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INTERNATIONAL EYE FOUNDATION

KENYA RURAL BLINDNESS PREVENTION PROJECT

PHASE II

EVALUATION REPORT

BLINDNESS PREVENTION

AND

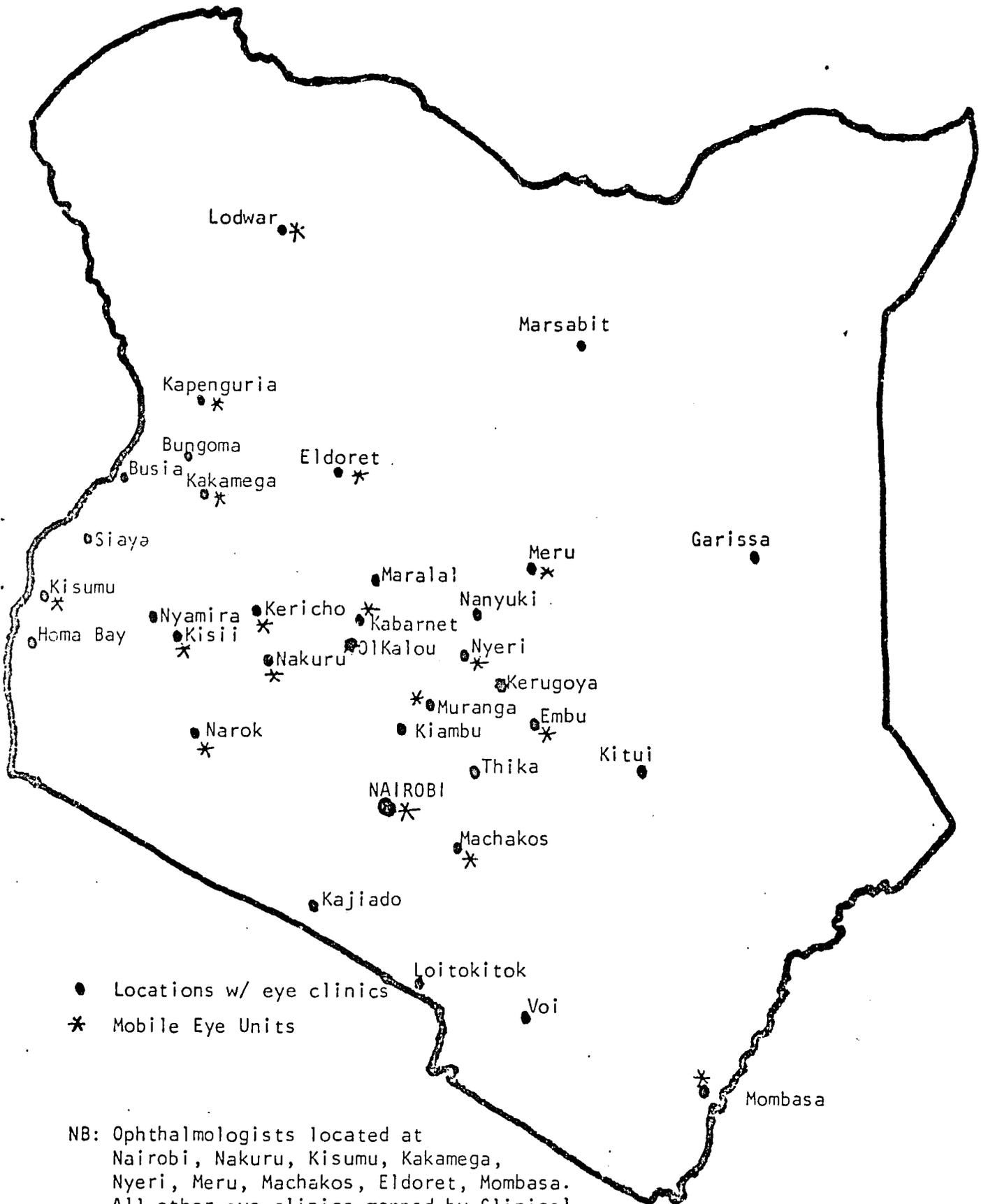
HEALTH EDUCATION PROGRAMME - KENYA

U.S.A.I.D. GRANT NO. 615 - 0203

11th November, 1983

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RURAL EYE SERVICES IN KENYA



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EXECUTIVE SUMMARY

1. SUMMARY

The implementation of the three year USAID Operational Programme Grant No.615-0203 to IEF/KRBPP began in April 1980 and a nine month no-cost extension was granted until 31st December 1983. The purposes and the objectives of the project were achieved. The Grant supported seven aspects: 1) Surveys; 2) Teaching and educational programmes; 3) Provision of therapeutic materials and equipment; 4) two community based health projects; 5) Mobile Eye Units; 6) Technical personnel; and 7) Commodities and operational support.

By November 1983 - time of the final evaluation - surveys on the prevalence of blindness had been completed and the data were being analysed. Seventeen Mobile Eye Units (MEUs) were established and are now functioning. Effective teaching materials were developed for various health personnel and are widely used in several African countries.

Equipment, drugs and sutures were provided as operational support. Teaching and educational programmes had been completed; one community based health project was established and one supported. Counterparts were trained.

The programme had a great impact on eye work in Kenya which could have been greater if the project had been extended for another two years. Co-operation among IEF and various government and non-government organisations was satisfactory, and that facilitated institutionalisation to some extent.

However, integration of more Kenyan staff into the project could have helped the process of institutionalisation.

Funding of the project was appropriate.

## 2. EVALUATION METHODOLOGY

The operational Programme Grant Agreement (USAID Project No.615-0203) called for a final evaluation.

The goals of the evaluation were to assess:

- to what extent stated purposes of the project have been achieved
- to what extent inputs have been appropriate for outputs
- what has been achieved by the project including unintended side-effects
- what impact the project had on the overall ophthalmic programmes of the Ministry of Health
- what lessons have been learned.

Two consultants - an ophthalmologist and a medical education specialist - were engaged to carry out the evaluation. Dr. V.Klauss, Senior Lecturer in Ophthalmology, University of Nairobi, concentrated on the surveys, preventive and curative aspects of the programme. Dr. A. Mutema, Head of Faculty of Medical Education, Training and Research, Medical Training Centre.Nairobi, assessed the teaching aspects of the programme and the community based health projects.

Document analysis, interviews and site visits were used as methods of project evaluation.

### 3. EXTERNAL FACTORS

The Ministry of Health (M.O.H.) is now committed to community based health care that is preventive and promotive rather than curative.

The appointment of a Senior Deputy Director of Medical Services, M.O.H., as the person responsible for all eye activities in Kenya, and the transformation of the Prevention of Blindness Committee into an effective decision making body in 1981/82 facilitated the implementation of the programme.

Chronic shortages of drugs and sutures supplied by the M.O.H. reduced the effectiveness of the project.

One of the community based projects suffered from a temporary ban on fund raising activities.

### 4. INPUTS

#### I.E.F INPUTS

- salaries and fringe benefits for IEF Staff
- travel and transportation, subsistence and per diem
- surveys on blindness prevalence
- surgical equipment
- teaching materials
- drugs and medications, sutures
- continuing education
- 3 Mobile Eye Units
- evaluation and dissemination of information.

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M.O.H. INPUTS

- salaries and fringe benefits for health workers
- medicines, sutures and eye equipment
- transport and allowances for seminars
- personnel for surveys
- support of two Field Training Officers
- clinical and surgical facilities
- house allowance for two project ophthalmologists

5. OUTPUTS

<u>TARGETS</u>	<u>ACTUAL PROGRESS</u>
1. Definition of prevalence of avoidable blindness	1. Nine surveys were conducted by IEF and the results are being used by the MOH for planning of eye work in Kenya. The data are also useful to KSB (Kenya Society for the Blind), University of Nairobi and other African countries. The data formed the basis for the 5 year ophthalmic plan of the MOH.
2. Conduct of teaching programmes for different health and other personnel.	2. Fiftyone seminars were held and 1769 participants taught on primary eye care and blindness prevention. These seminars will be continued by 2 Kenyan Field Training Officers.
3. Development of Effective Teaching Materials.	3. Effective teaching materials were developed and distributed. They are in use in Kenyan Teaching Institutions and outside Kenya.
4. Provide a shift in rural eye care from therapeutic to preventive approach through education programmes.	4. IEF carried out preventive activities with support of KSB and MOH. A Primary Eye Care Prevention Education Unit has been established.

<u>TARGETS</u>	<u>ACTUAL PROGRESS</u>
5. Strengthening the capabilities of established therapeutic and Mobile Eye Units (MEUs)	5. IEF provided equipment, drugs, sutur and glasses to eye clinics. The two project ophthalmologists supervised C.O.(O)s, postgraduate students in ophthalmology and Kenyan Counterpar in their respective Provincial Hospitals.
6. Therapeutic and teaching activities.	6. Valuable therapeutic and teaching activities were provided by the two provincial ophthalmologists. Two counterparts will take over the duties of Provincial Ophthalmologis
7. Information of the Government of Kenya on the prevalence of avoidable blindness.	7. Co-operation and flow of information between MOH and IEF were improved since 1981/82. Survey data were communicated to the MOH.
8. Establishment of a Teaching Block on Primary Eye Care and Blindness Prevention Curriculum in six Rural Health Training Centres (RHTCs)	8. IEF with tutors in RHTCs developed a curriculum on Primary Eye Care and Blindness Prevention. The Curriculum has been incorporated into the RHTC teaching Programmes.
9. Establishment of Two Community based health projects.	9. One Community based health project was established and the other was supported by I.E.F. These projects will continue after I.E.F. withdrawal.
10. Conducting on-the-job training of Kenyan Counterparts.	10. The Project Director taught and supervised Ophthalmologists and C.O.(O)s in their respective Provincial Hospitals. Two C.O.(O)s had practical experiences with the Field Training Specialist and the two C.O.(O)s will gain additional knowledge and skills in London. The two C.O.(O)s and one Ophthalmologist will form the Primary Eye Care Prevention Education Unit in the Ministry of Health.

6. PURPOSE AND GOALS

1) The overall purpose of Phase II of the IEF project was to continue and institutionalise the rural blindness prevention activities through the Ministry of Health (MOH) and the Kenya Society for the Blind (KSB).

2) Conditions expected at the end of the project:

- functioning of two community based health projects with teaching activities on primary eye care and blindness prevention;
- availability of useful survey data for planning of eye work in Kenya;
- positive change in supplying equipment, sutures, drugs, to Mobile Eye Units and Hospitals by the MOH;
- progress in development and distribution of effective teaching materials by MOH;
- established teaching curriculum in RHTCs on Primary Eye Care and Blindness Prevention;
- complete institutionalisation/integration of IEF activities by MOH and KSB.
- two Kenyan Field Training Specialists to continue teaching activities (e.g. seminars);
- two established provincial eye centres with effective supervision of running of Mobile Eye Units.

