surgery’ service. The advantages are a separate entrance, separate toilets, parking, and an open space that can be economically renovated to be a modern out patient clinic. This new clinic will house the ‘high pay’ services that will also provide housing for the new optical services. Overall, there is greater advantage to catering to fewer but higher paying patients than catering to mid-level patients.²

4) Cost-recovery plan structure

- Outreach – 100% free services for patients brought in from outreach. The majority of all patients are those identified during the outreach sessions. The objective is to screen large numbers, identify adult cataract patients, counsel these patients to return to the hospital on the same day; and receive free surgery and are discharged within three days. The ‘hypothesis’ is that a greater number of

² The majority of all cataract surgery in the USA is done on an ambulatory basis. On the scheduled day of surgery, the patient receives surgery and departs on the same day.



patients receiving free high quality surgery stimulates the number of 'Walk-in' patients. A total of 2,300 patients are targeted.

- Walk-in – Free and Paying services for patients seeking services from areas surrounding the hospital. Walk-in patients are those potential patients who seek services on their own as the reputation of the hospital grows and through promotion of services. Walk-in patients are subject to a fee structure ranging from \$0, 55¢, \$9, \$45, \$90. Fees are structured at the out patient department and for cataract surgery only. A total of 1,500 patients are targeted.

Based on the total combined target of 3,800 surgeries, eighty two percent (3,100) are completely free. As of the period 1999/2000 the unit cost per cataract surgery is approximately \$60 reduced from \$150 in 1997/1998. Further reduction in unit cost is dependent on increasing the surgical volume and initiating cost recovery from fees at the out patient department, cataract surgery, and optical services.

Targets for cost recovery are to increase self earned revenue in excess of the:

- 1) cost of the annual cost of surgical consumables (\$30,000),
- 2) costs of consumables and costs of the new staff positions,
- 3) break even point for all expenditure from all sources.

A optical service is also planned. A one page summary of the core cost recovery plan follows below.

Additional planning spreadsheets are attached describing potential revenue based on patient volume and the availability of services (basic, optical, day surgery center). As noted elsewhere, a major constraint was the recent devaluation of the Malawi Kwacha. The projections below are calculated at the rate of one US\$ to 55 Malawi Kwacha (MK). The MK was devalued to US\$1/MK80. Corresponding increase in prices for general goods and services is not known at this moment but will impact on preliminary projections.



Table 5: LSFEH Sustainability plan 2001 (3,800 patient volume)

	Volume	%	Revenue		Expense (expressed as % recovered by unit cost/surgery)				
			Price MK	Sum MK	Sum US\$ @ 55	\$20	\$25	\$30	\$35
OPD paying									
Free new patients		19%	0	0	\$ 0				
	5,000				0				
New patients		38%	30		\$				
	10,000			300,000	5,455				
Review patients		19%	30		\$				
	5,000			150,000	2,727				
Review patients		19%	0	0	\$ 0				
	5,000				0				
By appointment		5%	500		\$				
	1,300			650,000	11,818				
Sub total OPD									
	26,300	100%		1,100,000	20,000				
Surgery									
General		20%	500		\$	45%	36%	30%	26%
	300			150,000	2,727				
Semi private		13%	2,500		\$	227%	182%	152%	130%
	200			500,000	9,091				
Day surgery		13%	5,000		\$	455%	364%	303%	260%
	200			1,000,000	18,182				
Free walk in		53%	0	0	\$ 0	0%	0%	0%	0%
	800				0				
		100%			\$	100%	80%	67%	57%



	1,500		-				
Free outreach	61%		\$	0%	0%	0%	0%
	2,300		-				
Total free	82%		\$	0%	0%	0%	0%
	3,100		-				
Total Annual target	3,800						
Sub total surgery	3,800		\$	39%	32%	26%	23%
		1,650,000	30,000				
Total							
OPD & Surgery		2,750,000	\$	66%	53%	44%	38%
			50,000				

Assumptions: Twelve months full implementation
Cost of consumables standardized
Hospital ability to achieve targets for volume and efficiency
Prices are acceptable to patients
Free outreach stimulates walk in-patients
Management systems are maintained
Government and donor support continues
Above does not include revenue from spectacle business



d. Other complementary support activities

1) Optical services –

Early in development of the sustainability plans, it was apparent that development of optical services was crucial to providing comprehensive services and for generating revenue. Several proposals were discussed including short term measures to provide a stock of low cost ready made glasses. Creation of a ‘spectacle bank’ would provide some basic service, but limits the potential to provide comprehensive, scalable, and high quality services. The additional constraints are the lack of expertise (optometrists) specializing in prescribing and making glasses to order, capital to start up such a business, and the ability to undertake another new ‘cost recovery’ effort while still consolidating existing changes.

An international donor was approached and a proposal was submitted for support of optical services. However, for various reasons, this option was not viable. Still later, a private business person from Tanzania was contacted who expressed interest to assist developing an optical business at the hospital. Under this arrangement, all costs for setting the business up, staffing and operational costs would be the responsibility of this person under their business. The hospital would receive a flat percentage of the profits after costs. After three years the hospital would have the option to take full control of the business at no cost. This option was deemed the most advantageous and a fully functional optical business is planned for mid-2001.

2) Operational research –

IEF recognized the need for better data on the prevalence of adult cataract in Malawi. The only other baseline data available was the Malawi Eye Care Survey undertaken during the early 1980’s. It was also recognized that most eye care surveys tended to focus on measurement of prevalence of the eye problems. Although measuring the magnitude of the eye care problems, the current program depends on improving the quality of visual outcomes to stimulate demand for services. However, there is little data from developing countries on the quality of surgical outcomes, i.e., can people see better after surgery?

During late 1999, the IEF organized a survey ‘Cataract Surgical Coverage, Barriers to Use of Services, and Outcome of Service Received in Chikwawa Malawi”, in collaboration with the B.C. Centre for Epidemiologic and International Ophthalmology, Christoffel Blindenmission (CBM), and the MOH. The purpose of the survey was to:

- Determine the prevalence of blindness and vision loss due to cataract (>50 age group),
- Determine the cataract surgical coverage,



- Identify the patterns of eye care service use and barriers to use, and
- Evaluate the outcome of service delivery.

