



A JOINT ASSESSMENT
OF THE
HELEN KELLER INTERNATIONAL
MATCHING GRANT

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Prepared for

The Office of Private and Voluntary Cooperation
Bureau of Food and Voluntary Assistance
Agency for International Development

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Automation Research Systems, Ltd.

Helen Keller International Matching Grant

HIKI

A Joint Assessment.....

A.I.D. / H.K.I.

Morocco...Tanzania...Headquarters

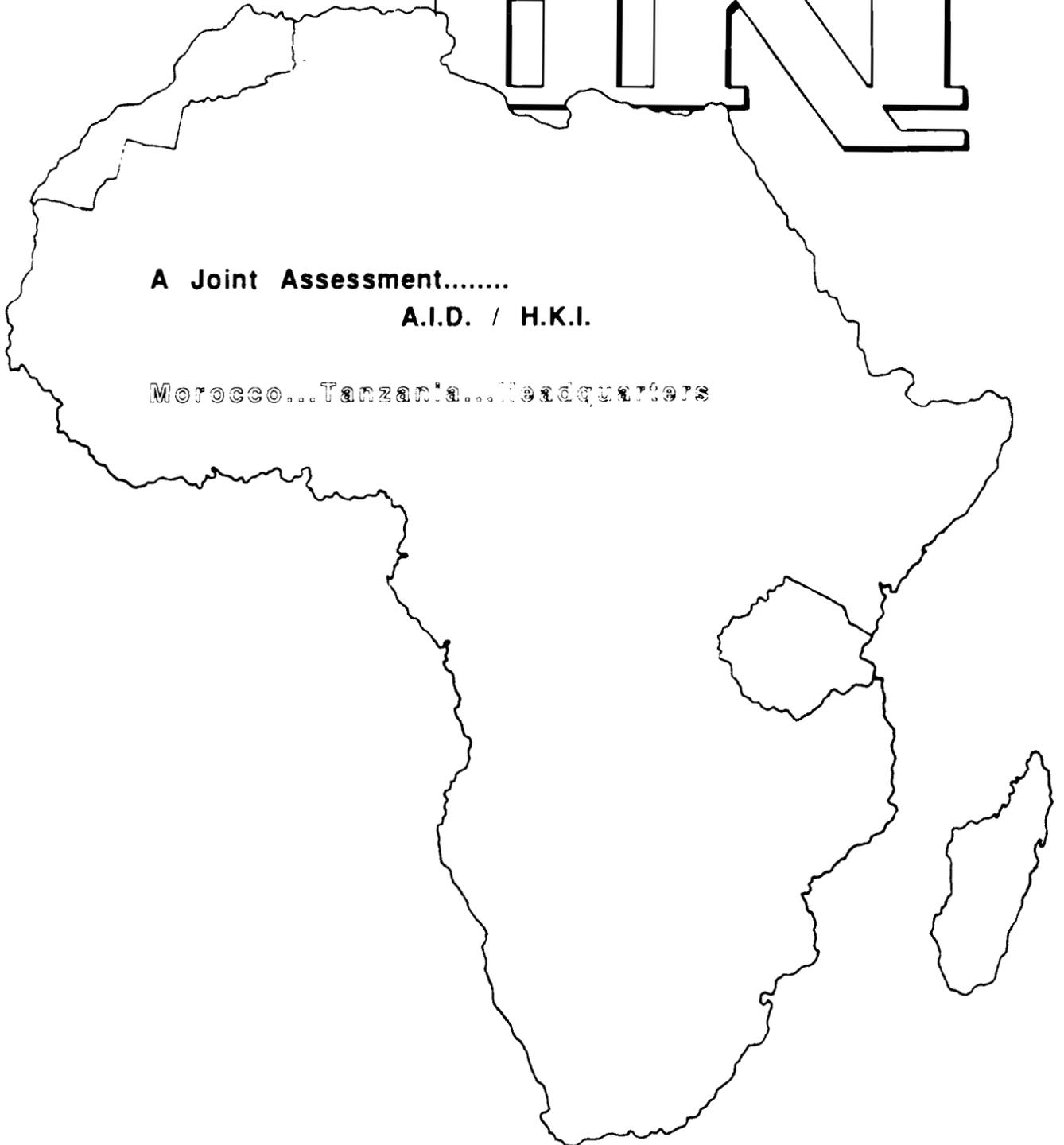


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SECTION I - EXECUTIVE SUMMARY

In June of 1988, a review team was charged with the task of assessing three aspects of Helen Keller International's function as it relates to Matching Grant funds from USAID/FVA/PVC. Assessments were done of:

- The HKI Headquarters' capacity to effectively manage and support their expanding program portfolio,
- The Field Program in integrated eye care/blindness prevention of the Dodoma Region of Tanzania, and
- The Field Program in integrated eye care/blindness prevention in the Southern Provinces of Morocco.

The review team found substantial evidence that HKI Headquarters in New York City had, during the past 21 months, engaged in a substantial upgrading of its organizational structure, financial accountability, managerial systems and planning strategy. HKI's technical assistance capacity and expertise appears to remain intact and continues to support its role as a leader in the field of blindness prevention, treatment and rehabilitation. The organization maintains its avowed mission to serve as a catalyst for eye care service development and improvement through the demonstration of appropriate and innovative methods, rather than serving primarily as a deliverer of eye care services. That posture is reflected in its field programs and its extensive involvement in the Vitamin A/nutritional blindness activities.

Slippage in HKI's managerial and accountability performance during a period of rapid resource growth in the early to mid-80s, has been substantially reversed during the past two years, and we find a renewed stability in the organization which should allow it to continue its leadership role.

The most significant remaining concerns are:

- The implementation of a standard reporting system to gather consistent, ongoing performance data on HKI's numerous field projects and programs to assist HKI to measure progress toward its objectives, and
- The more effective inclusion of a system of incentives and rewards tied directly to the achievement of defined objectives in its field programs.

The two in-country programs observed by the review team provided an interesting contrast in comparative socio-political settings which tend to dictate the differing set of obstacles to be overcome in both Field Programs. The review

team found HKI's country representatives to be highly effective agents; dedicated to improvements in and development of eye care services. In each program HKI appeared to be assisting the demonstration of improvements which are technically appropriate for that setting.

Tanzania's blindness prevention program has the potential for strong community involvement at the village level and the opportunity to train community level providers who are strongly motivated and caring. It lacks the basic resources for supplies, facilities and worker salaries which would be necessary to sustain an expanded capacity.

Morocco's blindness prevention program is quite adequately housed, staffed and supplied. While it could effectively utilize more and better equipment, there is a need to change the orientation from curative services provided by highly-trained physicians to preventative and curative services provided in rural settings by well-trained nurses.

Recommendations have been made that might benefit both programs given their very different socio-political environments.

SECTION II: HELEN KELLER INTERNATIONAL MATCHING GRANT
BACKGROUND

Helen Keller International (HKI), founded in 1915 by Helen Keller and other Americans to aid allied military personnel blinded in World War I, is one to the oldest U.S. humanitarian organizations involved in international technical assistance and development. It is the oldest U.S. voluntary organization committed to solving the worldwide problems of eye disease and blindness.

Throughout its history -- first in Europe, later in Asia, South America and Africa -- HKI successively introduced programs of braille printing, education and rehabilitation services for the blind. Beginning in 1972, HKI began programs in blindness prevention. Over the years, HKI has provided material and technical assistance to more than 80 countries. Since 1955, HKI's field operation have been concentrated exclusively in developing countries.

HKI's major priorities are to prevent blindness and also to implement programs to rehabilitate and educate those already blind. HKI programs are designed to:

- make the greatest possible impact;
- meet key technological and methodological needs;
- demonstrate an innovative approach to the application and adaptation of existing technology;
- act as a "bridge" between the development of new technology and its application within the socio-economic framework in developing countries;
- have the possibility of being replicated by governments international and national health and welfare institutions
- be linked to HKI's need to attract essential financial support from private individuals, the public sector, foundations and corporations (all of which perceive differently the content of programs worth supporting). HKI's field programs constitute the "bottom line" and embody one or more of the aforementioned principles. HKI's basic approach is to provide technical and managerial assistance, staff, funds, equipment and supplies to government or private indigenous agencies active in or responsible for prevention of blindness activities.

Program activities in the field are designed to be innovative and cost effective interventions which emphasize blindness prevention, the restoration of sight where possible, and the wide dissemination of program results in order to promote replication.

HKI addresses those diseases that cause blindness or decreased vision. HKI does so within the broad context of primary health care by integrating eye care services into existing primary health care systems. Local medical and paramedical workers are trained and equipped to prevent or treat common blinding conditions likely to occur in the population they serve. For cases that cannot be treated by these local workers, an expanded structure that provides both logistical and referral support is established. Along with preventive and curative work, HKI develops rehabilitation programs to deliver basic survival and vocational skills, which insure the full participation of incurably blind persons in family and community life.

In 1981, FVA/PVC awarded HKI a three year, \$1.5 million grant for Headquarter's Development and projects in Peru, Tanzania, and the Philippines. Because expenditure rates were slower than projected, the grant was extended to 1/85.

The grant made it possible for HKI to consolidate its first decade of blindness prevention experience in Indonesia, Pakistan, Bangladesh and Haiti (all of which focused principally on xerophthalmia). On the basis of this earlier work, the grant facilitated HKI's development of a more comprehensive response to the challenge of needless blindness in other countries where widespread eye disease and blindness are problems of public health magnitude.

Programs integrating eye care and basic rehabilitation services into the existing rural health and social service systems in developing countries were initiated under HKI's auspices, in the four countries covered by HKI's matching grant -- Peru, Sri Lanka, Tanzania and the Philippines -- and in five other countries; Indonesia, Fiji, Papua New Guinea, Bangladesh and Haiti.

In FY 85, FVA/PVC awarded HKI a 3 year matching grant with a total value of \$1,850,000 to enable them to integrate eye care and basic rehabilitation services into the rural health and social service systems in Peru, Sri Lanka, Morocco, and the Philippines (Operations in Tanzania were continued with HKI funding and used as part of the match), through the provision of technical assistance, training and equipment.

SECTION III. THE REVIEW PROCESS

A. Team Composition/Methodology

Between June 8 and July 2 an evaluation team reviewed certain aspects of the activities undertaken by Helen Keller International, Inc. (HKI) with funding assistance from the AID/FVA/PVC Matching grant program. The review team consisted of:

Mr. Franklin C. Moore, Team Leader
Ms. Anne Paxton, HKI Africa Regional program Manager
and HKI Representative
Dr. Dana Copp, U.S. Public Health Service
Dr. William Hawks, Ophthalmologist

The evaluation was undertaken in 4 phases:

Phase 1: June 8 to June 10, Team Planning Meeting
Phase 2: June 14 to 20, HKI Headquarter's Operations
Phase 3: June 21 to July 2, HKI field implementation
in Tanzania and Morocco
Phase 4: June 25, July 1 and July 6 to July 15,
In-Country analysis and Conclusions, and
Report Writing

Three members of the team (Moore, Paxton and Copp) met in Rosslyn, Virginia for the Team Planning Meeting (TPM). This provided the team with the opportunity to be familiarized with client identification and expectations; to interact with AID staff from the Office of Private and Voluntary Cooperation as well as other individuals from the Bureau of Food for Peace and Voluntary Assistance, The Bureau of Science and Technology, and the Bureau of Program and Policy Coordination; and to organize the approach for the other phases of the evaluation. It was agreed from the beginning that the evaluation team was charged with cooperatively analyzing the functional aspects of HKI's matching grant program activities with an eye toward constructive suggestions. The purpose of the evaluation was summarized by the evaluation team: "so as to be in a position to assist HKI with future plans, the evaluation team will: assess the ability of HKI headquarters to support successful field programs; assess the field implementation of HKI matching grant country programs in two countries, and to detail recommendations for HKI's future planning and programming."

B. Scheduling

The evaluation team took one week to implement phase 2 of the evaluation, the HKI headquarters activities. This week

included a review of documents; a staff meeting which included all headquarters staff involved in the matching grant activities; and three days of individual meetings between members of the headquarter's staff and Moore and /or Copp. The last day of the headquarter's phase the team was joined by the fourth member, Dr. Hawks. The team provided headquarters with impressions and gathered final information.

Phase 3 of the evaluation consisted of one week in each of two countries where HKI had field operations, Morocco and Tanzania. The protocol in each country was similar. It included a briefing by the country representative, a visit to the USAID office, and visit to the Ministry of Health. In each country these meetings were followed by visits to the field to observe several levels of operation. In Tanzania this included visits to the Regional level, the district level and the village level; in Morocco this included visits to the Provincial level and the Regional level. In each country the last day was used for the in-country analysis and conclusions.

Since the team was able to devote only 3 weeks to these phases of the evaluation, it is important to appreciate that the observations and understanding of these relatively complex operations is less than comprehensive. Methodologically, the team is somewhat like the blind who examined the elephant...each feeling is a different part of the animal, then providing very disparate descriptions of what an elephant is like. However, the team's opportunities to compare perceptions and discuss findings on a regular, almost daily, basis seems to have resulted in substantial unanimity of viewpoint during the in-country analysis and drawing of conclusions. Thus, the conclusions and recommendations of the team are offered with the full realization that the conclusions and recommendations are derived from an intense, but incomplete, exposure to parts of HKI's operations. The team sincerely hopes these thoughts will be useful in improving the ultimate objective we all share,...the prevention of blindness, restoration of sight, and the rehabilitation of those whose vision cannot be restored.

C. List of Contacts

- At team Planning Meeting, Rosslyn, VA

John McEnaney
Ada Jo Mann
Karen Poe
Hope Sukin
Tom Marchione

- At HKI Headquarters, New York City

John Palmer, Executive Director
Stephanie Shea, Personnel Officer
Ed Glaeser, Associate Director
Susan Eastman, Vitamin A Program Director
Ed Foster, Management Consultant to HKI
Larry Campbell, Education/Rehabilitation Program
Director
Ron Texley, Development/Fund-Raising Director
Meredith Lloyd, Cataract Program Director
Victoria Sheffield, Training Materials Specialist
Nick Puma, Comptroller/Financial Officer
Pam Stebbins, Desk Officer for Asia/Latin America
Dr. Louis Pizzarello, Ophthalmologist Medical
Advisor

- Tanzania

Dr. B.B.O. Mmbaga, Country Representative
Rev. E.B. Mpina, Program Administrator
David Kikwembe, Health Officer in Kongwa
Dr. Temba, MOH/ /Dar Es Saalam
Dr. G.L. Upunda, MOH/Regional Medical
Officer/Dodoma

- In Morocco

Madame Fatima Akalay, Country Representative
Dale Gibb, USAID
Dr. M. Medina, Ophthalmologist, Quazazate
Dr. Meshbal, Technical Director/Ministry of
Health/Rabat
Dr. Fikri, Service of Epidemiology/Ministry of
Health/Rabat
Dr. Aidi, Service of Blindness Prevention/Ministry
of Health

SECTION IV - NARRATIVE OF THE REVIEW FINDINGS

A. Headquarters Operations

It was evident from the briefings at Team Planning Meetings in Washington that some of the principal concerns about HKI's operations related to the program management and technical capabilities of the HKI Headquarter's Staff. The review team focused on organizational structure, staff assignment and responsibilities, internal communication processes, and linkages between headquarters and the field in assessing their management and technical support capacities. While there exist areas of concern and the potential for improvement, the review team found the HKI Headquarters management and technical assistance capabilities to be, in general, both competent and increasingly well disciplined in adopting sound management and fiscal principles. The striking contrast between recent AID perceptions and our own direct findings became understandable as we developed the chronology of changes which have occurred within the time frame of the recent Matching Grant.

1. Then and Now...

Since 1980, the HKI resources for program operations have grown five-fold, from less than a million dollars to almost five million dollars. This expansion has included the addition of major program categories such as integrated eye care and cataracts, as well as the great expansion of the Vitamin A/Nutritional blindness activities (see exhibit #1). HKI moved from operations in 4 countries to operations in over 20 countries.

Until September 1986, that growth was stimulated and guided by an executive director whose unusual skills in attracting grant funds resulted in expanded resource levels that stresses the organization's ability to adapt. This adaptation included a de facto decentralization. Some Country Directors, with little supervision from headquarters, pursued their own priorities. In Indonesia, for example, both the government and USAID Mission viewed HKI as two organizations; one organization for research and another for field implementation. Unfortunately, HKI's rapid growth and attempts to adapt and diversify preceeded the necessary changes in management systems and organizational infrastructure to institutionalize these changes. This resulted in a simultaneous deterioration or organizational efficiency and staff morale.

The growing program portfolio brought staff increases, but without adequate attention being devoted to financial accountability, clear cut objectives or needed

changes in organizational structure. Decision making was once more centralized and arbitrary, internal communications broke down and, ultimately, the A.I.D. Inspector General was brought in to deal with questions of financial accountability.

On October 1, 1986, the HKI Board of Directors brought a new Executive Director on board. Since that time, there has been a clear "paper trail" of thoughtful, participative management. The financial accounting and country financial reporting systems have been completely overhauled and new software programs have been implemented. This has led to three financial system changes.

- (1) A new TeleCommunications System has allowed HKI, through the use of a local area network, to minimize any backup associated with printing or recording documents. Through the use of a dedicated PC it will also allow 24 hour access to many of the field programs for sending information to headquarters and vice versa. HKI, finally, has a data capable Fax system allowing immediate document transfer through the local network.
- (2) Field Audits. HKI will be deploying a person to the field every year on a periodic basis to make a cursory review of the condition of the incountry books and records and to guarantee homogeneity with the chart of accounts at headquarters.
- (3) Budget Process. HKI is persuing a process by which Field Directors have more input into the budget on all levels concerning the mechanics of the budget. This includes budget amounts and implementation of functional line items.

Clerical support staff has been supplemented in a move designed to allow the Technical/Professional staff to make more efficient use of their time. Staff retreats have provided the policy changes which form the basis for a newly released Strategic Plan, mapping HKI's direction for 1989-1993 (see exhibit #3).

While that strategic plan is written in general terms, it was produced in collaboration with staff and provides them ownership in a reclarification of their mission, objectives, priorities and in a revision of the organization's structure. In the Team's individual interviews with staff members, their candor in forth rightly dealing with question and problems reflected the renewed confidence they share in the strength of their revitalized organization. They know there are still

problems to solve and improvements to be made, and seem confident in their ability to do so. They have accomplished a great deal in the past two years and have effectively rebuilt a stable organization which warrants the renewed confidence of those who have worked with HKI, as a leader in the eye care field.

2. Standardized Reporting

Despite the general confidence of the HKI staff in the epidemiologic baseline data against which the program plans are developed, our in country surveys raised some appreciable questions concerning their validity. Prevalence rates for blindness, eye infections, and other conditions appear to be based on mathematical projections of relatively small samples. In some cases those projected estimates vary widely, such as the number of blind in Tanzania is variously estimated from 140,000 to as much as 500,000. We appreciate that these data are often difficult to obtain in third world nations, but every effort should be made to more closely define the standards of what is being counted and to narrow the range of baseline estimates.

Of even greater concern is that HKI staff did not display a high degree of confidence in the ongoing data collection used to monitor progress in HKI programs. It is understood that (other than the cataract program, which can measure the number of surgical procedures, eye glasses dispensed, etc.) HKI field work is not so discreetly a service effort. Still HKI program managers have begun efforts with the HKI epidemiologist to identify appropriate indicators for monitoring program accomplishment. The evaluation team believes it will become increasingly important for HKI to develop a standard set of performance or outcome measures and to incorporate those into a standard, uniform reporting procedure for all HKI field operations. Field personnel should participate in the selection of those critical indicators so that they have a vested interest in timely, accurate data collection/reporting. Also, Pam Stebbins and Karima Kirby (The Program Operations Unit) could collate the reported data into a worldwide summary of HKI operations and provide the "big picture" as feedback to the country directors. Such a standardized reporting methodology would:

- Give HKI leadership a better sense of ongoing progress, and a better tool for planning,
- Give Country Directors a comparative sense of how they're doing, and

- Strengthen the field staff's identification as part of the larger HKI team and encourage communication between country programs, sharing the lessons they learn from both disappointment and success.

