FIRST ANNUAL REPORT
MATCHING GRANT

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>II.</td>
<td>The Start-up Process</td>
<td>4</td>
</tr>
<tr>
<td>III.</td>
<td>HKI's Strategic Planning Progress</td>
<td>10</td>
</tr>
<tr>
<td>IV.</td>
<td>Report of Country Specific Accomplishments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Peru</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>- Sri Lanka</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>- Tanzania</td>
<td>37</td>
</tr>
<tr>
<td>V.</td>
<td>Financial Analysis</td>
<td>40</td>
</tr>
<tr>
<td>VI.</td>
<td>Appendices</td>
<td></td>
</tr>
<tr>
<td>VII.</td>
<td>References</td>
<td></td>
</tr>
</tbody>
</table>
I. INTRODUCTION

Overview

Blindness and eye disease are becoming increasingly recognized as significant public health problems in many countries throughout the developing world.

The World Health Organization (WHO) estimates that the world's blind population has increased to a record level of 28.1 to 42.2 million (depending on the definition of blindness used). WHO points out with alarm that this number will double by the year 2000 unless effective measures to treat and prevent blindness are developed and systematically implemented.

Eighty percent of the world's blind people live in developing areas of the world. They are, for the most part, the poorest of the poor, existing beyond the monetized economy and largely dependent upon rudimentary health systems for the most basic health care.

Beyond those already blind, millions more suffer from some form of infectious sight-threatening eye disease, such as trachoma and conjunctivitis. Estimates of those suffering from trachoma are put at 500 million by WHO.

The technology to treat and prevent eye disease is largely inexpensive and readily available. Fully two-thirds of blindness is preventable through the delivery of basic treatment and other inexpensive public health measures. Trachoma, for example, was a persistent problem in many areas of the United States until the 1930's when it was all but eliminated by the Public Health Service.
Eye problems are vast and the solutions must be rooted in carefully targeted, realistic approaches aimed at producing the strongest possible impact for the minimal investment allowable. Sharply competing priorities and strained and often reduced resources amid alarming increases in rates of disease and disability demand solutions which lead to integration of services and the effective use of the resources already in place.

HKI's Matching Grant aims at accomplishing this by implementing, in four developing countries, targeted programs which attack the problems of widespread eye diseases and blindness through existing health and community structures. By integrating primary eye care into the delivery of primary health care, HKI can establish effective strategies that can be replicated at minimal investment in other areas and countries where risk prevails.

Since August 1981, when the Matching Grant agreement was signed, HKI has been intensively at work creating such programs. In all respects, the program is on or ahead of schedule. Our experienced planning and development staff has been realigned and augmented. Experts in public health, rehabilitation and education have been working on a team basis, with the active support of an expanded cadre of outside technical consultants --public health ophthalmologists and epidemiologists.

Extensive research has been carried out and a series of in-depth planning trips by the HKI field teams have been made to Peru and Sri Lanka. A full implementation plan--exactly on schedule--is ready for Peru, and field activity is expected to begin in July.
Initial project activity is also underway in Sri Lanka and a full operational plan will be completed in November. Full-scale operations there should begin in January, again ahead of schedule.
II. THE START-UP PROCESS

A. Initial Organizational Planning: Immediately following the official signing of the Matching Grant, HKI's Executive Director created a Matching Grant Task Force. It consists of senior HKI staff members and public health ophthalmologists with experience as consultants for HKI.

The first objective of this working group was to develop a framework for approaching the tasks ahead, based upon the goals and objectives of the grant, past experience, current organizational structure and personnel resources.

The results have been substantial. The first meetings set a tone for HKI's Matching Grant effort. A specific strategy was developed to accomplish the first year objectives of the grant, including:

1. Phased steps in both the planning the intervention stages of HKI's efforts, including personnel needs and a schedule of projected time needed to accomplish each step;

2. Preliminary analysis of the health and education/rehabilitation infrastructures of a number of countries, based upon available data. (Countries studied included Peru, Sri Lanka, Tanzania, Zimbabwe, the Sudan and Mali.) Particular attention was given to the type and scope of preliminary assessments required to secure additional needed data;
3. Development of country teams, drawn from personnel resources in the areas of ophthalmology, epidemiology, education, rehabilitation, management, evaluation and training;

4. Analysis of existing personnel resources with recommendations and specific criteria for new personnel required;

5. Action recommendations, covering the first year of operation, for each of the countries discussed.

B. Institutional Reorganization: HKI brings to the task of integrated delivery of primary eye care and rehabilitation services some 67 years of experience as an international technical assistance agency. Throughout most of its history, this technical assistance has been delivered in three important, but largely separate, program areas: education of blind children, rehabilitation of blind adults, and prevention of blindness. In recent years, in recognition of the critical need for a more integrated and cohesive approach to dealing with blindness, HKI had begun to consolidate the services it offered and to develop a more integrated approach. The Matching Grant has given the agency the impetus and resources to move ahead to complete this reorientation. Activities under the grant focus specifically on prevention of blindness and eye disease through integrated efforts at the primary health care level. Such efforts are designed to reach individuals with eye disease or at risk of eye disease who are beyond the reach of traditional eye health delivery systems. Program efforts further address the needs of individuals suffering from irreparable visual impairments through integrated community-based rehabilitation efforts.

The organizational implications of this integrated strategy for addressing both the prevention of eye disease and blindness
and the development of services for those already blind were among the first issues addressed by HKI under the Matching Grant. As a result, HKI's existing departmental divisions of Education, Rehabilitation and Blindness Prevention have been replaced by a combined program department. This change facilitates the planning and development of integrated efforts, while allowing the organization to manage ongoing efforts in nutrition blindness control and community-based education and rural rehabilitation.

Planning teams for each potential country program are now functioning and consist of personnel with extensive work experience overseas and with training in public health, services to the blind, management and evaluation. These teams, throughout the first year of the Matching Grant, have been actively involved at various stages of efforts in Peru, Sri Lanka, Tanzania and Zimbabwe. (A detailed report on these countries is included in Section IV of this report.)

These changes, in turn have had a number of very visible positive effects on HKI's worldwide operation. Of particular note are:

1. A greater interaction and involvement of professional staff in the planning and decision-making process;

2. Changes in the substance of HKI operations in Fiji, Haiti, Indonesia and the Philippines, where we have moved away from categorical project efforts and developed instead a more integrated approach to dealing with the problem of blindness; and

3. A marked increase (21%) in response to HKI's direct mail fundraising appeals since the new directions embodied in HKI's Matching Grant have been brought to the attention of private donors.
C. New Personnel Resources: During the early stages of the planning process, the Matching Grant Task Force identified key personnel resources in three major areas that would be required to achieve the stated purposes of the grant: overall planning and management; additional program officers; and additional medical and evaluation resource personnel.

An extensive recruitment and screening process in these areas was initiated. The following has been accomplished:

1. **Associate Director-Planning and Development:** The task force recognized that HKI employs personnel with highly specialized technical backgrounds in the areas of blindness prevention, education and rehabilitation. While these highly specialized personnel are obviously crucial, such persons cannot be properly employed if their special expertise is not effectively placed in a broad and realistic framework of overall development issues and priorities of the countries in which HKI is working.

The Task Force recommended, therefore, the selection of an Associate Director with broad and generic experience in the field of development to bring to HKI strong management, planning and evaluation capabilities, and the capacity to place HKI efforts within a broader context, complementing HKI's already well-established technical capacity.

In December 1981, HKI secured the services of an individual with just such a background, a person with 18 years of experience in planning, implementing
and evaluating a range of community development efforts overseas. The new Associate Director has primary responsibility for the planning and implementation of all HKI project efforts, including the Matching Grant.

2. Program Officers: Following analysis of existing manpower resources, the Planning Task Force recommended the addition of at least one Program Officer to function as the Team Leader for HKI's initial Matching Grant effort in Peru. The person's qualifications would include:

- work-experience in public health;
- proven planning capacity;
- full-time work experience in a developing country;
- cultural and interpersonal sensitivity; and
- fluency in Spanish.