7. BENEFICIARIES

The beneficiaries of the IEF programme are:

- Ministry of Health
  - Clinical Officers Ophthalmic
  - Ophthalmologist Counterparts
  - Under and Postgraduate Medical Students
  - Two Field Training Specialists
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- Health personnel in health centres and dispensaries
- Prevention of Blindness Committee MOH.
- The population within the two community based health projects
- A great number of eye patients
- A great part of Kenya's rural population

8. UNPLANNED EFFECTS

- Within the Community based Health Projects the population's awareness has grown not only towards eye diseases but towards community health in general
- Community motivation to plan for projects on their own initiative
- Community awareness of their latent potential in planning and organising health activities
- Replication of project activities (teaching material, survey data, general concept) in other countries

9. LESSONS LEARNED

Institutionalisation/integration is facilitated by close co-operation among all parties concerned in programmes of this type. Specifically, the policy makers of the host country need to be intensively involved in the planning, implementation and evaluation of the project. Also integration of local manpower is necessary for the institutionalisation process.

Plans of action must be distributed to all concerned well in advance of the implementation of any project activities. Similarly, termination of the contract must be notified to all concerned 12 months in advance. (See page 48, para.3).

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10. SPECIAL COMMENTS

Remarkable progress has been made in several aspects of Kenya's ophthalmic programmes over the last two years as a result of the newly revitalised Prevention of Blindness Committee under Dr.J.J.Thuku's enthusiastic Chairmanship. However, unless concentrated effort is made by all concerned after the withdrawal of I.E.F.'s support, progress may be expected to slow down or stop completely.

An appeal is made to U.S.A.I.D. to seriously reconsider their support for Kenya's ophthalmic programme in the form of regular supplies of essential inexpensive eye drugs, sutures and money for the reproduction of teaching materials for a period of 2 years from 1st January, 1984.

## INTRODUCTION

Under the terms of the Operational Programme Grant AID Project No.615-0203 between the Agency for International Development and the International Eye Foundation (IEF) the second phase of the Kenya Rural Blindness Prevention Project began in April, 1980.

The Project Agreement calls for a final evaluation by the end of phase II.

The goals for the evaluation are to assess:

- to what extent stated purposes of the project have been achieved.
- to what extent inputs have been appropriate for outputs.
- what has been achieved by the project including unintended side-effects.
- what impact the project had on the overall ophthalmic programmes of the Ministry of Health.
- what lessons have been learned.

The terms of reference for the Evaluation Team include the following ten objectives:

1. Definition of the prevalence of avoidable blindness;
2. Conduct of teaching programmes;
3. Development of effective teaching material;
4. Shift from therapeutic to preventive approach in rural eye care;
5. Strengthening the capabilities of established therapeutical and mobile eye units;

6. Therapeutic and teaching activities of two project Ophthalmologists ;
7. Information of the Government of Kenya on the prevalence of avoidable blindness ;
8. Establishing a teaching block on primary eye care and blindness prevention curriculum in six Rural Health Training Centres (RHTCs) ;
9. Establishing two community based primary eye care projects; and
10. Conducting on-the-job training of Kenyan counterparts ;

Two consultants - an ophthalmologist and a medical education specialist were engaged to carry out the evaluation. Dr.V. Klauss, Senior Lecturer in Ophthalmology, University of Nairobi, concentrated on the surveys, preventive and curative aspects of the programme. Dr. A. Mutema, Head of Faculty of Medical Education, Training and Research, Medical Training Centre Nairobi, assessed the teaching aspects of the programme and the community based health projects.

Document analysis, interviews and site visits were used as methods of project evaluation. (Project Staff List - see Annex 1)

EVALUATION TIMETABLE 27th OCTOBER - 12th NOVEMBER 1983

Thursday, 27th October	9.00	Meeting with Mr. C.Mantiņone USAID Headquarters
	11.00	Review of KRBPP documentation
	3.00	Meeting with Deputy Director USAID, Nairobi
Friday, 28th October	9.00	Mr. D. Arbuckle, KRBPP
	11.00	Sir Ivan Ewart, Royal Commonwealth Society for the Blind  Mr. S. Tororei, Kenya Society for the Blind
	2.00	Dr. R. Britanak, USAID Headquarters
Saturday, 29th October		Review of KRBPP Documents
Monday 31st October	8.30	Depart for Maragua
	10.00-11.00	Discussion with rural health tutors at Maragua Rural Health Training Centre
	11.30-12.30	Discussion with MOH and C.O(O) at Muranga District Hospital
	2.00-5.00	Discussions with Dr.H.S.Chana and 2 C.O(O) at Nyeri Provincial Hospital
	5.00-7.00	Discussion with Dr.R.Whitfield, Programme Director, KRBPP
Tuesday, 1st November	9.00-11.00	Discussion with PMO Central Province and Provincial Health Education Officer, Central Province, Nyeri
	11.00	Depart for Meru
	2.00-5.00	Discussion with MOH, Meru District Hospital and 1 C.O.(O) at Meru Hospital.
	5.00-7.00	Discussions with Dr. F.M.Mburu, Health Planner, KRBPP
Wednesday, 2nd November	7.30	Depart for Laare Health Centre (Ithima Communit Health Project)
	9.00	Meeting the Chief of Location
	11.00	Visit Ithima Community Health Project.  Discussions with Clan Leaders and Neighbourhood Health Workers
	1.00	Discussion with Community Field Health Worker and Clinical Officer at Laare Health Centre.
	2.00	Depart for Nakuru
	7.00-9.00	Discussions with Dr. F.M.Mburu

Thursday, 3rd November	10.00	Discussion with Provincial Medical Officer Rift Valley Province, Nakuru
	11.30	Discussion with Dr.M. Joshi, Provincial Ophthalmologist, Rift Valley Province
	12.30	Discussion with 2 C.O.(O), Nakuru
	2.30	Return to Nairobi
Friday, 4th November	9.00	Meeting with Dr. F.M.Mburu
	10.00	Meeting with Dr.R. Whitfield
	12.00	Meeting with Dr.J.J.Thuku, Senior Deputy Director of Medical Services, Ministry of Health
	1.30	Meeting with Dr.J.J.Thuku and Dr.A.M.Awan, Chief Consultant in Ophthalmology, Kenyatta National Hospital.
Saturday 5th November		
Tuesday 8th November		Drafting Evaluation Report
Wednesday 9th November		
Saturday 12th November		Drafting Final Evaluation Report.

## II. ASSESSMENT OF ACHIEVEMENT OF 10 PROJECT OBJECTIVES

### II. 1. DEFINITION OF THE PREVALENCE OF AVOIDABLE BLINDNESS IN VARIOUS COMMUNITIES OF RURAL KENYA

During Phase 2 of the project four blindness prevalence/ocular status surveys were conducted.

- Survey 1 : Kisii 1980
- Survey 2 : Baringo 1981
- Survey 3 : Kajiado 1981
- Survey 4 : North Meru 1983

It had originally been planned to conduct Survey 4 in the Taita Hills. The four surveys during Phase 2 add to the information obtained from 5 surveys during Phase 1 (Meru, Nyeri, Kakamega, South Nyanza, Kwale).

The target of four surveys set at the beginning of Phase 2 has been reached. The locations were selected in a way to obtain representative information for the greater population groups in Kenya. . The groups were in themselves homogenous regarding social status, housing, nutrition, hygiene, sanitation. The number of people examined in each survey was adequate. Nevertheless, the results from a total of 9 surveys do not allow for precise conclusions to be drawn regarding Kenya's total population. The International Eye Foundation team was aware at the beginning of the project that this would not be feasible with the manpower, time and money available, but it is fully justified to use the results for the planning of eye work in Kenya.

The individual surveys have been planned and conducted by the I.E.F. staff in a perfect manner. A number of Kenya Government employees were actively involved as eye surgeons and clinical officers took part. The data collected are of high value. So far population based data do not exist from African countries so that the I.E.F collected data can be - and in fact

are already - used by other African countries for the planning of their ophthalmic services. The first data were released in 1980, since then raw data has been given to the Ministry of Health (M.O.H.) in Kenya soon after every survey. The M.O.H fully appreciates the value of the data and uses them for the planning of eye services in the country. The data are included in and form a basis for Kenya's Ophthalmic 5-Year Plan. All the M.O.H. representatives the evaluation team talked to had a highly positive view of the surveys. The data have already been made freely available to the M.O.H., Prevention of Blindness Committee (PBC), all organisations in Kenya and outside Kenya working in the field of ophthalmology, all eye surgeons in Kenya, and to the University of Nairobi, where they form part of the teaching material. The data have generated world-wide interest. In Kenya they are valuable for the planning of specific programmes in specific areas (e.g. trachoma), for staff-posting, for distribution of drugs, for the training of ophthalmic surgeons and clinical officers ophthalmic (C.O (0)) in accordance with the country's needs.

The survey costs (average \$5,000 per survey) are low. The input in terms of personnel, time and money was low considering the value of the results. (Surveys in other parts of the world have cost ten to fifty times more, giving comparative results). Side effects of the surveys include the growing awareness of the examined population towards eye diseases. A negative side effect could be observed during the repeat survey in North Meru in 1983 where parts of the survey population ran away from the survey teams because blood for the determination of Vitamin A levels had been taken from children during the previous survey. Although the people had been informed before the survey that no blood samples would be taken, a number of them appeared to be afraid.

The evaluation team talked to a number of C.O.(O)s who had taken part in surveys, who were well aware of the value of the surveys and who all appreciated the experience that they had gained in data collection. One of them mentioned that the money spent on surveys would have been better spent on eye drugs.

Data Analysis has taken a long time and the final data tabulations have only recently been completed. This has been done partly for technical reasons (computer defects and errors) but also partly organisational reasons within the I.E.F. staff. The scope of work for the "Health Planner" includes "Analysis of all survey data and of data collected from both prevention and therapeutic units and clinics." However, the first part (survey data) was analysed by the Project Director, the second part (data collected from both prevention and therapeutic units and clinics) was not analysed at all. The evaluation team has the impression that a lack of communication between Health Planner and Project Director has delayed the data analysis by almost two years. The data analysis has taken valuable time from the Project Director, that could have been used differently. A computer firm could have done the data analysis on a contract basis, though at a high financial cost.

#### SUMMARY

During Phase II four blindness prevalence/ocular status surveys were conducted as planned. They were conducted in a perfect, cost-effective manner. The resulting data are of great value for the planning of eye services in Kenya and other African countries. Data analysis was slow.

## II. 2

CONDUCT OF TEACHING PROGRAMMES FOR DIFFERENT HEALTH AND OTHER PERSONNEL

During Phase two of the KRBPP several teaching activities were carried out for various health and other personnel. (See Annex 2)

Table 1 shows the types of health and other personnel that were reached.

Table 1

TYPES AND NUMBERS OF HEALTH AND OTHER PERSONNEL REACHED DURING PHASE TWO OF THE KENYA RURAL BLINDNESS PREVENTION PROGRAMME 1980 -83

Types of Personnel	Numbers
Nursing Students	441
Village Health Workers	219
Ophthalmic Clinical Officers and Trainees	130
Rural Health Teams	121
Teachers of visually handicapped	25
Teachers and Students in Teaching Colleges	900
AMREF Mobile Health Teams and Guests	10
Rural Health Training Centre Tutors	30
Ophthalmologists and Assistant Medical Officers (Tanzania)	30
Students at International Centre for Eye Health	20
Health Unit Teams	197
Field Health Educators	148
Neighbourhood Health Workers	72
Unspecified Health Workers	310
<b>TOTAL:</b>	<b>2653</b>

In view of the personnel involved it may be concluded that most of the relevant and very useful personnel were able to be reached.