3. Supplemental Staffing

AID had considerable interest in whether HKI was adequately staffed to effectively manage the increased volume of resources and program responsibilities taken on. In this context, it must be remembered that HKI is, and has chosen to remain, a catalyst for change and improvement in the field of eye care and the prevention of blindness. Their role is one of facilitating, developing, training, demonstrating and advising. - Farmore than the hands on delivery of services to the patient. As such, they do not have to expand a service delivery staff in portion to expanded funding investments. We were impressed with the qualifications, enthusiasm and practical capacities of the HKI key staff. With the already added clerical support and the acknowledged intent of the organization to remain "lean and mean", we believe they probably have the capacity to handle current program responsibilities with the existing staff. However, we do suggest that they look at their key program areas (vitamin A, cataracts, training materials/and rehabilitation) with an eye toward whether or not serious disruptions occur whenever these program directors are in travel status for several weeks or preoccupied with some special project that must meet deadlines. These thoughts might particularly apply to Susan Eastman and Victoria Sheffield, - but we suggest HKI might want to consider the addition of a technical assistant for the program directors, - functioning in much the same way that the Program Operations Unit (Karima and Pam) Support the Regional Manager Positions. Technical assistants could help:

- To provide continuity of program response to question or reports from the field, and
- To allow more "creative" time for these acknowledged experts in the special program areas.

4. Review of Staffing

During the period of dramatic growth in program resources (1980-88), HKI records reveal a doubling of the Headquarter's employees. The addition of new staff, along with turnover in some of the key positions has resulted in a lower average tenure; but that average length of service is still three years. Vitality has taken its place alongside stability as complementary

characteristics of the HKI staff (see exhibit #3). It was reassuring to note that three (9%) of the headquarters staff are blind and effectively integrated into their operations. Still another employment policy, that of utilizing indigenous Personnel in the country representative role, rather than American expatriates, - has some intriguing possibilities and potential difficulties. The experiment is not yet far enough along for HKI to draw any in-depth programmatic conclusions, but our interactions with Dr. Mmbaga and Madame Akalay were enlightening experiences.

Mr. John Palmer, as HKI Executive Director, has brought a sense of equanimity, realism and order to the group which was apparently, greatly needed. He believes that changes must be introduced in increments and has a realistic perspective on his organization's limited capacity to be a receptor for growth funds without losing control of its own destiny. He engaged his staff in the planning process, and appears to be decentralizing the authority for programmatic decision making. Some refinements in internal communications will be necessary, assuring the integration/sharing of program information before that authority program decisions are made. In one recent circumstance, representatives of a vertical program were so enthusiastically received at a field program site that they committed to, and implemented, their program without first discussing such a move with the regional manager responsible for that locale. Such communication oversights have the potential for creating budgetary chaos and damaged relationships. Since HKI represents a group of dynamic, talented people with highly individualistic personalities, - it will be particularly important to formalize a methodology for the sharing of information and decision making.

B. Tanzania Field Program

In this nation of 22 million people, the HKI Project in Primary (integrated) Eye Care is located in the dry central plateau, primarily in the Mpwapwa district, East of the new capital at Dodoma. Currently HKI is serving about 200,000 residents of the Kongwa subdistrict and talking about expanding their role to five additional villages. The project has an administrative office in Dodoma, an eye care Facility in Kongwa, and small dispensaries in five villages.

This is a modest demonstration project in an area of endemic trachoma (75% of all school children examined showed some signs of residual or active trachoma) designed as a grassroots effort to educate, provide treatment or

rehabilitation, and otherwise prevent blindness through community participation. It is directed by Dr. B.B.O. Mmbaga, an Assistant Medical Officer/ Ophthalmology, and utilizes the services of an a Nursing Officer/Ophthalmology at the Kongwa Health Center and village health workers trained by the project at the periphery of the system. Since formal communications (radio, news papers) are lacking in the area, community information/education/ intervention efforts are reliant on word-of-mouth transmission.

While the government conducted trachoma surveys in 1945, 1962-64 and again in 1978, these were strictly statistical surveys with no follow-up or intervention. Currently, a new survey is being conducted in the HKI target area which deals with a much more sociologic and ethnographic orientation to eye problems (face washing, fly control, mother's education, access to bus routes, cultural perceptions, daily activities, etc.). This should provide a better basis on which to improve health education and eye care intervention efforts.

The political structure of Tanzania provides an almost ideal setting for an effective grass roots program and for ongoing data collection. While the government's health care priorities are dominated by malaria, diarrheal diseases and nutrition, it nonetheless acknowledges the importance of eye problems (trachoma, cataracts and nutritional blindness) as a significant concern. No matter how heavy the central bureaucracy might become, the socialist philosophy provides a strong infrastructure for implementation of local initiatives at the periphery of the system and encourages community based solutions to problems. Villages are organized in "10 cell units", with a leader for every ten families in order to implement work objectives for latrine construction, land cultivation, etc. As a result, the walls of the village "office" are covered with current lists describing the status of its 2 000 inhabitants. Village officials authoritatively cited information that 15% of the village is unable to work, - about 8% of those due to old age and 7% due to physical disability. This suggests that data gathering and demographics as an ongoing function are already part of the social infrastructure.

Estimates of baseline information are crude, with the figures for blindness variously estimated from 140,000 to 500,000 nationally,...all based on projections from relatively small samples, and without any common definition of what constitutes blindness.

The negative effects of a relatively poor economy on health care are also in evidence. The large 400-bed hospital in Dodoma is poorly equipped and supplied, a constant frustration for the over worked staff.

Dr. Mmbaga's eye clinic contains a 35 year old slit lamp, only 1 of his 3 ophthalmoscopes was working and his supply of instruments was quite antique and basic. Only 4 of the 400 beds are available for eye surgery patients.

At the Kongwa Health Center, we were unable to observe their routine clinical interaction with patients, but saw no tonometer and were curious as to why their small operating room was used for storing supplies.

There was clear evidence of considerable dependence on the supplementary resources of other PVOs (an Italian group working on water/agriculture/health, The Christoffel Blinden Mission operating a major hospital, The Royal Commonwealth Society for the Blind, and "Survive" a foundation providing transportation vehicles), yet, there was evidence of slippage in coordination between their efforts. For example the ophthalmologic assistant at Kongwa had been sent by RCSB to London for a year of training without even consulting HKI, who pays part of his salary.

At the village level, we observed the work of two VHWS who demonstrated gentleness and consideration for their patients, but who were limited by their level of technical skill, and their inadequate supplies and infrastructure. They did not have the most basic equipment for performing a good eye exam, were unsure of whether a visual opacity was in the cornea or the lens, and had only 1% tetracycline ointment with which to treat eye infections.

Currently HKI supplies the project village directly. However, if this demonstration project is to work properly, more information, training, supplies, equipment and eye care responsibility should be made available to the villages, at the periphery of the system. VHWS should be taught to move their eye charts outside the clinic where better light and adequate distance will permit accurate assessment of vision. Also, they should be taught to do "pinhole" visual testing to offset refractive error, and to keep accurate records of visual acuity/eye disease incidence in their villages.

In general, there is a distinct aura of genuine concern and humanitarian caring in this program with little appreciation of the fact that they are losing ground in their struggle against blindness. Tanzanian Ophthalmologist would probably have to triple their productivity on cataract surgery just to "break even" with the new cases of blindness occurring annually. Such an effort is unlikely so long as they feel overwhelmed by the magnitude of the problem, are frustrated by inadequate equipment or supplies, and have no recognizable incentive to invest their time and energy in the effort.

The project needs a sense of order and confidence, starting with its administrative function. The project director, Dr. Mmbaga, functions very well in his contacts with national and regional health officials but his time is too important as an ophthalmologic surgeon to have him handling routine responsibilities that could be performed by someone without medical training. The Reverend Mpima was hired to take on those administrative chores but seems to lack the skills for budgeting and record keeping in addition to handling requisitions and supply logistics. In a brief inquiry, he could produce no other financial records beyond two checkbooks, and appeared confused about which items could be purchased from which account.

Dr. Mmbaga needs a thoroughly competent full-time administrative assistant to take on all those responsibilities falling outside the field of clinical/medical liaison and supervision. The program should also develop a system of incentives/rewards/public recognition which will stimulate enthusiasm for an expanded effort. The review team was impressed by the fact that Tanzanians always had us sign their guest book at every stop during the week, yet there was a notable lack of record keeping for project activities, ordering, patient records, financial accounting, and other material concerns. We believe this reflects a "people orientation" in the culture, which indicates that public recognition might be a strong incentive.

(C) Morocco Field Program

This land of 25 million people stands in stark contrast to Tanzania. Unlike that somewhat egalitarian socialist state, Morocco is a highly centralized monarchy.

The ruling monarchy and its attendant bureaucracy pays a great deal of genuine attention to the health education and prevention and treatment facilities. However, there is little evidence of empowerment or participative involvement by those whose needs they serve.

The evaluation team, visited Ouarzazate at the same time a team of ophthalmologists from several parts of the country had gathered for a week-long "eye mission". The dominant impression gained from government health officials and providers alike was a sense of pride in providing essential services to poorer, underserved provinces in the South. Unfortunately, the providers' manner of service and delivery seemed to pay little attention to the details and refinements of their services.

Hospital patients records at the Eye Camp in Ouarzazate are cursory. Charts on the inpatients consist of two sheets of paper which outline the identity of the patient, date of admission, diagnosis and proposed surgical intervention. There are no vital signs recorded (or taken on most patients). No history of other medical problems, and no written record of the outcome of the procedure.

Outpatients' diagnoses and prescriptions are entered in a log book as a oneline entry. Unless the patient can recall the specific date of their prior visit, there is no way to reconstruct any information about earlier examination and/or treatment. Little or no patient info is exchanged between the referring health center physician and the treating specialist, in either direction. We spoke with several departing patients, most whom were either confused or uninformed about their diagnosis, treatment or what they were supposed to do in the way of follow-up.

Little thought had been given to creating a system of orderly patient screening and flow during the week-long "eye camp." Each morning there was a chaotic mob scene at the front doors of the hospital when the doctors arrived. A constructive attempt was in place to provide a health education slide show on sanitation and the prevention of eye infections in the patient waiting area. However, patient movement through this hallway area created noise distractions, and none was situated in the viewing area long enough to see and hear more than half the presentation. In seeing 200-300 patients daily, there were major "bottlenecks" in patient flow which could easily be eliminated with some thoughtful planning.

The clinical facilities in both Ouarzazate and Agadir were very adequate, even impressive. Equipment was mostly quite good, but refraction equipment was very basic and poorly utilized. Testing for lens prescription was done across the width of the common examination room, with several patients wandering back and forth between the examiner (at the eye chart) and the patient, making it impossible to adequately see the chart or hear the questions being asked.

There were no established standards for surgical intervention...each ophthalmologist applying his own independent judgement on the need for intervention, which Dr. Hawks found to differ considerably between physicians. There was no individual, - doctor, administrator, charge nurse, etc. - who was charged with the overall responsibility of organizing the 7-10 day eye camp. Everyone more or less reported to the hospital and performed their individual function without coordination or interference from others.

Dr. Medina, a senior Ophthalmologist from Agadir, was utilizing the patient load at the eye camp as a clinical

opportunity to provide intensive training to eleven ophthalmologic assistants (mid-level providers) who work in provincial or district health centers. This was an effective and very positive aspect of the program which amplifies the capacity for providing competent diagnosis, treatment and minor surgical intervention at the periphery of the health care delivery system.

At the Regional Hospital in Agadir, we were shown a large modern, clean facility and invited to observe surgery. A new wing is under construction which will house the expanded ophthalmology section. Eye surgery has access to two surgical suites, but utilizes only one because the second has no equipment. HKI may wish to use the possibility of equipping this second surgical suite as incentive for commitments from the Ministry of Health to engage in extensions and refinements of this blindness prevention program in the south.

The program in Morocco has very different characteristics from that in Tanzania. It has excellent clinical facilities in which to work. An increasing reservoir of trained indigenous ophthalmologists, and some very good equipment/supplies. The great need here is to increase the humanitarian aspects of the system: more thoughtful planning of patient flow, improved screening methods, doctor patient communication, improved surgical/anesthesia techniques, and patient sensitive health education; all intended to make the system more "user friendly".

The approach to upgrading physician skills in patient communication and surgical techniques will require thoughtful planning on the part of HKI.

We believe providers in this setting might be resistant to "instruction from an outsider, sent into Morocco to lecture and demonstrate,...effectively telling them how improper their present practices are.

It might be effective to provide an opportunity for them to observe and participate in an efficient and caring operation where they can be impressed by a "better way" to increase both their productivity and sensitivity. This principle would likely apply to Dr. Mmbaga and the Tanzanian program, as much as it does to the providers and administrators in the Moroccan Program.

Such opportunities for HKI to provide continuing education, travel for on-site experience in other projects, needed equipment and public recognition for their achievements are the potential incentives necessary for negotiating and achieving program improvements.

SECTION V - RECOMMENDATIONS

1. The review team was so impressed by the dramatic progress made by HKI during the past 21 months in planning and implementing effective changes in their administrative procedures, participative management, financial accountability, communications and staff morale, we strongly suggest that key personnel from AID/FVA/PVC avail themselves of the earliest opportunity to witness these changes directly. Anyone who has not had direct personal contact with Mr. John Palmer and HKI Headquarters Operations for two years or more would greatly enhance their understand of HKI's organizational philosophy and its management/technical assistance capabilities by interacting with the Headquarters staff personally.
2. We suggest that HKI internal communications and Program Functioning would be greatly enhanced by the expeditious identification of performance indicators for program progress, and the adoption of a set of Standard Reporting Measures. Country program directors should participate with the HKI epidemiologist and key Headquarters Staff in the selection of these indicators and the standardization of reporting criteria, looking at both activity and outcome measures for inclusion in the Standard Reporting System.
3. We suggest that HKI give careful consideration to whether or not there is a staffing need for technical program assistants to work with any of the headquarters program directors in coordinating logistical support for field program activities, responding to field request for information/assistance, summarizing field program reports, providing help with correspondence or report writing, and generally maintaining program liaison during the sometimes extended absences of the Program Directors on travel status.
4. We suggest that HKI urge their country program representatives to either actively join and participate in PVO councils/coordinating groups in their service area or, where nonexistent, form such a coordinating group to facilitate complementary planning and operations for supplementing one another's activities with duplicating similar efforts.
5. We suggest that HKI consider adopting a standard "MODUS OPERANDI" which carefully assesses the local equipment and training needs of each country's program, then negotiates an incentive reward system which matches the procurement and delivery of those resources to the accomplishment of specific objectives (i.e., The

successful training of 20 village health workers in Glaucoma screening could be matched with delivery of 20 tonometers as "graduation presents" with which they can utilize their new skills, - or the doubling of productivity in cataract operations during a defined period might result in the receipt of a new slit lamp or a trip to receive some desired special training). In Health Care Systems such as we observed, where all levels of care providers are lacking incentives for working "harder" or "better", the linking of resources to performance becomes an essential stimulant to progress.

6. In similar manner, many of the important performers who determine the success of HKI's programs are not employed by HKI. We suggest that the Liberal System of Public Acknowledgement and Recognition for Good Performance (certificates, awards, special training, badges, unique articles of clothing with project logo, small items of equipment for their work, etc.) might be the incentives which make a significant difference in program outcome.
7. We suggest the inclusion in future HKI grant proposals of specific budget items to cover travel and per diem for selected key persons (country program representatives, providers administrators, etc.) to visit and actively participate in successful, efficient, well run projects in other countries. Observing and functioning in an effective project setting such as the Aravind Eye Hospital in India, or other appropriate exemplary settings are experiences which readily transfer lessons without implying criticism but allow for adoption of better methods.
8. Acknowledging both the merits and difficulties of the field programs we observed in Tanzania and Morocco, the review team suggests that both programs warrant continued funding support, but with some stipulations. Both programs are providing important contributions to the prevention and treatment of blindness in their respective populations. But neither project appears to have captured a sense of their responsibility in determining the future of HKI and/or USAID support for their efforts. We suggest that this relationship between performance and future funding be more sharply defined by negotiating measureable objectives and matching future commitments to the realization of those goals.

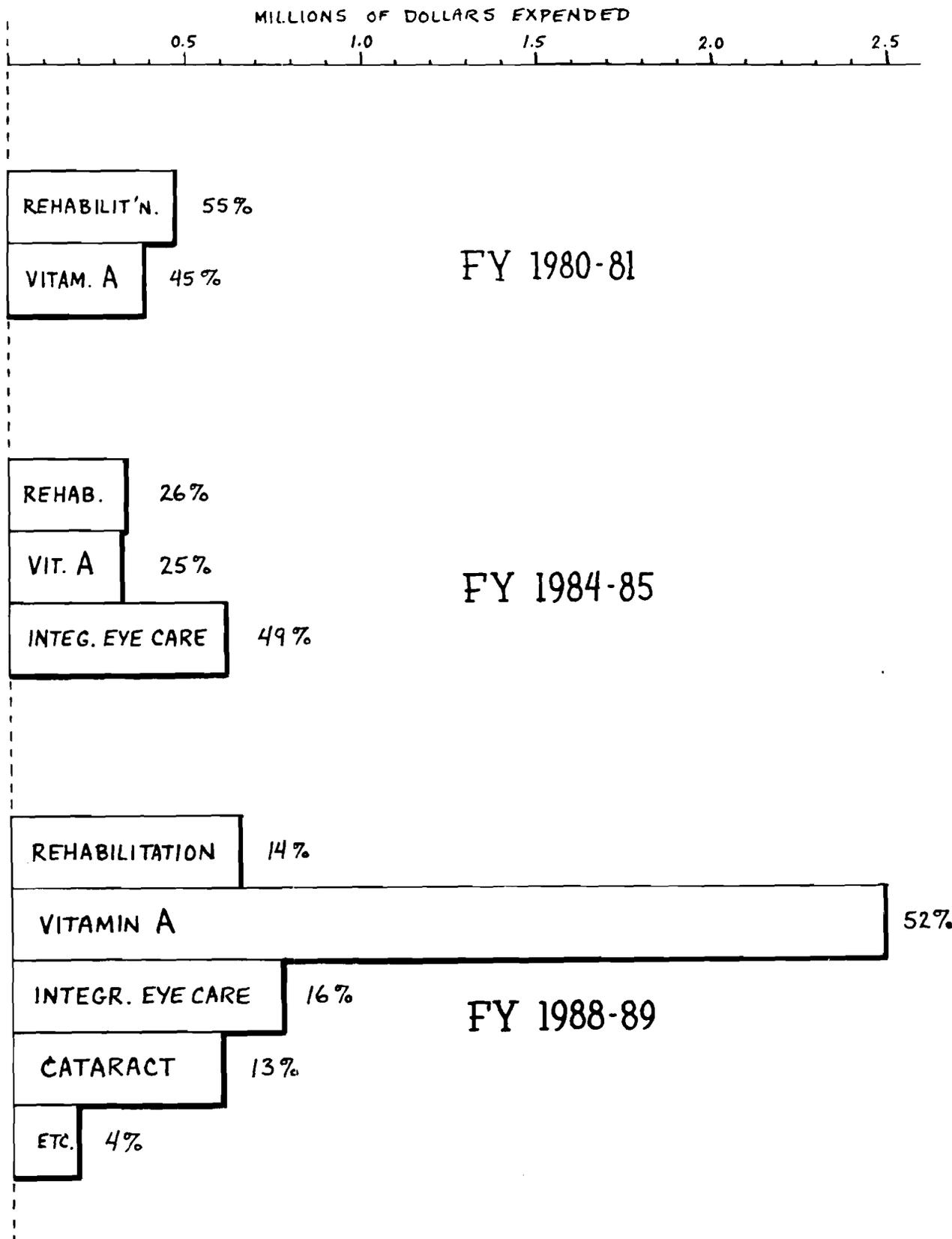
***NOTE:**

It should be noted that the recommendations of this review group are all in line with HKI's stated intent to serve as a "catalyst" in improving indigenous program efforts which are locally sustainable. The review team supports and encourages that posture as an appropriate role for HKI, and advises caution with respect to funding commitments for supplies, salaries or other ongoing operational costs which the host governments would be unable or unwilling to sustain.