In February 1982, after extensive screening, an individual meeting these criteria was identified and hired. This person, formerly a U.S. Public Health Service Planner and Peace Corps Volunteer, now functions as the HKI Team Leader for Peru.

3. Medical and Evaluation Resource Personnel: Over the years HKI has developed a rather substantial cadre of consultant personnel with particular experience in public health ophthalmology and epidemiology. Recognizing that HKI's ongoing activities, in addition to those proposed under the Matching Grant, would require further personnel, the Planning Task
Force recommended that additional professionals be identified to assist HKI with assessments related to planning and designing country-specific efforts as well as providing ongoing technical and evaluation assistance during implementation.

At the Annual Meeting of the American Academy of Ophthalmology in Atlanta, Georgia, in October, 1981, HKI interviewed interested professionals. The response by the ophthalmic community was considerable. Over 60 ophthalmologists, many with previous experience in developing countries, submitted their credentials to become actively involved in HKI's Matching Grant program. Two ophthalmologists identified in this way are currently carrying out assessments in Peru and Sri Lanka and both have agreed to remain active during the implementation phases of the program.

Alfred Sommer, M.D., M.P.H., HKI's Medical Advisor and Director of the Center for Epidemiology and Preventive Ophthalmology, Johns Hopkins University, has been the other principal source of recruitment. Through extensive contacts, both within and outside of the U.S., Dr. Sommer has provided HKI with additional ophthalmic and epidemiological personnel resources. Using this channel, HKI has identified a public health ophthalmologist with six years of experience in Africa, who will support HKI's efforts in that region during the second year of the Matching Grant.
III. HKI'S STRATEGIC PLANNING PROCESS

The timeline chart in the original proposal projected the selection of two countries, and the completion of assessments and planning for one of these two countries by the end of the first year. As of July 31, 1982 HKI will be on or slightly ahead of this schedule.

To accomplish the goals established for this first year, both generic and country-specific strategies were developed. Generic planning is the responsibility of the Matching Grant Task Force, (some of whose major activities have already been described). This Task Force regularly reviews progress made toward all activities undertaken as part of the Matching Grant, makes necessary adjustments in general and country-specific strategies and carries out forward planning related to the second and third year of HKI's efforts. Country Planning and Implementation Teams, consisting of four to six individuals, are charged with the responsibility of developing country-specific integrated program efforts. (Although there has been some minor variation from country to country, the approach developed by HKI has, to date, been quite consistent and effective.)

What follows describes HKI's generic strategy; Section IV provides a detailed description of country-specific accomplishments.

Phase I: Preliminary Assessment - This phase involved re-establishing contact with a number of host governments to verify their continued interest in an integrated approach to primary eye care and the delivery of basic services to those already blind.

During this period, the HKI "country team leader" makes one or more trips to study and analyze the health and social service
infrastructure; to identify key leadership personnel; to discuss the country's general eye health situation with indigenous ophthalmologists, and general practitioners; to visit health care facilities and those serving the handicapped; and to establish liaison with other private voluntary organizations and the local AID Mission. Demographic, social economic, health and disability data are collected during this phase of the planning process.

Following preliminary visits, all information gathered is shared with the country team. The ensuing analysis culminates in the completion of a written scope-of-work plan as preparation for the more detailed assessment carried out in Phase II. This plan is then reviewed by the Matching Grant Planning Task Force to make a determination as to whether the country under consideration warrants further investment of time and resources in the planning process. In the cases of Botswana, the Sudan and Mali, the decision was that HKI should not proceed.

Phase II: Detailed Assessment - During the second phase of the planning process, an HKI team consisting of the team leader, a public health ophthalmologist and other resource personnel, as required, makes one or more visits to the country to identify personnel resources, and to focus directly on technical assistance needs related to such areas as personnel training, public education, collection of baseline data, equipment, materials, and medical supply needs. This phase also serves for the collection of hard data about the extent and type of various eye diseases, treatments employed and the referral networks in place. To do this, existing data from primary, secondary and tertiary health facilities are analyzed, discussions with medical and paramedical personnel take place and random ocular examinations are carried out in potential target areas by HKI's public health ophthalmologist. The HKI team
Simultaneously, an HKI staff member with experience in community-based rehabilitation of the blind collects data and impressions on a number of factors related to the provision of services to those already blind. This includes existing rehabilitation facilities as well as data on such factors as population density, terrain, local transportation, local attitudes, village economies, cottage industries, agricultural tasks, physical structure and daily lifestyle of the community.

Finally, the team determines the requirements to secure a working agreement with the government, along with locally available financial and personnel resources, including those of other PVOs, that may be committed to the effort.

Phase III. Development of a Plan of Operation - With all information gathered through the preliminary and detailed assessments, the next step in the strategic planning process is the development of a detailed plan of operation. This plan forms the basis for a formal agreement with the government and a commitment as to what the technical assistance effort, under the Matching Grant, will accomplish within a specified time frame.

The development of the plan of operation involves a close working relationship among the HKI team, key government health and rehabilitation planners, local health and rehabilitation personnel and the community in selected target areas. Many factors are discussed and analyzed. Although from country to country, and also within countries, there is some variation in the nature
and extent of the attention which each requires, experience to date indicates that all of the following factors need scrutiny before an effective working plan can be devised:

A. Selection of Target Areas - Target regions must represent areas where blindness and eye disease are a significant problem. The selection process needs to take into account social, political, economic, cultural and geophysical variations which will allow HKI and the government to maximize use of what is learned through such efforts. At the same time, those selected need to represent areas in which it is reasonable to conclude that the purpose can be accomplished within the established time frames. The purpose of efforts under the Matching Grant is not to establish nationwide programs, but to demonstrate the effectiveness of an integrated delivery system.

B. Refinement of Objectives - An inherent danger to any technical assistance effort in a developing country is the tendency to overstate objectives. This is frequently done by either setting more objectives than can reasonably be accomplished or by setting such broad objectives that it is impossible to evaluate progress and measure impact. During this stage of the planning process, objectives are defined and refined to avoid this pitfall.

C. Collection of Baseline, Monitoring and Impact Data - Although the preliminary and detailed assessments carried out in the earlier stages of the strategic planning process have resulted in valuable data, there is need for additional and more refined data which must be clearly identified in the plan of operation.

Of primary importance is the matter of baseline data to insure the progress toward stated objectives can be measured. The plan
of operation also includes consideration of the need for the ongoing collection of data to monitor project efforts and allow personnel to make the necessary refinements and "mid-course corrections" in project efforts and to carry out impact studies.

It is important to note here that the HKI Matching Grant Task Force has given careful consideration to the sensitivities of governments to the issue of data collection. There is an understandable wariness in most developing countries toward outside organizations which have, over time, carried out extensive research on problems, without equal consideration to the implementation of programs to do something concrete about dealing with the problem under study. HKI teams have, as a result, endeavored to incorporate detailed baseline studies as part of project implementation, instead of viewing them as separate steps to be taken before implementation begins.

D. Assistance Required at Various Levels - Since primary eye care programs at the community level cannot be developed in isolation, the plan of operation defines the nature and type of technical and material assistance required at the secondary and tertiary levels to support primary level efforts.

Of utmost importance in this area of HKI's work is the referral network currently in place and the assistance required to make the secondary and tertiary levels of the delivery system responsive to the community-based efforts being developed as the primary thrust of HKI's work under the Matching Grant. The success of these targeted community-based efforts depends to a large extent on the effective response of the higher levels of the system.

E. Nature and Extent of Training - The core of HKI's program efforts under the Matching Grant centers on the training of personnel
at all levels to assure that eye disease and blindness, as well as basic rehabilitation services to those already blind, receive careful attention. The range of training needs runs a gamut from the development of education and awareness programs at the individual community level to highly technical and specialized ophthalmological training for individuals at the tertiary levels of the health care system.