Thus the goal of conducting teaching programmes for health and other personnel on Primary Eye Care and Blindness Prevention was accomplished.

The data from document analysis and interviews revealed that these health personnel perceived the teaching programme to have been well organised and invaluable in increasing their knowledge and skills in Primary Eye Care and Blindness Prevention.

The KRBPP staff and especially the Field Training Specialist and Provincial Health Education officers were invaluable as the inputs of the project. The teaching programmes are able to reach the relevant personnel who are currently involved in spreading the idea of primary eye care in preventing blindness in the rural areas of Kenya especially in areas where trachoma and cataract are the main causes of blindness.

In general the teaching activities have had great impact on the overall ophthalmic programmes of the Ministry of Health since various health personnel can work as a team in teaching different ways of preventing blindness in Community programmes. One of the unintended side effects of the project is the continuous use of various use of various teaching materials that were developed by health and other personnel in primary eye care in rural areas.

During this period the curriculum materials developed by project staff for use with different groups included notes for:

- i) General clinical officer students
- ii) Nursing Students
- iii) Primary School students
- iv) Village health workers
- v) Mother and Child Health Clinics
- vi) Chiefs' Barazas
- vii) Agricultural Fairs
- viii) Provincial and District Seminars
- ix) Rural Health Teams
- x) Clinical Officers Ophthalmic
- xi) Continuing Education in Primary Eye Care.

On examination of each of the developed notes for the different groups in terms of "Principles of Developing Teaching/Learning Materials for Various Students" it is quite evident that the developers of these materials had clear guidelines on how to develop them. For example, the general objectives, the specific objective, the content, the learning activities and the evaluation criteria are included in most of the lecture notes for clinical officers, nursing students, and provincial and district health personnel. The Field Training Specialist took a lot of time and effort in compiling these notes and the Project Director participated in the final drafts to a great extent. The lecture notes for clinical officers and nursing students were quite detailed. However, the lecture notes for the other personnel were simple and clear. As the evaluation team found however, the lecture notes for health personnel were unnecessarily detailed. On examination of these notes it may be thought that health personnel and especially nurses and clinical officers have no formal teaching block in ophthalmology. The project has been able to develop meaningful notes that will continue to be used by health personnel in the future, and the other personnel who are involved in primary eye care. The teaching programmes were easy to conduct in terms of financial support and it is expected that these programmes will continue to be organised by Kenyan Field Training Officers currently in training, who are expected to take eventual responsibility.

Also the following teaching materials were developed. These are:

- 1) Red Eye Chart No.1
- 2) Macho Ya Kenya
- 3) Wall posters for use in schools
- 4) "C" Charts - Vision testing
- 5) Bibliography of Ophthalmology Publications
- 6) I don't want to be blind - "Maiyen Na Madooku"

The teaching materials that were developed were very useful to the various health and other personnel in Kenya and other countries in terms of their content. Red Eye Chart No.1 is useful to Clinical Officers, Nursing students and other health personnel who are involved in problems pertaining to the eye. The "Macho Ya Kenya" and the wall posters are widely used in schools by children, and their use has created awareness of Primary Eye Care and Blindness Prevention. The Vision Testing chart is used by clinical officers in teaching and also by the neighbourhood health workers. The neighbourhood health workers and all the health personnel that were interviewed stated that these were very useful materials. The Teachers in Rural Health Training Centres used these materials in implementing their Primary Eye Care curriculum, and they found them to be relevant. Some African Countries, e.g. Tanzania, Zimbabwe, Ethiopia, Sudan, Malawi and Botswana have received these teaching materials through the WHO office and are making good use of them. The KRBPP staff have shown enthusiasm in developing these materials, they field tested them several times and revisions were done before final drafts were developed.

One of the achievements and unintended side effects of the KRBPP was the distribution and use of these materials by some African countries. This in itself may be perceived to be a great achievement since the concept of primary eye care and blindness prevention is spreading to other countries through this project.

Although these teaching materials have been found relevant and useful, there is fear by the tutors in RHTCs, clinical officers and also by officials of the Ministry of Health that the Ministry of Health will not be in a position to continue reproducing them since no money was set aside for this work. However, the Ministry of Health officials indicated that the Health Education Unit which is a part of the Ministry of Health will continue reproducing and distributing materials for use in the future.

The teaching activities of RBPU's were mainly in the following areas:

- 1) Primary eye care
- 2) Blindness Prevention Awareness
- 3) Public Health in Relation to Ophthalmology
- 4) Teaching on vision
- 5) General ophthalmology.

The Field Training Specialist held several teaching sessions with various health and other personnel on the above topics and each participant received a copy of the material for future use. These teaching activities were organised for the appropriate health personnel who found them quite useful. The programmes were held in areas that were prevalent to eye diseases and the personnel that were interviewed revealed that such programmes would be useful if continued. The programmes made various community members aware of ways of blindness prevention, through primary eye care and also how to identify individuals who had eye problems. The involvement of different Ministry of Health personnel together with other personnel from other Ministries, in primary eye care and blindness prevention and the involvement of neighbourhood health workers in blindness prevention were some of the achievements and unintended side effects of this project, because different personnel are able to work as a team in spreading the concept of primary eye care and blindness prevention.

A total number of 51 seminars were held during the 1980-83 period. Out of these, six were Provincial level seminars, and the rest were District level seminars. Table 2 shows the number of seminars that were held in the provinces and the number of participants that were involved.

Table 2

SEMINARS HELD IN SIX PROVINCES FOR MINISTRY OF HEALTH PERSONNEL

PROVINCE	NUMBER OF SEMINARS	NUMBER OF PARTICIPANTS
Central	6	205
Eastern	19	677
Nyanza	5	167
Western	4	153
Coast	7	285
Rift Valley	10	278
<b>TOTALS:</b>	<b>51</b>	<b>1765</b>

These seminars were organised for various health and other personnel at the Provincial and District levels using the teaching materials that were developed by the Field Training Specialist. Initially, 37 district level seminars were planned for the project. These district level seminars were held in the following provinces: Central, Eastern, Western, Nyanza, Coast and Rift Valley. However, in North Eastern Province no seminars were held due to lack of security for the organisers in this area. In Eastern province more follow-up seminars were held compared with other provinces.

These seminars were planned and implemented by KRBPP staff, PMO's and the Provincial Health Educators. The personnel interviewed indicated that the organisers were appropriate and the teaching materials used were useful. However, document analysis especially from the "Evaluation Report on Seminars" prepared by Dr. Henry Matovu, revealed that some aspects of the seminars were not well planned. For example the objectives of the provincial and some district level seminars were not clear, and the contents of these seminars were inappropriate for some of the participants. Also the "Evaluation Report on Seminars" questioned the validity of Pre-test/Post-test assessments in determining the effectiveness of the seminars. However, these seminars were able to make various personnel aware of primary eye care and blindness prevention, and currently non-medical personnel are involved in the blindness prevention programme activities.

The seminars on primary eye care and blindness prevention had great impact on the overall ophthalmic programmes of the Ministry of Health. The Ministry is now aware of such seminars and plans have been made for two ophthalmic clinical officers to undergo a programme in London. One officer is already undergoing the programme and the other one is expected to go to London in mid-1984.

The cost of these seminars was very low and the Ministry of Health officials stated that such seminars will continue to be held, and the two clinical officers (ophthalmic) who are currently being trained will be responsible for such activities.

There are six Rural Health Training Centres in Kenya, one in each province. In 1982 the KRBPP staff organised a seminar at Mosoriot, one of the RHTCs, for all the RHTC tutors in order to develop a curriculum on "Primary Eye Care and Blindness Prevention" to be incorporated into their teaching block. The clinical officers that were interviewed revealed that the curriculum was successfully developed and each RHTC was expected to include it in their teaching block. However, at Maragua RHTC where the evaluation team visited, only one teaching programme had been incorporated into the teaching block since only one seminar for Rural Health Teams had so far been held. The tutors perceived the materials developed on "Primary Eye Care and Blindness Prevention" to be useful and they showed interest in using them as teaching material. The Red Eye Chart was available in the clinics and in the offices of tutors of Maragua RHTC. The Field Training Specialist visited and organised a training session in each RHTC using the materials on Primary Eye Care and Blindness Prevention, and the tutors interviewed felt that they could plan and carry out sessions on various topics on primary eye care and blindness prevention without any problems.

However, from the interviews it was apparent that few sessions had been given by tutors in RHTC's due to the low priority given to them by the Ministry of Health in terms of what programmes they should organise. It is hoped that when the two ophthalmic clinical officers have taken full responsibility for implementing the primary eye care and blindness prevention programme more sessions will be incorporated into the programmes for Rural Health Teams.

The provincial Health Education Officers were very active in participating in seminars both at provincial and district level on Primary Eye Care and Blindness Prevention. In all the 51 seminars that were organised the Provincial Health Education officers were involved to some extent. In some cases they were involved in identifying the venue, and the participants. They were also involved in teaching some of the topics.

The Provincial Health Education officers were some of the key personnel who made the activities of the seminars so successful. Two officers were able to organise two radio programmes, one in Kikuyu and one in Kiluo on Primary Eye Care and Blindness Prevention. These programmes were thought to be very useful for their audiences by both the Ministry of Health Officials and the officers themselves.

The materials developed by the KRBPP were used in preparing these programmes and the Provincial Health Education Officer who was interviewed expressed the need for more such programmes. We hope that the Provincial Health Education Officers will continue being active in the seminars in the future.

The teaching activities of the two project ophthalmologists and the project health planner involved various personnel. The two project ophthalmologists taught seven clinical officers (ophthalmic) how to extract cataracts. Every postgraduate student in ophthalmology in the University of Nairobi spent three weeks elective term with the Ophthalmologist either in Nakuru or Nyeri Provincial Hospitals. Also, the project Director, Dr. R. Whitfield gave three lectures on preventive ophthalmology to third year medical students between 1980 and 1983.

Students of Medical Training Centres in Nakuru and Nyeri had several lectures on ophthalmology from the two project ophthalmologists. The teaching activities of the Project Director appear to be limited. However, his major responsibility in the project was to develop the overall programme design, objectives, implementation, personnel and outputs of which the data showed that he had succeeded.

One of the major responsibilities of the Assistant Project Director was "Teaching and Training of all levels of Health Workers in the Ministry of Health based in Nakuru". The data obtained revealed that he was able to teach clinical officers (ophthalmic) how to extract cataracts.

The information available indicated that he was involved in the teaching of nursing students, clinical officer trainees and other medical personnel in Nakuru provincial hospital. In view of these facts the evaluation team concluded that the Assistant Director was satisfactorily involved in teaching activities for all levels of health personnel as expected. However, it should be noted that the heavy medical and surgical service, as well as clinical teaching that he offered might have prevented the achievement of the teaching activities in classroom settings. In general the teaching activities of the two project ophthalmologists were achieved more in the clinic than in the classrooms.