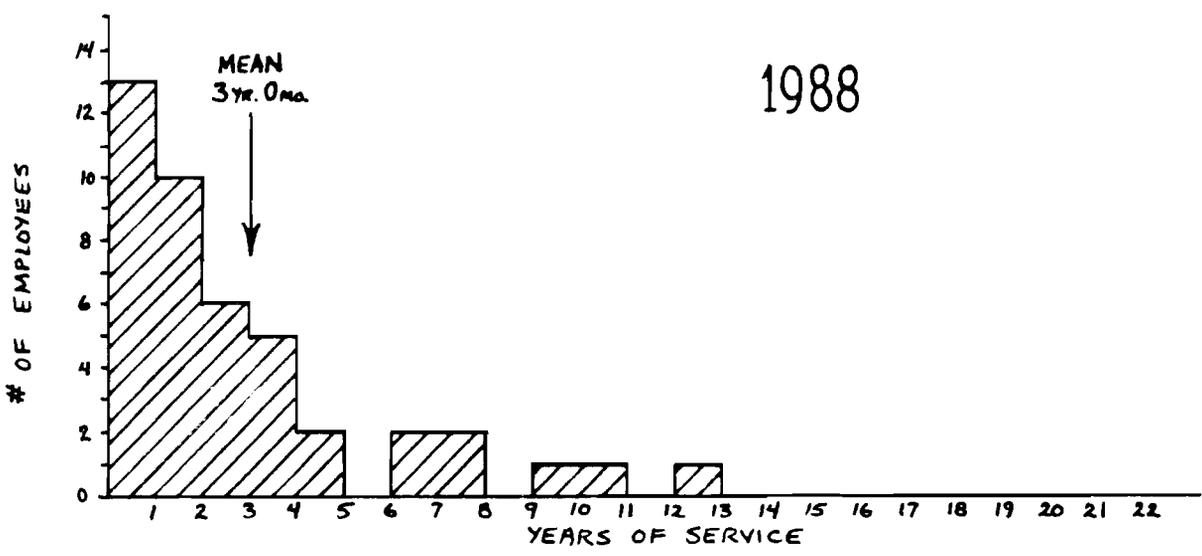
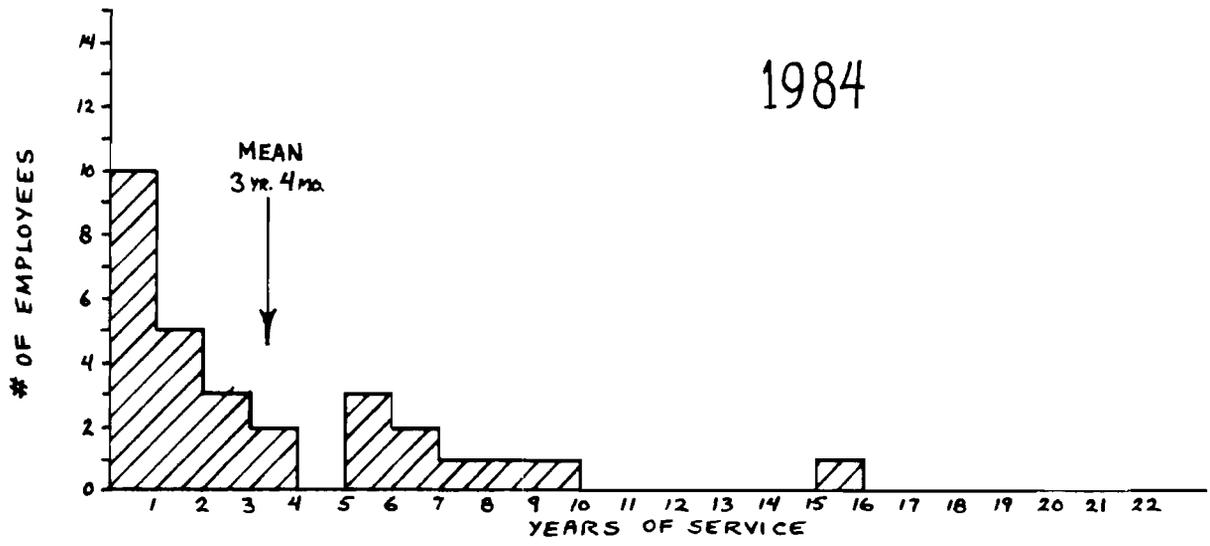
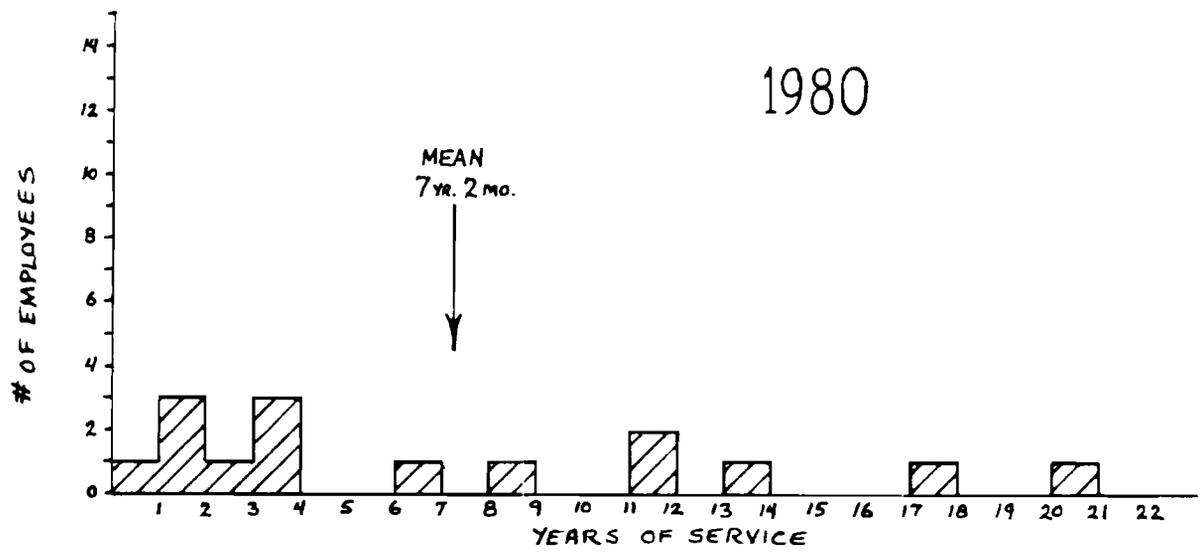
SECTION VI - EXHIBITS

1. Changing HKI Program Expenditures, by Major Programs
2. Length of Service Comparisons - HKI Headquarters Staff
3. HKI Strategic Plan, 1989 - 1993 (Draft of June 30, 1988)
The Display documents from Section 7 and the Appendix
have been deleted.

CHANGING H.K.I PROGRAM EXPENDITURES, BY MAJOR PROGRAMS



LENGTH OF SERVICE COMPARISONS - H.K.I. HEADQUARTERS STAFF



HELEN KELLER INTERNATIONAL
STRATEGIC PLAN
1989-1993

DRAFT OF JUNE 30, 1988

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- II. Background**
- III. Strategic Objectives**
- IV. Five Year Action Plan**
- V. Overall Resource Plan**

**Display G: Current Programmatic Thrusts in
in Asia-Pacific Region**

Section 14. Latin America-Caribbean Program Plan - - - - - 62

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- II. Background**
- III. Strategic Objectives**
- IV. Overall Resource Plan**

Section 15. Management Plan - - - - - To Be Prepared

Section 16. Evaluation Plan - - - - - To Be Prepared

Appendix: Philippines "Blue Sky" Program Plan

INTRODUCTION AND SUMMARY

This 1989-1993 Five Year Strategic Plan has been developed to define and focus the overall priorities and objectives of HKI and to articulate financial, program and managerial plans for addressing those priorities and objectives.

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

Basic to the plan are projections of HKI's program outreach based on two different financial scenarios:

- A realistic budgetary projection;
- A challenge-level plan and projection.

The first, the realistic projection is just that. The first year of this projection is the FY-1989 budget and related program plan. Financial, program, and regional plans for the following four years are spun out, projecting reasonable financial developments and program choices.

The challenge-level projection is based on improved funding and expanded program. Income increases are projected on the basis of what might potentially be attained with a more aggressive combined Board/staff/consultant financial development effort. Program plans indicate how that additional funding would be put to use.

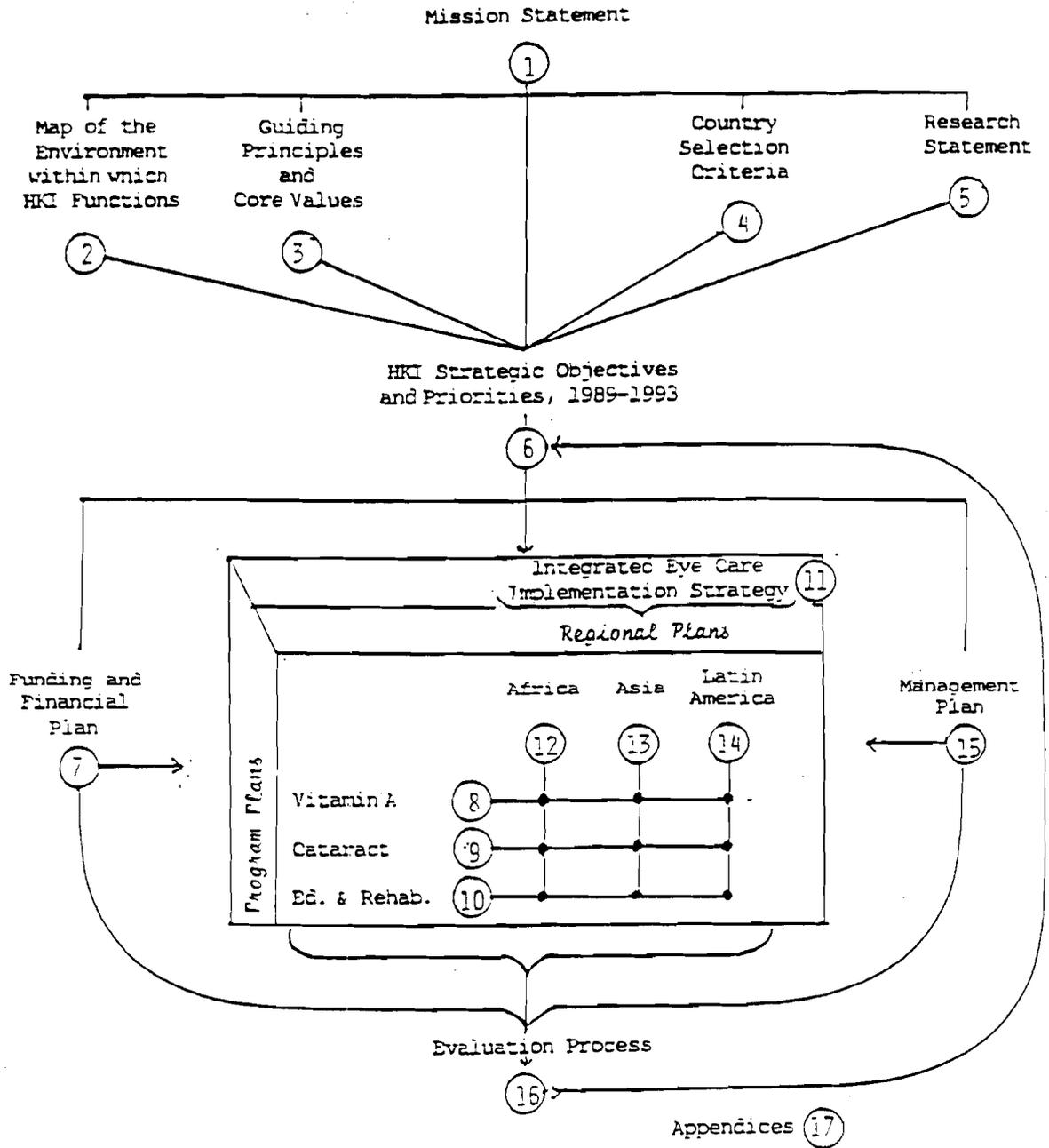
On the following page is a chart showing graphically how the HKI Strategic Plan is structured.

- Sections 1 through 5 describe the basic framework of the HKI mission and program;
- Section 6, on Strategic Objectives and Priorities, outlines what is to be achieved in the five year period;
- Sections 7 through 15 describe the plan in more detail, indicating costs, sources of funds, program development and implementation, and management developments;
- Section 16 briefly describes the annual evaluation and update process;
- Section 17 is reserved for appendices, providing additional detail and examples.

In summary, the first priority and objective of the agency over in the next five years is to assure long-term viability by moving as rapidly as possible to achievement of a balanced budget, eliminating the current usage of endowment funds to cover operating costs.

To assist in meeting this goal, financial development efforts will be focused on a new more effective mix of restricted and unrestricted income. New programs will not be initiated unless financing is assured and new programs will be limited largely to broadening and deepening programs in existing countries.

Elements and Structure of the
HELEN KELLER INTERNATIONAL STRATEGIC PLAN



6/13/88

SECTION 1

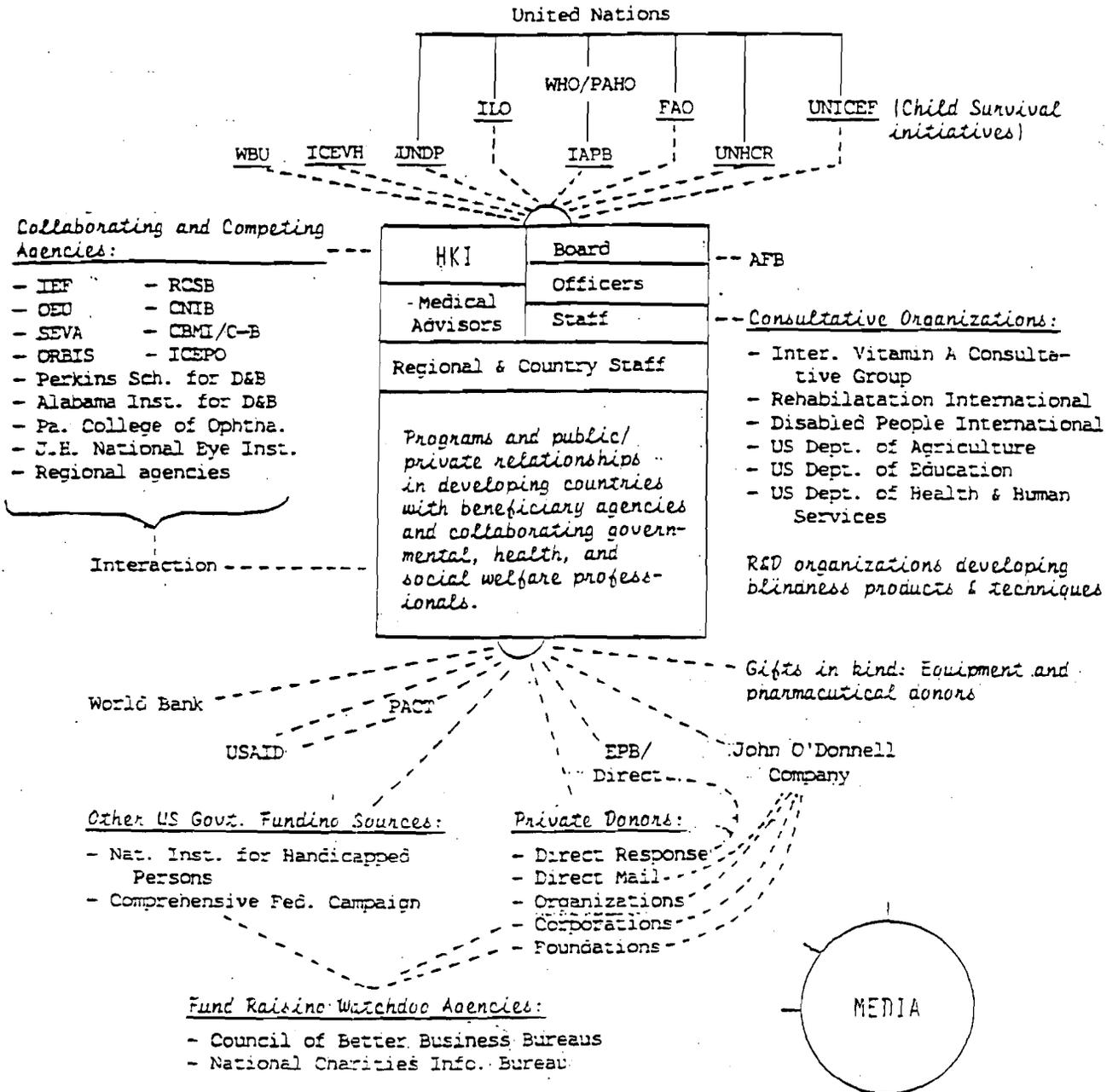
MISSION STATEMENT

Helen Keller International exists to prevent blindness, to restore sight and to educate and rehabilitate the incurably blind through the development of indigenous capacity where the need is great.

SECTION 2

ENVIRONMENTAL FRAMEWORK
WITHIN WHICH
HELLEN KELLER INTERNATIONAL FUNCTIONS

6/30/88



NOTE: It is the senior staff consensus that those organizations currently most important to HKI are: 1. USAID; 2. UNICEF; 3. (tied) WHO/PAHO; ICEPO; and the John O'Donnell Co.

SECTION 3

HKI GUIDING PRINCIPLES & CORE VALUES

HKI Programs are designed to:

- 1) serve the needs of disenfranchised and at-risk under-serviced populations in the developing world.**
- 2) provide accessible, affordable services to people most in need.**
- 3) catalyze local or national action for local priorities and practical needs.**
- 4) enhance the management and service delivery capacities of national colleagues and counterparts.**
- 5) creatively publicize the magnitude of blindness and alternative, practical and cost effective solutions.**
- 6) encourage consumer oriented action and disabled peoples participation in decision making and community action.**
- 7) develop a successful synthesis of service and approaches for applying and adapting already existing appropriate technology.**
- 8) have the possibility of being sustained and replicated by governments and other national health and welfare institutions.**
- 9) meet, where circumstances dictate, emergency conditions creating wide-scale risk to sight or needs for rehabilitation.**
- 10) strengthen the linkage between national health programs and practical programs for blindness prevention and sight restoration.**
- 11) strengthen the linkage between national education and social welfare programs, and rehabilitation and education programs for the blind.**

SECTION 4

COUNTRY SELECTION CRITERIA

HKI's strategy is to apply and adapt methodologies for blindness prevention, sight restoration, and education and rehabilitation of the blind to diverse, representative countries where the need is great. Below are major criteria for selection of new countries:

- 1) There is a significant amount of blinding eye disease and/or a need for services for the blind in the country.
- 2) There is an interest on the part of government and/or groups in a position of leadership to address the problem and a willingness to commit resources alongside HKI to do so.
- 3) There exists a general health delivery and social service system functioning with a modicum of efficiency into which blindness prevention, sight restoration and services to the blind can be integrated.
- 4) There are discrete areas within the country in which blindness prevention, restoration of sight and services for the blind can be conclusively demonstrated in a reasonable time frame.
- 5) There is a relative certainty that what is demonstrated in the joint HKI-government or indigenous PVO program can be adapted in a self-sustained manner in whole or in part for use on a wider scale in the country.