The plan of operation defines the extent and nature of such training at the community, regional and national levels.

F. Equipment, Material and Supply Needs - Equipment, material and supply needs, like training, include a range of possibilities, from basic public education training materials, to simple kits of surgical equipment, supplies of appropriate drugs and sterile dressings, to ophthalmoscopes, slit lamps and more sophisticated surgical equipment.

The plan of operation carefully defines needs in this area and identifies those items which will be provided through HKI under the Matching Grant.

G. Local Support - In addition to the resources committed by HKI and USAID, the Plan of Operation defines the very important resources contributed to the program by government and private sources at the local level. For example, in Peru the personnel resources that have already been committed by the Government and by OPELUCE (an indigenous PVO) are very substantial and are expected to increase as the program gains momentum. Not only does such local support represent a substantial financial commitment, but is a preliminary indication of local will and commitment to combat the problem of blindness and eye disease as part of their emerging primary health care infrastructure.
H. **Local Agreement** - This aspect of the plan of operation identifies specific issues related to HKI's status in the country, the tax-status of non-local personnel, visas, and the duty-free importation of project equipment, materials and supplies.

I. **Cost Analysis** - Finally, the plan of operation contains an analysis of costs involved in the implementation of country-specific efforts. This analysis is based on the best possible projections from data collected during the two previous planning stages. It will be refined and appropriate adjustments will be made as actual implementation is underway.
TIME/LINE CHART: A COMPARISON OF ORIGINAL PROJECTIONS WITH ACCOMPLISHMENTS AND REVISED PROJECTIONS

TIME/LINE PROJECTIONS

1. Formulation of Planning Task Force
2. Task Force in Operation
3. Standardization of Assessment Methodology
4. Recruitment of Personnel
5. Preliminary Country Assessment
6. Country Selection
   - Country 1: Peru
   - Country 2: Sri Lanka
   - Country 3: Tanzania
   - Country 4:
7. In-country Planning
   - Country 1: Peru
   - Country 2: Sri Lanka
   - Country 3: Tanzania
   - Country 4:
8. Project Implementation
   - Country 1: Peru
   - Country 2: Sri Lanka
   - Country 3: Tanzania
   - Country 4:
9. Evaluation
   - Overall Project
   - Country Specific

Key:
- Time/line projections
- In original proposal
- Accomplishments and/or revised projections

MONTHS
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36
IV. REPORT OF COUNTRY SPECIFIC ACCOMPLISHMENTS AND FUTURE PLANNING

Introduction: Using the process described in Section III, HKI has, over the last seven months, completed planning for a three-year blindness prevention, eye care and rehabilitation effort in Peru. This will begin in August 1982. Planning is also underway in Sri Lanka, Tanzania and Zimbabwe.

PERU

An HKI team, including a specially recruited U.S. ophthalmologist (who formerly served as a Peace Corps physician in Peru) have designed and carried out an expansive research and planning effort working in close collaboration with:

1. private and public Peruvian officials;
2. officials of the Pan American Health Organization;
3. U.S. and Canadian PVO's active in community development and health projects;
4. public health ophthalmologists at Johns Hopkins and Yale Universities and the Air Force Academy.

Since the signing of the Matching Grant, HKI personnel have spent a total of approximately three months in Peru conducting initial and detailed assessments and working with their Peruvian colleagues in the development of an Implementation Plan.

Eighteen million people live within the 771,130 square miles of Peru, a density of 26 per square mile. The country has three topographically distinct regions: a coastal plain, the Andes mountains, and the Amazon region.
The overall health situation in Peru is poor. The major contributing factors are low income, inadequate housing, lack of water and sewage disposal. This situation leads to high rates of diseases related to environmental sanitation, such as typhoid, tuberculosis, diarrheal diseases, infectious hepatitis and intestinal parasites. These same overall conditions also contribute to the significant amount of eye disease and blindness that have been identified during the preliminary and detailed assessments carried out by HKI.

The government is attempting to strengthen the health care delivery system and has recently embarked on an ambitious national program of primary health care. Peru is beginning to provide effective health care to the general population for the first time. The system consists of unpaid promoters at the village level, trained paramedical workers covering a number of villages and a referral system above the multivillage level. Beyond the village level are clinics, and area and regional hospitals. It is within the context of this emerging health care network that carefully targeted HKI/Government of Peru efforts to integrate primary eye care and basic services are being developed.

The lack of eye health care at the community level is a fairly serious problem throughout Peru. While on a national level there is a need for more solid statistical information with regard to blindness, including those already blind or at risk of losing their sight, there is information -- in the form of studies as well as professional experiences -- which provides useful data. Estimates of the blind population of Peru vary between 35,000 and 70,000.
The serious lack of eye care in Peru is very much related to the extremely uneven distribution of ophthalmologists. The majority (72) are located in the capital city of Lima, which has approximately one-third of the population of the country. Although some 32.5% of the population is rural, all of the ophthalmologists reside in urban centers. This means that 5 million inhabitants have virtually no access to eye care by specialists (who are the only people authorized to prescribe glasses in Peru). Even in cities where ophthalmologists are available, private care is normally too expensive for most of the population. The lack of trained and properly equipped community-based eye health personnel among the ranks of primary level health promoters, paramedical workers, nurses, and even doctors, further aggravates the situation.

A study in one of HKI's target areas, the jungle region of San Martin province (population 300,000), revealed that conjunctivities, pterygium, ameotropies, cataracts, trachoma and glaucoma are the most frequent eye diseases diagnosed. Ophthalmologists working in the same area on short-term assignments indicate that external ocular infirmities, especially trachoma, narrow-angle glaucoma and ocular trauma, are prevalent. In the mountain region of Puno (population 870,000), where HKI will operate, data being recorded by auxiliaries/"sanitarios" trained in primary eye care cite conjunctivitis and trauma as the principal reasons that patients request care. An HKI ophthalmology consultant believes that the most common cause of binocular blindness in that region is cataracts, followed by glaucoma.

Studies of monocular and binocular blindness indicate that diseases of the choroid and retina and cataracts account for 50% of the incidence of blindness, diseases of the cornea and sclera and glaucoma cause 34.72% of the blindness. Seventeen and one-half percent of the cases of monocular blindness are caused by amblyopia
accompanied by strabismus. In children, infectious-contagous diseases and congenital hereditary afflictions are important causative factors. In addition, studies indicate ocular involvement in 7% of all accidents among children, and 12.5% to 14.6% of work-related accidents.

Although data collected on preliminary and detailed assessments conducted by HKI has been adequate to develop the framework of an Implementation Plan, both HKI and the Ministry of Health recognize the need to collect additional baseline data in the target areas and to implement a data collection system to monitor the program and measure impact.

Project Description. Purpose: to demonstrate a cost-effective, high-standard primary eye health care and rehabilitation program integrated into the existing Peruvian health care structure, aimed at reaching selected unserved and underserved populations of Lima and three diverse rural states.

General Program. Using the existing health infrastructure, the joint HKI/Ministry of Health/OPELUCE (Organisation Peruana de Luca Contra la Ceguera---[an indigenous PVO]) project will deliver primary eye care and rehabilitation services over a three-year period in four geographic areas of Peru -- a jungle area (San Martin), a mountainous area (Puno), the cost (Ancash) and selected shantytown slum areas of Lima. (See Figure II, page 22).

At the national or "tertiary" level, HKI will coordinate the various program components with the government ophthalmological center (Santo Toribio Hospital) as well as downward through the structure, i.e. among the regional health areas, general hospitals, health centers, health stations and health posts. Patient and public mobilization is expected at all levels through both Santo
Toribio's activities and OPELUCE campaigns in the national mass media, and in regional and local publicity in the demonstration areas.

