2009 A2Z Child Blindness Program Partners Meeting
Washington, DC
November 2-3, 2009

MEETING REPORT

Prepared by: Roshelle Payes, A2Z Child Blindness Program Manager

This meeting and report was made possible through United States Agency for International Development (USAID) through A2Z: The USAID Micronutrient and Child Blindness Project managed by the Academy for Educational Development under the terms of Cooperative Agreement No. GHS-A-00-05-00012-00. The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.

BACKGROUND

As a component of A2Z: The USAID Micronutrient and Child Blindness Project, the A2Z Child Blindness Program uses competitive grants to reduce child blindness and improve eye health. Grants provide support to national and international eye care and health NGOs that deliver services to populations in need. Since 2005, the A2Z Child Blindness Program has awarded 32 grants to 23 local and international organizations to support work in 25 countries across Latin America, Asia, and sub-Saharan Africa.

The goals and priorities of the program are to:

- Expand delivery of high-impact direct services (including screening, treatment, education and rehabilitation);
- Scale-up innovative approaches to service provision and program implementation; and,
- Contribute to the global knowledge base on effective approaches to large-scale child eye health programs.

Grant-funded interventions include eye health education, vision screening, clinical and surgical services, training of health workers and community members, provision of necessary medical treatments including eyeglasses, and education and rehabilitation services for blind children.

As 2010 represents the fifth year of activity for the A2Z Child Blindness Program, AED invited 16 grant-recipient organizations to review field experiences implementing large-scale pediatric eye care projects and to explore lessons learned from these experiences. The partner's meeting served as a unique forum through which grantees were able to come together to discuss and reflect upon their programs. While it was not possible for all grantees to attend the meeting, the participating organizations represented expertise across the spectrum of care from clinical and health facility based programs to education and rehabilitation interventions. Participants also reflected the geographic diversity of the A2Z Child Blindness Program, as experiences from Latin America, sub-Saharan Africa, and Asia were all reviewed during the two-day event.

The main objectives of the meeting included:

- Review successes, challenges, and lessons learned from large-scale pediatric eye care and special education interventions;
- Explore identified gaps in expanding service delivery; and,
- Identify emerging priority areas and potential way forward for the USAID/A2Z Child Blindness Program.

A detailed meeting agenda and participant list are available in Appendix A. and B.

OPENING

The meeting was opened by leaders from USAID and AED. Margaret Parlato, Senior Vice President of AED's Global Health, Population and Nutrition Group, welcomed participants to AED and thanked the organizations for their efforts and achievements over the last four years. The A2Z Child Blindness Program has contributed to the development of new partnerships and lessons learned for AED.

USAID technical advisors, Emily Wainwright and Frances Davidson, also made opening statements emphasizing the evolution of the overall program. F.Davidson highlighted the cross-cutting nature of eye health and how it must be viewed within the context of child survival, quality of life, and education. The USAID/A2Z Child Blindness Program has provided an opportunity for assessing these issues within a larger situation.

A2Z CHILD BLINDNESS PROGRAM OVERVIEW

A2Z Child Blindness Program Manager, Roshelle Payes, presented a program overview, including a summary of the completed competitive grant cycles, the major service delivery results through FY09Q3, and major challenges facing grant recipients across the program. The 16 common indicators on which partners report on a quarterly basis have facilitated results reporting across the program. The individual and cumulative M&E reporting tables have also enabled partners and A2Z to identify potential gaps in service delivery and areas for improvement in program planning.

R.Payes also reported on the preliminary lessons learned which shaped the meeting planning for the 2009 A2Z Child Blindness Program Partners Meeting. Starting in FY09, documentation and communication of grantee service delivery experiences has been a priority for A2Z. To begin exploring grantee experiences and perspectives, A2Z conducted a web-based specialized informant survey in March 2009. The summary responses revealed common perceptions in regards to program successes, including capacity building of eye care personnel, awareness raising among communities, and expanding eye care services to underserved populations, especially children. As for service delivery barriers or challenges to project implementation, respondents identified three major areas in need of additional support:

- Human resources development;
- Need for increased policy and advocacy; and,
- Gaps in program research related to pediatric eye care and special education.

The specialized informant summary and findings are available in Appendix C.

PRESENTATION OF FINDINGS FROM 2009 DOCUMENTATION ACTIVITIES

Beginning in 2009, A2Z developed a documentation and communication strategy. A major activity under that strategy included the development of case studies profiling grantee experiences in providing eye care services to refugee populations, medical and surgical services for children, refractive error interventions, and education and rehabilitation services. The first A2Z case study was finalized in October 2009 and the remaining case studies are currently under development. This activity was a collaborative effort between A2Z staff and selected partner organizations, which took the lead in developing content for the studies. Among these organizations are the International Rescue Committee (IRC), Kilimanjaro Center for Community Ophthalmology (KCCO), and the Seva Foundation. A2Z worked with these organizations to develop a basic outline and framework for the studies. The grantees then reached out to other grant recipients to collect experiences, data, and beneficiary information for inclusion in the case studies.