A total of 13,277 residents were enumerated and 2,634 residents (19.8%) examined including 1,380 >50 years of age. The results of the survey indicate a prevalence of 11.8% and the cataract surgical coverage of 34%. Among those who received cataract surgery, the majority had moderate to poor visual outcome (visual acuity \geq 8/18 to $<$ 6/60 in the best-corrected eye). Although the survey was conducted in the southern region, the results of the survey can be generalized to the central region as serves as a proxy baseline.

Additional work to develop and test standard outcome indicators was under consideration in partnership with the BCCEIO. However, Christoffel-Blindenmission (CBM), SightSavers International (SSI) and the International Centre for Eye Health (ICEH) selected the LSFEH as a test center for the same study activity. This undertaking is being considered in other IEF partner countries.

3) Queen Elizabeth Central Hospital –

During the reporting period IEF has also facilitated development of a proposal to the Lions Club International SightFirst Program. The proposal under review is for support to construct a new hospital department building, provide new equipment, support training of new staff, and establish sustainable eye care services modeled after LSFEH. The total funding requested is \$1.8 million and is currently under review. Any funding approved will be granted to the local Lions Club in Blantyre as the SightFirst program restricts their funding to the local Lions Clubs and not to a PVO.

e. Problems, constraints, and lessons learned

The last two years has proved to be a tremendous learning opportunity for IEF, its partners, and colleagues. Numerous problems, constraints, and lessons were encountered and learned.

- 1) Awareness building: During the earlier exploratory and planning period, there was often misunderstanding over the purpose of the intervention. Many viewed the proposed activity as a supplemental ‘cost recovery’ project, or that ‘cost recovery’ is neither feasible nor ethical. In fact, the implications proved to be a comprehensive redesign of services addressing every aspect of service delivery; and demonstration that people are willing to pay something for good quality services. Due to misunderstandings and healthy skepticism many stake holder’s require continued persuasion that this approach can be successful.



- 2) Change implications: Growing experience in sustainability planning provides greater understanding of the crucial elements needed to change and manage the transition period:
- Leadership from the hospital director and from the NGDO continues to be essential. IEF has not had answers to everyone's concerns and there are many problems yet to be overcome. However, without hospital Director's excellent leadership and commitment (Dr. Chirambo) the program would be stalled.
 - Time and resources: It is apparent that greater time and resources are necessary to consolidate changes underway in a setting like Malawi. The LSFEH was a low volume and high cost operation attempting to increase volume to levels not thought possible several years ago.
 - Extent of change: As a consequence of adopting modern standards for cataract surgery (ECCE with an IOL) as a basic requirement to improve the quality of the visual outcome, service delivery is shifting emphasis from district outreach and mobile surgery services to strengthening the urban base hospital. This adoption of technology (IOL) highlights a shift in program focus in Malawi. In the previous model, Cataract Surgeons traveled to districts to perform ICCE cataract surgery (without an IOL). However, these same surgeons (non-ophthalmologists) are not trained to perform modern ECCE cataract surgery with an IOL, and given the few ophthalmologists available, taking them away from the base hospital for district surgery camps drains this crucial resource from the base hospital. These circumstances have sharply contrasted two different approaches to delivery of eye care services.
 - Coordination: The IEF never intended to be the sole support for the changes underway at LSFEH. The hospital depends on several sources of support including the government and donor NGDOs. A continuing role of IEF is to facilitate and negotiate between the different groups involved. This becomes difficult as the implications of the changes underway highlight questions of authority, responsibility, and control of resources.
- 3) Technical assistance: Due to the fundamental reorientation underway, technical support visits require longer periods in-country. The exchanges visits between LSFEH and LAICO demonstrate that several weeks by a team were needed to address issues comprehensively. Likewise, the nine week stay by Raheem Rahmathullah is likely to be repeated in 2001 when cost recovery is initiated.
- 4) Management: Strengthening management capacities is essential to the program. Upon examination of the organizational structure of the LSFEH, there were no management positions established with authority over staff, supplies, and financial resources. Creation and strengthening this area is central to the program's success.



- 5) Human resources: The program reinforces the central need for more ophthalmologists and nurses. Cost recovery is dependent on increasing volume and volume is dependent upon the number of available surgeons, and support staff.
- 6) Optical services: The sustainability plan highlights the need to create a new spectacle business to complement the fee structure for cataract surgery. Fees for out patient and cataract surgery alone will not be sufficient due to the large percentage of patients who will receive free services. This effort will require additional resources, planning and coordination between partners.
- 7) Documentation: Although numerous reports have been generated on these efforts, due to the complexity of the program IEF realizes further effort is needed to summarize information from multiple sources in order to document changes underway. Finalizing the expenditure / revenue analysis has taken weeks of several persons time. Establishing valid 'capacity building' indicators is an ongoing process.
- 8) Devaluation: The Malawi Kwacha continues to devalue against the US\$ -- from the 20's in 1998, to the 40's in 1999, to the more recent devaluation of over 80 reported this month. Devaluation has major implications for the revenue projections and financial sustainability models.



III. Budget and Expenditure

1. Budget expenditure

Overall, the budget is under spent as of December 31st 2000. The budget is composed of two sections, i.e., headquarters and related expenses, and partner sub grants.

Headquarters: The headquarters expenditure is on track with approximately 18% of the projected annual budget spent. Expenses are primarily for planned personnel, consultants, travel and per diem costs.

Sub-grants: The under expenditure is due primarily to less sub-grantee expenditure than planned. During this reporting period, the LSFEH in Malawi was the primary partner with plans sufficiently developed to implement changes. The majority of expenses are those allocated from the IEF headquarters for technical assistance and little in-country direct expenses have occurred. The LSFEH is now entering a Phase II and a new sub-grant agreement and budget was designed allocating \$160,000 over the next two and a half years. The second partner, the El-Magraby Eye Hospital, in Cairo Egypt has recently developed their plans and a sub-grantee agreement is currently being negotiated for approximately \$100,000 over one and a half years time.

Secondly, there has been no expenditure on the Revised and Expanded “Seeing 2000” program from this grant due to the extension of the existing “Seeing 2000” Cooperative Agreement. “Seeing 2000” expenditure is not anticipated until March 2003. The IEF has matched 50% of the expenditure to date.