SECTION 5

RESEARCH STATEMENT

Helen Keller International will participate in applied research activities that have programmatic benefit within its mandate of preventing blindness, restoring sight and educating and rehabilitating the blind. HKI will be open to selective, collaborative research with academic institutions. Decisions on such collaboration will involve an internal agency review focused on ethical consideration and potential, clinical and programmatic results.

SECTION 6

HKI STRATEGIC OBJECTIVES AND PRIORITIES

1989-1993

1. **Implement a short-range finance policy directed towards restoring the financial stability of HKI (Section 7):**
 - A. **First priority on new unrestricted income will be to continue the support for currently budgeted expenses, replacing dependence on the use of endowment funds.
(STOP THE NEED TO DRAWDOWN ENDOWMENT FUNDS TO SUPPORT ONGOING FUND RAISING/MANAGEMENT/PROGRAM EXPENSES).**
 - B. **Program initiatives will largely be limited, at least for the next three years, to the continuation of existing programs in existing countries unless over-riding restricted income/agency strategic considerations occur. These programs will be expanded selectively by adding new program elements when either unrestricted or restricted income becomes available, after endowment drawdown has been eliminated.**

2. **Help to assure the long-term financial viability of HKI (Section 7):**
 - A. **Expand funding sources and base, thus reducing dependence on AID support;**
 - B. **Develop specific initiatives to raise funds for rehabilitation and education;**
 - C. **Develop maximum flexibility in the use of funds;**
 - D. **Clarify to donors and potential donors HKI's programs of developing self-sustaining community health delivery systems in beneficiary countries.**

3. **Continue to develop and implement innovative programs and delivery systems within the context of HKI's mission committment.**
 - A. **Maintain HKI's leadership in nutritional blindness deficiency prevention - Vitamin A (Section 8);**
 - B. **Continue the development of a strong cataract program component in the HKI blindness prevention initiative, with the objective of incorporating a sight restoration/cataract element in all appropriate blindness prevention projects, and of becoming a leader in the development of innovative approaches in the provision of direct cataract services (Section 9);**
 - C. **Complement HKI's primary program emphases with concerns for trachoma, onchocerciasis and other causes of blindness.**

- D. Reaffirm blindness prevention/sight restoration as the primary mission components of HKI, but recognize its continued commitment to blindness education and rehabilitation (Section 10):
 - Establish a target of building and maintaining a pre-determined funding balance (perhaps 70%/30%) as between prevention and rehabilitation;
 - Work to better integrate rehabilitation and education concerns and prevention programs.
 - E. Focus the implementation of all HKI blindness prevention, sight restoration and education/rehabilitation programs within a context of integrated eye care (Section 11).
4. Strengthen HKI's management structure and its capacity to manage through the development and implementation of a strategic management plan and philosophy (Section 15):
- A. Develop regional staff resources and organization by improving:
 - regional and local management oversight and communications;
 - technical backstop capabilities;
 - inter-country cooperation;
 - reliance on beneficiary country resources and personnel.
 - B. Improve the capabilities and efficiency of the core headquarters professional staff by:
 - adding a Medical Director position;
 - further developing the support staff structure;
 - encouraging the development and utilization of skills of professional staff;
 - evaluating and rewarding performance (e.g., "performance management").
 - C. Minimize imbedded expense associated with programs having limited time frames by avoiding the addition of individuals to the core staff whenever possible or insuring costs of such individuals are covered in restricted grants.
 - D. Improve the manner in which technical advisory resources are structured and utilized.
 - E. Establish an effective program monitoring and evaluation framework, a system for continuing project follow-ups after completion to assess long-term results, and, disseminate project results systematically and widely.

F. Develop and implement an improved and more computerized management information system.

5. Establish HKI as a strong advocate and source of information on

- blindness prevention;**
- sight restoration;**
- blindness rehabilitation and education;**
- eye health service delivery; and,**
- applied research**

in the Third World.

6. Continue and expand the emphasis on program coordination between HKI and other health care and social welfare service delivery organizations with related programs, providing operation assistance to others whenever such is appropriate and staff resources can be freed.

7. Build towards a long-term capability to significantly increase the size, scope and effectiveness and, within management constraints, the number of demonstration projects, involving more countries and environmental situations.

(This recognizes that while first priority in HKI must be given to strengthening the agency, its management, finances, program scope and advocacy capabilities, the longer term approach of HKI should be to focus all of the above on the basic objective of providing the most extensive possible demonstrable evidence that blindness in developing nations can be measurably reduced and that blindness rehabilitation in those environments is both practical and effective.)

SECTION 7

FUNDING AND FINANCIAL PLAN

I. BACKGROUND

In 1983, HKI was a PVO with 10 field programs and an expense budget of just over \$1,000,000. In 5 years it has expanded dramatically. FY-1989 expenses are forecast at over \$6,500,000 and include support for programs in almost thirty countries, and many of these are large and complex with multiple cost-centers.

This growth, largely the result of restricted grants from the U.S. Government, has made HKI a major international force. Its large and varied programs are reshaping blindness prevention, treatment and service delivery to the blind among major government and private institutions throughout Africa, Asia and Latin America. The size and scope of the agency and its well-established track record has broadened its appeal to private and institutional donors.

Conversely, the rapid growth has presented problems. These include complex and time-consuming reporting requirements on over 14 different AID grants, and complicated reporting requirements to eight corporate and foundation donors. The AID requirements are particularly demanding since each grant carries different guidelines, rules and regulations depending upon its originating source within AID. Each grant also demands adherence to cost-sharing formulae and exposes HKI to expensive and time-consuming audits. All this produces a heavy administrative burden and jeopardizes HKI in terms of possible liabilities. Overall, the AID-HKI partnership has left the agency well placed in terms of its global program portfolio but carries with it an uncomfortable degree of dependence on a single donor.

AID and other restricted grants that HKI has obtained have required the enlargement of the HKI staff. Program growth has meant more staff and therefore increased overhead and other indirect costs. These costs exceed that which major Government and other benefactors cover through overhead allocations. HKI's unrestricted income (i.e., direct mail, media response, individual and corporate gifts, gifts-in-kind, the Combined Federal Campaign, investment income, legacies and trust) has not been adequate to cover both the agency's general managerial expenses and grant matching requirements. In each of the past five years, the agency has had to withdraw from its "savings" to cover an operating deficit. That deficit remains HKI's most serious challenge. In 1988, for example, a drawdown of over \$1,000,000 (the endowment supplement and the deficit combined) will have to be made from the endowment to cover operating costs.

II. FINANCIAL PLANNING STRATEGIES

To change the financial imbalances and the endowment drawdown, HKI is adopting the expenditure and financial development priorities already put forth as the first two points in Section 6.

This expenditure strategy has been utilized to develop the proposed FY-1989 budget and related financial projections for the years 1990-1993. These financial projections are presented as Display A, immediately following the text of this section. This financial projection indicates the prospect that a balanced budget will not be achieved until FY-1992.

Financial development strategies are presented in greater detail in the paragraphs that follow. These strategies should greatly enhance HKI's financial picture. Potential results from these strategies have been brought together in a "Challenge" plan, indicating what might be achieved if the Board, staff, and outside consultants all work in a coordinated fashion and intensify efforts to raise a higher combined level of unrestricted and restricted income.

This Challenge Plan is presented as Display B. It indicates the prospect of a balanced budget by FY-1990 and significant new income in the following years. This Challenge Financial Plan is ambitious enough to make its full achievement unlikely. It, however, presents a definite target to be pursued and the opportunity to measure successes against that target.

Displays C, D and E focus on just the program elements of HKI's operations. These tie in directly to the Display A (Realistic) and Display B (Challenge) levels and provide considerably greater detail of HKI's forecast of income and expenses by subject matter area and regions over the next five years. Display F illustrates recent and projected unrestricted income under the Realistic Plan.

The program sections of this HKI strategic plan that follow this section include descriptions of activity at both the realistic and the "challenge" funding levels. Enhanced program opportunities that depend upon increased income are also described.

III. FINANCIAL DEVELOPMENT STRATEGIES

The objective of expanding funding and funding sources will be pursued via the following:

A. In all Fund Raising, Emphasize HKI Program and Objectives Clearly

Potential donors react positively to appeals that feature the delivery of direct services to specific individuals sponsorship or groups of individuals (HKI has never promoted sponsorships). It is more difficult for an agency such as HKI to attract donor support for its more indirect objective of establishing demonstration projects to convince third world governments of the value of providing general programs. The fact is that HKI delivers services but in the context of programs designed to demonstrate concepts and methodology that will lead to different program choices.

This is a continuing challenge for HKI and its fund raising consultants. It is recognized however that this distinction must be made, and this point is listed as a financial development priority of the agency. Maintaining honesty in fund raising is critical to the continued life and health of HKI.

B. Reinforced Direct Mail Efforts

HKI's direct mail program will continue to develop and expand donor contributions. The income projection in Display A is clearly within reach. It includes as previously outlined by the JOD Company, provisions for continuing prospecting to acquire new donors on a regular basis; the encouragement of existing donors, regular and large to donate more often and to upgrade gifts in order to increase total annual giving. Personal contacts with some large donors to be made by HKI's CEO and Development Director in order to increase involvement with HKI and to explore other potential areas of contributions such as legacies and bequests. HKI will continue with 6 or 7 annual mailings to donors and mailings to other special donor groups.

The direct mail challenge plan is forecast at the same income level as the realistic plan. There will be continuing tests of appeal packages that may lead to increased income. HKI prospect mailings will also continue to test new donor lists and appeals to expand the donor base.

C. Intensified Media Response Initiatives

Under both the regular and challenge financial plans the media response program will be intensified to increase efficiency and to continue to grow. Every effort will be made to increase dollar amount goals for individual monthly contributions and to insure that all donors will be encouraged to give on a monthly basis. Additionally, the media response program will continue to test new program areas to expand donor base and annual giving. For example, telemarketing of lapsed donors, new print ads and credit card options will be tested to assist HKI with its International service Agencies' programs and increase HKI's visibility in the Combined Federal Campaign program and other state, local and overseas campaigns each fall. Particular attention will be given to advertising in areas with large concentrations of U.S. Government employees. EPB will also continue to work with HKI's newsletter.

Special efforts will be made under the challenge plan to improve upon program efficiency and reduce the cost per dollar raised. Specific test programs such as telemarketing of lapsed donors, increased monthly contributions, and ad campaigns will be intensified.

D. Unrestricted Income from Corporations and Foundations

During FY-1988 HKI began an organized and systematic campaign to develop corporate and foundation contacts and to raise substantial unrestricted funds. With no track record established, it is difficult to predict full program details for future years. The forecast at both the realistic and challenge levels is therefore highly speculative.

However, HKI is encouraged by the approaches used by the JOD Company to date. HKI's name is now before many additional potential donors. The key to success in this endeavor (and in reaching projected income levels) is to continue to aggressively market HKI with carefully devised proposals designed to broaden the agency's appeal and allow funds raised to be used flexibly.

To do this, HKI is developing "blue skies" proposals for specific countries with budgets that broadly reflect overall costs for country programs, including unrestricted headquarters costs associated with such programs (a prototype "Blue Skies") proposal is attached as appendix .

In the overall effort, it is expected that HKI's Board and executive staff involvement will continue and expand. Also, as the Board of Directors itself is expanded, there is potential for greater national outreach. The CEO will also intensify his direct involvement to make contact with corporate and foundation donors outside of the New York Metropolitan area.

For the challenge plan, large corporation and foundation contributions will be emphasized, i.e., HKI's "\$100,000 Club".

E. International Service Agencies (ISA) (Combined Federal Campaign, State, Local and Overseas)

HKI will continue to expand its national and international donor base through efforts to increase HKI's visibility among U.S. government employees. Public education and public relations activities, as well as the release of new media and ad efforts will be timed to complement the ISA government fall campaigns.

For the challenge plan, HKI projects additional income as a result of an overall increase in donor contributions to ISA. ISA's success in getting into a larger number of State and Local campaigns will also increase total contributions.

F. Legacies, Trusts and Bequests

A Legacy, Trust and Bequest program will be developed from the on-going direct mail and media response programs, and through increased personal contacts with large donors, HKI will be able to approach donors about possible legacy, trust and bequest contributions. Counsel from JOD or other outside agencies may be needed.

As of the current date, efforts will not be significantly expanded in pursuing legacies, trusts, and bequests under the Challenge Plan.

G. Gifts-in-kind

HKI's gifts-in-kind program will be expanded to better support overseas field operations and specific program needs. An improved in-house capacity to track program requests and match them with inventory will increase program efficiency.

The challenge plan for the gifts-in-kind program will include expanded staff to handle the receiving and shipment of the program and some warehousing facilities.

H. Selective Efforts for New AID Grant Funds

AID grants, as indicated earlier, are HKI's great good fortune but are the cause of persistent difficulties and an uncomfortable degree of dependence on one partner. Turning this overdependence into a more beneficial relationship is a challenge.

To accomplish this, HKI will:

- 1) write new proposals to incorporate more of the headquarter's direct costs associated with staff;

This will enable HKI to allocate staff resources and enhanced technical abilities through staff development to restricted funding sources. Recent developments in applying AID grant funds makes it possible to shift these allocations from unrestricted HKI cost centers to U.S. AID support. This should be seen as a short term (3 year) opportunity to generate adequate unrestricted funding for the future growth and support of agency programs.

- 2) make every effort to adjust the current overhead rate in FY-1989 and continue to upgrade this as appropriate in future years; and,
- 3) cap" AID funds in future years at the levels indicated in both Displays A and B.

In Display A, the realistic plan, HKI effectively targets a \$3,000,000 to \$3,300,000 level not including overhead over the next four years. At the Challenge level, Display B, AID funds would be capped at almost the same levels. The small increase in the challenge level is due to increased funding for African programs.

At these relatively stable but still substantial levels of AID funds, HKI staff would continue to focus on the two main issues at hand: to increase unrestricted funding and to broaden the base of restricted grants, other than those from AID.

I. Restricted Income from Corporations and Foundations

Restricted grants combine the efforts of HKI's development office with those of the agency's program staff in a manner distinct from the pursuit of the more generic proposals used to solicit unrestricted funds. Restricted grant fundraising often requires that the program staff take the lead, make and follow-up on initial contacts and write proposals which are often technical and carefully tailored to redress a specific problem on regional or country situation. Of the 23 Corporation/Foundation grants on HKI's book in FY-1989, 21 were generated by program staff in New York or by initiatives of HKI staff serving abroad.

In Display A, the projection of restricted Corporation/ Foundation income, forecasts that HKI's existing program staff, here and abroad, with about the same level of effort as before, will be able to continue to raise slightly increased (by 5%) amounts of funds in future years. Each regional strategy in the sections that follow indicate that for the first three years of this plan, HKI will concentrate on existing country programs with virtually no additions of new countries. Thus, in terms of fundraising this level actually means a substantial effort to refinance these existing programs.

In Display B, however, an average 25% increase in funds in this category is forecast. This would entail a greater level of effort of program staff, here and abroad.

To realize this enhanced level, staff increases would be necessary. One alternative might be to include assistance to program directors for development and program backstopping at headquarters. A second approach might be to hire one additional person in the fundraising department at headquarters to oversee the restricted fundraising effort and to travel. Many potential donors of restricted funds are based in Europe or Japan and/or have representatives in countries where HKI operates. To attain this higher level of restricted fundraising without additional staff would jeopardize another of the objectives in this Plan: that of assuring the smoother implementation of field activities, both administratively and in terms of technical support. Even at the lower levels forecast in Display A, an estimated 40% of the time of the headquarters program staff is spent on writing proposals, regular reports, and evaluations.

J. Cooperative Fundraising

Over and above the fundraising initiative outlined above, HKI will continually explore opportunities for strengthening its programs through cooperative fundraising with other PVOs, and including international contracts, possible affiliations and mergers.

K. Specific Initiatives to Raise Funds for Education and Rehabilitation

One of HKI's financial development priorities for the FY 1989-93 period is to focus on raising additional unrestricted funds for the support of educational and rehabilitation programs.

Education and rehabilitation services will be presented within HKI's general package of descriptive materials mailed to donors. HKI will continue to offer education and rehabilitation as a specific gift option for designation (i.e., also included are nutritional blindness, cataract, and general programs). Where possible, new packages will be tested to increase our donor base for education and rehabilitation.

Through HKI's public education program (Annual Report, newsletter, videos, etc.) education and rehabilitation will be presented as a significant component of HKI's overseas efforts. Through this "education" of donors, we will be able to expand direct donor support. Other public education and public relations activities will include special events that highlight HKI's rehabilitation services. For example, a forthcoming HKI Award will honor an international leader in the development of education and rehabilitation programs overseas.

Corporate and foundation fundraising efforts will continue to include efforts to raise unrestricted program funds for education and rehabilitation as well as restricted funds for country specific or discrete projects. Additionally, as HKI's pool of overall unrestricted funds is increased, all program areas will benefit.

* * * * *

In summary, HKI's financial health is directly tied to its capacity to generate the unrestricted income required to match cost sharing grants, to fund programs of its own choice, and to pay general operating expenses. Display F illustrates unrestricted income sources, experience in 1987 and 1988, and projections through 1993 under the realistic budget plan. This display highlights:

- the significant net shortage that existed in 1987, that was reduced in 1988, and that is projected to stop in 1992;
- the anticipated increase in the AID overhead percentage allowance, anticipated in mid-1989; and,
- a "turning of the corner" in HKI's fund raising efforts, where costs exceeded income in 1987, almost balanced in 1988, and begin to show significant growth starting in 1989.

Though not similarly illustrated, net unrestricted fund raising income will grow even faster as elements in the challenge plan are realized.

As previously indicated, Display D details the allocation of projected restricted funds (from AID and from corporations and foundation), by program and by region, throughout the five year period, under both realistic and the challenge plans.

In a simplified format, Display E summarizes these projections to show actual projected program and regional plans.

The sections of the plan that follow describe current programs and those that will be implemented under both funding scenarios.

Following the three program plans and preceding the three regional plans, is a section titled "Integrated Eye Care Delivery Plan" that outlines both the technique and the rationale of HKI in its field operations.

SECTION 8

VITAMIN A PROGRAM PLAN

I. STATEMENT OF MISSION

To prevent nutritional blindness in children through the use and development of indigenous capacity

To participate in research activities that have programmatic benefit

II. BACKGROUND

Nutritional blindness is the most common cause of blindness in children in the developing world. The blindness is essentially due to severe vitamin A deficiency, often accompanied and precipitated by protein energy malnutrition, measles or diarrhea. The eye signs are one of the earliest indicators of vitamin A deficiency. Xerophthalmia (xeros-dry, ophthalmia-eye) is used to cover the range of ocular signs and symptoms of vitamin A deficiency, which includes night blindness, xerosis, ulceration and scarring.

HKI is the lead agency globally in vitamin A programming. In 1972, the agency inaugurated a blindness prevention initiative. Xerophthalmia was chosen as the first blinding disease to receive attention for a number of reasons: it was and remains the most common cause of childhood blindness in the developing world; it was and remains preventable; minimal attention was being addressed to it in the international community.