The health planner and the Field Training Specialist had to teach Kenyan Counterparts and identify institutions for eventual takeover of responsibilities according to their scope of work. The teaching of counterparts was done by the Field Training Specialist but the time of identifying them was not ideal. The evaluation team was informed by several health personnel that the two Kenyan Counterparts ought to have been identified and sent for training earlier. One counterpart is currently undergoing training and the other is expected to go to London at the end of the year. The evaluation team and Ministry of Health officials also felt that these counterparts ought to have been trained earlier. The identified counterparts were qualified to take the responsibilities, but the selection procedure of these candidates was questioned by various health personnel. The Ministry of Health officials ought to have been informed and involved in their selection. However, the officials of the Ministry of Health indicated that they ought to have been involved more in such activities. The current health planner had been involved in several teaching activities, e.g. the teaching of neighbourhood health workers on primary eye care and blindness prevention in the Ithima Community based project and also at Saradidi Health Community Centre in Siaya district. The health planner has also assisted the Field Training Officers who took the responsibilities of the

Field Training Specialist in organising provincial and district level seminars. The health personnel interviewed indicated that these services were well organised. The health planner participated actively in teaching some topics on primary eye care and blindness prevention in Ithima Community based project in Meru District.

Although the teaching activities of the Health Planner appear to be limited they contributed a lot especially when the Field Training Specialist left, since some of the responsibilities of the Field Training Specialist were taken over by the health planner. One of the achievements of the teaching activities of the health planner and an unintended side effect was the use of referral forms by neighbourhood health workers in assisting health workers to provide curative and preventive services to clients from the Ithima Community in Meru District.

#### SUMMARY

The KRBPP staff have reached different health and other personnel through teaching programmes on primary eye care and blindness prevention at the Provincial and District level Seminars. Provincial Health Education Officers and Tutors in Rural Health Training Centres assisted in the programmes. These activities were useful and were satisfactorily carried out. The Ministry of Health is expected to carry on these activities in the future.

## 11.3

DEVELOPMENT OF EFFECTIVE TEACHING MATERIALS FOR USE IN THE INSTRUCTION  
OF DIFFERENT HEALTH AND OTHER PERSONNEL AND FOR USE IN RADIO, PRESS AND  
OTHER MEDIA

Several teaching and training materials were developed by the KRBPP staff.

These included 14 different lecture notes on

- i) Anatomy and physiology of the eye
- ii) Diagnosis
- iii) Treatment of Common eye disorders,
- iv) blindness prevention for health and other workers.

The teaching materials were developed by the Field Training Specialist, the Health Planner, the Director of Field Operations, and the Project Director participated actively in proof reading and revising them after field testing before the final drafts.

On examination of documents and particularly the "Report on Evaluation of the Provincial and District Seminars" it was revealed that the participants found these materials very useful for quick reference on Primary Eye Care and Blindness Prevention. The Field Training specialist appears to have spent a lot of time and effort in developing these useful and relevant lecture notes. However, on further examination of the lecture notes, it might be said that, if specific objectives, content, learning experiences/activities and evaluation criteria were clearly written the materials could have been more useful to the participants.

These teaching materials have been used in provincial and district level seminars and in the training of clinical officer trainees and nursing students. The usefulness of these materials was indicated by the ophthalmic clinical officers and the students who have used them.

These teaching materials played a great part in the achievement of the goal of "conducting teaching programmes". Without these materials the achievement of this goal could have been difficult. One of the achievements of this project and an unintended side effect is the availability of the lecture notes to other health workers and other personnel who were not involved in the project. Without this project it could have been difficult for them to get these materials.

The other teaching materials that were developed by KRBPP staff included the following:

1. RED EYE CHART This chart has a series of photographs of the actual eye conditions that a health worker is expected to recognise and either treat or refer, such as corneal foreign body, hyphema, scleral perforation, acute iritis, etc.
2. PRIMARY EYE CARE MANUAL This is an eight page booklet that includes an explanation of the red eye chart and further amplifies each abnormality under the following headings:
  - a) Condition
  - b) Causes and prevention
  - c) Treatment  
and
  - d) Whom to refer to.
3. "C" CHARTS - Vision Testing.

These materials have been field tested several times and revisions were made before final drafts were developed. These materials took a lot of time and effort on the part of the KRBPP staff. However, the time and effort spent on them was worthwhile since these materials are found very useful by different health workers and especially by teaching staff in Rural Health Training Centres. The Clinical Officers (Ophthalmic) and the field health workers use these materials intensively in their primary eye care and blindness prevention

teaching programmes.

MACHO YA KENYA. This is a comic booklet with stories, riddles, puzzles, etc., which are endorsed by cartoons, poems, and information about athletes to illustrate causative factors in eye problems. This is a very interesting booklet especially for children. It is easy to read and understand the content that is presented.

RADIO AND TELEVISION "SPOTS" These consist of statements by prominent national figures on the importance of proper eye care, and also give short stories to illustrate proper eye care.

The project was able to develop effective material that has been distributed to other African Countries, e.g. Botswana, Malawi, Uganda, Zimbabwe, Southern Sudan, Zambia, and Tanzania through the World Health Organisation office in Kenya. Also these materials have been used in Central and South America. All the health personnel interviewed stated that these materials were very useful and they hoped that the Ministry of Health will continue to reproduce them. The Ministry of Health officials revealed that the Health Education Unit will continue to reproduce this useful material in order to teach more health personnel the concept of primary eye care and blindness prevention.

The cost of production of these materials was high, approximately KShs.200,000/- However, reproduction of the material will cost the Kenya Government less, since the cost will only be in reproduction.

The development of these teaching materials is a good indication of the time and effort put in by the KRBPP staff in making the project a success. The project was able to develop effective teaching materials that will continue to be used in teaching the concept of primary eye care and blindness prevention in Kenya and other African countries. One of the

unintended side effect of the project is the use of teaching materials produced by other countries, In general the development of these materials has made the Ministry of Health and other relevant personnel aware of the effect of Primary eye care in blindness prevention, and the RHTCs are making use of the developed materials in their teaching programmes.

Two radio programmes on "Primary Eye Care and Blindness Prevention" were developed by two Provincial Health Education Officers, one in Kikuyu and the other in KiLuo. These programmes were perceived by the Ministry of Health officials to be very effective. One official states that the programme in Kikuyu was very useful in terms of content and the expected audience. Other radio programmes were developed in Kiswahili and English and all were perceived to be relevant in teaching primary eye care in blindness prevention. These programmes had a great impact because many people could be reached.

Although effective teaching materials have been produced by the KRBPP, the Provincial Health Education Officers, the clinical officers and even officials of the Ministry of Health were unable to indicate whether there will be money to continue reproducing these teaching materials. The health personnel that were interviewed indicated that it would have been useful for the IEF to continue funding the production of these teaching materials for one more year. During this period the Ministry of Health will be in a better position to take the responsibility.

#### SUMMARY

Effective teaching materials for use in the instruction of different health and other personnel were developed and these teaching materials have been found to be very useful in teaching activities. They have also been distributed to several African Countries and in Central and South American Countries through the World Health Organisation office. However, the Ministry of Health has not been able to make provisions for the reproduction of these materials as yet.

## II.4

PROVIDE A SHIFT IN THE MAJOR EMPHASIS IN RURAL EYE CARE AWAY FROM THE PURELY THERAPEUTIC APPROACH AND, INSTEAD, TOWARD THE CONCEPT OF BLINDNESS PREVENTION THROUGH EDUCATIONAL PROGRAMMES CARRIED OUT, INTER ALIA, THROUGH THE RURAL BLINDNESS PREVENTION UNITS (RBPU)

Objective 4 is to a large extent referred to under objectives 2, 3, 8, 9, and 10. It cannot be dealt with separately from the others as it is the overall main objective of the project, that should reflect in each single activity. (see operational programme grant agreement pages 1 -3).

The personnel to achieve the shift from a curative to a preventive approach in ophthalmology were the I.E.F. Field Training Specialist, the IEF Health Planner, the IEF Director of Field Operations and their two Kenyan Counterparts - the Field Training Officers as well as all C.O.(O) working with a MEU. The tools used were the IEF developed teaching materials and transport provided by the Kenya Society for the Blind (KSB).

During Phase II of the project the idea of separate Prevention Units was abandoned for mainly two reasons: (1) there are few C.O.(O) who want to engage themselves into teaching exclusively, (2) the population is more open to suggestions regarding prevention of eye diseases if curative services are provided at the same time. Resulting from this now all C.O.(O)s are supposed to teach in their stations and during their visits to outside health stations. The only exception to this are the two C.O.(O)s working as Field Training Officers. Where there is more than one C.O.(O) in a station the C.O.(O) distribute the work among themselves according to personal abilities and interests so that one may do more teaching and the other one more curative work. The C.O.(O)s met by the evaluation team all stressed the importance of teaching health workers and the general population and stated their willingness to do so, but again all said that they had so much clinical work that too little time remained for preventive work and teaching.

Another problem facing the C.O.(O) engaged in preventive work is the lack of eye drugs, mainly Tetracycline eye ointment. It becomes frustrating for the C.O.(O) if he screens persons in a village or students in a school and cannot treat the patients suffering from trachoma. This situation will no doubt deteriorate after the end of the IEF programme. (see objective 5)

As an indication of the success of the preventive activities all eye personnel met during the evaluation stressed that the incidence of trachoma in their respective area has decreased and that the awareness among the population and among health workers regarding eye diseases has grown.

Regarding the target groups for preventive work there was a shift during the duration of the IEF project from the general population to health personnel and health teachers to have a greater multiplication effect.

The preventive work will be continued after termination of the I.E.F project mainly through the two Field Training Officers but also through every C.O.(O), supported by the MOH., and KSB. The two Field Training Officers will be integrated into the "Primary Eye Care Prevention Education Unit" in the MOH. (also an ophthalmologist yet to be identified will be part of it).

The evaluation team talked to one of the Field Training Officers who feels that he and the MOH are not fully prepared to take over the preventive activities from the IEF. One reason for this is the late identification of the two Field Training Officers by IEF and MOH. For the continuation of the preventive programme an earlier selection of the Preventive Ophthalmologist and the two (or more) Field Training Officers (C.O(O)) would have been of great importance. A number of MOH personnel expressed the opinion that mainly for the preventive part of the IEF activities another one or two years would have been beneficial to firmly establish the "Primary Eye Care Prevention Education Unit" within the MOH while the IEF programme continues.

No provisions have been made by the MOH headquarters or MOH representatives at provincial level to guarantee funds for the continuation of preventive work after the withdrawal of I.E.F. These funds are necessary for the organisation of seminars, production of teaching material and supply of Tetracycline Eye Ointment. The evaluation team has been asked by MOH and KSB representatives to make USAID aware of this problem and provide funds for two more years to establish the "Primary Eye Care Prevention Education Unit".