2. Cost sharing status

There is considerable cost sharing demonstrated in the program to date. One of the major activities completed with the LSFEH in Malawi was completion of an expenditure and revenue analysis. This assessment demonstrates that the majority of expenditure for fixed costs (salaries, rent, utilities, capital equipment etc) and other costs are the responsibility of the Ministry of Health. The variable costs (primarily surgical and medical supplies) and other costs are supported by the Ministry of Health and the NGDOs. The new sub-grantee budget will support some new staff positions, the cost of all medical consumables; other costs associated with renovations, and a computerized information system. The budget also depends upon cost sharing with another NGDO for outreach services and the capital start up costs of optical services.

A similar cost sharing arrangement is anticipated with the El-Magrabi Eye Hospital, with the exception that the majority of the costs are those of the private hospital eye care partner. A Pipeline analysis is attached.

3. Fund raising

Several proposals are in development to support IEF’s SightReach programming.



IV. Work plans

The major activities planned for the second year are outlined below:

1. Support activities

A web-based draft spreadsheet tool was developed to assist hospitals assess their expenditure and revenue. This tool requires testing by two or more hospitals to evaluate the utility and value of the tool for refinement. There are other complementary 'tools' under consideration including assessment of the partner criteria checklist and 'baseline' hospitals organizational capacity assessment. IEF may engage a consultant with an accounting and business background to assist in this process. Additionally, IEF will develop a case study on one or more partner's progress.

2. Collaborator activities

During the new reporting period, formal agreements are to be finalized between two collaborating organizations (LAICO and the BCCEIO) for execution of planned activities. The LAICO collaboration addresses continuing technical assistance to SightReach partners and will also address developing the capacity of LAICO itself. The BCCEIO collaboration is intended to assist SightReach develop monitoring and evaluation tools and provide direct technical assistance in the evaluation of surgical outcomes.

3. Partner implementation

Three hospital partners will be fully operational during the next reporting period. Malawi is currently entering a full implementation phase, while Egypt is entering a planning and pilot phase. The third hospital partner will be identified by the end of June 2001. Other partners will be evaluated on a case by case basis.

A detailed Gantt chart is attached.



V. Attachments

1. Web-based planning tool
2. Resumes
 - Raheem Rahmathullah
 - Todd Robin
3. Trip reports
4. Malawi
 - Expenditure/Revenue summary 1997/98 – 2003
 - Financial planning scenario summary (volume, cost, services)
 - New three year budget
5. Work plan Gantt chart
6. Financial data
 - U.S.A.I.D. Financial profile tables
 - Detailed pipeline analysis (combined, SRManagement, SRSurgical)
7. IEF Strategic and Business Plan



International Eye Foundation
First Annual Report
IEF Strategic and Business Plan
September, 1999 – December, 2000

Submitted to:

USAID/BHR/PVC
Matching Grant FY 1999
Cooperative Agreement No.: FAO-A-00-99-00053-00

Duration of project:

September 28, 1999 – September 27, 2004

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Names and Acronyms

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Green, David	MPH, Consultant working with IEF, Al Noor Foundation, and Seva Foundation
O'Donnell, Gwen	MA, MPH, Vitamin A/Child Survival Coordinator at IEF/HQ
Rahmathullah, Raheem	Sustainability Specialist, IEF/HQ (full time)
Robin, Todd	Pre-med, intern working with IEF/HQ

Acronyms:

AAO	American Academy of Ophthalmology
AID	USAID
BCCEIO	British Columbia Centre for Epidemiologic and International Ophthalmology
DIP	Detailed Implementation Plan (prepared for all USAID-funded projects)
IAPB	International Agency for the Prevention of Blindness
IEF	International Eye Foundation
LSEH	Lions SightFirst Eye Hospital, Lilongwe, Malawi
NGDO	Non-governmental Development Organization (usually working internationally)
NGO	Non-governmental organization (usually working domestically)
PHO	Public Health Ophthalmology Program (masters level) at Johns Hopkins School of Hygiene and Public Health
PVO	Private voluntary organization (USAID term for NGDO)
S2K	“Seeing 2000” childhood blindness program (IEF)
SRM	SightReach SM Management program (IEF)
SRP	SightReach SM Prevention program (IEF)
SRS	SightReach Surgical SM program (IEF)
USAID	United States Agency for International Development
VISION 2020	VISION 2020: The Right to Sight”, a global initiative of the IAPB, WHO, and NGDOs to eliminate avoidable blindness by the year 2020.





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Background

The International Eye Foundation's Matching Grant First Annual Report represents activities under the IEF's SightReach® program entitled "*SightReach Management: Sustainability planning and capacity building for sustainable eye care services*" supported by Cooperative Agreement No. FAO-A-00-99-00053-00, and with a project life from September 28, 1999 – September 27, 2004. The activities described include four components of the umbrella SightReach program:

5. SightReach® Management, eye hospital sustainability planning,
6. IEF's Strategic/Business Plan,
7. SightReach Surgical ®, IEF's social enterprise, and
8. "Seeing 2000" sub-grants to hospitals supporting pediatric eye care surgery,

This report represents component two, the IEF Strategic/Business Plan.



Achievements During Year 2000

Mission:

The IEF is dedicated to *helping people see!* Core programs are under the umbrella of *SightReach*SM which has three components addressing disease targets, the barrier of cost, and financial sustainability*:

SightReachSM Prevention

Programs target the 4 conditions responsible for 80% of the world's blindness – cataract, trachoma, onchocerciasis, childhood blindness.

SightReachSM Management

Enhances financial self-sufficiency of eye care providers leading to improved quality of service outcomes and sustainability of eye care services.

SightReach SurgicalSM

A social enterprise dedicated to eliminating the barrier of high cost of providing quality eye care and surgery. Offers high quality ophthalmic medical and surgical supplies, instruments and equipment at low cost in order to bring down the price of eye care and surgery while ensuring that the poor and indigent still receive quality care.

* SM refers to “Service Mark” which IEF uses after these names while they are in review by the US Patent and Trademark Office. When the names are officially proprietary to IEF, the “registered” mark ® will be substituted for the SM.

Goals

1. Reduce avoidable blindness
2. Create self-sufficiency within IEF to sustain core programs *
3. Create self-sufficient eye care services in partner developing countries
4. Increase capacity within IEF to offer and expand *SightReach*SM programming to partner NGOs and governments *
5. Build IEF's image, credibility and reputation as a leader in blindness prevention and financial self-sufficiency programming within eye care institutions

*Relates to Low Capacity/High Consensus objectives in DOSA



Executive Summary

The following report documents accomplishments during the past year by goal and planned activities of the IEF's Strategic Plan. An "Operational Action Steps" table was prepared for each of the five goals (noted as 5.0 to 5.5 in the original Plan.) The table of Action Steps was used for this report. A comment is made after each action step associated with the goals.