Asia was selected as first priority for agency involvement in xerophthalmia control. This geographic area was seemingly where xerophthalmia hit the hardest. (Although this remains true in terms of absolute numbers of children involved, limited data have obscured the seriousness of vitamin A deficiency throughout Africa). Extensive national surveys undertaken by HKI and the respective Governments in Indonesia and Bangladesh demonstrated the high prevalence of the blindness, as well as answering questions in terms of the etiology of the blindness, treatment and prophylactic protocols, and associated risk factors. Specifically, the causal relationship between Vitamin A deficiency and xerophthalmia was still under investigation; a minimum effective vitamin A dosage remained undetermined; and the extent to which xerophthalmia was a public health problem was unknown. Answers to these critical issues have since been determined by HKI and its colleagues in Indonesia and Bangladesh. These two countries now represent the largest HKI vitamin A programs.

The emergency situation in Africa in 1983-84 highlighted the need for vitamin A intervention on the continent. HKI was asked to assess the vitamin A status of the refugee populations, where it found xerophthalmia rates beyond those indicating a public health problem. Rapid assessments along the Sahel belt confirmed the serious prevalence of the deficiency. WHO recently updated countries by

degree of public health significance of vitamin A deficiency (See Attachment 1). Over half of the countries in Class 1 (significant public health problem in part or whole country) are in Africa. Of the agency's fifteen countries with vitamin A programs, the majority are in Africa.

Analysis from the Indonesian field data gathered in the late 1970s demonstrated that vitamin A deficiency was correlated not only with nutritional blindness, but with higher child mortality, diarrhea and respiratory rates. Furthermore, a vitamin A supplementation field trial in Indonesia indicated that children in villages with vitamin A capsule provision had significantly lower mortality rates. Finally, new hospital-based data from Tanzania demonstrated an association between vitamin A deficiency and measles mortality. All of these findings culminated in a child survival hypothesis, linking vitamin A deficiency and morbidity or mortality. Replication studies are currently underway. In the meantime, extensive funding has been provided to expand vitamin A programming.

Realizing that the child survival hypothesis has galvanized international attention to vitamin A programming--and recognizing the tremendous spinoff on the child's well-being suggested in vitamin A intervention--HKI will actively promote and support the hypothesis. However, given the agency mandate to prevent blindness, and in agreement with the current consensus within the international community, HKI will limit its actual vitamin A programming to those countries designated by WHO as having a serious problem in vitamin A deficiency, xerophthalmia and nutritional blindness.

Given the agency's experience in xerophthalmia control programs, HKI has been key in vitamin A policy-making, in working with Governments, international organizations and professional associations. More recently, HKI initiated a program offering technical assistance in vitamin A to other private voluntary organizations (PVOs) to increase the network of vitamin A activities throughout the world.

To optimize the agency's impact in vitamin programming and technical assistance, it is proposed that the agency strengthen and economize on its current capabilities through:

- a. improving the efficiency and effectiveness of current vitamin A programs,
- b. determining role of vitamin A in other HKI field programs,
- c. consolidating the availability of technical resources,
- d. strengthening the PVO network of assistance
- e. representation and advocacy in international arenas defining vitamin A policy and programming.

III. STRATEGIC OBJECTIVES

- A. To strengthen vitamin A program management and planning capabilities in headquarters and field offices
1. Assess needs and resources available for current program operations;
 2. Project needs and resources required for any program expansion;
 3. Assess program support operations in terms of rapid response (technical, financial, communications), access to information (files, computer base) and clarity in terms of accountability.
- B. To strengthen vitamin A technical capabilities and resources available for operational assistance
1. Determine minimal requirement for full-time staffing at headquarters (technical skills, language requirements);
 2. Assess availability for regional consultation of technical staff in field programs;
 3. Develop roster of experienced consultants (or agencies providing same) in terms of skills and language capabilities;
 4. Prepare standard guidelines and educational material for distribution.
- C. To examine alternative means of delivering vitamin A in order to maximize cost/effectiveness of delivery
1. Continue program evaluation in effectiveness and efficiency of:
 - a. vitamin A distribution (i.e., oral/liquid, treatment/prophylaxis);
 - b. vitamin A food fortification;
 - c. use of nutrition education and home gardens in improving vitamin A status.
 2. Examine and address program management issues, with special attention to monitoring (i.e., target population reached), barriers to implementation (i.e., logistics and supplies), and sustainability (i.e., integration with other child survival strategies).
 3. Provide in-service technical assistance or fellowships to build local program management capabilities.

- d. To assure vitamin A intervention in all countries designated by WHO as having a serious vitamin A deficiency problem, with priority
1. Information exchange with international organizations (in particular, UNICEF and WHO's Office of Nutrition) to determine status of vitamin A programming in designated countries;
 2. Technical assistance in the assessment of vitamin A status to help determine prevalence of serious vitamin A deficiency;
 3. Provision of educational materials and supplies;
 4. Direct program assistance (or referral to other appropriate agencies) for vitamin A intervention;
 5. Provision of technical assistance to other PVOs to increase vitamin A programming in existing HKI countries (such as Nepal, India, Brazil).

IV. FIVE YEAR ACTION PLANS

A. Realistic Plan (13,600,000)

1. ASIA: (\$7,000, 000 PLUS GIFTS IN KIND)

a. BANGLADESH (\$235,000 in 1989 with 10% annual increments)

To examine alternative strategies to improve vitamin A status of the at-risk population in Bangladesh, through:

- 1) Strengthened system of vitamin A capsule delivery, with training, education, and monitoring system in place;
- 2) Increased awareness of importance of vitamin A and improved behavior through social marketing (nutrition education and mass communications);
- 3) Feasibility field trial of wheat fortification with vitamin A;
- 4) Pilot studies of effective home gardening and vitamin A consumption;
- 5) Increased use of network of local non-governmental organizations for vitamin A programming.

b. INDONESIA (\$600,000 in 1989 with 10% annual increments)

To examine alternative strategies to improve vitamin A status of the at-risk population in Indonesia, through:

- 1) Improved awareness of importance of vitamin A and improved behavior through social marketing;
- 2) National phase of MSG fortification with vitamin A;
- 3) Integration of vitamin A into child survival activities (i.e., immunization, oral rehydration therapy);
- 4) Pilot project of home gardening and vitamin A;
- 5) Integration of vitamin A into primary eye care system;
- 6) Improved monitoring and surveillance of vitamin A status and delivery;
- 7) Support of national policy development in vitamin A strategies.

c. PHILIPPINES (\$350,000 IN 1989 WITH 10% annual increments)

To examine alternative strategies to improve vitamin A status of the at-risk population in the Philippines, through:

- 1) Examining feasibility of integrating vitamin A program into ongoing government system (both urban and rural setting);
- 2) Examining feasibility of integrating vitamin A into primary eye care system;
- 3) Using social marketing as an effective method for increased vitamin A awareness and improved behavior change;
- 4) Working with the Government in developing national strategies and priorities in vitamin A policy;
- 5) Examining feasibility of MSG fortification with vitamin A for the Philippines.

d. NEPAL (\$75,000 in 1989 with 10% annual increments)

To demonstrate feasibility of integrating vitamin A into existing program, through:

- 1) Examining integration of vitamin A into community-based rehabilitation program for the blind, with intent of CBR program becoming a full-fledged integrated program of blindness prevention, treatment, and rehabilitation.

2. AFRICA (\$4,000,000 PLUS GIFTS IN KIND)

- a. BURKINA FASO (\$105,000 in 1989 with 10% annual increments)

To examine feasibility of integrating vitamin A into ongoing health care system, through:

- 1) Implementation of a demonstration project in four provinces developing vitamin A components in capsule distribution, home gardens, training and public education.

- b. ETHIOPIA (\$30,000 annually for two years, with phase down in 1991 to Vitamin A monitoring)

To integrate vitamin A into national eye care system, and to provide vitamin A in a relief situation to at-risk populations in displaced settlements, through:

- 1) Development of vitamin A education and training materials;
- 2) Provision of vitamin A consultants when necessary for training and materials production;
- 3) Setting-up a tracking system for provision of vitamin A capsules to settlements;
- 4) Procurement or provision of vitamin A capsules when necessary;
- 5) Setting-up monitoring system of emergency and relief status regarding vitamin A programming.

- c. MALAWI (\$46,000 START-UP, \$23,000 in 1989 with 10% annual increments)

To assist in the development and support of training ophthalmic assistants in eye care, including the detection, treatment, and prevention of xerophthalmia, through:

- 1) Development and provision of training materials;
- 2) Provision of equipment and supplies.

- d. MAURITANIA (\$75,000 in 1989 with 10% annual increments)

To demonstrate feasibility of integrating eye care--including xerophthalmia control--into national health care system, through:

- 1) Nationwide training;
- 2) Development and provision of materials.

- e. NIGER (\$130,000 followed by expansion to \$280,000 annually, at 10% increments)

To demonstrate feasibility of integrating vitamin A program into ongoing health care system, through:

- 1) Undertaking feasibility study in two provinces, with vitamin A capsule delivery, training, public education, monitoring and evaluation;
- 2) Demonstrating social marketing as effective method for improving vitamin A status through increased awareness and behavior change.

- f. SUDAN (\$230,000 for project completion, followed by phase down for vitamin A status monitoring alone at \$5,000 annually)

To assist in the integration of vitamin A activities in refugee populations and Sudanese nationals where indicated through:

- 1) Setting-up system for provision of capsules, training, and education in refugee situations;
- 2) Developing early warning system to assess future needs for vitamin A intervention;
- 3) Assess vitamin A status in Sudanese populations in select areas (i.e., Darfur and Red Sea Provinces);
- 4) Develop program interventions as warranted;
- 5) Make recommendations for future strategies.

- g. OPERATIONAL ASSISTANCE IN AFRICA (\$142,000 for the first year, followed by global expansion at \$500,000 annually)

- 1) Improved skills in vitamin A assessment, monitoring and evaluation;
- 2) Development and utilization of educational materials in training and public promotion;

- 3) Support of regional and national workshops;
- 4) Provision of supplies when necessary;
- 5) Development of roster, and provision of consultants to field projects for vitamin A program assistance.
- 6) Development of strategies and guidelines to integrate vitamin A into PVO projects;
- 7) Information and dissemination of vitamin A reference material and data on PVO experience.

3. LATIN AMERICA AND THE CARIBBEAN (\$600,000 plus gifts-in-kind)

a. HAITI (\$100,000 in 1989 with 10% annual increments)

To examine alternative strategies of improving vitamin A status, through:

- 1) Identifying most feasible method for vitamin A capsule distribution in both urban and rural setting, through problem assessment, social marketing, and improved monitoring;
- 2) Integrate vitamin A programs into existing PVO network in Haiti, through problem assessment, development and provision of materials, training and evaluation.

4. HEADQUARTERS (\$1,900,000)

Program development, management, training and evaluation.

B. CHALLENGE PLAN (\$15,800,000)

The five-year vitamin A challenge plan is essentially the same as the realistic plan for Asia and Latin America. In particular, HKI remains strongly committed to its vitamin A programs in Asia, and is confident that it will be able to access resources to fulfill that commitment over the next five years.

The difference in level of vitamin A resources needed between the realistic and challenge plan (about \$2 million) is an area combining the most needed, and least available resources. HKI intends to expand its programs in Africa--to build on the foundation built only over the last few years--it will seek additional resources from AID, as well as corporate and foundation sources.

The other major area of expansion is the technical assistance initiative. A modest but significant AID grant enabled the agency to build a reputation in offering vitamin A technical assistance to other PVOs, to help them integrate vitamin A activities into their existing field projects in Africa. The effort has been well-received. Resources are being sought to strengthen and expand that activity so that PVO projects globally can access the agency's resources and expertise.

In sum, the five-year challenge budget for vitamin A is as follows:

<u>Asia</u>	\$7,300,000
<u>Africa</u>	\$6,000,000
<u>Latin America And The Caribbean</u>	\$ 600,000
<u>Headquarters</u>	\$2,000,000

V. OVERALL RESOURCE PLAN

A. Staffing:

As indicated in the strategic objectives, a first priority is to audit our existing staffing status: in terms of technical and language skills, full and part-time requirements, headquarters and field resources. Secondly, we need to determine medium and longer-term personnel needs to achieve the proposed objectives. Thirdly, we need to map out a plan of accessing these resources in a timely fashion (i.e., consultant roster, cooperative agreements, advanced travel plans).

B. Funding:

During the entire plan period, HKI should have no particular difficulty in maintaining and/or expanding its vitamin A portfolio. The network of support for these activities is extensive. It includes direct access by HKI to AID grants and to a range of other institutions --- Manoff International and the Academy of International Development, the U.S. Department of Agriculture, Johns Hopkins University -- which also enjoy AID financing and from which HKI draws technical support.

On the Corporation/Foundation side, HKI has relationships and can count on support from donors such as Hoffmann-La Roche, IBM, Band Aid/Live Aid and the International Research and Development Centre/Canada. The Swedish, Danish and British Government and aid agencies also provide funding directly to the field projects. The support network also includes UNICEF which supplies vitamin A capsules to many national programs, and has supported the reproduction of training materials and key training sessions.

In the regional program plans that follow, as shown on Displays D and E, more detail about the magnitude of the vitamin A program is provided. Over the near future, this program accounts for more than 50% of HKI's program portfolio. HKI's headquarters operation is responsible for representation, project development and technical and administrative support for the overall worldwide vitamin A program. In FY-1989, this headquarters unit draws \$295,000 from HKI's unrestricted funds to operate. Over the next several years, every effort will be made to reduce this level of unrestricted funds used by allocating more headquarters expenses, mainly salaries (including part of that for the new medical director and to restricted grant funds. AID has made it evident that it concurs with this step.

SECTION 9

CATARACT PROGRAM

I. STATEMENT OF MISSION

Helen Keller International's cataract initiative aims to dramatically increase the number of sight restoring cataract surgeries in developing countries by assisting indigenous groups to integrate affordable cataract services into the existing health system.

II. BACKGROUND

Cataract is the leading cause of blindness in the developing world. In 1986 the World Health Organization estimated that approximately 17 million people are unnecessarily blind from cataract. Moreover, the disease is becoming more frequent as the world's population grows and ages, and locally available services do not keep up. (Evidence also suggests that cataract develops at an earlier age and with greater frequency in tropical climates). Begun in 1982, HKI's integrated eye care activities have identified cataract as the cause of over 50% of all blindness.

In light of the magnitude of this problem, and because affordable, simple technology exists to surgically remove cataract and restore sight, HKI designated the elimination of the cataract backlog in developing countries as a priority initiative. This new program builds on the agency's long experience in integrating eye care services.

To this end, in June 1986, with assistance from the National Eye Institute (NEI), HKI convened an international workshop to determine operational areas needing attention in order to optimize the delivery of cataract services to the largest number of underserved patients. Research projects appropriate to other organizations, on the mechanisms responsible for causing cataract, were also identified. The results of this meeting were widely distributed to those whose support is vital to the accomplishment of HKI's goal.

HKI's cataract activities are carried out within the context of national health care systems. These cataract activities focus on project development and employ operational research to identify, demonstrate and promote safe, cost-efficient service delivery components. Priority is given to countries in which HKI already has ongoing integrated eye care programs.

Over the past two years HKI has implemented cataract programs in ten countries in Asia, Latin America and Africa (Indonesia, Philippines, Sri Lanka, China, India, Peru, Brazil, Tanzania, Malawi, and Morocco). Exploratory activities are currently underway in three additional countries (Thailand, Nepal and Papua New Guinea). Each project emphasizes the development of technical and management capacities within the host country.

In the Philippines, Sri Lanka and Indonesia, integrated eye care pilot projects are underway, with particular attention to cataract surgical intervention at peripheral hospitals and health institutions (secondary eye care). In Madurai, India, training of hospital administrators is taking place in order to staff and increase the efficiency of satellite cataract hospital units. In China, technical and financial assistance is being provided to two ophthalmic institutes to increase the number of cataract surgeries. In addition, primary health care workers are being trained to identify and refer cataract patients; and the feasibility of using intraocular lenses (IOLs) for out-patient cataract surgery is being explored.

In Peru and Brazil cataract-free zone projects demonstrated that the level of cataract blindness can be greatly reduced in a designated area within a specified period of time. Out-patient surgery has also been shown to be a viable and less costly alternative to in-patient surgery with worldwide implications.

In Malawi, surgical ophthalmic medical assistants are being trained to perform cataract surgery in order to supplement the few full-time ophthalmologists available. This model will be replicated in other parts of Africa. In Tanzania, an integrated eye care/ataract pilot program has been carried out in five villages and is scheduled to expand throughout the Dodoma region and to regional hospitals. In Morocco, a pilot project in the southern province of Ouarzazate trains nurses to identify and refer cataract patients and mobilizes cataract surgical teams.

To most effectively impact the cataract backlog, at an affordable cost, the agency proposes to strengthen its capabilities to address the key components of the problem of treating cataract blindness: identifying and motivating the cataract-blind; providing an effective infrastructure for referral and surgical services; providing follow-up care needed for optimal visual rehabilitation, and; mobilizing national and international efforts to reduce the cataract backlog.

III. STRATEGIC OBJECTIVES

- A. To identify and motivate those blind due to cataract to seek surgery.
 - 1. Explore alternative cost-efficient strategies for identifying cataract-blind people and motivating them to utilize available services.
 - 2. Identify and reduce psychosocial and economic barriers to seeking cataract surgery.
- B. To develop a cost-effective delivery system for cataract surgery and accompanying pre- and post-operative care.
 - 1. Improve access to cataract surgery for all underserved cataract-blind patients.

2. Assist in developing locally appropriate criteria for screening and selection of patients.
3. Assist the ophthalmological community in employing appropriate surgical technology through education and demonstration.
4. Improve operating room organization and logistics to maximize the number of patients being operated.
5. Explore ways to shorten postoperative stay to reduce cost to patient and increase the surgical capacity of the facility.
6. Explore cost-efficient methods for providing essential surgical equipment and supplies.
7. Train selected medical and paramedical workers to refer cataract patients and to provide necessary assistance in cataract surgery and follow-up care.
8. Increase manpower trained to perform cataract surgery in underserved regions. Depending upon host country policy this would entail some or all of the following:
 - a) increasing the number of indigenous ophthalmologists performing cataract surgery;
 - b) training of general surgeons and medical officers;
 - c) training of paramedical personnel, or;
 - d) using expatriate volunteer ophthalmologists to provide assistance.
9. Develop an information system for collecting, monitoring and evaluating data to provide feedback on the safety and efficacy of technical procedures used in cataract surgery.
10. Conduct follow-up studies in several developing countries to evaluate alternative methods, including new techniques such as IOLs, for safety and effectiveness.

C. To restore the best possible visual acuity to post-operative cataract patients.

1. Explore alternative refractive methods for correction of aphakia.
2. Investigate different approaches to making affordable cataract glasses available.
3. Establish a viable agency policy for the use of IOLs and explore the possibilities for their use in HKI programs.

D. To mobilize national and international efforts to reduce the cataract backlog.

1. Establish an international consultative group on cataract following up on the Stonehouse meeting.
2. Convene national and international forums to disseminate and maximize results of cataract program findings.