There was criticism among the C.O.(O) regarding the way the two Field Training Officers have been selected as the posts have not been advertised for all C.O.(O)s. The two Field Training Officers were identified as outstandingly capable by the I.E.F. staff and appointed by the MOH.

The evaluation team is of the opinion that government ophthalmologists in provincial and district hospitals should have been more integrated into or informed about the prevention activities, e.g. through seminars specifically addressing them. During these seminars they could have been made familiar with the IEF developed teaching material for use in their own provinces. One of the PMOs interviewed stressed that also medical officers should be invited to eye seminars.

Most persons interviewed were of the opinion that the IEF activities -in conjunction with MOH and KSB activities - had a positive impact on the population's and the health staff's awareness about eye diseases and their prevention. Special mention was given to the work in the 2 Community based health projects where the population's knowledge about prevention and care of eye diseases was improved through teaching and the work of the neighbourhood health workers. In these two areas the number of patients treated for trachoma decreased markedly according to the records of neighbourhood health workers and health centres.

The evaluation team received a great number of comments from the MOH officials and other health workers that the preventive work by the IEF has "achieved its goals to a great extent", "has risen awareness and expectations among the population", "will leave behind - after the end of I.E.F. activities - an awareness among the population and health staff about the importance of preventive work".

#### SUMMARY

IEF personnel has played an important role in achieving a greater among the population and health staff regarding the importance of prevention of eye diseases. Preventive activities have led to a quantifiable success reflecting in trachoma incidence and clinic attendances. IEF has identified health workers and health teachers as the most important target group for teaching activities in order to bring greater multiplication effect. All preventive activities were a joint effort between MOH, KSB and IEF.

The establishment of a "Primary Eye Care Prevention Education Unit" has been decided by the MOH in 1983 (1 ophthalmologist, 2 Field Training Specialists -C.O.(O) ), but this happened so late within the IEF project period that a follow-up of the activities and success of this Unit through I.E.F. will not be possible. The success of the Unit will depend on supplies of teaching materials and Tetracycline eye ointment for which the MOH has not yet made provisions.

## II. 5

STRENGTHENING THE CAPABILITIES OF ESTABLISHED THERAPEUTICAL AND MOBILE EYE UNITS

Over the two phases of the IEF programme all static eye clinics in Kenya staffed by an ophthalmologist or a C.O.(O) have received equipment from the IEF. This equipment includes slitlamps, ophthalmoscopes and surgical sets. A complete list of the instruments handed over to Kenya Government Institutions was not obtainable by the evaluation team. The total value of "surgical equipment" is given as \$10,758/- for Phase II. Additional surgical equipment was donated to IEF and was not bought from project funds. All ophthalmic personnel interviewed by the evaluation team stated that their clinics could not function well without the IEF equipment. Supplies from other sources - mainly M.O.H - are not sufficient.

IEF supplied a great number of eye drugs and surgical sutures to eye clinics and mobile teams. Health staff interviewed stated that 50% to 100% of their supplies were obtained from IEF. The PMO Central Province said that no elective surgery could be done at Nyeri Provincial Hospital for 8 months because of lack of sutures, referring to general surgery, not ophthalmology. Spectacles were supplied by IEF mainly in Central and Rift Valley Province. (Supplies with drugs, sutures, spectacles during Phase II see Annex 3). The evaluation team learnt that MOHs interviewed are not aware of the amount of supplies contributed by IEF. All had not made provisions for supplies from January 1st, 1984, when IEF supplies will stop.

The supplies with drugs and sutures through the MOH have been insufficient and a matter of great concern for the Prevention of Blindness Committee for the last 10 years. The MOH officials state that not enough funds are available for the purchase of drugs and sutures. It can be observed that at times expensive combined preparations are available whereas the most required eye drug - Tetracycline eye ointment - that is inexpensive - is out of stock.

If the MOH spent most of the limited amount of money available for eye drugs on Tetracycline eye ointment the country's need might be met. MOH officials in the Provinces stated that eye drugs rate high on their priority list and they would try to ensure that the well established eye services would continue after withdrawal of the IEF.

In this connection it became apparent that a great number of Ministry of Health Officials and eye workers were not aware about the termination of the IEF programme on 31st December 1983. Regarding supplies and continuation of the IEF programme everybody in co-operation with the IEF should have been informed at least one year before the end of the programme about the exact date of termination.

Supplies with drugs and sutures is entirely the duty of the MOH. Over the last 10 years the MOH was not in a position to supply sufficient eye drugs that it was fully justified that the IEF brought in drugs to enable the programme to function. All persons interviewed expressed their great concern regarding future supplies after IEF withdrawal. The termination of the IEF programme comes at a time when the MOH expenses for drugs have to be cut by 30% due to lack of funds. The evaluation team got the impression that a great number of persons working with IEF considered the supplies of drug and sutures to be the most valuable part of the programme (although it accounted for less than 1% of the project costs). Ministry of Health officials expressed their concern regarding the future of the KRBPP and of the two community based health projects because the Government was uncertain about the drug situation and asked if USAID could continue to supply drugs and sutures for another two years at the rate IEF did.

One Provincial Ophthalmologist expressed the opinion that IEF had too easy access to outside supplies so that not all possible Government channels were opened up.

All ophthalmologists and C.O.(O) with whom the evaluation team had discussions expressed their high opinion about the two project ophthalmologists as clinicians and teachers - and as "hardworking persons".

Health personnel in both provinces where the project ophthalmologists worked were satisfied with the co-operation they had, the time the ophthalmologists spent to do clinical work, to plan the eye work in the province, to establish eye programmes, to teach and supervise C.O.(O)s in their clinical and preventive work, and to teach health workers at all levels. There is no doubt about the commitment of the two ophthalmologists towards eye work in their respective provinces.

Number of Ophthalmic Clinical Officers trained in cataract extractions by the two project ophthalmologists:

Dr. R. Whitfield: four

Dr. L. Schwab/Dr. P. Steinkuller: three

In 1978 a postgraduate course in ophthalmology was started at the University of Nairobi. So far 5 ophthalmologists have been trained in the three year course, 11 are in training at present. In 1981 and 1982 all postgraduates and in 1983 one postgraduate, went for a three week elective term to Nyeri or Nakuru and worked with the IEF ophthalmologists to gain field experience and get involved in planning and administration of provincial eye work and teaching programmes. They went out with MEUs and had a chance to do cataract surgery. All postgraduate students commented on their elective term in a positive way and consider it to be a most valuable experience for their future work as provincial or district ophthalmologists.

Due to lack of funds I.E.F. could only sponsor one postgraduate student in 1983 and the support is now given by Professor Weve Foundation, Holland for elective terms in Kakamega/Mukumu.

The main emphasis in training therapeutic unit personnel is on improvement of clinical and surgical knowledge and skills of C.O.(O)s after their initial one year training course at Kenyatta National Hospital, Nairobi. Experience has shown that - as can be expected - the C.O.(O)s are not in a position to work independently after a one year training in ophthalmology. The Prevention of Blindness Committee in the Ministry of Health has decided to have all C.O.(O)s work with a provincial or district ophthalmologist for one year before they can be posted to a station alone. This time shall also be used to identify those C.O.(O)s who are interested and capable of learning cataract surgery. All C.O.(O)s met by the evaluation team who worked with the project ophthalmologists were most satisfied with the way they had received continuing training in clinical ophthalmology and surgery.

I.E.F. has helped the Prevention of Blindness Committee through the survey data and through the experience of their project ophthalmologists in their respective provinces to take the appropriate decisions regarding the posting of ophthalmologists, C.O.(O)s and opening of static and mobile eye units.

#### SUMMARY

IEF has contributed a substantial amount of eye-equipment, drugs, sutures and glasses to eye programmes in Kenya during Phase II of the programme. The programme could not have been successful without these supplies. MOH officials (in Nairobi and the provinces) are not aware of the amount of support and have not made provisions for supplies after termination of the

IEF project. The supply of equipment, drugs and sutures is considered by a great number of persons working with the IEF as their most valuable contribution to eye work in Kenya. There is great concern about the supplies after the termination of the IEF programme.

Supervision and clinical support provided by the two project ophthalmologists, training of seven C.O.(O)s in cataract surgery, supervision of elective terms of postgraduate students in ophthalmology and in-service training for therapeutic unit personnel were all done satisfactorily and successfully.

## II.6

THERAPEUTIC AND TEACHING ACTIVITIES OF PROJECT OPHTHALMOLOGISTS

The two project ophthalmologists have worked in the place of Government Ophthalmologists in their respective provinces covering the duties of a Provincial Ophthalmologist that include planning of eyework for the province, planning of seminars and teaching activities for different levels of health personnel, supervision of all eye personnel in the province, clinical teaching of C.O.(O)s, making programmes for MEUs, supervision of MEUs, clinical work, participation in the Prevention of Blindness Committee in the MOH (see also II.5)

Speaking to counterparts, students, administrators who worked with both ophthalmologists, all this work has been done very satisfactorily.

The evaluation team would like to quote the acting P.M.O.,

Central Province:

" Dr. Whitfield has set a standard for the eye work in the Province through his teaching, training and clinical activities. It will be difficult to maintain this standard with other ophthalmologists to follow as we have made the experience with postgraduates trained at Nairobi University in different specialities that their attitude towards work is different. They immediately want to set up a private practice and only work a few hours for the Government as they have seen their seniors do at Kenyatta National Hospital and in the Medical School. "

The evaluation team had access to a report by Dr.P.Steinkuller on "Surgery Done" that demonstrates the large number of operations done by Dr. Steinkuller. As important as his own surgery are the "Assists" that account for about 20% of operations and that show his teaching activities in surgery. There is no list available from Dr.Steinkuller indicating how many patients he has seen

Dr. R. Whitfield submitted a list indicating that in 1981, 47,359 eye patients were seen in Nyeri District and 80,924 in Central Province. 1160 eye operations were performed in 1981, out of which 345 were cataract-extractions.

In 1982 67,417 eye patients were treated in Central Province, and 1,174 eye operations performed (336 cataract-extractions).

The work of Provincial Ophthalmologist at Nakuru and Nyeri will be continued by Dr. Steinkuller's and Dr. Whitfield's counterparts: Dr. M. Joshi and Dr. H.S. Chana.

#### SUMMARY

Both project ophthalmologists have rendered very valuable services as Provincial Ophthalmologists that included therapeutic and teaching activities. (see II.5).

A report should be written by every I.E.F. team member before the end of the contract to summarise the work done.

## II.7

INFORMATION OF THE GOVERNMENT OF KENYA ON THE PREVALENCE OF AVOIDABLE  
BLINDNESS

During the total duration of the project (Phase I and II) co-operation with the Ministry of Health was considered to be of great importance by the IEF staff. Co-operation proved to be difficult as there was no permanent person in charge of eye work in the MOH. Only since Dr.J.J.Thuku Senior Deputy Director of Medical Services, took responsibility for all eye-work in Kenya in 1981 and became the chairman of the Prevention of Blindness Committee institutionalisation of KRBPP activities became possible. Since that time great progress had been made in planning and institutionalisation of eye programmes in Kenya. Another difficulty regarding the continuation of KRBPP activities by the MOH were and are the financial constraints of the Ministry.