Through the careful placement of ophthalmologists, particularly at secondary level, the training of various levels of key health system personnel and public school teachers, and the provision of equipment and supplies, the project will demonstrate a functioning integrated system for the prevention, early diagnosis, treatment and referral of eye disease and the rehabilitation of the already blind. In addition, a general nation-wide eye care and blindness prevention public education effort, as well as specific campaigns on the principles of eye care and individualized patient education activities in each of the four demonstration areas will be mounted. Caseline studies of the eye care situation in each demonstration area will be made during the initial phase of the project. As the project proceeds, these will be used to measure the effects of the eye care system.

Description of Principal Activities. The key to delivering quality, cost-effective services is the coordination of manpower, facilities, services and finances, within the specific socio-economic and political milieu of Peru. Local community participation in project activities will be encouraged wherever possible. An in-country administrative structure which involves the least possible cost and at the same time allows for proper management of the demonstration activities is planned. It will include a project director, an administrative assistant and three Peruvian ophthalmologists in key positions in the rural demonstration areas. Additional positions, such as that of training coordinator, will be phased-in on an as-needed and cost-effective basis.

The four main activities of the project are: training, development of materials, provision of equipment and supplies, and assessment.
1. Training. Training/education of consumers and providers of eye health care services, as well as the general public, is the broadest and most important aspect of the project. The training/education activities will be directed toward bridging the gap between what science knows and what people do in the context of prevention, treatment and rehabilitation activities for eye health.

Training of health care personnel at various levels will be of varied length and intensity and will, to the extent possible, be given at the level closest to where services actually are to be delivered.

(a) In rural provinces unpaid "promotores," the lowest level of the system, will be trained. These courses will be of one-day duration. They will acquaint the "promotores" with the prevention and treatment of eye problems most prevalent in their areas. With this basic information, the "promotores" will be able to recognize diseases better and to refer those with serious eye problems to the next higher level in the system for treatment. Two hundred and fifty "promotores" will be trained in the program.

(b) Government service paramedical workers, "sanitarios," manning health posts are the general populations' first professional level entry point into the formal health network. "Sanitarios" represent the principal primary level training focus of the project. Training of these individuals will consist of a one-month course given to small groups by trained ophthalmologists at the tertiary center in Lima. As the project
proceeds, this training will be shifted to the secondary level hospitals in rural areas. Through the training the "sanitarios" will learn basic preventive skills, the ability to recognize, diagnose and treat selected eye problems, and gain sufficient knowledge and skill to know when to refer patients with serious eye disease to a higher level. One hundred and thirty-seven "sanitarios" are slated for training in the project.

(c) Nurses and general practitioners working out of rural health centers and general or area hospitals are key to the proper supervision and overall function of the entire referral system. These individuals, special supervisory nurses, exercise day-to-day control of the primary level "sanitarios."

Nurses will receive essentially the same training as that given the "sanitarios," whom they are expected to supervise. In addition, they will review and/or be exposed to principles of supervision and motivation. Nurses' training will last for two weeks. General practitioners will receive a briefer two-day refresher course in eye care. This training will be administered at regional hospitals, or offered as part of regularly scheduled medical conferences. Seventy-one nurses and 22 general practitioners will receive training.

(d) Personnel outside the governmental primary health care system who work primarily in the demonstration
areas include general practitioners, pediatricians, other interested physicians, privately financed health auxiliaries in factories and mines, and public school teachers.

School teachers will be trained by nurses and/or ophthalmology residents in one-day courses to do visual acuity screening and to recognize strabismus and other eye problems affecting children. In addition, they will be trained to give talks about eye disease prevention and to decide when to refer serious problems to higher levels. One thousand and fifty teachers will receive training.

Private general physicians and pediatricians will be offered the same two-day courses given to government general practitioners. Six hundred such doctors will be trained.

Health auxiliaries working in factories and mines will be offered a specially developed three-day course concentrating on recognizing basic eye disease, instituting safety measures in the work setting, and learning basic treatment techniques for eye trauma. Two hundred and seventy-five auxiliaries in factories and mines will receive this training.

(e) Rural rehabilitation workers for the blind will be trained through the use of techniques developed by HKI in a number of developing countries. These people will be recruited from the locales in which
they will be expected to serve. The approximate population in each worker's service area will be 40,000-50,000 persons. These workers will receive six to eight weeks initial and four additional weeks of training over a year's period. The rehabilitation workers will work closely with clients and their families to render individualized rehabilitation programs of varying length. These workers will be integrated into the existing health programs for Puno and Ancash. Thirty-three rehabilitation workers will be trained.

(f) The project will provide specialty training through partial support of ophthalmology residencies for two G.P.'s selected from the demonstration area. In exchange for this financial support and training, these doctors must agree to serve for five years in the demonstration areas from which they were selected. Three residents will be trained.

2. Materials Development The project will support development of two different types of materials -- materials and appropriate methodologies to support the training given to the several thousand persons active in the new eye care network, and materials for use in public health education. The former will consist of an eye care manual for all groups and other materials and handouts for basic and refresher training specifically designed for each group. The latter will include both general TV and radio materials and films for general use throughout the country and materials for use with the general public in demonstration areas.
3. **Equipment and Supplies**  Equipment and supplies will be provided in the following categories: surgical, examination, laboratory, diagnostic, teaching and administrative.

At the lowest levels, health personnel and teachers will be provided such basic materials as acuity charts, manuals and, in the case of the "sanitarios," basic medicines, tweezers, magnifying glasses, ophthalmic flashlights, and glaucoma tonometers. At each succeeding upward level, in order to ensure the availability of high standards of eye care, equipment of an increasingly sophisticated and comprehensive nature will be supplied.

4. **Assessments**  This activity will provide solid baseline information concerning the incidence and prevalence of eye disease and blindness in the selected target areas, as previously noted. In addition, assessments will serve as a measure of the effectiveness and efficiency of carefully planned eye health care training and service delivery activities. Peruvian and HHI consultants will be utilized to assure the soundness of assessment methodologies and data evaluation. Assessments in program operation areas such as numbers of visits, treatments and costs will also be undertaken.

**RURAL VERSUS URBAN METHODOLOGY**

In the three rural areas, all the activities described above will be supported by the project. In the poor urban districts surrounding Lima (Pueblos Jovenes), however, there will be differences in implementation style. In Lima, where 72% of Peru's ophthalmologists reside and practice (as opposed to Puno and San
Martin which at the moment have no ophthalmologists and Ancash, which now has only two ophthalmologists, both in private practice), the tertiary center will extend its service in primary eye health delivery beyond its walls in an attempt to improve access to portions of the urban population which is underserved.

Presently, the ophthalmology outpatient department of the Santo Toribio tertiary center sees more than 200 patients per day (35,000 per year), which are handled by one ophthalmologist and five residents who must work under inadequate conditions. Since they cannot meet the actual demand, many people who have come from outside Lima or its nearby shantytowns cannot be seen or must return the following day hoping that they will be examined. In order to improve access for selected populations in the shantytown, the tertiary center will implement primary eye care activities in those shantytowns and slums on the perimeter of Lima. To do this, it will send ophthalmology residents there to conduct prevention, selected treatment activities, and make referrals. This will be done in coordination with organizations such as educational institutions, UNICEF, homes for the elderly, and other Ministry of Health facilities (e.g. health centers).
SRI LANKA

Background During the past ten months HKI has made significant progress toward the development of an integrated community-based program to deal with the problem of blindness in Sri Lanka. HKI personnel have spent approximately four months working with individuals from both private and government agencies planning an integrated primary eye care and service program. A preliminary assessment has been completed and a detailed assessment initiated. By November 1982, a Plan of Operation will be finalized, with the initial stages of implementation underway shortly thereafter.

In addition to these planning efforts, and as a preliminary step towards the development of a full-scale operational program, HKI has established a modest pilot program in rehabilitation of the rural blind in South Colombo and Kalutara. This pilot effort is being carried out in cooperation with the Sarvodaya Movement, using the private resources of HKI.