During the meeting, representatives from the selected organizations presented the main findings from their specific case study exercise. Dr. Thein from IRC Thailand highlighted the challenges of balancing services to refugee and host community populations. Additionally, limited human resources have been an implementation challenge, as many eye care providers often end up leaving the camps for repatriation to other countries.

From the KCCO-led medical and surgical services case study exercise, Dr. Paul Courtright summarized common trends across five USAID-grant funded initiatives providing medical and surgical services to children. All the programs explored and combined multiple strategies for identifying children in need of cataract surgery. Overall, the featured projects demonstrated that mass screening efforts are not as effective as targeted screening approaches for finding children requiring surgical intervention. This is especially true in sub-Saharan Africa.

Lastly, Amanda Marr presented findings from the Seva Foundation-led exercise featuring grantee work in delivering refractive error services in Nepal (Seva and HCP), Cambodia (Seva), and Vietnam (Fred Hollows Foundation). All three programs used multi-prong training and screening approaches. Female community health workers, teachers, and mothers received training on performing initial screening of visual acuity. In these sites, this strategy was effective in identifying children with refractive effective and other visual impairments. All three organizations met or surpassed their service delivery targets, especially in regards to number of children screened for refractive error and number of eyeglasses provided. Nonetheless, there is still a need for a standard set of protocols for screening activities to be sustainable.

PRESENTATION SESSION: SERVICE DELIVERY EXPERIENCES

The remainder of the first day was devoted to individual presentations on service delivery experiences from the participating organizations. Presenters were asked to follow a similar presentation structure in order to ease comparison across experiences. Additionally, organizations were grouped regionally (sub-Saharan Africa and Asia) to make broad comparisons across regions.

In sum, grant funding supported several notable successes including increased availability of eye care services to children and other vulnerable populations; capacity-building in primary and tertiary eye care personnel; and, the development of innovative approaches to service delivery. The presentations also sparked discussion in regards to several issues across the spectrum of care.

Clearly, case detection is an important first step in providing eye care services. The presentations demonstrated that various stakeholders play a role in identifying children with potential visual impairment. In most settings, one or more of the following community members contribute to identifying children: community health workers; local volunteers (paid and unpaid); key informants; teachers; parents; female community health workers; traditional healers; and, volunteer schoolchildren. Training varied across sites from one-day to week-long training sessions.

Another issue emphasized in several of the presentations was the importance of strengthening links between services and the referral network to ensure children who need services actually receive them. There are barriers at both the community and

health care provider levels which impact whether children receive the care required to properly address an identified vision problem.

Finally, nearly all the project presentations underscored the importance of follow-up care to ensure positive visual outcomes. Organizations have made significant progress in identifying children in need of services and providing those services, but now the programmatic hurdle has been patient compliance with follow-up care. Families often do not realize the importance of follow-up care for long-term positive outcomes. Organizations need to explore new strategies, incentives, and communication messages to overcome barriers to follow-up care.

A list of the meeting presentations can be found in Appendix D. PDF versions of the presentations are also available for download at http://www.a2zproject.org/~a2zorg/node/73.

REGIONAL DISCUSSIONS: EXPLORING CHALLENGES, BARRIERS, AND GAPS IN EYE CARE SERVICE DELIVERY FOR CHILDREN

The second meeting day was largely devoted to facilitated discussion groups exploring challenges, barriers, and gaps in eye care service delivery for children. A2Z Country Manager, Linda Tawfik, facilitated the Africa discussion group. Meanwhile, A2Z Communications Officer, Morgan Hillenbrand, led discussions in the Asia group.

The objective of the facilitated discussions was to answer three broad questions:

- What have your organizations achieved?
- What have your organizations learned?
- What do your organizations still need?

Each group followed the same discussion guide, but participants were also encouraged to delve deeper into issues that were raised in each particular group. At the end of the 90 minute discussion period, the two groups reconvened to share their discussion findings. Meeting notes were posted around the meeting room and participants were asked to compare and contrast the summarized points from each group.

The table below reflects the main points from each discussion group by each question heading.