IV. FIVE YEAR ACTION PLANS

A. Realistic Plan (\$3,000,000)

1. ASIA

a. CHINA \$432,712 (plus Gifts-in-Kind)

- 1) **Zhongshan Ophthalmic Center (ZOC)**
 - Evaluate alternative methods for identifying and motivating cataract blind patients in Xinhuei county. FY-1989.
 - Mobilize cataract surgical teams from ZOC to perform 500 cataract surgeries per year in Xinhuei county. FY-1989.
 - Demonstrate practicability of out-patient IOL surgery in Guangzhou/ZOC. FY-1989.
 - Provide IOL's and cataract sets. FY-1989.
 - Continue to provide technical and financial assistance through FY-1993.
- 2) **Peking Union Medical College Hospital**
 - Train 420 country doctors to identify and refer cataract patients in Shunyi County. FY-1989.
 - Provide assistance to Shunyi County Hospital to increase surgical volume from 200 to 500 cataract surgeries. FY-1989.
 - Provide management training for one staff member. FY-1989.
 - Continue to provide technical and financial assistance through FY-1993.
- 3) **General**
 - Convene national meeting to present operations research findings to Ministry of Health and Chinese ophthalmic community. FY-1989.
 - Publicize HKI-China partnership to PVO community and to generate American community support through FY-1993.

b. INDIA (\$40,400)

- 1) Follow-up on HKI consultant report on possibilities for replication of Aravind Eye Hospital model or expansion of satellite eye hospitals. FY-1989.
- 2) Develop, field test, evaluate curriculum for training hospital administrators at Aravind Eye Hospital, and share outcome with the Indian Health Community. FY-1989.
- 3) Determine ways to maximize impact of Aravind/ University of Chicago and Harvard resident exchange program. FY-1989-93.
- 4) Assess Aravind experience with IOL's: post-operation complications and appropriate technology for IOL insertion through FY-1993.

c. INDONESIA (\$381,000 plus Gifts-in-Kind)

- 1) Continue to support cataract activities in Bali (400 cataract surgeries) and East Java (275 cataract surgeries). FY-1989-90.
- 2) Support the development of Intermediate Level Public Health Ophthalmology Centers in three pilot areas (South Sulawesi, West Java [200 cataract surgeries] and West Sumatra [300 cataract surgeries]). FY-1989.
- 3) Provide needed ophthalmic supplies to health centers providing cataract surgery. FY-1989-90.
- 4) Provide technical assistance in managing operating room logistics for high-volume surgery. FY-1989.
- 5) Assist in developing methodologies to monitor and evaluate different cataract service delivery models. FY-1989-90.
- 6) Continue to provide technical assistance through FY-1993.

d. NEPAL (\$10,000)

- 1) Explore local production of ophthalmic solutions and follow-up on development of anti-microbial. FY-1989.

e. PHILIPPINES (\$180,000 plus Gifts-in-Kind)

- 1) Implement cataract sponsorship program in Metro Manila. FY-1989.
- 2) Continue to sponsor and monitor 3 year Modified Residency Training Program in Bicol region. FY-1989.
- 3) Support Institute of Ophthalmology's outreach cataract sessions in rural areas. FY-1989.

- 4) Develop plan for implementing a cataract spectacles workshop. FY-1989.
- 5) Provide technical assistance in managing operating room logistics for high-volume surgery. FY-1989.
- 6) Provide ophthalmic materials as part of the Gifts-in-Kind Program. FY-1989.
- 7) Support cataract surgery sponsorship program in Metro Manila (patients per year) through FY-1993.

f. SRI LANKA (\$90,000 plus Gifts-in-Kind)

- 1) Expand district level cataract services in Kurunagala. FY-1989.
- 2) Provide technical assistance in managing operating room logistics for high-volume surgery. FY-1989.
- 3) Provide ophthalmic materials as part of gifts-in-kind program. FY-1989.
- 4) Expand district level cataract services in Kurunagala through FY-1993.

2. AFRICA:

a. MALAWI (\$100,000)

- 1) Continue to support and evaluate the Ophthalmic Medical Assistant's (OMAs) training program. FY-1989-90.
- 2) Provide volunteer ophthalmologists to assist in OMA cataract surgery training course. FY-1989-90.
- 3) Establish a low-cost spectacle workshop. FY-1989.

b. TANZANIA (\$75,500 plus Gifts-in-Kind)

- 1) Conduct matching grant evaluation of integrated eye care/ataract program. FY-1989.
- 2) Train nurse auxiliaries and health workers for cataract program. FY-1989.
- 3) Provide ophthalmic surgical equipment and supplies. FY-1989.
- 4) Continue support of cataract surgical sessions in Dodoma region through FY-1990.
- 5) Identify methods for motivating patients to seek cataract surgery. FY-1989.

c. MOROCCO (Financed elsewhere)

- 1) Train nurse auxiliaries to identify and refer cataract patients. FY-1989.
- 2) Support cataract surgery sessions in Ouarzazate province. FY-1989.

3. LATIN AMERICA:

a. BRAZIL AND PERU (\$200,000 plus gifts-in-kind)

- 1) Expand cataract free zone (CFZ) project to additional region in Brazil (Divinalandia) and Peru (Ica). FY-1989-90.
- 2) Provide support for producing cataract glasses in Institute of Ophthalmology, Lima. FY-1989-90.
- 3) Explore feasibility of developing operations manual for implementing CFZs. FY-1989.
- 4) Convene a workshop (WHO, NEI, PAHO, PAAO) to review results of the CFZ studies. FY-1990.
- 5) Provide technical assistance through FY-1983.

4. NEW INITIATIVES (FY-1989-91):

- a. Establish a West African regional training program to train ophthalmic eye nurses and general physicians in cataract surgery. (\$100,000)
- b. Establish low cost eyeglasses manufacturing shops where there is a need for this type of facility. (\$75,000)
- c. Conduct operations research studies. (\$15,000)
- d. Expand cataract program activities to several new countries, i.e. Bangladesh, Burkina Faso, Niger, Bolivia. (\$62,500).

5. HEADQUARTERS (\$1,260,000)

Program development, management, training and evaluation.

B. CHALLENGE PLAN (\$4,440,000)

In addition to the Realistic Plan, the activities listed below would also be added.

1. ASIA:

a. CHINA (\$482,712 plus gifts-in-kind)

Expand to three new cities - Shanghai, Chengdu, and Xian. FY-1989-93.

- b. INDIA (\$60,400 plus gifts-in-kind)
 - Operations research into low-cost package for IOL implants.
- c. INDONESIA (\$441,000 plus gifts-in-kind)
 - Expand to three new provinces. FY-1989-93.
- d. NEPAL (\$50,000 plus gifts-in-kind)
 - 1) Explore providing integrated eye care/cataract services in Mechi Zone. FY-1989-93.
- e. PAPUA NEW GUINEA (\$100,000)
 - 1) Provide support to strengthen regional cataract services. FY-1989-93.
- f. PHILIPPINES (\$230,800 plus gifts-in-kind)
 - 1) Continue action plan A activities 1, 2, 3 and 7 through FY-1993.
 - 2) Expand cataract services to three new regions by FY-1993.
 - 3) Conduct a cost-benefit study to demonstrate the sustainability of integrated eye care/cataract program activities to the Ministry of Health. FY-1989.
- g. SRI LANKA (\$155,000 plus gifts-in-kind)
 - 1) Continue action plan A activities 1 and 3 through FY-1993.
 - 2) Expand cataract services to three new regions by FY-1993.
 - 3) Conduct a cost-benefit study to demonstrate cataract program sustainability to the Ministry of Health. FY-1989.
- h. THAILAND (\$100,000)
 - 1) Explore possible cataract activities and aphakic eyeglasses production. FY-1989.
- 2. AFRICA:
 - a. MALAWI (\$160,000)
 - 1. Continue to support OMAs training course through FY-1993.
 - 2. Continue to provide volunteer ophthalmologists to assist in OMA training course through FY-1993.

b. MOROCCO (\$100,000)

1. Continue to support cataract activities in Ouarzazate province through FY-1993.
2. Expand cataract activities to three new areas by FY-1993.

c. TANZANIA (\$146,500 plus gifts-in-kind)

- 1) Continue to replicate CFZ project through FY-1993.
- 2) Conduct a cost-benefit study to demonstrate the sustainability of integrated eye care/cataract program activities to the Ministry of Health. FY-1989.

3. LATIN AMERICA (\$200,000)

a. BRAZIL AND PERU (Plus Gifts-in-kind)

- 1) Continue support to expand CFZ projects in Brazil and Peru through FY-1993.
- 2) Expand CFZ project to three new countries. FY-1989-93.

4. NEW INITIATIVES (FY-1991-93):

- a. Establish a West African regional training program to train ophthalmic eye nurses and general physicians in cataract surgery. (\$100,000)
- b. Establish low-cost eyeglasses manufacturing shops where there is a need for this type of facility. (\$75,000)
- c. Conduct operations research studies. (\$15,000)
- d. Expand cataract program activities to several new countries, i.e., Bangladesh, Burkina Faso, Niger, Bolivia. (\$62,500).

5. HEADQUARTERS (\$1,960,000)

Program development, management, training and evaluation.

Y. OVERALL RESOURCE PLAN

A. Fund-raising

HKI's cataract program is a relatively new initiative. To date it has been primarily funded by a single donor. To ensure the growth and sustainability of the program a series of fundraising considerations will have to be continually reviewed.

In 1986 and 1987 the Japan Shipbuilding Industry Foundation (JSIF) awarded two grants to Helen Keller International totalling approximately one million dollars for cataract programming costs. Funds from these grants have underwritten the "Stonehouse Report" and supported the initiation of activities such as the cataract free zone studies in Peru and Brazil, and the launching of the China program.

HKI has presented a renewed proposal to JSIF, asking for an additional one million dollars a year for the period 1988-1999 in order to mobilize international resources toward "virtual eradication of cataract" by the year 2000. If this new grant is awarded, program resources will double starting in FY-1990 and extending through FY-1993 and the Challenge Plan in Display E can be realized, expanding cataract relief services into new countries. If these funds are not forthcoming, a conservative program plan based on JSIF's renewal of the \$500,000 a year grant is outlined in the Realistic Plan section of Display D.

In addition, Matching Grant funds have been requested from USAID to underwrite the basic management of country programs in integrated eye care in at least five countries: Morocco, Peru, Philippines, Sri Lanka and Tanzania. Funds realized from this source will be important by providing a platform for increased numbers of cataract initiatives.

Foundation support, with the help of the John O'Donnell Co., will be solicited from those major foundations interested in providing significant support for the eradication of a "curable disease". The impact of cataract blindness on the elderly, the training of medical and surgical manpower, and infrastructure development at the national level, will be emphasized. Corporations, with particular interest in the "cataract free zone" concept, in countries where they may have operations, will also be contacted.

Finally, the concept of individual or corporate "sponsorship" of individual cataract patients will be assessed in terms of potential for fundraising and existing management constraints. Additionally, such groups as American ophthalmologists, successfully treated cataract patients, senior citizen groups, cooperative societies, and churches or religious organizations should be evaluated for possible participation in the effort to eliminate the cataract backlog.

B. Program Management

HKI has established a firm management and administrative base for its cataract programs at HKI headquarters under the Director of Cataract Programs. Also in place is an excellent team to manage current operations and pursue strategic planning. Along with the Director, there are two senior medical advisors from leading U.S. universities, Drs. Alfred Sommer and Louis Pizzarello, a multidisciplinary Cataract Advisory Committee, and Dr. Norval E. Christy as Senior Consultant. Program administration currently

includes an executive secretary, and may be expanded if management needs warrant, to include an assistant to the Director.

The Cataract Advisory Committee, with meetings twice yearly, is convened to review management concerns and policy issues. The members are asked to provide direction in terms of new areas of investigation and overall emphasis. Networking information resulting from Advisory Committee meetings, and relevant information from the National Eye Institute, American Academy of Ophthalmology, WHO and other blindness prevention colleagues will be a priority.

Program initiatives with emphasis on the use of affordable, appropriate technology will be researched and presented for internal and Cataract Advisory Committee review. Feasibility studies and reports in such areas as appropriate use of IOLs, operating microscopes, and low cost production of aphakic spectacles, will be commissioned.

The Cataract Corps concept will be formulated with specific reference to field program needs. Where opportunities arise for placing qualified ophthalmologists in short-term field assignments, they will be pursued.

Funding for this administrative base has increased from \$100,000 in 1986 to \$186,000 in 1987. These costs include all cataract program expenses in addition to all program travel, telephone,, and overhead costs. Fees for medical advisors and consultants are also covered by the grant. In FY-1988 , with consultants added to do operations research, technical assistance and as members of the Cataract Advisory Committee, it is anticipated that a major program definition will take place. In FY-1989, HKI with NEI will host a follow-up meeting to the Stonehouse Meeting to occur concurrently with the IAPB Meeting in Washington.

Public relations and promotional efforts will be launched in FY-1989 to bring attention to cataract blindness in the U.S. and around the world. Administration, medical advisors and public education constitutes 25% of the total cataract program budget and will be held at that level throughout the Five Year Plan.

C. Cataract Program Costs

Cataract program "front-loading" costs--those investment costs used either for operations research, equipment, training, or managing of cataract programs--have been expended in Latin America, Asia and Africa. These costs reflect an approximation of what it costs to initiate a program in a given country and total up to 65% of a given country program budget. The remaining 10% is a cost attributed to subsidies for the patient's surgery in the form of surgical disposables, transport and/or aphakic spectacles.

As a result of substantial investment, HKI plans to maximize future grants by aiming at a greater return on the initial investment through dramatic increases in the numbers of cataract operations in program where "front-loading" costs have been invested.

SECTION 10

EDUCATION AND REHABILITATION PROGRAM PLAN

I. STATEMENT OF MISSION

HKI's objective is to improve the quality of life of blind and visually impaired persons in developing countries and to assure that such persons have access to appropriate education and rehabilitation.

II. BACKGROUND

Helen Keller International was founded with the objective of responding to the needs of blind persons. While the approaches the agency has used to achieve this objective have changed over time; the agency, for almost seventy-five years, has led the way in innovative approaches responding to the needs of blind and visually impaired persons in more than eighty countries. Throughout its history the values, commitment and spirit of Helen Keller have been its guiding force. The liberating effect of education, the dignity of work and the importance of shaping positive public attitudes toward the blind continue to be integral to all our efforts.

While the initial efforts of the founders of this agency were to meet the needs of the Allied war blind following World War I, the lessons learned as those programs were developed help to significantly shape the future of rehabilitation for the blind in Europe and the United States. Over the next forty years, with Miss Keller as a role model and guiding force, the conscience of world leaders was awakened to the needs and rights of disabled individuals to be more than the object of charity and pity. The schools, rehabilitation centers, braille presses and sheltered workshops that were developed by HKI along with the vital personnel resources that were trained to staff them have become the foundation of the infrastructure in many developing countries.

In the late 1960's, recognizing that institutionally based services could never hope to meet the needs of the vast numbers of blind persons requiring education and/or rehabilitation HKI became the first international agency to explore and develop approaches to meeting the education and rehabilitation needs of blind persons in their own communities using the services of non-professional staff. This innovation was initially viewed with great skepticism, but over the past twenty years has become the most widely accepted approach to meeting the needs of disabled individuals within the developing world and has been adopted as policy by many governments and by the World Health Organization.

With increasing acceptance of the community based philosophy and approach to education and rehabilitation the challenge over the coming decade is to provide the leadership to develop more efficient and sustainable program models which achieve the integration of services for the disabled into broader economic and community development initiatives. This will require the development evaluation, and documentation of several new approaches for delivering education and rehabilitation services at the community level using existing community resources rather than specialized fieldworkers who only serve blind individuals.

As HKI's efforts in education and rehabilitation move forward to meet this new challenge the work of the Division of Education and Rehabilitation will be guided by the following principles:

1. All specialized services shall assist blind persons to gain access to the same infrastructures and development efforts available to non-disabled citizens.
2. The consumer shall play an active and central role in the development of education and rehabilitation services.
3. All education and rehabilitation programs will make every effort to utilize local and regional staff with particular attention to the employment of disabled individuals.
4. HKI education and rehabilitation programs will actively seek collaboration with other national, international and intergovernmental agencies to make maximum use of existing personnel and material resources.
5. HKI education and rehabilitation initiatives will be integrated with ongoing blindness prevention initiatives wherever possible.

The work of the Division is at an exciting crossroad as it moves to address services to disabled persons within the context of "generation three" development initiatives. While HKI's work in conceptualizing and developing community based approaches has received wide acclaim we must not lose sight of the fact that services to disabled persons remain a low priority within the broad context of the field of development. This is reflected in the priorities of most governmental and intergovernmental donor agencies.

With this important fact in mind, the three to five year strategic plan focuses on consolidation and strengthening existing program initiatives, with the development of only a modest number of new initiatives in additional countries. This strategy will allow HKI fund raising initiatives the time necessary to generate revenues to support broader program expansion.

III. STRATEGIC OBJECTIVES

The strategic objectives of the Division are directed at one or more of the following developmental goals:

- Providing material assistance that will substantially increase the percentage of blind persons with access to education and/or rehabilitation
 - Enhancing institutional capacity that will have impact at a district or regional level.
 - Creating policy impact at the National level which assures equilization of opportunity for blind and visually impaired persons.
- A. To place top priority over the next 3 to 5 years on the consolidation, evaluation and documentation of existing programs in the Asia/Pacific and Caribbean Region. (See Action Plan)
- B. To revise the community based rehabilitation programs in two regions of Peru based upon findings of recently completed evaluations.
1. Retrain existing workers along with a cadre of replacement workers, implement a new monitoring and evaluation procedure and measure results on or before December, 1989.
 2. Develop a series of public education messages and materials for use in program expansion efforts in other Regions of Peru and elsewhere in the Latin American Region.
 3. Develop and implement, with the Peruvian Ministry of Health and PAHO, a plan to expand CBR services to other disability groups in at least one Region of Peru
- C. To develop in three demonstration projects new and innovative service delivery systems with particular attention to the issue of sustainability.
- D. To develop field test and disseminate a limited number of public education and professional training materials.
1. Three to five training manuals for use with non-professional personnel
 2. Two training videos and one public education video.
- E. To plan and develop (on funds available basis) a West Africa Regional initiative in education of the blind.
(See Africa Regional Plan)
- F. To provide technical assistance to "non-disability" agencies to assist them in including blind individuals into broader community health and development programs.

An action plan detailing the cost of these program initiatives under the realistic plan follows.

IV. REALISTIC ACTION PLAN 1989-1993

<u>PROGRAM DEVELOPMENT AND MANAGEMENT:</u>	<u>FY-1989</u>	<u>FY-1990</u>	<u>FY-1991</u>	<u>FY-1992</u>	<u>FY-1993</u>
HKI / NY Core Costs	\$ 182,000	248,000	356,000	356,000	396,000
Field Core Costs	44,000	(Funded by Regional Initiatives.)			
Publications Development	-----	30,000	50,000	50,000	65,000
Leadership Development	-----	20,000	50,000	50,000	70,000
<u>ASIAN PROGRAMS:</u>					
General Regional	\$ 15,000	50,000	100,000	130,000	150,000
China	16,000	30,000	50,000	70,000	75,000
Indonesia	8,000	15,000	30,000	50,000	50,000
Nepal	52,000	100,000	100,000	25,000	25,000
Papua/New Guinea	95,000	95,000	(Funded by Regional Initiatives)		
Sri Lanka	11,000	25,000	40,000	40,000	40,000
Thailand	132,000	125,000	50,000	50,000	50,000
<u>AFRICAN PROGRAMS:</u>					
General Regional	\$ -----	20,000	30,000	30,000	50,000
Tanzania	10,000	20,000	30,000	30,000	30,000
Kenya	9,000	25,000	25,000	25,000	25,000
<u>LATIN AMERICAN PROGRAMS:</u>					
General Regional	\$ 55,000	70,000	50,000	50,000	50,000
Peru	17,000	25,000	40,000	40,000	40,000
Haiti	51,000	20,000	30,000	30,000	30,000
Jamaica	7,000	15,000	25,000	25,000	25,000
<u>EDUCATIONAL AND REHABILITATION PROGRAM TOTALS:</u>	\$656,000	918,000	1,165,000	1,051,000	1,171,000

V. OVERALL RESOURCE PLAN

This financial plan is based upon a mix of resources which includes grants from USAID which will provide the majority of support for initiatives in Thailand, Papua New Guinea, Peru, Sri Lanka and Tanzania. We anticipate modest increases in support available from PACT which currently contributes to our Nepal and Haiti programs. Support from foundations such as that which has been secured from the International and Freuauff during FY'88 is expected to increase with the assistance of our fund raising consultants. We also hope that a special effort will be made to secure additional unrestricted resources through direct mail and telemarketing initiatives for initiatives which have a special appeal, such as our work in the Peoples Republic of China.