Key accomplishments are noted by goal in this Executive Summary.

Goal 5.1: Reduce avoidable blindness

- Child Survival/Vitamin A Coordinator hired at headquarters for SightReachSM Prevention program under the Childhood Blindness component.
- Sustainability Specialist hired at headquarters for SightReach® Management program.
- Staff presenting courses and writing papers on financial sustainability planning promoting SightReach® Management program.
- SightReach SurgicalSM sales increasing as sales representatives and promotion increase.
- IEF website reconstructed to include e-commerce and fundraising via the Internet.

Goal 5.2: Create self-sufficiency within IEF to sustain core programs *

- Initial progress in review and development of comprehensive financial plan.
- IEF Board accepted Strategic Plan with recommendations to expand time limits.
- Increased involvement of Board of Directors in fundraising.

Goal 5.3: Create self-sufficient eye care services in partner developing countries

- Established SightReach® Management programs.
- Identified SightReach® Management partners in Malawi, Guatemala and Egypt.
- Established SightReach SurgicalSM business plan and increased sales.
- IRS approved IEF's "Change of Activities Letter" authorizing a social enterprise while protecting our tax-exempt status.
- Patent and Trademark Office approved the registration of the name SightReach® while SightReach SurgicalSM is still pending.

Goal 5.4: Increase capacity within IEF to offer and expand SightReach® Management programming to partner NGOs and governments *

- Established core team for sustainability planning under SightReach® Management that includes David Green/consultant, Todd Robin/intern working on special assignments, and Raheem Rahmathullah/full time sustainability specialist.
- Mr. Raheem Rahmathullah, from Madurai India, was identified to be a new IEF staff person specializing in hospital sustainability planning. Mr. Rahmathullah has considerable experience with the Aravind Eye Hospitals in Madurai, India and will assist IEF with in-country technical assistance.



- Established improved system for communication and monitoring progress. During the reporting period, regular staff meetings are now scheduled on a weekly basis. Additionally, the program department implemented a monitoring and evaluation system to take place on a quarterly basis. The purpose of the quarterly monitoring meetings are for each staff member to formally brief others on accomplishments; identify constraints and lessons learned; and present planned activities for the next quarter. The first meeting was held in September 2000 and will continue on a calendar basis. Recently discussed was the opportunity to make the quarterly meetings more inclusive of all IEF activities including IEF's strategic objectives. The first expanded quarterly meeting will take place in January 2001.
- Completed revised staff job descriptions and evaluation format. During the reporting period, job descriptions were rewritten to be more explicit and focused on individual staff accountability and performance. A major emphasis of the job descriptions is an increased focus on improving IEF's capacity to supervise, monitor, and evaluate program and strategic activities. The staff evaluation format was also redesigned to provide more objective evaluation of staff performance.
- Established a proposal development strategy. A critical objective is diversification and increased funding. A key strategy is to focus more resources on developing new grant proposals to a variety of corporations and foundations. IEF, with assistance from a Board member have undergone and orientation and training on "presentation skills" for targeting corporations. Additionally, the key program areas have funding targets established and objectives for developing and submitting new proposals to foundations. IEF has also invested in Foundation Center software to search their database of foundations.



Goal 5.5: Build IEF's image, credibility and reputation as a leader in blindness prevention and financial sustainability programming within eye care institutions

- An important part of the strategic plan to increase IEF's visibility is to publish more scientific papers and articles, and make presentations in professional forums on IEF's activities and accomplishments. During this reporting period, the following presentations and papers were completed:
 - SRM results presented by J. Barrows and D. Green at the 6th General Assembly of the IAPB, Beijing, September 1999.
 - Presentation by V. Sheffield and J. Barrows: "Achieving Sustainable Eye Care in Developing Countries. What Do We Need to Know to Get Started?" at the AAO International Forum, Orlando, October 1999.
 - Panel discussion with J. Barrows, D. Green, P. Courtright, M. Chirambo: "Training of Surgeons in Difficult Environments/Sustainability Planning," International Symposium on Sustainable Eye Care in Developing Countries, BCCEIO & the Canadian Ophthalmological Society, Vancouver, June 2000.
 - Article published by J. Barrows, C. Baerveldt: "Improving Eye Care in Malawi: Strengthening through Collaboration," IAPB Newsletter, No. 25, January 2000.
 - Lecture on "International Ophthalmology" given to Ophthalmic Medical Personnel trainees at Georgetown University Center for Sight, August 2000 (annually.)
 - Articles in preparation for publication by P. D. Courtright, J. Barrows, et al: "Cataract Surgical Coverage," "Barriers to Use of Services," and "Outcome of Service in Chikwawa District, Malawi."
 - V. Sheffield to speak at the AAO International Forum and at a special International Guest Reception on the role of NGOs in the VISION 2020 program during the AAO meeting in Dallas, October 2000.
 - Lecture "Management Planning and Financial Sustainability of Eye Care Programs" to be given to the PHO students at Johns Hopkins by V. Sheffield, J. Barrows, and D. Green, February 2001.

Status of Goals and Activities



A. Goal 5.1: Reduce avoidable blindness

Activity 1: Target cataract through IEF's SRM and SRS programs from July 2000

- Make the increase in cataract operation, improvement in cataract surgical outcomes, and decrease in prevalence rate part of the goals in all SRM programs
 - **IEF focuses the increase in volume of cataract surgery and monitoring of surgical outcomes (final vision) within all SightReach Management programs.**
 - **IEF's first initiative is the Lions Sightfirst Hospital in Lilongwe, Malawi.**

- Make indicators that reflect the number of cataract operations performed, cataract surgical outcomes, and prevalence rates where possible in all SRM programs
 - **IEF hired Mr. Raheem Rahmathullah as Sustainability Specialist at IEF/HQ.**
 - **Mr. Rahmathullah, John Barrows, and David Green along with Dr. Moses Chirambo and local staff have developed M/E tools and registers to monitor cataract volume, and follow-up patients for surgical/visual outcome.**
 - **Todd Robin (intern) has completed a cost analysis per patient operated that will be used to monitor costs.**

- Document results
 - **Results are documented at the Lions SightFirst Hospital, Lilongwe, Malawi.**