The KRBPP has kept the MOH informed at all times about the results of the different surveys so that these results could be used to determine priorities and to initiate interventions by staff posting, distribution of drugs, setting up of new clinics. The data have only had a positive effect on the planning of eye work in Kenya since the Prevention of Blindness Committee (PBC) turned into an effective body in 1981.

The greatest achievement in planning of eye work for Kenya is the production of the "Five Year Development Plan" for eye work in Kenya. The IEF Project Director and the IEF Director of Field Operations played an important role in drafting the plan. The plan integrates all KRBPP activities as MOH activities for the next five years. ( see conclusion

Through this plan the KRBPP survey results will in future be used as important information for the planning of eye work.

KRBPP is a joint effort of the MOH, I.E.F. and KSB that represents a number of foreign donor agencies. The MOH has contributed by supplying:

- personnel for surveys (see II.1)
- transport and allowances for seminars (see II.2)
- support for two Field Training Officers (see II.10)
- medicines, sutures and eye equipment (see II.5)
- clinic and surgical facilities

After termination of the IEF programme the teaching activities will continue through one Ophthalmologist and two Field Training Officers forming the Primary Eye Care Prevention Education Unit.

The seminar activities and the production of teaching materials will be supported by the KSB. The future support of two community based health projects is open but the communities are determined to continue the programme without outside support (see II.9).

Two ophthalmologists will continue the work as provincial ophthalmologists in the respective province (Central and Rift Valley),

The supply of drugs and sutures will be the greatest problem for the future KRBPP activities as the MOH is not in a position to provide these items in a sufficient quantity.

#### SUMMARY

Co-operation and flow of information between MOH and IEF improved since 1981/82 when the Prevention of Blindness Committee became an efficient decision making body and when the Senior Deputy Director of Medical Services in the MOH took responsibility for all eye work in Kenya. The production of the "Five Year Development Plan" for eye work in Kenya institutionalises all KRBPP activities. IEF staff contributed considerably in drafting parts

of the Plan. The KRBPP survey data are included in the 5 year Plan and are used for decision making.

KRBPP activities will be taken over by the MOH and KSB. The short supply of drugs and sutures will be the greatest problem for future KRBPP activities.

## II.8

ESTABLISHING A TEACHING BLOCK ON PRIMARY EYE CARE AND BLINDNESS PREVENTION CURRICULUM IN SIX RURAL HEALTH TRAINING CENTRES (RHTCs)

The Field Training Specialist was responsible for establishing teaching curricula and conducting initial seminars at RHTCs, and also to co-ordinate these activities with the Ministry of Health. The Field Training Specialist was able to organise a seminar for all tutors teaching in RHTCs in order to develop a curriculum on Primary Eye Care and Blindness Prevention to be incorporated in their teaching blocks. The curriculum was successfully developed. However, the RHTC tutors that were interviewed stated that they were able to incorporate only one session on Primary Eye Care and Blindness Prevention among the several teaching blocks they had organised. The examination of documents revealed that the Field Training Specialist was able to organise seminars in all the six RHTCs to introduce the curriculum on Primary Eye Care and Blindness Prevention. However, since the evaluation team visited only one RHTC it was difficult to judge the extent to which teaching blocks in primary eye care and blindness prevention curricula had been established. The tutors who were interviewed stated that they can plan, and organise, teaching programmes without problems. The KRBPP staff stated that some materials e.g. the Flip Chart and the booklet on Primary Eye Care and Blindness Prevention were under print. These materials will be distributed to all Rural Health Training Centres, Medical Training Centres and Schools of Nursing in mid-November 1983.

The KRBPP staff were able to develop a curriculum on Primary Eye Care and Blindness Prevention and this curriculum had great impact on the overall ophthalmic programmes in Kenya. The materials will continue to be used and they are now being used to make different health personnel aware of ways of preventing blindness through primary eye care.

The evaluation team hope that more teaching blocks on Primary Eye Care and Blindness Prevention will be given priority in the Rural Health Training Centres in the future.

#### SUMMARY

The Field Training Specialist was able to establish a teaching block in six Rural Health Training Centres on Primary Eye Care and Blindness Prevention. However, it is the responsibility of the RHTC tutors together with the Ministry of Health to make this continue to work.

## II.9

ESTABLISHING TWO COMMUNITY BASED PRIMARY EYE CARE PROJECTS

One of the objectives of the KRBPP was the establishment of two Community-based Primary Eye Care projects in Kenya. The two community-based projects that were established are the Saradidi Project in Bondo Division, Siaya District, and the Ithima Project in Nyambene Hills, Meru District.

The sites for these two community based projects were appropriate because their selection was based on the 1977 Ocular Status surveys. These surveys indicated that the two areas had a high prevalence of trachoma which is one of the leading causes of visual loss in Kenya. A high prevalence of trachoma was a selection criterion for KRBPP staff in choosing a site for a community-based project.

The development of the Saradidi Community based health project was presented by Professor Gunter K. von Noorden MD., and Dr. Alfred A Buck MD., Dr. P.H., in their "Evaluation Report of KRBPP 1981 - 12:14"

The establishment of the Ithima Community Health Project was presented in a report "The Ithima Community Health Project, August, 1983" by the Director of Field Operations, IEF and the Health Planner, KRBPP.

The choice of these two sites for these projects has had great impact in teaching primary eye care and blindness prevention to the appropriate communities that need such services. The two communities are able to see practical advantages in primary eye care and blindness prevention. The Clan Leaders and the neighbourhood health workers who were interviewed at Ithima indicated that since the introduction of the project more people have been able to go to the health centre for treatment and also less people appeared to have trachoma.

The data gathered at the onset of the community based project activities were thought to be useful by the Community Leaders, health workers

and the health planner. Such data involved referral systems of community members to the health centre especially in Ithima. This information was found useful by the evaluation team in determining the incidence of eye problems among the various age groups, sexes, and also the frequency of treatments given to individuals. Since the establishment of this simple system in Ithima, more people went for treatment at the Health Centre. The evaluation team did not visit the Saradidi health project, and therefore no community leaders were interviewed regarding the usefulness of such a system. In view of these points the data gathered at the onset of community activities allowed the assessment of the impact of the projects on the two communities.

Community participation in the two projects was quite satisfactory although there was a time lag in accomplishing the planned activities. However, the Community leaders in Ithima, e.g. the Chief and the Clan Leaders explained to the evaluation team the reasons why the project activities were not achieved as planned. The community appeared enthusiastic and interested in the project.

The activities of the health planner in the two community based health projects indicate that the KRBPP has been able to develop the two community projects to some extent. The health planner spent a lot of time and effort in organising community members to be actively involved in these projects, and especially in the Ithima project.

Considering the activities that were carried out in these Community health projects, the KRBPP was able to provide the Field Training Specialist, and the health planner, who were involved in planning and organising seminars for the Neighbourhood health workers. Without these personnel these Community projects could not have been established.

The Field Health Nutritionist was another health worker who was actively engaged in implementing these activities. The KRBPP provided funds for the chicken-wire for building two water tanks, corrugated iron sheets, and some other expenses for the building in Ithima in Meru District.

Thus the inputs of KRBPP for these community projects were the personnel, materials, and funds. These inputs that were provided by the KRBPP together with the contributions from the communities made the projects a success. The people of Ithima community took time to raise the funds but it is expected that by the end of the year the building will be completed, as the evaluation team was promised.

The Chief of Ithima told the evaluation team that the raising of funds for Meru College of Technology, and Secondary Schools were given high priority compared with the community health project. At Ithima where the evaluation team visited, the community was involved in the following activities:

- 1) Raising funds for the "Eye Clinic" as many people referred to it.
- 2) Constructing water tanks, which were already completed.
- 3) Clearing a site for the "Eye Clinic" and laying the foundation for the building.
- 4) Teaching Primary Eye Care and Blindness Prevention
- 5) Digging pit latrines, which had mostly been completed.

The Health Planner indicated that the Community at Saradidi had been involved in constructing water tanks, teaching activities, and digging latrines.

The two communities spent a lot of time in organising these activities. At Ithima, for example, the Community provided sand and stones for the "eye clinic" and the KRBPP provided the corrugated iron sheets and chicken wire for constructing water tanks.

Considering these activities at Ithima and Saradidi, the evaluation team was of the opinion that some groundwork had been done. The Saradidi community project was successfully developed and will continue with its activities after the KRBPP withdrawal. However, the Ithima project may not continue, since different community leaders had different views on what it should be and what it should achieve. The community in Ithima unanimously agreed to complete the project

The little support that was given by the Ministry of Health was through the services that were offered by the field health workers who are employees of the Ministry of Health.

One of the purposes of the KRBPP that was developed for Phase II of the project was to establish two community based health projects in areas that had a high prevalence of eye diseases and especially trachoma. The activities carried out in the Saradidi and Ithima projects indicate that this goal has been achieved. The inputs of the KRBPP and those of the Ministry of Health were appropriate. The KRBPP provided the required personnel, materials and other funds that were needed. The MOH provided field health workers who are its employees, and the community provided some materials, funds and labour. In this case the KRBPP succeeded in developing the two community based health projects that are currently integrating primary eye care and blindness prevention teaching programmes. There were 65 neighbourhood health workers at Ithima, and 25 village health workers in the Saradidi project. The teachings involve specific eye diseases, sanitation, personal hygiene and rural water supply. The neighbourhood health workers that were interviewed revealed that they were interested in acquiring knowledge on communicable diseases such as T.B. In fact they requested the evaluation team to see whether arrangements could be made for them to have teaching sessions on such conditions.

The evaluation team was informed by the Clan leaders and the neighbourhood health workers in Ithima that since the introduction of these teaching programmes in the area the number of patients with trachoma had reduced, and especially children.

Also, the evaluation team was informed by the Chief of the location and by the Clan leaders that more people attended the health centre for treatment of eye diseases. However, the evaluation team had no access to documents to show the significance of the Ithima project in reducing the incidence of eye

disease in the area. The field health worker stated that they treated more patients in the health centre since the establishment of the Ithima project. The opinions expressed by the Clan leaders, the Chief, and the field health worker indicate the impact the project at Ithima has had on the overall ophthalmic programmes in the Ministry of Health.

#### SUMMARY

Two community based health projects have been successfully developed and their activities include primary eye care and blindness prevention. These projects are useful and health activities like sanitation, personal hygiene, and rural water supply have been incorporated in their teaching programmes. The Saradidi project is well established and will continue with its activities after the withdrawal of KRBPP from the scene. The Ithima project is still developing and the evaluation team was of the opinion that the activities planned will continue with the determination of the chief, the field health worker, the neighbourhood health workers and the community in general, that was demonstrated when the evaluation team visited the project. The construction of more latrines, water tanks, and the completion of the "eye clinic" will continue if the health worker continues to motivate the community in these activities. However, if the community at Ithima is provided with more skills in constructing water tanks, better results could be expected. These projects had great impact on the overall ophthalmic programmes of the Ministry of Health.