We feel the situation of disabled persons, particularly children, in developing countries has a powerful, and yet to be fully tapped potential.

We will continue to utilize HKI's unrestricted funds to leverage contributions to our work from a variety of partnerships which have been developed with organizations such as CBM, RCSB, Perkins, PAHO, UNESCO etc.

During the period covered by this plan; particularly during the third, fourth and fifth years, we expect that a continued growth in USAID support, combined with increased revenues generated HKI fund raising strategies will allow us to achieve the stated balance in the overall agency portfolio of 30% education and rehabilitation to 70% blindness prevention.

SECTION 11

INTEGRATED EYE CARE IMPLEMENTATION STRATEGY

I. IMPLEMENTATION STRATEGY

HKI's eye care programs are designed to address the greatest needs in each country within which it works.

Thus, the program in a particular country may focus on:

- Vitamin A deficiency;
- cataract relief services;
- trachoma prevention;
- rehabilitation services for the blind;
- education for blind children, or;
- general enhancement of eye care services.

In addition to any programmatic focus however, HKI's implementation strategy is to upgrade eye care services utilizing a systematic approach to the introduction of the eye care and rehabilitation and education services for the blind. Aspects of the implementation strategy include strengthening of eye health service delivery through training of eye health workers at various levels in the health infrastructure; operational and programmatic research; transfer of appropriate technology; public education to promote community awareness and cooperation in the prevention of eye disease; and monitoring and evaluation to make constructive changes for improvement of overall programs.

II. IMPLEMENTATION PLAN

HKI's overall program purpose is to act as a catalyst for the integration of eye care services which would be available to all people in developing countries. HKI's programs will be designed to fit the specific needs of the country concerned respecting the following objectives:

- Programs will address the leading causes of blindness in the country in order to assist the greatest number of people with the most efficient and cost-beneficial use of available manpower and resources.
- Activities to strengthen primary, secondary, and tertiary eye care services at various levels will be integrated and institutionalized within the existing health infrastructure.

- Programs will, from the outset, include participation of members from various levels of the health infrastructure and will aim to support and strengthen the referral network.
- Programs will be designed and implemented with respect to the use of available, affordable, and appropriate technology within the country concerned.

III. LEVELS OF EYE CARE

HKI seeks to enable the training of personnel, the bolstering of health resources, and the strengthening of the health infrastructure at a variety of levels ready for the integration of eye care services.

A. Primary Eye Care

Train village health workers and dispensary nurses at the secondary level to recognize and treat conjunctivitis, trachoma and xerophthalmia. Recognize and refer cataract, painful red eye, eye injuries, and vision worse than 6/18. Provide them with tetracycline eye ointment, vitamin A capsules, examining torch, vision charts, eye pads and tape, etc. Give them tools and training to do preventive community education. (HKI currently does this in Sri Lanka, the Philippines, Indonesia, and a number of other countries).

B. Secondary Eye Care

The provision of services to manage cataract, trichiasis/entropion, severe eye infections, and ocular trauma. This can be provided at secondary and tertiary facilities by ophthalmic assistants, such as "Ophthalmic Clinical Officers" (Kenya), "Assistant Medical Officers-Ophthalmic" (Tanzania, such as Dr. Mmbaga), "Ophthalmic Technicians" (Mauritania), general practitioners who have been trained in eye care, or ophthalmologists working at secondary and tertiary levels. (In Sri Lanka, HKI has sent an ophthalmologist to Colombo for specialized training, provided surgical equipment to the ophthalmologist in Kurunegala, as well as a slit lamp, and other equipment to upgrade the services in the Kurunegala Eye Clinic).

C. Tertiary Eye Care

The WHO states that specialized eye care requiring sophisticated equipment, and specialized staff to perform such services as corneal transplant surgery and repair of retinal detachment should be carried out by ophthalmologists in a tertiary facility, such as a national or university hospital. In reality, ophthalmologists can be found at secondary level facilities performing such surgery, if the facility has the sophisticated resources necessary.

Research related to the delivery of eye care, technical leadership, and training of ophthalmologists all falls under tertiary care. (In the Philippines, HKI supports the modified residency training program at the Institute of Ophthalmology, and has implemented research studies in Indonesia, Bangladesh, and other countries where the results will benefit program planning).

In some countries, HKI assists in the implementation of general eye care programs, and rehabilitation (Philippines and Sri Lanka). Integration of rehabilitation services for the blind vary from country to country. For example, in Sri Lanka, HKI is working through an indigenous organization, the Sarvodaya movement, to train its workers to be trainers of community based rehabilitation. In Indonesia, HKI provides technical assistance and resources to the Ministry of Social Service to enhance the services available to the blind.

The bottom line for HKI is to be flexible and creative in the way it designs and implements appropriate and affordable country-specific programs in the interest of sustainability and replicability.

IV. FIVE YEAR ACTION PLANS

The Integrated Eye Care Action Plan primary comprises Primary Eye Care, Cataract, Education and Rehabilitation activities, detailed in the separate program plans: Cataract, Education and Rehabilitation, and vitamin A funding comes primarily through USAID Matching Grant and Foundation/Corps (Dollar amounts reflect grand totals under Realistic Plan and Challenge Plan.)

A. Realistic Plan (\$4,202,252)

1. ASIA (\$2,111,610)

a. INDONESIA

- Pilot program to implement integrated eye care scheme on East Java. FY-1989-90.
- Training in primary eye care and referral for comprehensive cataract service in Bali. FY-1989.
- Develop public health ophthalmology centers in West Java/West Sumatra. FY-1989.

b. PHILIPPINES

- Expand Integrated Eye Care Services in Bicol Region. FY-1989.
- Continue Modified Residency Training Program. FY-1989.
- Continue Cataract Sponsorship Program in Metro Manila. FY-1989.

c. SRI LANKA

- Expand Integrated Eye Care Services in Kurunegala District. FY-1989.
- Maintain five cataract operating sessions in Kurunegala. FY-1989.
- Integration of rural rehabilitation services through Sarvodaya and SHIA. FY-1989.

2. AFRICA (\$739,895)

a. MALAWI

- Train primary health care workers in vitamin A deficiency, recognition and distribution methods. FY-1990.
- Support for Ophthalmic Medical Assistants. FY-1989-90.
- Evaluation of OMA training. FY-1990.

b. MOROCCO

Expand Mobile Cataract Services to Errachidian Region. FY-1989- 93.

c. TANZANIA

- Expand Integrated Eye Care Services concept in Dodoma Region. FY-1989.
 - Training in primary eye care/cataract referral for health workers. FY-1989.
 - Conduct regular cataract surgery sessions monthly. FY-1989.
 - Train village health workers in CBR. FY-1989.
 - Logistic support ICEPO Trachoma intervention. FY-1989.

3. LATIN AMERICA (\$509,210)

a. PERU

- Expand Integrated Eye Care Services in Puno, Ancash, and San Martin region. FY-1989.
 - Continue support of health workers, ophthalmologists, and rehabilitation workers through MOH and OPELUCE. FY-1989.
 - Set up Aphakic Spectacles Production Workshop in Lima. FY-1989.

-- Set up CFZ Project in ICA. FY-1989.

4. FIELD - GENERAL (\$260,000)
5. HEADQUARTERS (\$581,357)

Program development, management, training and evaluation.

B. CHALLENGE PLAN

In addition to activities carried out under the Realistic Plan, the following activities will be added. (Dollar amounts reflect grand totals.)

1. ASIA (\$2,642,186)
 - a. INDONESIA
 - Expand Public Health Ophthalmology Centers. FY-1989-93.
 - Continue technical and financial assistance to MOH through Public Health Program. FY-1989-93.
 - b. PHILIPPINES
 - Monitor and provide support to Integrated Eye Services in Bicol region. FY-1989-90.
 - Replicate Bicol model in additional regions. FY-1989-93.
 - Provide technical and financial support for the establishment of the Modified Residency Training Program in new regions. FY-1989-93.
 - Continue Metro-Manila Cataract Sponsorship Program. FY-1989-93.
 - c. SRI LANKA
 - Replicate Kurunegala District's Integrated Eye Services in new region. FY-1989-93.
2. AFRICA (\$767,295)
 - a. MALAWI
 - Provide technical and financial assistance to OMA Training Program for expansion service to Southern Africa regions.
 - b. TANZANIA
 - Continue expansion of Integrated Eye Care Services in Dodoma Region. FY-1989-93.

3. LATIN AMERICA (\$653,635)

a. PERU

- Continue expansion of Integrated Eye Services in Puno, Ancash, and San Martin. FY-1989-93.

b. REGIONAL

- Expand Integrated Eye Services to new Latin American regions. FY-1989-93.
 - Develop implementation of CBR Training. FY-1989-93.
 - Develop CFZ replication. FY-1989-93.

V. OVERALL RESOURCE PLAN

The Integrated Eye Care approach is built into many of HKI's blindness prevention activities, including Vitamin A Programs. Integrated Eye Care also takes form in specific projects which provide "Full Service" care in whatever eye diseases are prevalent in a given country. HKI's Matching Grant activities in Peru, Sri Lanka, Morocco, Tanzania, and the Philippines, and three projects in Indonesia are such specific Integrated Eye Care Programs.

In both the Realistic and Challenge Plans, from AID, the agency projects building such programs from a FY'89 level of \$280,000 to a FY'93 level of \$540,000. With corporation and foundation funds, in the Realistic Plan, it is expected that today's annual level of \$340,000 in this category, can be maintained and shifted to initiate at least one Latin American program, with a \$340,000 level by FY'93.

The challenge plan makes this same shift, but projects a 25% annual increase above the Realistic Plan level.

SECTION 12

AFRICA PROGRAM PLAN

I. STATEMENT OF MISSION

Helen Keller International's goal in Africa is to catalyze interest and to develop technical and managerial capacities within African countries to prevent blindness, restore sight and to rehabilitate and educate the incurably blind and visually impaired.

II. BACKGROUND:

A. Blindness Prevention and the Restoration of Sight:

HKI currently has active blindness prevention programs in eight countries in Africa (Burkina Faso, Ethiopia, Malawi, Mauritania, Morocco, Niger, Sudan, and Tanzania), and provides technical assistance in vitamin A control deficiency to NGOs in five other countries.

The oldest of the present programs of HKI in Africa is that in Tanzania. The Tanzania program is a small, village-based, primary eye care program which concentrates primarily on the blinding diseases of cataract and trachoma. Other, more recent, primary eye care/cataract initiatives are in Morocco, where HKI has a demonstration project in the southern province of Ouarzazate, and in Malawi where HKI is participating in the training of ophthalmic medical officers.

The majority of the programs in HKI's Africa portfolio are direct or indirect outgrowths of HKI's response to the famine emergency in the Sahel and the Horn of Africa in 1984-85. At that time, at the request of the Centers for Disease Control, HKI became actively involved in the control of vitamin A deficiency, and to a lesser extent trachoma, with others in the relief community in Ethiopia and Sudan. Beginning in February 1986, HKI conducted rapid assessments of vitamin A deficiency and trachoma in four Sahelian countries -- Burkina Faso, Chad, Mali, and Niger. HKI now has vitamin A and/or trachoma control efforts underway in Burkina Faso, Niger, Mauritania, Sudan and Ethiopia, and provides technical assistance to PVOs in Mali and Senegal.

Africa is a vast continent where most of the world's blinding diseases - cataract, glaucoma, trachoma, xerophthalmia, and onchocerciasis - are highly prevalent. Relatively limited reserves of trained manpower and relatively weak health infrastructures are among the constraints to launching effective blindness prevention programs. Of course, there are always financial constraints

as well. However, there is a great deal of interest within governments and public health communities in providing blindness prevention services to the public.

A number of international blindness prevention organizations are active in Africa, but are concentrated in the east from Ethiopia down to Malawi. With its foundation in place, HKI is in a unique position to strengthen efforts in West Africa.

B. Education and Rehabilitation of the Blind and Visually Impaired:

HKI was active in Senegal and Liberia in the 1970s in the area of integrated education for blind children. HKI was also instrumental in making a number of braille presses available to several African countries. HKI is currently investigating a number of opportunities to become active in Africa in education and rehabilitation of the blind and visually impaired, most immediately in Kenya and Tanzania. Again, the interest is great, as demonstrated by the recent formation of an Africa Union of the Blind (the regional unit of the World Blind Union), but assistance, both technical and financial, is needed.

III. STRATEGIC OBJECTIVES

A. Overall objectives

1. HKI plans to consolidate its activities in countries where HKI is already active, where the need is great and the government has demonstrated a commitment to action, in the interest of making the greatest impact in the Africa region.
 - a) An analysis of the environment of present countries where HKI is active and new countries will be performed in 1988 to determine future involvement and/or new opportunities.
 - b) Priority attention will be given to HKI's current country projects, most of whose financial support ends during FY 1989.
 - c) Priority for expansion will be given to West Africa countries where HKI is already active, due to the relative lack of blindness prevention and rehabilitation groups active in the region, the great need and interest demonstrated by those in the region, and HKI's unique present position.
 - d) Ideally, as a long range objective, HKI would like to provide a full range of services in blindness prevention, restoration of sight, and education and rehabilitation of the blind in each African country where HKI is active.
2. HKI aims to continue a trend of filling strategic managerial and technical positions in Africa with African professionals.
 - a) HKI will develop a resource bank of technical and managerial professionals for consultancies in programs and operational assistance in the period '89-91.

- b) HKI will decide upon a solution to the question of regional management of its projects in Africa with HKI country representatives in FY'89.
3. HKI will collaborate with other NGOs, whether international or local, which can effectively integrate some blindness prevention or rehabilitation strategies into their programs.
 - a) Extensive collaboration with NGOs is being undertaken in the control of vitamin A deficiency through the operational assistance program. HKI hopes to expand this program to include assistance to all NGOs in those countries listed by WHO as having a serious vitamin A deficiency problem.
 - b) HKI will continue to share information and plans with other international agencies committed to similar goals (RCSB, IEF, CBM, OEU, etc.) but will attempt to not duplicate efforts of partnership organizations.
 4. HKI will develop a management manual and training seminars to assist MOHs to write proposals and budgets to seek independent funding for activities.

B. Objectives for Vitamin A program in Africa

The strategic objectives for HKI's Vitamin A deficiency control program are outlined in the Vitamin A Strategic Plan (section "8" of this document). Below are objectives in vitamin A deficiency control specific to Africa.

1. Continue to collaborate with governments and research groups to address vitamin A deficiency in the Sahel of Africa (Mauritania through Ethiopia).
2. Continue to identify effective strategies (both short and long term) of controlling vitamin A deficiency in various environments in Africa (especially in countries with weak primary health care infrastructures).
3. Serve as a resource and liaison during emergency situations by making information, contacts, materials and/or capsules available to relief organizations. Establish an informal early warning system to anticipate food deficit emergencies in African countries.
4. Disseminate information about vitamin A deficiency in Africa through operational assistance to U.S. and indigenous organizations and through documentation of on-going projects.
5. Strengthen vitamin A technical capabilities available for operational assistance both at headquarters and in resource bank.

C. Objectives for Trachoma Control in Africa

Considering the high prevalence of trachoma in the countries where HKI has projects, HKI will begin in the next five years to address the disease more vigorously. Below are the two main objectives in the control of trachoma:

1. Pursue opportunities to examine various trachoma control interventions (health education and improved hygiene vs. community- or school-based tetracycline distribution) in Africa both through program implementation and evaluation, and applied research. Attempt to link trachoma prevention activities to water and sanitation projects.
2. Provide training and support for qualified nurses/ophthalmic technicians to perform T/E operations in rural areas (where permitted).

D. Objectives for Integrated Eye Care/Cataract Strategies in Africa

The strategic objectives for HKI's integrated eye care and cataract programs are developed in the Cataract Program Plan in section "9" of this document. Some objectives to highlight are as follows:

1. Attempt to develop an integrated eye care/ataract component in each HKI program in Africa.
 - a) Integrate a new primary eye care/ataract component in 2-3 HKI Africa projects over the five year period choosing those countries with a defined blindness prevention scheme and a clear idea of the assistance they wish from HKI.
 - b) Address the physical barriers to efficient provision of eye surgery to rural populations such as accessibility of the service, adequacy of surgical facilities and bed space, and adequacy of skilled manpower.
2. Evaluate manpower needs and resources in each country where HKI intends to develop an integrated eye care/ataract program in order to determine where HKI can best place its efforts.
 - a) Evaluate Ophthalmic Medical Assistant's training program in Malawi to determine how this course can best meet needs in other African countries.
 - b) Review ophthalmic technician training program in Bamako, Mali (Institute of Ophthalmology in Tropical Africa). Examine where and how graduates are now functioning in West African countries to see if HKI can give support which will enhance their services to their respective countries.

- c) Explore the possibilities of training general surgeons and/or medical officers to perform cataract surgery. Ensure schemes to return trained personnel to underserved areas.
 - d) Continue to train primary level personnel in basic eye care while supporting the referral level personnel where necessary.
3. Develop lists of needed drugs, supplies and equipment in collaboration with local Blindness Prevention Committees or institutes.
 - Increase the donation of ophthalmic materials and supplies to all countries in Africa where HKI is active through the gifts-in-kind program.
 4. Investigate regional center for the production and distribution of low-cost eye glasses.

E. Objectives for Onchocerciasis

1. Continue to follow progress of research in use of the drug Mectazin with a view to possible incorporation into HKI programs.
2. Explore, with partnership agencies, the feasibility of various intervention strategies for the control of onchocerciasis with Mectazin.

F. Objectives for Education and Rehabilitation of the Blind and Visually Impaired

1. Based upon available resources, identify two to six countries for HKI involvement with the idea of making a two year commitment.
2. Concentrate on the following two areas:
 - a) teacher training and primary school education
 - b) community based rehabilitation.
3. Seek countries for involvement where some work is already being done, and the policy or political climate is compatible with HKI's mode of operations.

IV. FIVE YEAR ACTION PLANS

The Five Year Action Plans for Africa is currently projected are detailed in the action plans for each of the program areas.

In 1989 HKI program staff will plan a strategy for the development of a management manual and training program for counterparts in Africa. Possibilities include hiring consultants or working with PACT.

The exact nature of the Africa program over the next five years however depends upon a number of variables:

- a) the performance of the current programs,
- b) the needs in the current countries where HKI is active and in the selected new countries,
- c) the resources available at HKI - both financial and managerial - for the Africa program.

It is considered preferable to develop strong programs in a manageable number of countries (such as six) than to expand into many new countries and not be able to give each country adequate support and resources.

HKI plans to continue with its present program commitments as per individual country plans of action. Grants which cover the costs of the majority of HKI's current programs expire during FY 1989. HKI plans to continue after 1989 in all of these countries, although in some cases (such as in Ethiopia and Sudan), the mode of operation will most likely change. This assumes that HKI will be able to find additional resources at the current level of funding to continue programs beyond FY 89.

New initiatives both within existing countries and in new countries will focus on meeting the indicated program objectives. Decisions will be made jointly by headquarters management and program staff, and field staff and counterparts from the countries in question, during semi-annual meetings to review new requests and proposals.