Day 2 Summary of breakout group discussions

Asia	Africa
Research Questions We'd Like Answered: • Economic impact of visual impairment • Education impact of visual impairment • Caretaker burden impact • Are people using/identifying best practices/quality indicators/evidence-based? • Effectiveness of awareness activities	**Research Questions We'd Like Answered:** • Are we measuring the right things with regards to M&E and cost data? • What is the guidance on data use? • What is the cost-effectiveness of strategies needed for advocacy? • Models of linkages, i.e. policy services-where do you link education and health? • Anthropologic work: -what is the cost of surgery to family

	-how do we reach these families -how do we launch in different regions -how do we differentiate by gender -what is the best use of personnel
Activities Difficult to Implement: • Collecting data to report • Reporting quality indicators and outcomes • Follow-up care (especially in mobile and outcome measurement communities) • Retention of anesthesiologist • Finding appropriate training candidates and retaining them • Keeping the grass-roots level engaged/activated • Conducting eye camps for children only has been unsuccessful. • Cost-sharing (refugee context) and other vulnerable groups	**Activities Difficult to Implement:** • Access to quality services for children • Moving the child blindness debate forward; 20 years ago the field was in the same debate • Human resource issues/retention of personell • Integration of approaches • The Vision2020 policy platform • Screening and service delivery difficult to issue due to financial difficulties
Operational Challenges: • Short grant time-frame • Outlets for discussing set backs, challenges and failures • Procurement challenges • Transportation issues make it difficult to access services and follow-up • Financial sustainability • Credibility with local communities	**Operational Challenges (and unresolved challenges):** • M&E discussions and analyses need to be brought together • Rigor needs to be increased • Intermediate goals and roadmap needed for: -Collaborative groups for learning and knowledge exchange -Extraction and review of data and programs, then sharing with a core group/network. • Retrospective evaluation- what were the challenges or failures of projects? • Organization - specific site visits, exhibit best practices
How Should A2Z Measure Success: • Final evaluation of each project • Evaluate the quality of each project • The quality of the implementation of the skills learned at trainings • Establishment of strong referrals systems and linkages • Retrospective review of all the reports- what achievements have been made across the board? • Qualitative review	**How Should A2Z Measure Success:** • Achievement of MDGs: peri-natal and neo-natal health goals in (ROP Children) Latin America • Output, outcome, and <u>impact</u> • High-level goals • Have projects contributed to capacity building through degree programs? • Strategy to elevate child blindness issues • Procurement of new data
What Was Achieved with Grant Funding: • Examined trends/assumptions/challenges • High numbers of people screened, eye	**What Was Achieved with Grant Funding:** • Increase number of girls screened for preventative eye care and treatment

glasses distributed, surgical services, sight restored. • Capacity built: -Eye health personnel trained -Child eye health network -Training of parents/school administrators/teachers • Awareness of parents and teachers raised (child <u>can</u> go to school) • More kids going to school • Larger focus on comprehensive teams • Economic impact assessed/income generation • Strengthened link between referral and service delivery	• Infrastructure of education services in 3-4 countries improved, improved case finding strategies • Regionally, contextually relevant programs • Results • Capacity building: -Surgery, long-term treatment -Establish services (ongoing) -Networks established: institutional, and community -Diffusion of technology
In the Next 5 years…: • Incorporating stronger blindness rehab into programs • Incorporating cost-recovery (where applicable) • Expansion (into other districts) • Inclusion of ROP programs • More emphasis on services/screening for children under age 7. • Creation of a replicable package of services.	**In the Next 5 years…:** • A collaborative network of organizations and sectors involved in Child Blindness (advocacy, education, health, and continuum of care). • Strong system in places (from birth onwards) • Comprehensive health care for refugees • Inclusion of an eye-care core curriculum in MOH training over the next 10 years • Routine standard services
Service Delivery Strategies: • Forming partnerships with: -Eye hospitals -Parents -Schools -Ministry's of education and health -Local authorities • Awareness raising: -Active case finding (house to house visits) -Community outreach, communication (print materials, media) • Empower existing health systems: -Providing resources education -Trainings (systematic/ongoing/mentorship) • Strengthening management systems • Advocacy: -Village leaders -Support parent organizations -Provincial government and health managers/create child blindness plan -UN bodies -Push medical schools to include eye training in programs	**Service Delivery Strategies:** • Build more pediatric centers • Find realistic ways to estimate outputs and outcomes • Innovation -Decentralization -Use of key informants -Increased involvement of stakeholders -Regional networking -Child Health Days • Strengthen systems • Increase use of media • Multi-sector collaboration

RECOMMENDATIONS

The two-day event was a useful exercise in convening A2Z Child Blindness Program stakeholders to take stock of program achievements and challenges, as well as to begin discussing the future direction of the overall program. Through the presentation and breakout sessions, the following recommendations were determined.

Program data and evidence need to be further analyzed and utilized

The A2Z Program has collected valuable information on grantee service delivery results over the last four years. The available data should be more widely shared with partners and other stakeholders. Outcome indicators should be expanded to collect information on the quality of services and longer-term visual outcomes. This is especially important in the case of cataract treatment and other surgical interventions. Additional costing information on refractive error, cataract, and low vision interventions is also needed.