II.10

CONDUCTING ON-THE-JOB TRAINING OF KENYAN COUNTERPARTS

The responsibility of training the Kenyan Counterparts involved the Project Director, the Health Planner, and the Field Training Specialist.

The two project Directors acted as Provincial Ophthalmologists and their duties included therapeutic and teaching activities (see Objective 6). The project Director is currently working with Dr.H.S.Chana in Nyeri Provincial Hospital, and the Assistant Project Director worked with Dr.M. Joshi the current Provincial Ophthalmologist at Nakuru Provincial Hospital. The two Project Directors were "hard working" and were actively involved in teaching Kenyan counterparts and especially Clinical Officers (Ophthalmic).

The evaluation team was of the opinion that their Kenyan Counterparts are not involved as much in teaching activities as the project Ophthalmologists.

One of the activities of the Health Planner was to train Kenyan Counterparts or "identify institutions for eventual takeover of responsibilities". So far the Health Planner has not been able to identify somebody in the Ministry of Health or other institutions to take these responsibilities.

The Field Training Specialist together with other KRBPP staff was able to identify two competent Clinical Officers (Ophthalmic) to be trained to take her job. One officer is now undergoing training in London and the other officer is expected to go for the same training in June 1984. However, the identification of these officers was done rather late. These officers had practical experience with the Field Training Specialist and they are able to plan, implement and evaluate teaching programmes on primary eye care and blindness prevention. On completion of their training, these two officers will be responsible for the Primary Eye Care Prevention Education Unit with one ophthalmologist in the Ministry of Health.

SUMMARY

The Project Directors were able to teach and supervise Kenyan Counterparts to some degree and especially the Clinical Officers(Ophthalmic).

Two Clinical Officers (Ophthalmic) had practical experience with the Field Training Specialist and these clinical officers will gain useful knowledge and skills to enable them to carry on the activities of the Primary Eye Care Prevention Education Unit in the Ministry of Health. The training of these clinical officers will have great impact on the overall ophthalmic programmes in Kenya, since they will continue with KRBPP activities that had already been developed.

## III.

ASSESSMENT OF PROJECT CONTRACT, SUPPORTING DOCUMENTS AND PROJECT FINANCING

The Project Contract has been fulfilled by both parties, U.S.A.I.D. and I.E.F. Staffing of the KRBPP has been appropriate in terms of training, capability and motivation (see under II.5 and 6) (Integration see under IV).

The reports submitted by KRBPP for use by U.S.A.I.D., M.O.H., K.S.B., P.B.C. (Prevention of Blindness Committee) were in accordance with the terms and conditions of the contract and adequately portrayed the activities and progress of KRBPP.

The KRBPP activities were conducted in accordance with the terms and conditions of the contract.

The contributions made by KRBPP to strengthen and improve the Ministry of Health's ophthalmic programmes are presented under section II (assessment of achievement of ten project objectives) of this evaluation report.

The level of financing of the project was perceived by the evaluation team to be adequate. However, the distribution of money for different aspects of the programme appears to be disproportionate since almost 50% were spent on personnel (see under V : conclusions and recommendations).

The Ministry of Health's contributions to the KRBPP are listed under II.5, II.7 and II.8. The Kenya Rural Ophthalmic Programme also got substantial financial support from Operation Eyesight Universal, Canada, Royal Commonwealth Society for the Blind, Britain, and Christoffel Blinden Mission, West Germany. The money coming from those organisations is administered by the Kenya Society for the Blind.

#### IV. CONCLUSIONS AND RECOMMENDATIONS

The conclusions drawn and recommendations made in this section do not pertain to single objectives of the programme since those have been presented under Section II. 1 to 10. This section of the evaluation makes conclusions and recommendations referring to the overall KRBPP which are based on the following aspects:

##### IMPACT

The impact of the project can be measured by the positive changes initiated for Kenya's eye programmes and the effect beyond the duration of the programme. The evaluation team was of the opinion that the major aim of creating awareness of primary eye care and blindness prevention among great numbers of rural Kenyans and health workers - specifically eye personnel - was achieved to a great extent.

The specific successful areas that need to be mentioned are:

- development of effective teaching materials;
- conduct of teaching programmes;
- on-the-job training of C.O.(O)s;
- development of eye departments in two Provincial Hospitals where 10-25% of outpatients are eye patients;
- supervision of MEUs that achieved a high standard of running;
- direct (through two project ophthalmologists) and indirect (through C.O.(O)s) influence on prevalence of trachoma and cataract;
- valuable contribution of IEF staff members in Prevention of Blindness Committee and production of the "5-year Development Plan";
- supplies with drugs, sutures, spectacles, diagnostic and surgical equipment;

- initiation of one and support of one community based health project;
- and
- provision of survey data on prevalence of blindness to the Ministry of Health.

All these are indicative of the impact the KRBPP had on Kenya's ophthalmic programmes.

#### PROJECT DURATION

Phase I of the project was planned for a 4-year period from 1976 to 1980, Phase II for an additional 3 years from 1980 to April, 1983.

A nine month no-cost extension was agreed upon by U.S.A.I.D. and IEF until 31st December 1983. IEF applied for another low cost extension until the end of 1984 but that was not granted by U.S.A.I.D.

Looking at the objectives of Phase II a three year and nine month project duration should have been sufficient to achieve the given goals. As is apparent from Section II all objectives have been accomplished in a satisfactory way although a number of activities were initiated and established late during the project. (e.g. Two Community based health projects; identification of two counterparts for Field Training Specialist; establishment of Primary Eye Care Prevention Education Unit; and co-operation with the Chief Health Education Officer).

The evaluation team came to the conclusion that the late initiation of some parts of the programme was only partly the responsibility of the IEF team. These specific problems could not be solved by the IEF team alone without the co-operation of the Ministry of Health and the communities concerned.

As stated earlier, highly effective co-operation with the M.O.H. was possible only when Dr. J.J.Thuku, Senior Deputy Director of Medical Services took responsibility for all eye work in Kenya and when the Prevention of Blindness Committee became an effective decision making body in 1981/82.

Planning of eye work in Kenya had reached an important stage by the time of evaluation. Many activities were in the phase of being established and the next year or two will determine if the establishment will be of longer duration. All persons interviewed by the evaluation team - including M.O.H. representatives (see also Annex 4) - expressed the opinion that another one or two years of IEF cooperation within the Kenya Eye Programme would have helped to establish what had already been started.

Regarding the duration of the programme, the evaluation team strongly felt that negotiations about the end of a project should be terminated at least one year before the eventual end of the programme. It is only when everybody in connection with a programme is aware about the termination in advance, that satisfactory provisions can be made for a smooth handing over. In this case discussions between U.S.A.I.D. and IEF about the extension of this project went on until August 1983 when the final decision was reached to terminate the project by 31st December 1983. The evaluation team met a number of health personnel in co-operation with KRBPP who - by early November 1983 - had not received information about the end of the project.

#### CO-OPERATION

KRBPP was in co-operation with a number of governmental - at central, provincial, and district level - and non-governmental organisations.

Co-operation was termed excellent by government respondents

at provincial and district levels and by respondents of the Kenya Society for the Blind and University of Nairobi. However, the co-operation was not ideal with M.O.H. until 1981/82 when the Prevention of Blindness Committee under the Chairmanship of Dr. J.J.Thuku, Senior Deputy Director of Medical Services turned into such an effective body.

Also the co-operation between IEF and U.S.A.I.D. was perceived by the evaluation team to be poor, since no meeting was ever held during the duration of the project among MOH., U.S.A.I.D. and IEF. One such meeting was proposed by Dr. S. Kanani, MOH (see Annex 5), but the meeting was eventually held without the participation of IEF. The evaluation team felt that regular meetings at 3 or 6-month intervals among MOH, USAID, and IEF would have contributed to a more successful KRBPP outcome and institutionalisation.

#### INSTITUTIONALISATION / INTEGRATION

Institutionalisation of KRBPP activities into MOH or KSB programmes was the overall major objective of Phase II. The evaluation team was of the opinion that IEF made great efforts to achieve institutionalisation of its activities. This is reflected in:

- handing over teaching activities to Rural Health Training Centres;
- introduction of teaching programmes for continuation by Kenyan C.O.(O)s;
- training of two Kenyan Counterparts as Field Training Officers;
- development of teaching material for future use by M.O.H., and KSB.

- establishment of eye departments and rural services in two provinces, to be continued by Kenyan Counterparts;
- supervision of MEUs to be continued by MOH and KSB;
- contribution in the work of Prevention of Blindness Committee and production of "5-year Development Plan".
- initiation and support of community health projects;
- provision of survey data on prevalence of blindness to MOH for future planning of eye work;
- training of under-and postgraduate medical students, University of Nairobi, in preventive ophthalmology.

However, institutionalisation could have been achieved to a greater extent if a number of integration efforts had been started earlier during the project (see under "Project Duration"). Institutionalisation partly relates to involvement of MOH. The evaluation team believes that IEF could have started earlier and more intensively to establish close working relationship with the MOH. IEF had prepared a document on co-operation with the MOH in 1976, but the MOH did not sign the agreement. Persons interviewed by the evaluation team stated that:

- "the blame for lack of cooperation was due to the MOH"  
(MOH official)
- "the IEF acted too much as an autonomous body"  
(Kenyan Counterpart)
- "the IEF programme concentrated too much on provincial and district level personnel, instead of policy makers"  
(e.g. MOH) (Kenyan Counterpart)
- "the IEF activities were aimed more at C.O.(O)s than at ophthalmologists"  
(Provincial Eye Surgeon)
- "the IEF interfered with matters of Kenyan personnel"  
(MOH official)

As part of the institutionalisation process the IEF should have employed Kenyan personnel, e.g. an ophthalmologist as Assistant Project Director for Phase II, a Kenyan as Field Training Specialist from 1981 after one year of co-operation with the IEF Field Training Specialist, a Kenyan Director of Field Operations for Phase II and a Kenyan Health Planner from the beginning of Phase II.

The evaluation team was aware that some of these personnel might not have been available by the beginning of Phase II. An attempt was made to incorporate two Kenyans - one Health Planner and one Ophthalmologist at the beginning of Phase II but that was not successful. The employment of Kenyan personnel could have reduced the project costs considerably. A low cost extension with only Kenyan staff could have been considered.

As part of integration efforts the Chief Government Consultant Ophthalmologist was made "Chief Project Consultant". According to IEF records he was invited for all staff meetings, but he never participated. The "Chief Project Consultant" stated that he never received invitations for the IEF meetings.

The evaluation team was of the opinion that IEF had made great contributions to institutionalise the project, but there were areas where more efforts could have been made.