Summary of Health Status Sri Lanka is an island nation with a population of 14.2 million, located 18 miles southeast of the Indian subcontinent. The population density of 520 per square mile is weighted toward the southwest quarter, where agricultural conditions are most favorable to the use of traditional technology. Five and one-half million of Sri Lanka's population is under 15 years of age. The population is growing at a rate of 1.91% annually.
The population of Sri Lanka is predominantly agricultural, with 73% (approximately 11 million) living in rural areas.

An examination of the crude birth rate (28), infant mortality rate (43.7), and life expectancy (68.0) would indicate that Sri Lanka is more developed in its health sector, than its per capita gross national product of U.S.$187 would seem to indicate. In fact, Sri Lanka does have a fairly well-developed health structure, yet blindness and eye disease are still significant problems.

Sri Lanka's traditional policy orientation toward provision of curative services is currently undergoing significant change. However, as late as 1979, approximately 75% of the health budget was spent on relatively high technology curative medical services. Nowhere is this more apparent than at the tertiary level Eye Hospital in Colombo. The staff of 10 ophthalmologists deal with large numbers of patients who have either bypassed a lower level of the eye health system or more frequently, because of the lack of services at the periphery, travel to Colombo for treatment that could be more effectively provided at the community level.

A recent White Paper by the Ministry of Health points out the need to decentralize the health system. The paper advocates placing increased decision-making responsibility at the district level and developing stronger preventive medical programs at the community level. The objective of this would be to counter the tendency toward curative services which place unnecessary burdens on the health manpower at provincial hospitals and at specialized tertiary level facilities, such as the Colombo Eye Hospital.

At the same time, efforts are being made to bring together in a more effective way western and ayurvedic (traditional) medical
approaches. Fully, 70-80% of Sri Lanka's rural population seek initial medical treatment from ayurvedic practitioners. One of the most significant causes of blindness in Sri Lanka is corneal infection due largely to inappropriate treatment by these ayurvedic practitioners. To be effective, a primary eye care program in Sri Lanka must direct attention at both ayurvedic and Western health care providers.

Blindness and Eye Disease in Sri Lanka Despite the relatively well-developed health services in Sri Lanka, blindness and eye disease remain a serious problem.

Using W.H.O. classification standards, a recent survey (Wirasinka, 1980) of 116,827 persons in seven districts revealed an incidence of blindness of 3.43 per 1,000. Assuming a population of 14 million, one could draw from these results a blind population in Sri Lanka exceeding 48,000. Unfortunately, this survey only reports the incidence of blindness and gives no data on serious eye diseases that have, as yet, resulted in blindness.

A further examination of these data reveals that 89.5% of the causes listed in this study could be detected and treated if effective measures were in place at the district and community levels. This seems to verify a conclusion drawn by a committee appointed by the Minister of Health which stated:

Although Sri Lanka is free of trachoma the disease that contributes to the largest amount of blindness in the world, other diseases like cataract, infections, glaucoma and injuries are causing a significant amount of blindness warranting concerted action. This is even more so since almost all of these conditions are both preventable and easily curable with excellent results.
HKI's Previous Experience in Sri Lanka  From 1967-71, HKI was active in Sri Lanka in developing, with the Ministry of Education, a special education infrastructure at the community level which allows visually handicapped children to attend regular primary and secondary schools in their home communities. This technical assistance effort has long been institutionalized and has over the years provided thousands of visually handicapped children with equal access to educational opportunity. The resulting social and economic independence did not exist previously. On a recent trip to Sri Lanka, as part of the Matching Grant planning effort, an HKI staff member met one of the first children enrolled in the original demonstration effort in integrated education. This totally blind woman is now a lawyer working at the Supreme Court of Sri Lanka.

As a result of this earlier HKI/Government of Sri Lanka effort, there are now approximately 450 specially trained resource teachers working with blind, low visioned and other handicapped children in primary and secondary schools in 21 of Sri Lanka's 24 administrative districts. All of these individuals have had some background in blindness and eye disease and represent a valuable personnel resource that will be used as part of HKI's new integrated primary eye care and service effort in Sri Lanka.

Recent discussions with the Ministry of Education personnel indicate an interest and willingness to involve this cadre of resource teachers in targeted public education programs. This approach will help address what one of Sri Lanka's leading ophthalmologists recently referred to as one of the top two priorities of any blindness prevention program "the need to protect kids eyes and preserve sight."
HKI's Current Efforts  More recently, HKI has initiated, with the Sarvodaya Movement, a pilot program in community-based re­habilitation of the adult blind in Kalutara and South Colombo. Ten field-workers and a supervisor have been trained and to date have identified 32 visually handicapped persons through surveys of 1,154 households. Currently, rehabilitation plans have been developed and services provided to 50 visually handicapped individuals.

The primary thrust of this program is to return these indi­viduals to productive lives in their families and communities. Like the integrated education program, this effort involves the com­munity in the rehabilitation process, thus increasing awareness and changing attitudes about the capabilities of individuals with a serious and permanent visual impairment.

HKI's work in Sri Lanka during the past 10 months has con­centrated on efforts to develop an integrated primary eye care and service initiative under the Matching Grant.

During this period several visits have been made by HKI staff and an HKI ophthalmic consultant from Dartmouth College Medical Centers' Hitchcock Clinic. The planning trips have involved a close collaboration between HKI, officials of the Government of Sri Lanka and the private health and community development sector.

Through discussion and field visits to potential target areas, efforts to date have revealed:

1. **Government Involvement** The Ministries of Health, Social Welfare and Education have all enthusiastically endorsed an HKI initiative to develop a targeted
integrated program to provide primary eye care and services in carefully selected districts. It has been pointed out that HKI's broad plans are totally in keeping with the recommendations put forth in the 1973 Report of the National Committee appointed by the Minister of Health (A National Programme for the Prevention of Visual Impairment and Blindness).

2. Private Sector Involvement Work to date has also resulted in the enthusiastic endorsement of a number of agencies and a U.S. corporation representing the private sector. These include:

--The Sarvodaya Movement
--Sri Lanka Council for Social Welfare
--Eye Care Sri Lanka
--U.S. Save the Children
--Christoffel Blindenmission (West Germany)
--Royal Commonwealth Society for the Blind (United Kingdom)
--IBM Americas/Far East Corporation

Currently three target areas are under active consideration; each representing a Superintendent of Health Services (SHS) medical district. These are Anuradhapura, Badulla and Kalutara. Initial impressions data gathered by HKI through field visits and discussions with government and private health care providers indicate that eye disease and blindness are serious problems in each of these areas.

In July 1982, an HKI team will carry out further work and meet with the new Minister of Health to discuss details of the emerging implementation plan for Sri Lanka.
Within the next few months additional detailed assessments will be carried out leading to an Implementation Plan which is expected by November 1982.

Although further data needs to be collected before this plan can be developed, it is likely that the well-established infrastructure of the Sarvodaya Movement which is active in almost 70% of Sri Lanka's rural villages will be the primary vehicle for this effort which is likely to include the following elements.

1. Training and provision of materials for:
   - Sarvodaya and Government primary health care workers and their supervisors
   - Ayurvedic practitioners (including those with no formal training as well as those trained through the College of Ayurvedic Medicine)
   - Teachers
   - Nurses and Midwives
   - District Medical Officers and General Practitioners
   - Additional field-workers for expanded rural rehabilitation efforts

2. Provision of basic medical equipment and supplies

3. Procedures for collecting and analyzing baseline, monitoring and impact data.

4. Specific procedures for strengthening and utilizing the existing referral network, including ongoing and planned efforts of other PVO's.
HKI and Tanzania HKI has been involved in discussions with key health and social service planners since 1980. These discussions were initiated with the Ministry of Labour and Social Welfare, through a request for technical assistance in providing basic rehabilitation services to blind persons living in rural areas while at the same time incorporating blindness prevention efforts into this program.