V. OVERALL RESOURCE PLAN

HKI's programs in Africa, a continent with extraordinary needs, are all relatively new. The main challenge is to use HKI's existing projects as a base for solidifying and expanding programs in Africa. In terms of funding, this means that HKI must at least maintain its present level of commitment. This requires refinancing HKI activities in present countries of operation and continuing the already existing program of regional technical assistance in vitamin A. In this process, existing programs, many of which now concentrate solely on vitamin A, would be broadened wherever possible to include integrated eye care, cataract and rehabilitation and education. Display D in its realistic projection indicates an increase of 5% annually in funding from Corporations/Foundations and a significant

jump in AID funds within which this broadening of HKI's portfolio would occur. Both of these increases are quite feasible with concentrated attention to proposal writing, representation and the coordinated efforts of headquarters and HKI field staff already serving in Africa. The only specific difficulty in attaining the minimally increased Corporation/Foundation level is that one of the donors now supporting HKI programs in Ethiopia and Mauritania, USA for Africa, may be dissolved in the next year (it was set up during the emergency).

The challenge level in Displays D and E would require an even more intense effort and the addition of headquarters staff to free the Africa Regional Manager to devote more time to the development of a wider range of funding sources.

At either the realistic or challenge levels, HKI will attempt to maintain a balance between USAID and private grants in its funding for Africa.

SECTION 13

ASIA-PACIFIC PROGRAM PLAN

I. STATEMENT OF MISSION

Helen Keller International's goal in the Asia-Pacific region is to help build and reinforce the indigenous capacity to prevent blindness, restore sight, and educate and rehabilitate the incurably blind.

II. BACKGROUND

A. Blindness Prevention and the Restoration of Sight

HKI has active blindness prevention programs in the Philippines, Sri Lanka, Papua New Guinea, Indonesia and Bangladesh. Each of these countries has a full time country director and supporting staff.

As can be seen in Display G, following this section, the programs in the Region consist of similar blindness prevention efforts (Primary Eye Care, Secondary Eye Care/Sight restoration, and Vitamin A Deficiency Control). The emphasis of program thrusts, however, varies from country to country. The galvanized international attention to Vitamin A has led to the support of programs to control xerophthalmia, nutritional blindness, and Vitamin A deficiency, and allowed for significant HKI program development in the Region.

Since the early 1970s, Indonesia has been HKI's mainstay program in blindness prevention in the Region, and was where much of the Vitamin A pioneering work took place. From Indonesia, HKI expanded the Vitamin A activities into Bangladesh and the Philippines.

In the early 1980s, HKI began a series of model integrated eye care programs in the Region. HKI worked with the Government of Fiji, who has successfully implemented and integrated PEC into its national system. The program trains nurses and community health workers to prevent, treat where possible, and refer eye problems.

At that same time, programs were initiated in the Philippines and Sri Lanka, focusing on the modeling of primary eye care activities integrated into national health ministries. Training of health workers (physicians, nurses, midwives, health volunteers) to identify early signs of eye problems for treatment or referral is a major program emphasis. Local hospitals and clinics are also set up with equipment and supplies for treating secondary and tertiary eye referral cases. The experiences of these model activities provide direction for expansion programs in other provinces of the country.

Papua New Guinea is in the final planning stages in the development of a blindness prevention program, and is gathering experiences from within the Region for program development.

HKI has established a good foundation of blindness prevention activities. In each country, HKI has helped create an awareness of the issue of blindness in the public governmental sector. This has led to a growing commitment and enthusiasm for blindness prevention activities by country counterparts .

Systems are now in place to expand services to other underserved populations in desperate need of eye health services.

B. Education and Rehabilitation of the Blind and Visually Impaired

Early HKI activities in the Region centered around Rehabilitation. Field staff were assigned to the Regional office in Malaysia and made periodic trips to individual countries to assist in setting up programs. These original "pioneers" established good relations in the Region, and were seen as being beneficial technical experts who helped country counterparts to "get the show on the road" in the areas of community-based rehabilitation and integrated education.

In the 1970s, HKI worked closely with the Government of Indonesia in an integrated education program, mainstreaming education of the blind within the regular government system. In the 1980s, HKI worked with the Government of Fiji to successfully implement a national community-based rehabilitation program for adults and integrated education program for children.

Currently, HKI supports programs for rehabilitation/education in Nepal, Papua New Guinea, Philippines, Sri Lanka, and Thailand.

III. STRATEGIC OBJECTIVES

A. Overall Objectives

- 1. Country-specific and Agency Directions: to review activities in the Asia-Pacific Region and plan to refine and consolidate strategies to integrate sustainable programs.**
- 2. Communication and Support systems - to develop a well structured and organized support system between HKI headquarters and the field programs**
- 3. Positive Attitude and Team Building Efforts- to develop HKI as a positive and cohesive unit consisting of headquarters and field staff.**
- 4. Fund Raising for Long Term Financial Viability of HKI - to expand funding sources to Multinational Corporations working in countries where we have programs or where they have interest.**

B. Objectives for Community Eye Health in the Asia-Pacific Region

1. **Vitamin A Deficiency** - to motivate, catalyze and assist in-country agencies/organizations to develop and implement programs to control and prevent xerophthalmia, nutritional blindness and Vitamin A deficiency in countries at high risk. In addition to an integrated strategy--within an existing primary health care system--alternative approaches will be field-tested. These include food fortification, social marketing, and home gardening.
2. **Sight Restoration** - to help reduce the prevalence of remediable blindness by packaging appropriate activities for direct intervention. To train for the human resources identification and referral of blind persons.

C. Objectives for Rehabilitation and Education of the Blind and Visually Impaired

1. **Community Based Rehabilitation** - to catalyze an integrated community based rehabilitation program in selected priority areas through the social services structures to develop replicable models for implementation within the action region.
2. **Integrated Education** - to undertake similar approaches as the CBR program within the special education structures.

IV. FIVE YEAR ACTION PLANS

The Five Year Action Plans for the Asia/Pacific Region are included in the action plans for Vitamin A, Cataract, Education and Rehabilitation, and Integrated Eye Care.

V. OVERALL RESOURCE PLAN

HKI's financial picture in Asia is good. The agency already has significant programs in most key countries of the region, and has built an excellent track record with donors interested in these countries.

HKI's financial strategy in the region includes two major elements: a leveling of AID support, and a expansion of corporate and foundation funding.

The first, a leveling of AID support at approximately \$1.8 million annually, is proposed in both realistic and challenge plans. This amount provides support for a wide range of programs in all three sectors, Education/Rehabilitation, Integrated Eye Care, and Vitamin A/Child Survival, for what AID support is presently drawn. What will be required to maintain this level, will be to devise and propose to AID new projects that take already funded activities into their next logical iterations.

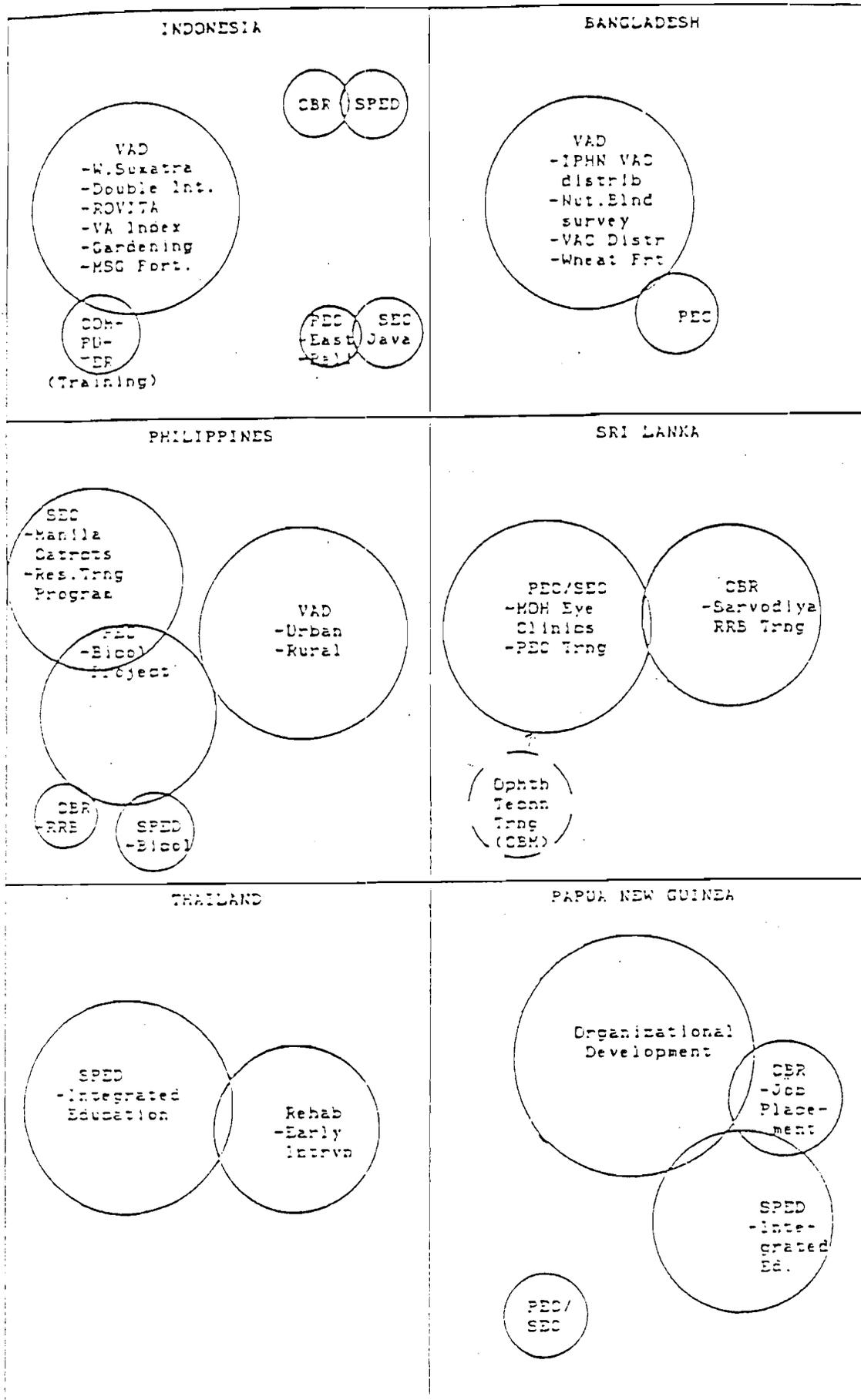
For example, in Indonesia the already ongoing fortification project, which has the objective of testing marketing and pricing strategies, will be completed in FY'91. If the project is as successful as the feasibility trials suggest, the next step will be to support a national strategy to produce and market the product, Vitamin A fortified MSG, nationwide. HKI's next program would likely deal with particular issues involved in that major initiative. In addition, once the project in Indonesia has resolved some of the technical and logistic issues involved in MSG fortification, HKI will work with other countries in the Region (i.e., the Philippines) to determine the applicability of a fortification initiative there.

Similarly, in social marketing, HKI is working with pilot efforts in nutrition education and the use of mass communications to bolster Vitamin A consumption in Indonesia, Bangladesh, and the Philippines. This pilot work will definitely require follow-up programs in each country.

The second element of HKI's financial strategy concerns corporate and foundation funding. Here again, HKI has enjoyed a wide range of support. In FY'89 thirteen separate donors are providing over \$720,000. Six of these donors were identified, and all arrangements for the grants were made by HKI's Country Directors in-country.

The expectation is that the combined and coordinated efforts of headquarters and field staff, overseen by HKI's new Asia Regional Manager and others at headquarters, will insure that this level of support is FY 91-FY'93 can not only be maintained but expanded. The realistic projections indicate a 5% increase; the challenge projection indicates a 20% increase over present levels. Either of these levels of corporation/foundation funding will allow HKI to continue to supplement HKI's major AID financial activities, and in many case provide part of the "Matching" funds for AID grants.

CURRENT HKI PROGRAMMATIC THRUSTS IN THE ASIA-PACIFIC REGION



SECTION 14

LATIN AMERICAN/CARIBBEAN PROGRAM PLAN

I. STATEMENT OF MISSION

Helen Keller International's goal in Latin American and the Caribbean is to build indigenous capacity to effectively address blindness prevention and education/rehabilitation of the irrevocably blind in a limited number of program settings which provide the potential for impact within those countries and elsewhere in the Region.

II. BACKGROUND

HKI has had a presence and programs throughout the Latin American/Caribbean Region for over twenty-five years. With resident representatives in Chile, and later Argentina HKI provided a substantial amount of material assistance and training within educational facilities for blind children in a number of countries. HKI was also instrumental in developing a number of rehabilitation centers and sheltered employment facilities during the 1960s HKI's decision to shift emphasis from institutional to community based approaches resulted in a period of relative inactivity in the Region in the mid to late 1970s.

In 1981 HKI embarked on a new initiative in Peru to demonstrate that integrated eye care programs could reduce eye disease rates and serve the needs of the population at highest risk; those living in under served rural areas. Over the past seven years this Matching Grant program has changed the thinking of professionals throughout the Region concerning blindness prevention, treatment and rehabilitation of the irrevocably blind. As a result of the work of HKI, (its colleagues and counterparts in Peru, at the Pan American Congress of Ophthalmology, the Pan American Health Organization and the National Eye Institute-USA) integrated eye care programs are underway in Venezuela, Colombia, Ecuador, Bolivia, Uruguay, Chile, Guatemala, Costa Rica and several countries in the Caribbean Region.

While the integrated eye care program was attracting the attention of ophthalmic community, the community based rehabilitation programs established in two regions of Peru were attracting considerable attention amongst professionals in the fields of education and rehabilitation. In 1986 and again in 1987 the Pan American Health Organization asked HKI to assist it in its effort to train health professionals from Colombia, Venezuela, Ecuador, Bolivia and Chile on the development of approaches for integrating rehabilitation into the rural health care infrastructure. Since the initial planning meeting in 1986, sub-regional meetings on community based rehabilitation have been conducted for all countries throughout the Region. Community based rehabilitation has now been endorsed by Ministers of Health throughout the Region as an integral component of any primary health care strategy.

In 1987 HKI undertook a new initiative in the region designed to study and energize efforts to address the main cause of blindness in the Region...cataract. The project began with a planning meeting at the National Eye Institute with representatives from Brazil and Peru and from other international agencies. The task was to design a program for both countries to clear geographical zones of each of the cataract backlog and to study all phases of the process during implementation to gain a better understanding of a variety of issues which contribute to the overall cataract problem i.e. patient motivation, screening, surgical outreach, follow-up care, cost etc. Cataract Free Zone projects were implemented in Peru and Brazil and carefully designed follow-up studies are now underway in both countries.

Since 1982, HKI has been working with the Caribbean Council for the Blind (a consortium representing agencies of and for the blind in 22 nations). The major thrust of HKI's work has been to provide technical advise and support to a Regional effort designed to establish an infrastructure of rehabilitation services with particular attention to the development of income generating opportunities for blind persons and their families. This effort of the CCB has received major support from the Canadian International Development Agency and has resulted in a specific new initiative in Haiti that is being carried out by HKI and its counterparts under a grant from PACT. with financial support from several other agencies. HKI has also worked with the CCB to develop a long-range plan for strengthening educational services for blind children. Through efforts at both the in-service and pre-service levels over the past three years, teachers already working with blind children have received training during summer holidays, while a pre-service training program at the University of the West Indies/Mico College has been designed and a faculty member has been trained at Teacher's College, Columbia University.

Finally, as an integral aspect of HKI's Vitamin A Child Survival Program HKI is currently working with a consortium of private voluntary agencies (PVO's) under a three year grant from USAID which is scheduled to be completed in 1989. HKI is hopeful that the results of current Vitamin A activities will allow us secure additional resources to accomplish the strategic objectives outlined below.

HKI's ongoing operational assistance grant is providing a rich base of experience in offering technical assistance to a variety of PVO's working in Africa. Soon after this initiative was underway, it became apparent that such technical assistance was much needed in other Regions. A future expansion of HKI's technical assistance using this modus operandi will include PVO's based in Central and Latin America.

III. STRATEGIC OBJECTIVES

During the five year period beginning FY-1989, HKI's strategic plan for the Latin America/Caribbean Region will address the following priorities through existing country specific initiatives and limited program expansion.

A. Overall Objectives:

- 1. Strengthen, consolidate and complete work on on-going programs in Peru, Brazil, Haiti and with the Caribbean Council for the Blind.**
- 2. Document and disseminate information on on-going and currently planned integrated eye health care, cataract and education/rehabilitation initiatives.**
- 3. Develop and strengthen indigenous technical and management capacity with a view toward:**
 - achieving sustainable programs in countries where HKI is currently working (Haiti is likely to be an exception)**
 - development of a core staff capable of managing a future HKI Regional Office**
- 4. Continue to foster the collaborative relationships which have been developed with a number of governmental, inter-governmental and private agencies.**

B. Objectives of Education and Rehabilitation programs for the Blind and Visually Impaired

- 1. Strengthen and document on-going community based rehabilitation initiatives in Peru and Haiti.**
- 2. Develop a series of training materials on community based education and rehabilitation which will have use throughout the Region.**
- 3. Develop and test two new service delivery models for community based rehabilitation.**
- 4. Develop and field test a series of public education materials designed to bring about more positive attitudes toward the abilities of blind individuals.**
- 5. Increase the access that blind and other disabled individuals have to ongoing community development and economic initiatives.**
- 6. Develop indigenous Regional capacity to provide technical assistance to other agencies who wish to develop community based education/rehabilitation programs as part of their on-going development work.**
- 7. Develop indigenous Regional capacity in the Caribbean to handle all in-service and pre-service education for teachers working with blind and visually impaired children.**

8. Foster collaboration with a number of Regional organizations on matters which contribute to the achievement of HKI's overall education and rehabilitation mandate in the Latin American/Caribbean Region.

C. The Objective of HKI's Cataract Programs in the Caribbean/Latin American Region

1. Expansion of Cataract Free Zone projects in additional regions of Brazil (Divinalandia) and Peru (Ica) FY-1989-90.
2. Provision of support for the production of cataract glasses at the Institute of Ophthalmology in Lima FY-1989-90.
3. Exploration of the feasibility of an operations manual for implementing Cataract Free Zones FY-1989.
4. Conduct a workshop with NEI, PAHO and PAOO to review results of Cataract Free Zone studies FY-1990.
5. Objectives of HKI's Vitamin A activities fall into two broad areas; country specific actions for Haiti and Regional activity under our technical assistance mandate.

These include:

- a. Examination of alternative strategies in the implementation of Vitamin A programs through private sector initiatives.
- b. Development of training modules and materials for promoting Vitamin A activities throughout the private sector.
- c. Demonstrate feasibility of a Vitamin A intervention in a rural setting for a local private sector organization.
- d. Ensure the institutionalization of an overall Vitamin A communications strategy for the country.

2. Central/Latin American Regional

IV. FIVE YEAR ACTION PLANS

The Five Year Action Plan for Latin America/Caribbean are included in the Action Plans for Education and Rehabilitation, Cataract, Vitamin A and Integrated Eye Care.

V. OVERALL RESOURCE PLAN

Over a five-year period from FY-1989 to FY-1993 HKI expects that support for its Caribbean/Latin American Strategic Plan will come from a mix of government and private sector resources; and is based upon the following assumptions:

1. **Continued Matching Grant support for a program in Peru with Regional impact.**
2. **Continued Vitamin A Child Survival and Operational Assistance grant support from USAID.**
3. **Modest expansion of USAID funding through co-financing or operational program grant arrangements with selected AID Missions.**
4. **Continued support from corporate and foundation sources.**
5. **Expanded support from corporate and foundation sources.**
6. **Continued support and collaboration from partner agencies such as CBM, RCSB, Perkins etc.**
7. **Continued technical and material support from inter-governmental agencies such as PAHO, UNICEF and OAS.**
8. **Further funding for selected rehabilitation initiatives from PACT and the Inter-American Development Bank.**