- Publicize results annually in scientific, technical, and/or lay journals
 - **Results presented by J. Barrows and D. Green at the 6th General Assembly of the IAPB, Beijing, September 1999.**
 - **Presentation by V. Sheffield and J. Barrows: "Achieving Sustainable Eye Care in Developing Countries. What Do We Need to Know to Get Started?" at the AAO International Forum, Orlando, October 1999.**
 - **Panel discussion with J. Barrows, D. Green, P. Courtright, M. Chirambo: "Training of Surgeons in Difficult Environments/Sustainability Planning," International Symposium on Sustainable Eye Care in Developing Countries, BCCEIO & the Canadian Ophthalmological Society, Vancouver, June 2000.**
 - **Article published by J. Barrows, C. Baerveldt: "Improving Eye Care in Malawi: Strengthening through Collaboration," IAPB Newsletter, No. 25, January 2000.**
 - **Articles in preparation for publication by P. D. Courtright, J. Barrows, et al: "Cataract Surgical Coverage," "Barriers to Use of Services," and "Outcome of Service in Chikwawa District, Malawi."**



Activity 2: Establish Trachoma/Onchocerciasis Program Coordinator position at HQ to develop and manage trachoma and onchocerciasis control programs by December 2001

- Design a position description and scope of work for a Trachoma/Onchocerciasis Program Coordinator at HQ by the December 2000
 - **Not finalized. Funds still being sought.**
- Budget funds to support the position at HQ in the FY 2002 budget
 - **Not finalized. Funds still being sought.**
-
- Solicit candidates in January 2001 – **planned.**
- Choose a candidate by June 2001 – **planned.**



Goal 5.1: Reduce avoidable blindness continued...

Activity 3: Retain Vitamin A/Child Survival Coordinator position at HQ from July 2000 to manage and expand vitamin A/child survival programs by one country every 2 years

- Advertise for new staff member in May 2000 – **completed.**
- Replace staff member by July 2000 – **G. O'Donnell hired September 2000.**

Activity 4: Retain memberships in the following coalitions:

*VISION 2020: The Right To Sight - \$10,000 per year as a "Supporting Member" - **pending***

*IAPB – currently \$1,000 per year - **paid***

Partnership Committee - none

WHO "Official Relations" - none

*WHO Alliance for the Global Elimination of Trachoma - \$5,000 per year - **pending***

*NGDO Coordination Group for Ivermectin Distribution - \$5,000 per year - **\$2,500 paid***

- **Budget funds in FY 2001 for dues required as noted above - completed**

Activity 5: Increase SRS sales to partner NGOs by 10% per year

- Send letters and product lists to all members of the Partnership Committee by July 2000
 - **Postponed until new staff hired for SRS**
 - **Expected early 2001**
- Follow-up with phone calls and meetings - **postponed**
- Invite all NGDOs solicited to the Society of Eye Surgeons (SES) breakfast annually - **done**
- Include a brief presentation about SRS at the SES breakfast annually – **planned (10-24-2000)**
- **Note: IEF has hired a firm to completely reconstruct its website. The new site will be able to conduct e-commerce and take orders over through the site.**



B.

C. Goal 5.2: Create self-sufficiency within IEF to sustain core programs *

Activity 1: Review IEF funding sources and list what % of total budget comes from each source by the end of October 2000:

- Foundation grants – EMCF, S&L
 - Corporate partnerships – Pfizer, Mail Call
 - Government sources – USAID
 - Contracts
 - Events – Eye Ball
 - Board Annual Fund Campaign
 - Direct mail marketing
 - Endowment income
 - Investment income in SRS- “shares”
 - Earned income - *SightReach Surgical*SM
 - Revolving fund for SRS customers
 - GIK – monetize donations?
 - Cost sharing by NGOs, sub-contractors, governments
 - Membership – Society of Eye Surgeons
-
- **Discussed with Board Development Committee – September 2000.**
 - **% of budget per funding source completed – October 2000.**
 - **To review with Development Committee after annual “Eye Ball” - November 2000.**

Note: IEF has developed a proposal strategy. A critical objective is diversification and increased funding. A key strategy is to focus more resources on developing new grant proposals to a variety of corporations and foundations. IEF, with assistance from a Board member have undergone and orientation and training on “presentation skills” for targeting corporations.

Additionally, the key program areas have funding targets established and objectives for developing and submitting new proposals to foundations. IEF has also invested in Foundation Center software to search their database of foundations.

Activity 2: Board Development Committee and relevant staff review each funding source/activity and prioritize according to income/visibility vs. inputs/cost by December 2000

- August 2000: Staff develops a list describing the percent that each fundraising activity contributes to the overall budget – **completed.**
- September 2000: Staff and Development Committee review each fundraising activity and determine which are the strongest income earners related to inputs and cost by



December 2000

- **Review November 2000 after “Eye Ball.”**

Activity 3: Develop indicators to measure non-financial benefits by September 2000

- Staff and Development Committee review the non-financial benefits of each fundraising activity (articles in media, % increase in event patrons, etc.) by September 2000 - **postponed to November 2000**
- Development Committee determines if non-financial benefits give more weight to overall value of each fundraising activity in September 2000 – **postponed to November 2000**



D. Goal 5.2: Create self-sufficiency within IEF to sustain core programs * continued...	
Activity 4:	Development Committee writes a policy that at least 60% of IEF's income shall be from private sources by December 2000
	<ul style="list-style-type: none">September 2000: Development Committee sets a policy that IEF income from private sources for the year will be at least 60% of overall budget – postponed to November 2000
5:	Board Development Committee and staff set targets for each fundraising activity by December 2000
	<ul style="list-style-type: none">September through December 2000: Development Committee and staff set fundraising targets for each activity - ongoing.Identify the most efficient private income sources – ongoing.<ul style="list-style-type: none">Note: IEF Executive Director and Public Affairs Officer met over the summer with all Board members to solicit their views on the Strategic Plan which was accepted by the Board at the September 2000 meeting.All Board members commented that the Strategic Plan was very ambitious and many activities should be extended.The Board recognizes they will be expected to take on a greater responsibility with fundraising.
Activity 6:	Educate staff and key Board members re: fundraising by December 2000
	<ul style="list-style-type: none">Development Committee presents results of fundraising activity reviews and shows which are strongest, weakest, and the percent each contributes to IEF's overall budget in December 2000 – November 2000.Show Board how private income is allocated to core programs in December 2000 – November 2000.Solicit individual Board member support for specific fundraising activities – started.
Activity 7:	Set fundraising goals for and with each Board member by October 2000
	<ul style="list-style-type: none">Meet with each individual Board member and design a fundraising goal for each by December 2000 and onwards – process started.Discuss various “give or get” ideas - done at Board lunch meetings over the summer 2000.<ul style="list-style-type: none">There has been increased progress in review and development of a comprehensive financial plan.