More recently, HKI representatives met with key Tanzanian medical officers concerned with ophthalmology at the Annual IVACG (International Vitamin A Consultative Group) Conference in Kenya. During this meeting there was expressed need for technical assistance in the area of blindness prevention, with particular attention to the documented problem of xerophthalmia in Tanzania.

In February 1981, HKI's Medical Advisor made a follow-up visit to Tanzania and met with representatives of the Ministry of Health, Muhimbili Medical Center and the Tanzanian Food and Nutrition Center. During this visit it was concluded that HKI should proceed in developing a program of intervention in blindness prevention.

Immediate plans include two HKI representatives attending the July 1982 Prevention of Blindness Seminar in Tanzania. At that time, they will meet with the majority of ophthalmic personnel available in the country, to discuss xerophthalmia and its relationship to blinding measles, and an integrated blindness prevention program.
Although it is premature to outline the scope of HKI's input to the development of a national plan of action to prevent blindness in Tanzania. at minimum it would involve a) support of an effort to look at xerophthalmia control and its relationship to measles; b) development of a targeted primary eye care and rehabilitation project (most likely in the Dodoma area where eye disease is prevalent).

A follow-up visit is tentatively planned in November 1982 to gather additional data and carry out detailed planning. The team will consist of HKI staff and an ophthalmic consultant.

Summary of Health Status. Tanzania's population is estimated at eighteen million (1980), with almost ninety percent living in rural areas. In 1978, the infant mortality rate was estimated at 152 per 1000 live births; life expectancy at birth is 51 years. Although the majority of the population have access to some health services, health problems are serious and countrywide. Malaria, schistosomiasis, and upper respiratory disease are widely evident. The most prevalent fatal and crippling diseases among children are measles and poliomyelitis. As many as five to ten percent of children have severe malnutrition; with an additional 46% below 30% of standard weight for their age group.

As in most developing countries, data on blindness are incomplete. However, in 1974, it was estimated that in a national population of 12.3 million, there were 30,000 blind (.3%). This national average does not indicate regional variations; for example, Dodoma has been reported as an area with a relatively high level of blindness. In addition, due to the severity and frequency of measles, childhood blindness as a result of complications is well documented.
The national objectives for the health sector are reflected in the 1967 Arusha Declaration, which committed Tanzania to socialism. Health is considered a priority, with a shift from high technology to simpler rural health care. The development of rural level dispensaries and paramedical personnel has been increasing during the last fifteen years.
V. FINANCIAL ANALYSIS

Impact on Private Sector Support  Early indications are that, at least for now, the Matching Grant has had a positive impact on HKI's ability to attract increased support from both private individuals and from corporations.

For the first time, HKI has been able to achieve considerable success in attracting active corporate support. Through the use of the Matching Grant as effective leverage, HKI was awarded a $50,000 two-year grant from IBM Americas/Far East Corporation. We are now in the process of negotiating grants from a number of other corporations, and the outlook appears optimistic. The credibility conferred by this type of grant and the clear fact that a potential contribution can be effectively doubled has great appeal in the corporate community.

In addition to the initiative of the "Match," the Matching Grant has led to a direct and immediate expansion in the scope and geographical spread of HKI's programs. This has generated new interest and increased response. Peru, the first Match Grant country, was particularly significant to IBM.

The "Match" concept and the increased program scope have struck a responsive chord among HKI's other contributors as well. We have used these in appeals to larger givers, small foundations and businesses, and in our regular mailings to small contributors (Appendix II). HKI's direct mail income for FY 81-82 increased by approximately 21 percent, a growth we attribute to the idea of the "Match."

While the positive impact of the Matching Grant is clear, and this year was particularly strong financially, it is difficult to project a continuation of this trend--particularly because
of the current economic situation. HKI expects, however, continued modest growth in private resources for fiscal year 1982-83.

**Matching Grant Drawdown** While HKI has achieved and indeed in many aspects exceeded its operational objectives for the first year of the Matching Grant, it did not utilize the full amount of funding estimated for year one. This is basically due to the fact that we anticipated a larger first-year drawdown for actual operations in Peru. The fact that this did not occur was necessitated by the realization that with "start up" we needed to proceed at a slower and somewhat more careful pace.

However, when we analyze the impact of this within the perspective of the three-year time frame of the grant, we feel that the overall spending projections will be met. We are projecting a drawdown of up to $780,000 for year two (Exhibit IV), which will bring us even with the initial two-year projection. A third-year funding level of $600,000 will then complete original projections.
**Public Support and Revenue**

I. Contributions
   - Individual: 670,000
   - Foundations/Corporations: 70,000
   - Legacies: 250,000
   - Miscellaneous: 8,000
   - Subtotal: 998,000

II. Revenue
   - Investment Income: 210,000
   - Trust Income: 26,000
   - Subtotal: 236,000

Total Public Support and Revenue: 1,234,000

III. Government Support
   - AID Matching Grant: 194,400
   - AID OPG’s: 528,600
   - Total Government Grants: 723,000

Grand Total: 1,957,000
MATCHING GRANT
Line Item Budget 8/1/81-7/30/82

I. Delivery of Integrated Services

A. Project Implementation
   1. Staff Travel
      a. Air Fares 30,000
      b. Per Diems 20,000
      Subtotal 50,000
   2. Consultants
      a. Fees 10,000
      b. Travel 4,000
      Subtotal 14,000
   3. Development 10,000
   4. Operational 80,000

   Total Project Implementation and Operational Costs 154,000

B. Project Support Staff
   1. Salaries 13,000
   2. Fringe Benefits 2,700
   Total Support Staff 20,700

   Total Delivery of Integrated Services 174,700

II. Management and Administration

   1. Direct 4,000
   2. Indirect 15,750
   Total Management and Administration 19,750

   Grand Total Matching Grant Costs 194,450
HKI ORGANIZATIONAL COSTS: Matching Grant
Annual Report

<table>
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<tr>
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<th>HKI</th>
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<td>f. Supporting Service</td>
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<td>TOTAL PROGRAM COSTS</td>
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<td>194.4</td>
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<td><strong>III. Supporting Services</strong></td>
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<td>Management and General</td>
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<td>Program Support</td>
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<td><strong>EXCESS INCOME</strong></td>
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### MATCHING GRANT PROJECTIONS - FISCAL YEAR 1982-83

#### I. Delivery of Integrated Services

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<th>Peru</th>
<th>Sri Lanka</th>
<th>Tanzania</th>
<th>General</th>
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<td>A. Assessment</td>
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<td>C. Training</td>
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<td>D. Services</td>
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#### II. Support Staff

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<td>A. Salaries</td>
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<td>B. Fringe Benefits</td>
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<td><strong>Subtotal</strong></td>
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#### III. Management and Administration

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<tr>
<td>A. Direct</td>
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<td>B. Indirect 8.8%</td>
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<td><strong>Subtotal</strong></td>
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#### IV. TOTAL HKI MATCHING GRANT

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<tr>
<td><strong>Total</strong></td>
<td>780.4</td>
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APPENDIX I

LOGICAL FRAMEWORK MATRIX
### III. LOGICAL FRAMEWORK MATRIX - PICO WORKSHEET

<table>
<thead>
<tr>
<th>STUDY A.1. GOAL</th>
<th>A.2. OBJECTIVELY VERIFIABLE INDICATORS</th>
<th>A.3. TYPES OF VERIFICATION</th>
<th>A.4. IMPORTANT ASSUMPTIONS</th>
</tr>
</thead>
</table>
| To improve the quality of life and productivity of the urban and rural poor in selected host countries through the prevention, treatment, and restoration of blindness and through the delivery of vision and contributing members of their communities. | 1. Number of people screened and treated in clinics, schools, hospitals in countries selected.  
2. Number of people who have gained access to preventive, therapeutic and restorative services.  
3. Number of blind restored to productive and contributing members of their communities. | 1. Ongoing follow-up joint evaluation and review.  
2. IMT reports and records.  
3. USAID reports and records.  
4. Host Country reports.  
5. Embassy reports. | 1. The delivery of blindness preventive and rehabilitation services contributes to the productivity and well-being of the poorest majority living in underserved areas.  
2. Host governments recognize the priority to develop ongoing integrated systems to treat and prevent blindness.  
3. Visual disability from preventable and/ or treatable eye diseases has a significantly greater social and economic impact in developing countries than in developed countries.  
4. Integrated programs to deliver primary care eye care significantly contribute to general health and development strategies. |