ANNEXES

1. Project Staff List
2. Letter from Dr. N. Janmohammed, M.O.H. Nanyuki to Dr. R. Whitfield (3rd November 1983)
3. List of Drugs and other supplies used within KRBPP from April 1980 to November 1983
4. Letters from D. J.J. Thuku, M.O.H.,
  - To Dr. R. Whitfield Jr., (15th May 1982)
  - To Dr. R. Britanak (20th July 1983)
  - To Mr. R.D. Arbuckle (23rd October 1982)
5. Letter from Dr. S. Kanani, M.O.H., to USAID, Kenya  
12th November 1981

ANNEX 1

PROJECT STAFF LIST

- 1) Project Director: Dr. Randolph Whitfield Jr., M.D.
- 2) Assistant Project Director: Dr. Paul G. Steinkuller, M.D.
- 3) Director of Field Operations: Mr. R. Douglass Arbuckle, M.A.
- 4) Fiscal Manager: Mr. Alex Mackay, M.A., (Kenyan)  
April 1980 to May 1981  
Mr. R. Douglass Arbuckle, M.A.  
May 1981 to end.
- 5) Field Training Specialist: Ms. Victoria M. Sheffield, COMT.
- 6) Health Planner: Mr. Dennis G. Ross-Degnan, M.P.H.,  
April 1980 to September 1981  
Dr. F.M. Mburu, Ph.D., M.P.H. (Kenyan)
- 7) Field Training Officer: Mr. L. Nyaguthii Mbugua, C.O.(O)  
(Kenyan)  
February 1982 to end.  
Mr. John W. Macharia, C.O.(O), (Kenyan)  
March 1982 to end.

ANNEX 2: LETTER FROM DR. N. JANMOHAMMED, M.O.H. NANYUKI  
TO DR. R. WHITFIELD (3rd November 1983)

3/11/83

Dear Dr. Whitfield.

Thank you very much for sending the things on Tuesday. Those posted from Nairobi have not arrived yet!

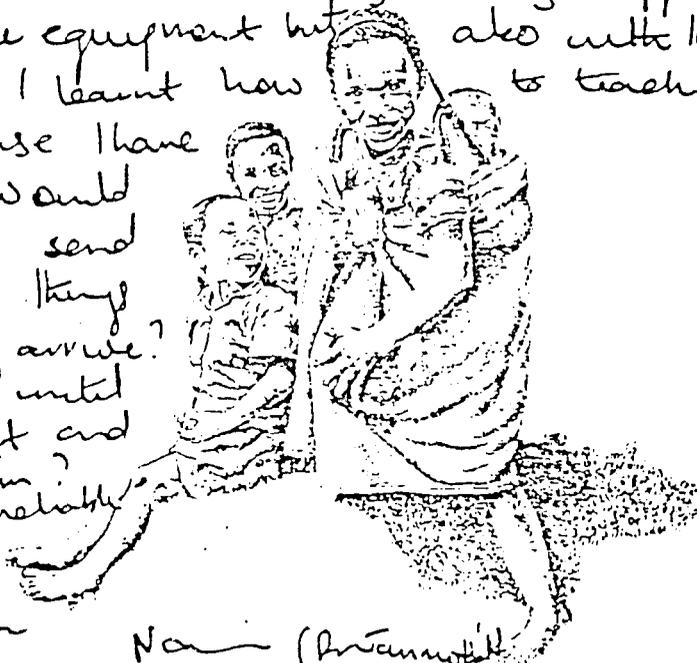
The course was very successful. All the participants agreed that their eyes were their most precious organs and so they would help others to preserve their eyes too.

Almost all the health workers in Nakifin have now had the 1<sup>o</sup> eye care course. This includes even the public health technicians and all health personnel in every health facility. And that's because the international eye foundation has been very very helpful not only with the equipment but also with the staff. That's how I learnt how to teach

And for this course I have to thank you. Would you like me to send back to you the things when they finally arrive? or should I wait until Charles is here next and give them to him? That seems more reliable to me.

Thank you again

Nani (Branan)



ANNEX 3: LIST OF DRUGS AND OTHER SUPPLIES USED WITHIN  
K.R.B.P.P. PROJECT FROM APRIL 1980  
TO NOVEMBER 1983.

Drugs & Other supplies distributed by IEF/KRBPP, April 1980 to present

<u>ITEM</u>	<u>Quantity</u>
Diamox tablets	40,000
Tetracycline Caps (250mg)	20,000
Vitamin A Capsules	55,000
Asprin B.P. Tabs	50,000
Isoniazid Tabs	10,000
Decadron Ointment (tubes)	8,400
Pilocarpine Drops	2,880
Atropine Ointment (Tubes)	4,800
Triple Antibiotic Ointment (tubes)	11,280
Terramycin Ointment (1%) (tubes)	81,600
Sodium Sulfacetamide Ointment (tubes)	12,000
Prednisone Tabs	20,000
5-0 Chromic sutures	1,080
7-0 Vicryl sutures	2,400
8-0 Silk sutures	1,200
Aphakic spectacles	4,000 (approximate)
Ophthalmic Diagnostic kits	10
Portable refraction sets	10
Books:	
General Ophthalmology	25
Nutrition in Developing Countries	3
Paediatric Priorities in the Developing World	5
Primary Child Care	5
Teaching Village Health Workers	5
Family Health Care	5
Duke-Elder	1 Complete set

ANNEX 4 : LETTERS FROM DR. J.J. THUKU, M.O.H.,

To Dr. R. Whitfield Jr, (15th May 1982)

To Dr. R. Britanak (20th July 1983)

To Mr. R.D. Arbuckle (23rd October 1982)

MINISTRY OF HEALTH

Telegrams: "MINHEALTH", Nairobi

Telephone: Nairobi 27381

When replying please quote

Ref. No. ....DC/7/4/61/33  
and date



AFYA HOUSE

CATHEDRAL ROAD

P.O. Box 30016, NAIROBI

.....15th May,....., 1982

Randolph Whitfield, M.D.,  
Project Director,  
International Eye Foundation,  
P.O. Box 55585,  
NAIROBI.

Dear Dr. Whitfield,

RE: INSTITUTIONALIZATION OF THE KENYA RURAL  
BLINDNESS PREVENTION PROJECT

Your letter of 4th February, 1982

I have had time to read through the correspondence on the above subject since my assignment as the Ministry's Co-ordinator on this programme, and I have the following comments to make:-

It would be a pity if this programme was to come to an end if as you say there is "insufficient time to complete the process of institutionalization due to the unwillingness of U.S.A.I.D. to renew funding despite the support of Dr. Kanani, the Kenya Society for the Blind and the Department of Ophthalmology of the University of Nairobi."

I have had discussions with Dr. Awan and on our part:-

- (a) Miss Lucy Nyaguthii has been posted to the Kenyatta National Hospital with immediate effect.
- (b) We have agreed that two of the new M.Med graduates in Ophthalmology will be posted to Nyeri and Nakuru to work with the project Ophthalmologists on completion of their studies.
- (c) This point about Clinical Officers carrying out surgical procedures needs further discussions.

Under the circumstances I hope you will be able to persuade U.S.A.I.D. to continue with the assistance till the completion of this project.

I look forward to hearing from you.

Yours sincerely,

*J.J. Thuku*  
(Dr. J.J. Thuku)

for: DIRECTOR OF MEDICAL SERVICES

c.c. Mrs. Allison Herrick,  
Mission Director,  
USAID/Kenya.

Dr. A.M. Awan,  
Kenyatta National Hospital

MINISTRY OF HEALTH



Telegrams: "MINHEALTH", Nairobi.  
Telephone: Nairobi: 27351  
When replying please quote  
Ref. No DC/774/6.1A/  
and date

AFYA HOUSE  
CATHEDRAL ROAD  
P.O. Box 30016, NAIROBI

..... 19

Dr. R. Britanak,  
Chief, H/N/P Division, U.S.A.I.D.  
P.O. Box 30261  
NAIROBI

11 - AUG 1983 *Rec'd*

Dear Dr. Britanak,

I have seen my copy of a letter addressed to you by Mr. Arbuckle, Director of Field Operations, International Eye Foundation, Kenya Rural Blindness Prevention Project.

I wish to support the sentiment expressed by Mr. Arbuckle and wish to re-emphasize that the Kenya Government is committed to seeing through this programme. Due to limited financial resources, however, we shall continue to seek assistance from outside.

With this in mind, I am writing to request that you consider extending your assistance for another one year at least. We are most grateful for what you have done up to now and what you may continue doing for us in this respect.

Yours faithfully,

DR. J. J. THUKU

(Dr. J.J. Thuku,  
PERMANENT SECRETARY)

for:

c.c. .

Mr. R. Douglass Arbuckle  
Director of Field Operations  
International Eye Foundation  
P.O. Box 55585  
NAIROBI

MINISTRY OF HEALTH



Telegrams: "MINHEALTH", Nairobi  
Telephone: Nairobi 27381  
When replying please quote  
Ref. No. DC/7/8/61/63  
and date

AFYA HOUSE

CATHEDRAL ROAD

P.O. Box 30016, NAIROBI

23rd October, 1982

Mr. R.D. Arbuckle,  
Director of Operations,  
International Eye Foundation,  
Kenya Rural Blindness Prevention Project,  
P.O. Box 55585,  
NAIROBI

Dear Mr. Arbuckle,

I wish to acknowledge receipt of your letter dated 17th August, 1982 addressed to the Director of Medical Services and copied to me.

Unfortunately this letter was received when I was on leave which was followed by a trip overseas. It has therefore taken a long time to reply.

I am writing to express our appreciation for your request for an extension of the Kenya Rural Blindness Programme for another period of nine months up to the end of 1983. This has our support. We also hope you will continue to give us assistance beyond this date. Sometime towards next month (November), I do hope to present to all concerned our proposals for the next five year period.

A handwritten signature in dark ink, appearing to read 'J.J. Thuku', written in a cursive style.

For: DR. J.J. THUKU/SDDMS  
PERMANENT SECRETARY

cc:- Dr. Rose Britanak,  
U.S.A.I.D.,  
NAIROBI

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ANNEX 5: LETTER FROM DR. S. KANANI, M.O.H., to U.S.A.I.D., Kenya.  
12th NOVEMBER, 1981

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12th November

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The Director  
USAID Kenya  
NAIROBI.

Re: Kenya Rural Blindness Prevention Project

In a meeting held recently between the Ministry of Health officials and officials participating in the Kenya Rural Blindness Prevention Project, it transpired that USAID would like to meet the Ministry of Health officials to review this important project with a view to seeking further support from USAID beyond April, 1983 when the second phase of the project comes to an end. During this meeting, the participants in the project indicated that there was a need to extend the project activities beyond phase two into phase three for another three years. It was generally agreed that the Ministry of Health would incorporate the project activities into the on-going Ministry of Health programmes at the end of the second phase of the project. It was, however, quite clear that by this time, the Ministry of Health may not be in a position to provide the necessary manpower to effectively integrate project activities into on-going Ministry of Health programmes. This is because the training programme for specialists in ophthalmology may not have reached a level where Kenyan doctors would be adequately deployed to carry out the work.

In the light of the above, the Ministry of Health wishes to invite USAID Kenya to a meeting during which the project can be reviewed with a view to exploring the possibility of extending the current project activities into phase three. Please let us know when it would be convenient for you to hold this meeting. The Ministry of Health very much appreciates the support that USAID has been giving to this very important programme.

DR. S. KANANI

Dr. S. Kanani  
for Permanent Secretary

c.c.

Dr. Randolph Whitfield, Jr.,