Activity 8: Restructure budgeting, bookkeeping, reporting to track income and expenses in terms of profit and loss by March 2001

- Board Finance Committee and relevant staff start the process of reorganizing IEF's Chart of Accounts in September 2000 - **process started.**

Finance Committee considers need for outside accounting firm/new software to assist IEF in setting up a new Chart of Accounts by October 2000

- Finance Committee considers using an outside firm in September 2000 – **determined not necessary.**



E. Goal 5.2: Create self-sufficiency within IEF to sustain core programs * continued...

Activity 10 Write strategic and/or business plans for all core programs and review at least annually

- Staff write strategic and/or business plans for IEF and each core program from July 2000 onwards
 - **Postponed until after DIPS and annual reports completed.**
- Review each at least annually

Activity 11: Include a cost center for HQ support in all program areas of at least 5%

- From July 2000, staff review all core programs to determine where an income source might come from
 - **Included in SRM program plans.**
- Staff write in an income level for HQ support of at least 5% in each core program – **pending.**



F. Goal 5.3: Create self-sufficient eye care services in partner developing countries

Activity 1: Include SRM principles and cost recovery in all partner programs from January 2001

- Staff continue to include SRM principles in all new programs
 - **Included in SRM, SRS, and some S2K programs.**
- Write business plans for income generating components of core programs – **pending.**
 - **IEF has established its SightReach Programs.**
 - **IEF has identified SRM partners.**
 - **IEF has completed a Business Plan for SRS. Sales including product sent and invoiced have been:**

20 September 2000:	\$58,184	(profit: \$8,639.00)*
14 June 2000:	\$50,910	(profit: \$7,755.00)*
08 March 2000:	\$36,954	(profit: \$5,500.00)*

This is gross profit reflecting the amount the product was sold for over IEF's procurement cost. It is not a net profit after IEF costs are deducted. At present, SRS is operating at a loss and expects to break even at the six-year point.

- **Equipment accounts for approximately 90% of all sales.**
- **With established distributors in Guatemala, Honduras, Nicaragua, and El Salvador, we expect sales of cataract surgical consumables to increase by 200% to 300% during the next year.**
- **Note: IEF has received an approved "Change of Activities Letter" from the IRS noting that it is implementing an income generating activity.**
- **Note: IEF has been completed the process of trade marking both SightReachSM and SightReach SurgicalSM and is awaiting authorization to use the ® mark.**

Activity 2: Identify indicators related to increased production and increased income in partner programs from January 2001

- Include production and income indicators in all M/E components of core programs
 - **Included in SRM and SRS programs.**

Activity 3: *Track progress toward production and income indicators from January 2001*

- *Track production and income indicators at least annually in all core programs – **ongoing.***



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- *Include this data in monthly, annual, final and all other reports – **ongoing**.*
 - *Share this information with the Public Affairs office for use in publications*
 - ***IEF Public Affairs Officer meets quarterly with each program staff member to follow-up on accomplishments and data collection.***



Goal 5.3:	Create self-sufficient eye care services in partner developing countries continued...
Activity 4:	Track the number of patients receiving free and subsidized care from January 2001 <ul style="list-style-type: none">Share this data with IEF's Public Affairs office so this specific program data can be included in informational materials to specifically publicize IEF's commitment to the poor<ul style="list-style-type: none">IEF Public Affairs Officer meets monthly with each program staff member to follow-up on accomplishments and data collection.IEF's direct mail consultant manager interviews different program staff monthly to review accomplishments and data.Public Affairs office specifically includes this data in articles about IEF programs<ul style="list-style-type: none">Ongoing.Executive Director reports accomplishments in Quarterly Report to Board.
Activity 5:	<i>Develop criteria for HQ to field supervision by December 2000 and evaluate annually</i> <ul style="list-style-type: none"><i>In September 2000, IEF should begin to develop a set of criteria describing IEF's view of supervision from HQ to the field which will highlight IEF's strong backstopping capacity</i><i>These criteria will be reviewed annually and reported during the annual Strategic Planning meeting</i><ul style="list-style-type: none">Postponed to January-June 2001.
	Solicit new partner eye care institutions and select one per year for SRM programming from January 2002 <ul style="list-style-type: none">By January 2002, send a solicitation to selected strategic partners to assess their interest in and feasibility of introducing SRM programming – planned.Send a similar solicitation every January 2003 – planned.
Activity 7:	Monitor specific differences (management, financial, political, social, cultural) between programs and document these for planning purposes once 2 SRM programs are in place <ul style="list-style-type: none">Develop criteria that describe the differences between various models of SRM programming by December 2002 – planned.
Activity 8:	Identify IEF's consulting team that will function within broad health care reform programs by July 2001 <ul style="list-style-type: none"><i>January 2001: Program staff will describe the positions in the program team that will respond to requests for SRM programming</i><ul style="list-style-type: none">IEF hired Mr. R. Rahmathullah, Sustainability Specialist, to work with J. Barrows and D. Green in SRM programming.



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- ***Position descriptions pending.***
 - *January 2001: IEF will actively explore opportunities to participate in broad health reform efforts supported by USAID, governments, and bilateral lending institutions*
 - ***IEF exploring health reform opportunities through Board members (eastern Europe, Latin America, Africa) and other forums.***