*Given the fact that reliable statistics are unavailable at the present's outset, quantitative indicators only can be projected as estimates and data are gathered in the planned assessment studies.*
<table>
<thead>
<tr>
<th>EVIDENCE</th>
<th>COMPLIANCE VERIFIABLE INDICATORS</th>
<th>MEANS OF VERIFICATION</th>
<th>IMPORTANT ASSUMPTIONS</th>
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<td>9.1. Purpose</td>
<td>Plan, implement, and evaluate over a three year period in four selected HIC's programs that demonstrate the degree to which preventive, tertiary, and restorative services can be integrated into the delivery of primary health care.</td>
<td>1. Blinding integrated into the existing health structures in 4 countries. 2. Primary eye services available at each health care level, particularly at the primary level. 3. Impact and cost of the integrated approach demonstrated. 4. Host governments recognizing and supporting the employment of integrated strategies in other areas where blindness is identified as a problem.</td>
<td>1. Primary eye health care can complement the delivery of primary health care and contributes to the goal of health for all by the year 2000. 2. Ministries of Health in countries selected recognize the potential for delivering blindness services through existing or planned delivery systems. 3. IBI will maintain its momentum in planning and implementing expanded blindness programs. 4. Other PO's, national and international organizations are interested and capable of integrating selected blindness components in their programs. 5. Host governments and institutions can and will assure responsibility to effectively carry on programs designed.</td>
</tr>
<tr>
<td>SUMMARY</td>
<td>OBJECTIVELY VERIFIABLE INDICATORS</td>
<td>PAGES OF VERIFICATION</td>
<td>IMPORTANT ASSUMPTIONS</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------</td>
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</tr>
<tr>
<td>C.1. Outputs</td>
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<td>1. Integrated community level</td>
<td>1. 4 projects planned and underway in 4 countries</td>
<td>C.3.</td>
<td>C.4.</td>
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<tr>
<td>progress planned and initiated in 4 LDC's</td>
<td>2. Assessments completed in 4 countries and baseline data available</td>
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<td>1. USAID has the management and financial expertise to plan and initiate integrated programs</td>
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<tr>
<td>2. Development of Assessment Methodologies</td>
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<td>2. Governments will make financial and manpower resources available</td>
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<td>3. Manpower education and training</td>
<td>3. a. I personnel trained</td>
<td></td>
<td>3. Personnel will complete training programs and remain in positions for which they are trained.</td>
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<tr>
<td>programs designed and in use</td>
<td>b. I trained at each level</td>
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<tr>
<td>4. Professional, paraprofessional and community health workers delivering eye care services</td>
<td>c. Length of training</td>
<td></td>
<td></td>
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<tr>
<td>5. Operational planning manuals</td>
<td>d. Examinations</td>
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<td>for eye care and institutions produced</td>
<td>e. Retention</td>
<td></td>
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<tr>
<td>and in use</td>
<td>f. Cost per worker trained</td>
<td></td>
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<tr>
<td>6. Increased planning and health</td>
<td>4. a. I visits per day</td>
<td></td>
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<tr>
<td>worker capacity within health</td>
<td>b. I treatments performed quarterly</td>
<td></td>
<td></td>
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<tr>
<td>governments and institutions</td>
<td>c. I treatments at each level</td>
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<td>7. Development and LDC use of</td>
<td>d. I referrals</td>
<td></td>
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<td>evaluation tools</td>
<td>e. Aggregate record keeping</td>
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<td></td>
<td>f. Cost per treatment</td>
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<td></td>
<td>g. Cost per rehabilitation</td>
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<td>1. IRI Management and technical SEE budget expertise.</td>
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APPENDIX II

MATCHING GRANT

FUND RAISING APPEALS
February 5, 1982

Miss Nell E. Lee
1008 W. Mansfield
Spokane WA 99205

Dear Miss Lee:

NOW, FOR EVERY CHILD'S SIGHT YOU HAVE HELPED TO SAVE IN THE PAST, YOU CAN COUNT TWO CHILDREN WITH YOUR NEXT GIFT TO HELEN KELLER INTERNATIONAL.

The Agency for International Development, eager for HKI to extend its successful programs to remote areas of South America and Africa, has pledged to match every private contribution we receive up to a total of $1.5 million.

This means that each new dollar you give will work TWICE as hard to fight xerophthalmia, trachoma, and other blinding scourges. TWICE as hard to rehabilitate children already blind, TWICE as hard to reach our goal of eradicating preventable blindness by the year 2000.

Your last gift to HKI helped to rescue the sight of thousands of children in Bangladesh, Indonesia, and other Asian countries, where vitamin A-deficiency disease (xerophthalmia) strikes more than 5,000,000 young victims every year.

Just think how many more children condemned to a lifetime of darkness would be spared if the most simple system of eye disease detection and care could be made available to them through HKI.

Won't you please consider increasing your previous gift of $3? A tax-deductible contribution of $6 or $8 will go two times as far in matched funds, and many times farther in showing you care.

Sincerely,

John H. Costello
Executive Director
September 1, 1981

Can you imagine more than twice the population of the United States afflicted with a disease that can blind them, when a 10¢ tube of antibiotic ointment could save their eyes?

Today, over five hundred million people around the world suffer from this disease — trachoma — and 13 million are already blind from lack of care.

With loyal support from you and other dedicated Americans, Helen Keller International is launching a $5 million project to wipe out trachoma, the world's #1 sight-destroying disease. At the same time, we are intensifying our fight against xerophthalmia, or vitamin A deficiency, the leading cause of blindness in children.

To mount this major new attack, HKI is taking public health services directly to people living in some of the poorest areas on earth, where trachoma thrives. For the first time, blindness prevention and rehabilitation treatment will be available on a regular basis at clinics serving people in jungles and poverty-stricken rural areas of developing lands.

Our first project is in the remote Taraputo region of Peru, where until now only one ophthalmologist has served one million people and eye health problems are rampant.

I take pride in sharing these latest advances with you. Your strong support of Helen Keller International is testimony to your deep concern for the healthy eyes of people everywhere, especially in the developing world where the need is greatest.

As we break new ground in our vital work to eradicate preventable blindness by the year 2000, your continued support of HKI will help bring greater hope to those at risk, greater dignity to those already blind.

I hope we can count on your renewed commitment at this crucial time.

With sincere thanks,

John H. Costello
Executive Director

JHC:mma
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This also means that you -- and thousands of other generous Americans for whom the needs of those threatened with blindness are a heartfelt concern -- have a new and unique opportunity to strengthen your commitment to a world of vision for all.

Your last gift to HKI helped to rescue the sight of thousands of children in Bangladesh, Indonesia, and other developing Asian countries, where vitamin A-deficiency disease (xerophthalmia) strikes more than 5,000,000 young victims every year.

Just think how many more children condemned to a lifetime of darkness could be spared if the most simple system of eye disease detection and cure could be made available to them through HKI.

May I ask you please to consider sending a doubly effective gift to HKI at this time, equal to or larger than your last contribution? Your continued support will go two times as far in matched funds, and many times farther still in showing you care.

With my warmest thanks,

John H. Costello
Executive Director

JHC/mrm
March 29, 1982

Because you care about prevention of diseases that have needlessly blinded 35 million people in developing nations, it is urgent that you know about Peru's problems and about how a small amount of help can go a long way.

In the remote villages of Peru, where 6 million people live, the threat of blindness has been constant for centuries. Trachoma and trauma-caused eye infections smolder, inevitably leaving large numbers of villagers without any sight. Even larger numbers suffer vision loss that consigns them to unproductive and unhappy lives.

The only thing sadder than inevitable blindness is blindness that could have been prevented if the simplest treatment had been available. That is why the people of Peru have turned to Helen Keller International.

Drawing on 67 years of experience in overcoming blindness, HKI has created a basic eye care program for Peru's fledgling health and development network. Ultimately, all the people who are most in danger will receive regular eye checkups by community health workers trained to detect and treat eye disease before permanent damage is done.

The people of Peru are counting on HKI, and we have begun our work for them. In turn, HKI is counting on the generosity of caring Americans, like you, to fulfill the promise of sight for yet another nation historically beset by blindness. With your help, Peru's centuries of affliction can end in this century.

Please renew your gift to Helen Keller International so that our work in Peru can join our eye-health projects in Bangladesh, Indonesia, Haiti, Sri Lanka, and other countries suffering the crippling effects of massive amounts of needless eye diseases.

When we know that 80 percent of the world's blindness can be prevented, we cannot justify waiting another day to do our utmost.

Sincerely yours,

John H. Costello
Executive Director

JHC:mrn
REFERENCES


Cox, Karen M. Goletkanycz, Health Situation in Peru, Division of Program Analysis, Office of International Health, Department of Health, Education and Welfare, December 1977.

Garcia, Pedro V., M.D., Patologia Ocular en la Region de San Martin (Peru), Reporte Estadistico Preliminar-Segunda Parte, Hospital General Base Tarapoto, Servicio de Oftalmologia, April 1980.

Hall, Thomas L., M.D., Peru - The Latin Style of Health Services, Johns Hopkins University School of Hygiene & Public Health, Department of International Health, 1974.

Helen Keller International, Memorandum from A. Sommer, M.D. Re: Contacts and Discussions Relevant to Primary Eye Care Programs Related to HKI Activities, December 2, 1981.


Organizacion Peruana de Lucha Contra La Cequera (OPELUCE), Plan Nacional para la Prevencion de la Cequera, Lima, Peru, 1980.


APPENDIX I

LOGICAL FRAMEWORK MATRIX
III. LOGICAL FRAMEWORK MATRIX - PPO WORKSHEET

<table>
<thead>
<tr>
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<tr>
<td>To improve the quality of life and productivity of the urban and rural poor in selected LIC's through the prevention and treatment of blindness; and through the restoration of those already blind to productive members of the family and community.</td>
<td>1. Number* of people screened and treated in clinics, schools, hospitals in countries selected.</td>
<td>1. On-going follow-up joint evaluation and review.</td>
<td>1. The delivery of blindness preventive as well as education and rehabilitation services contributes to the productivity and well being of the poorest majority living in underserved areas.</td>
</tr>
<tr>
<td></td>
<td>2. Number of people who have gained access to preventive, therapeutic and restorative services.</td>
<td>2. IBI reports and records.</td>
<td>2. Host governments recognize the priority to develop ongoing integrated systems to treat and prevent blindness.</td>
</tr>
<tr>
<td></td>
<td>3. Number of blind restored to productive and contributing members of their communities.</td>
<td>3. USAID reports and records.</td>
<td>3. Visual disability from preventable and/or treatable eye disease and trauma has a significantly greater social and economic impact in developing countries than in developed countries.</td>
</tr>
<tr>
<td></td>
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<td>4. Host Country reports.</td>
<td>4. Integrated programs to deliver primary eye care significantly contribute to general health and development strategies.</td>
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<td>5. Embassy reports.</td>
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*Given the fact that reliable statistics are unavailable at the program's outset, quantitative indicators only can be projected as estimates and data are gathered in the planned assessment studies.
10. LOGICAL FRAMEWORK MATRIX - PROP WORKSHEET

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>COLLECTIVELY VERIFIABLE INDICATORS</th>
<th>MEANS OF VERIFICATION</th>
<th>IMPORTANT ASSUMPTIONS</th>
</tr>
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<tbody>
<tr>
<td>B.1. Purpose</td>
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<td></td>
<td>Plan, implement, and evaluate over a three-year period in four selected IRC's programs that demonstrate the degree to which preventive, treatment and restorative services can be integrated into the delivery of primary health care.</td>
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</tr>
<tr>
<td>B.2. End of Project Status</td>
<td>1. Blindness integrated into the existing health structures in 4 countries</td>
<td>1. Ongoing joint evaluation</td>
<td>1. Primary eye health care can complement the delivery of primary health care and contributes to the goal of health for all by the year 2000.</td>
</tr>
<tr>
<td></td>
<td>2. Primary eye services available at each health care level, particularly at the primary level</td>
<td>2. Evaluation Impact</td>
<td>2. Ministries of Health in countries selected recognize the potential for delivering blindness services through existing or planned delivery systems.</td>
</tr>
<tr>
<td></td>
<td>3. Impact and cost of the integrated approach demonstrated</td>
<td>3. Host Government reports and policy</td>
<td>3. IBRI will maintain its momentum in planning and implementing expanded blindness programs.</td>
</tr>
<tr>
<td></td>
<td>4. Host governments recognizing and supporting the employment of integrated strategies in other areas where blindness is identified as a problem</td>
<td>4. Allocation of resources</td>
<td>4. Other IO's, national and international organizations are interested and capable of integrating selected blindness components in their programs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. USAID reports</td>
<td>5. Host governments and institutions can and will assume responsibility to effectively carry on programs designed.</td>
</tr>
<tr>
<td></td>
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<td>6. IBRI reports</td>
<td></td>
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<tr>
<td>SUMMARY</td>
<td>OBJECTIVELY VERIFIABLE INDICATORS</td>
<td>MEANS OF VERIFICATION</td>
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<tr>
<td>C.1. Outputs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Integrated community level program planned and initiated in 4 LDC's</td>
<td>1. 4 projects planned and underway in 4 countries</td>
<td></td>
<td>1. HR1 has the management and financial expertise to plan and initiate integrated programs</td>
</tr>
<tr>
<td>2. Development of Assessment Methodologies</td>
<td>2. Assessments completed in 4 countries and baseline data available</td>
<td></td>
<td>2. Governments will make financial and manpower resources available</td>
</tr>
<tr>
<td>3. Human resource education and training programs designed and in use</td>
<td>3. a.1 personnel trained</td>
<td></td>
<td>3. Personnel will complete training programs and remain in positions for which they are trained.</td>
</tr>
<tr>
<td>4. Professional, para-professional and community health workers delivering eye care services</td>
<td>b.1 trained at each level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Operational planning manuals for governments and institutions produced and in use</td>
<td>c.1 length of training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Increased planning and management capacity within host governments and institutions</td>
<td>d.1 examinations</td>
<td></td>
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<tr>
<td>7. Development and LDC use of evaluation tools</td>
<td>e. Retention</td>
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<td>C.2.</td>
<td>f. Cost per worker trained</td>
<td></td>
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<td>C.3.</td>
<td>1. Ongoing joint evaluation</td>
<td></td>
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<td></td>
<td>2. Evaluation Impact</td>
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<td>3. Host Government reports and policy</td>
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<td></td>
<td>5. USAID reports</td>
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<td></td>
<td>6. HR1 reports</td>
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<tr>
<td>1. UNI Management and technical expertise.</td>
<td></td>
<td>1. Carrying joint evaluation and review</td>
<td>1. USAID funding will be forthcoming</td>
</tr>
<tr>
<td>2. UNI financial resources...$1,500,000</td>
<td></td>
<td>2. UNI reports and records</td>
<td>2. UNI will maintain and expand its technical and financial strengths.</td>
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MATCHING GRANT
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Today, over five hundred million people around the world suffer from this disease — trachoma — and 13 million are already blind from lack of care.

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JHC:nma
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