Goal 5.4: Increase capacity within IEF to offer and expand <i>SightReach</i>SM programming to partner NGOs and governments *
<p>Activity 1: Hire 1 staffer with developing country hospital management & financing experience at HQ</p> <ul style="list-style-type: none">• Identify funds to pay HQ staffer by July 2000 – completed.• Advertise, interview and hire staffer by September 2000 – IEF hired Mr. Raheem Rahmathullah.<ul style="list-style-type: none">• Note: IEF has established its core team for sustainability planning. They are D. Green, R. Rahmathullah, and T. Robin along with J. Barrows at HQ. (see “Names and Acronyms” at the end of the table.)• Mr. Raheem Rahmathullah from Madurai, India has been hired as the new IEF staff person specializing in hospital sustainability planning. Mr. Rahmathullah has over 10 years of considerable experience with the Aravind Eye Hospitals System in Madurai, and will provide in-country technical assistance to SRM partners.
<p>Activity 2: Offer training in for-profit programming relevant to IEF’s strategic objectives</p> <ul style="list-style-type: none">• Program staff will explore relevant training opportunities (short-term) and their costs – ongoing.• Budget will reflect a line item for staff development in FY 2001<ul style="list-style-type: none">• Item to be edited. IEF offers support training as needed and offered. However, greater emphasis will be put in this area with all staff.
<p>Activity 3: Develop regional capacity to respond to SRM T/A requests by 2002</p> <ul style="list-style-type: none">• Identify key personnel from regional SRM programs who can serve as consultants to IEF for SRM programming expansion in their region<ul style="list-style-type: none">• Personnel being developed in Malawi.• Write a concept paper on how these teams will function and use as guidelines and for developing funding proposals – planned.
<p>Activity 4: Hold weekly staff meetings even if all staff are not present</p> <ul style="list-style-type: none">• April 2000: Executive Director and staff set a standard time and day for weekly staff meetings to be held by whomever is available even if all staff are not present – Tuesdays at 10:00 a.m.



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- Proceedings will be minuted, distributed and filed – **ongoing.**
 - Agenda items will include items related to the Strategic Plan
 - **IEF established an improved system for communication and monitoring progress.**
 - **IEF's Program Department established a monitoring and evaluation system that will review progress on the annual work plan on a quarterly basis. The purpose of the quarterly monitoring meetings is for each staff member to formally brief others on accomplishments in their planned activities, identify constraints and lessons learned, and present planned activities for the next quarter. The first meeting was held in September 2000 and will continue on a calendar basis. Recently discussed was the opportunity to make the quarterly meetings more inclusive of all IEF activities including IEF's strategic objectives. The first expanded quarterly meeting will take place in January 2001.**
 - **Administrative items are included in the weekly staff meetings as appropriate.**



Goal 5.4: Increase capacity within IEF to offer and expand *SightReach*SM programming to partner NGOs and governments * continued...

Activity 5: Conducts annual performance evaluations

- Supervisory staff complete annual performance evaluations for all staff under their responsibility in May each year
 - **Completed revised staff job descriptions and evaluation format.**
 - **During the reporting period, job descriptions of staff members were rewritten to be more explicit and focused on individual staff accountability and performance.**
 - **A major emphasis of the job descriptions is an increased focus on improving IEF's capacity to supervise, monitor, and evaluate program and strategic activities.**
 - **The staff evaluation format was also redesigned to allow more objective evaluation of staff performance.**
- New staff evaluations will be completed after six months – **was the case and will continue.**
- Evaluations will be reviewed by the each employee and discussed with the relevant supervisor - **completed or scheduled.**

Activity 6: Actively encourage staff to present at least one paper at scientific and lay meetings, and publish at least one article in scientific and lay journals/media

- Add the development of papers and articles to the weekly staff meeting agenda – **as appropriate.**
- Executive Director and Director of Programs actively assist all staff in the development of publications and presentations – **ongoing.**
- Presentation of papers and/or publication of articles will be an evaluation item on performance evaluations – **added to evaluation form.**
 - **SRM results presented by J. Barrows and D. Green at the 6th General Assembly of the IAPB, Beijing, September 1999.**
 - **Presentation by V. Sheffield and J. Barrows: “Achieving Sustainable Eye Care in Developing Countries. What Do We Need to Know to Get Started?” at the AAO International Forum, Orlando, October 1999.**
 - **Panel discussion with J. Barrows, D. Green, P. Courtright, M. Chirambo: “Training of Surgeons in Difficult Environments/Sustainability Planning,” International Symposium on Sustainable Eye Care in Developing Countries, BCCEIO & the Canadian Ophthalmological Society, Vancouver, June 2000.**
 - **Article published by J. Barrows, C. Baerveldt: “Improving Eye Care in Malawi: Strengthening through Collaboration,” IAPB Newsletter, No. 25, January 2000.**
 - **Lecture on “International Ophthalmology” given to Ophthalmic Medical Personnel trainees at Georgetown University Center for Sight, August 2000**



(annually.)

- **Articles in preparation for publication by P. D. Courtright, J. Barrows, et al: “Cataract Surgical Coverage,” “Barriers to Use of Services,” and “Outcome of Service in Chikwawa District, Malawi.”**
- **V. Sheffield to speak at the AAO International Forum and at a special International Guest Reception on the role of NGOs in the VISION 2020 program during the AAO meeting in Dallas, October 2000.**
- **Lecture "Management Planning and Financial Sustainability of Eye Care Programs" to be given to the PHO students at Johns Hopkins by V. Sheffield, J. Barrows, and D. Green, February 2001.**



Goal 5.4: Increase capacity within IEF to offer and expand *SightReach*SM programming to partner NGOs and governments * continued...

Activity 7: Conduct DOSA every three years and follow up on low capacity/high consensus indicators

- Executive Director schedules DOSA exercise every three years – **to be scheduled April/May 2001.**
- Low capacity/high consensus items are included in Strategic Plan – **ongoing.**
- Put the objectives identified as low capacity/high consensus items on the agenda of weekly staff meetings for follow-up – **as appropriate and at quarterly program meetings.**

Activity 8: Review Q/A within HQ annually

- July 2000: IEF staff meet to review areas of administration that should be improved
 - **This process is ongoing. Specific areas are discussed in staff meetings and will be included for the quarterly program meetings. When issues concern the IEF Board of Directors, the Personnel Committee is involved.**
- One staff member will facilitate the discussion and lead the group to identify specific areas and concomitant steps that lead to improvement
 - **This has typically been the Executive Director, Director of Programs, or Director of Finance and Administration depending on the subject and process.**
- Those items will appear on the agenda of weekly staff meetings for follow-up – **ongoing.**



Goal 5.4: Increase capacity within IEF to offer and expand *SightReach*SM programming to partner NGOs and governments * continued...

Activity 9: Establish “Task Forces” for:

- SRS
 - July 2000: Program staff describe the specific types of expertise they need for the SRS Task Force
 - Invitations are issued to selected individuals to serve
 - Scope of work, term of service, and terms of remuneration are written
- SRM Business
 - July 2000: Program staff describe the specific types of expertise they need for the SRM Task Force
 - Invitations are issued to selected individuals to serve
 - Scope of work, term of service, and terms of remuneration are written
- Seeing 2000
 - July 2000: Program staff describe the specific types of expertise they need for the Seeing 2000 Task Force
 - Invitations are issued to selected individuals to serve
 - Scope of work, term of service, and terms of remuneration are written
- ROP
 - September 2000: Seeing 2000 Task Force determines how this sub-group will function
 - November 2000: Describe the specific types of expertise needed, issue invitations, write scope of work, term of service, and terms of remuneration
- Low Vision
 - September 2000: Seeing 2000 Task Force determines how this sub-group will function
 - November 2000: Describe the specific types of expertise needed, issue invitations, write scope of work, term of service, and terms of remuneration

IEF’s Executive Director met with the Medical Advisory Committee in August to review the needs for the various Task Forces. It was felt that one Advisory Group would be able to cover the various medical issues in advising IEF. There may be some additional advisors invited when discussing SRS. IEF staff will review advisory needs and will prepare a Scope of Work for the Task Force by December 2000.

Activity 10: Schedule Task Force meetings at least twice per year

- Relevant program staff set schedule of Task Force meetings – **postponed until December 2000.**



<ul style="list-style-type: none">• Produce minutes of each meeting which are reviewed and followed-up – postponed until December 2000.
Activity 11: At least one proposal is produced by each staff member either independently or with other staff per year
<ul style="list-style-type: none">• Each program staff member writes and gets at least one proposal funded per year for new funds from non-USAID sources – job descriptions are being rewritten and staff are working together to achieve this objective. This objective falls within the IEF's Proposal Development Strategy.• Proposal submissions and successes are an evaluation item on performance evaluations – this item will be included on the revised evaluation form.

Goal 5.5: Build IEF's image, credibility and reputation as a leader in blindness prevention and financial sustainability programming within eye care institutions
Activity 1: Collect data on IEF's <i>SightReach</i> SM program achievements
<ul style="list-style-type: none">• IEF Public Affairs Officer meets monthly with each program staffer to gather updates on achievements toward goals and tracking program indicators<ul style="list-style-type: none">• Public Affairs Officer will be involved in the Quarterly Program meetings which will highlight achievements and progress toward goals.• A review of program achievements is an item on the weekly staff meeting agenda<ul style="list-style-type: none">• Staff feels that only key highlights will be discussed at weekly staff meetings with a more full review at quarterly program meetings.
Activity 2: Prepare a list of relevant scientific and technical journals and meetings which would increase IEF's visibility and credibility
<ul style="list-style-type: none">• July 2000: Program staff prepare a list of relevant journals, newsletters, and meetings to which IEF should seek invitations to present papers and/or publish articles – to be written up by November 2000.• List will be reviewed by all staff and reviewed at the first staff meeting of each month – ongoing.
Activity 3: Seek invitations to publish, present papers, and/or teach a course
<ul style="list-style-type: none">• Executive Director and Director of Programs assist staff in submitting abstracts and networking when relevant meetings are being planned – ongoing.
Activity 4: Each staff member publishes at least one article, makes one presentation, and/or teaches one course per year



- Add the development of papers, articles, and/or courses to the weekly staff meeting agenda – **ongoing.**
- Executive Director and Director of Programs actively assist all staff in the development of publications, presentations, and courses – **ongoing.**
- Presentation of papers, publication of articles, and/or teaching of courses will be an evaluation item on performance evaluations – **being included in rewritten job descriptions and evaluation forms.**
- **Note accomplishments in Goal 5.4, Activity 6 above.**

Activity 5: Funds are budgeted to retain memberships in key organizations dedicated to the prevention of blindness (*WHO, IAPB, VISION 2020: The Right To Sight, etc.*)

- Senior staff determine dues amounts for each relevant coalition and see that they are budgeted annually – **review is ongoing and dues are paid where appropriate.**



Goal 5.5:	Build IEF's image, credibility and reputation as a leader in blindness prevention and financial sustainability programming within eye care institutions
Activity 6:	<p>IEF Public Affairs officer prepares, distributes, and follows up on press releases sent to the media</p> <ul style="list-style-type: none">• Executive Director and Public Affairs Officer set criteria for what should/would rate a press release by June 2000 – greater attention is being paid to the follow-up and results.• Press releases are written and submitted on a timely basis, on the day of or one day after an event – same.• Each press release is followed up with a phone call – same.• Published press releases are collected and presented to the Development Committee, the Board, HQ and field staff – to be formalized as an activity.• Press releases are available to program staff for inclusion with proposals – incorporated by Public Affairs Officer at Quarterly Program Meetings.
Activity 7:	<p>Seek pro bono support from friendly firms such as Ogilvy Adams and Rinehart for expertise in publicizing IEF's achievements</p> <ul style="list-style-type: none">• September 2000: Executive Director and Public Affairs Officer solicit 5 firms and/or individuals to assist IEF with media expertise<ul style="list-style-type: none">• Three firms have been solicited to submit proposals to review IEF's fundraising and publicity programs. One of IEF's Board members has expressed an interest in funding such a review by an outside firm. The firm selected would also be asked to make recommendations to IEF on how to enhance IEF's public relations and fundraising programs.
Activity 8:	<p>IEF technical staff review computer hardware and software at least annually</p> <ul style="list-style-type: none">• Director of Finance and Administration and program staff review computer technology every 3months• Computer technology is an agenda item at weekly staff meetings<ul style="list-style-type: none">• Staff has determined that a scheduled review is not necessary because computer needs are reviewed on an "as needed" basis.
Activity 9:	<p>Make recommendations on necessary hardware upgrades, software updates, and training in the areas of fundraising and sales</p> <ul style="list-style-type: none">• Public Affairs and SRS staff review computer technology and make recommendations to



IEF to improve fundraising and SRS sales

- **IEF's website has been totally reconstructed to allow for e-commerce and donations on line. This objective is being revised to focus only on the "visibility" and promotion of IEF to raise the level of donations made to IEF on line.**
- **The notation about software related to sales by SRS on line will be incorporated into the SRS objectives in the revised Strategic Plan.**

Activity 10: Budget a minimum amount of funds for technology upgrades annually

- Computer technology is a budget line item for FY 2001
- **This objective will be removed as technology upgrades are procured on an "as needed" basis.**