Eye care community needs policy and advocacy support

Given the competing health priorities throughout project sites, eye care receives little or no support from Ministries of Health. However, the cross-cutting nature of visual impairment makes it an important public health and education issue. Eye care organizations, especially those providing services to children, need additional policy and advocacy support in order for eye health to move up the public health agenda.

USAID/A2Z should facilitate the development of networks and partnerships

Grantees repeatedly expressed the need for increased knowledge sharing between organizations implementing large-scale pediatric eye initiatives. Tools, research findings, communication materials, and strategies should be shared within a community of practice or organized forum in order to improve services across sites. USAID and A2Z may be in the position to facilitate the development or improvement of partnerships and regional networks. Creating an eye health group under the CORE Group was suggested as a possible activity which USAID or A2Z could support.

CONCLUSION

The 2009 A2Z Child Blindness Program Partners Meetings was successful in meeting planned objectives. Participants provided extremely positive feedback and noted the meeting was an excellent knowledge sharing and collaborative event. The meeting discussions and recommendations will contribute to future planning of grant cycles and the overall A2Z Child Blindness Program.

APPENDIX A. MEETING AGENDA

Monday November 2, 2009		GREELEY HALL (3rd Floor North)
8:30	***Breakfast***	
9:00	Welcome & Introductions	*M.Parlato*
9:15	Overview: USAID & Blindness Prevention	*F. Davidson*
9:45	A2Z Child Blindness Program 2004-present	*R. Payes*
10:15	***Coffee Break***	
10:30	Presentation of findings from 2009 documentation activities: ➢ Eye care services for refugee populations ➢ Medical & surgical interventions ➢ Refractive Error ➢ Discussion	 *Dr. N. Thein* *Dr. P. Courtright* *A. Marr* *All*
12:00	***Lunch Break***	
	Presentation Session: Service Delivery Experiences	
1:15	Kilimanjaro Centre for Community Ophthalmology	*Dr. P. Courtright*
1:25	SightSavers International	*B.Male*
1:35	International Rescue Committee (Kenya)	*M.Choge*
1:45	International Eye Foundation	*J. Barrows*
1:55	Orbis International	*K.Stalonas*
2:05	***Afternoon Break***	
2:15	Seva Foundation (Cambodia & Nepal)	*E. Sarou & Dr. R. Byanju*
2:35	Himalayan Cataract Project	*E.Newick*
2:45	Fred Hollows Foundation	*P.Bao*
2:55	International Rescue Committee (Thailand)	*Dr. N. Thein*
3:05	VisionSpring	*A.Singh*
3:15	Aravind Eye Care System	*Dr.P. Vijayalakshmi*

Monday November 2, 2009		GREELEY HALL (3rd Floor North)
3:25	Christian Blind Mission	*K.Heinicke-Motsch*
3:35	Perkins School for the Blind (Latin America & Philippines)	*S.Perreault & D.Gleason*
3:55	Q&A / Discussion	
4:20	Presentations from special guests: ➢ *Eye Bank Association of America*	*P. Aiken O'Neil*
4:30	Day 1 Closing Remarks	*R. Payes*
5:00	***Reception*** ➢ ***Balcony Lounge, 9th Floor South***	

Tuesday November 3, 2009		**GREELEY HALL (3rd Floor North)**
8:30	***Breakfast***	
9:00	Presentation of Day 2 goals & objectives	*R.Payes*
9:15	Regional Break-out sessions: ➢ *Exploring challenges, barriers, and gaps in eye care service delivery for children* ➢ *Africa: Breakout room #1—3rd floor North* ➢ *Asia: Breakout room #2—3rd floor North*	*L. Tawfik and M. Hillenbrand*
10:45	***Coffee Break***	
11:00	De-brief on discussions from breakout sessions	
12:00	***Lunch Break***	
1:15	Way forward for USAID/A2Z Child Blindness Program: ➢ *Emerging priority areas in child eye care* ➢ *Potential investment strategies*	*R. Payes*
2:30	Closing Remarks	

APPENDIX B. MEETING PARTICIPANT LIST

A2Z Child Blindness Program - Partner's Meeting November 2-3, 2009: Washington, DC	
Organization	**Name**
AED	Peggy Parlato
AED	Roshelle Payes
AED	Morgan Hillenbrand
AED	Linda Tawfik
AED	Elizabeth Deal
Aravind Eye Care System	P Vijayalakshmi
Christian Blind Mission	Karen Heinicke Motsch
EBAA	Patricia Aiken O'Neil
Fred Hollows Foundation	Phan Quoc Bao
Helen Keller International	David Friedman
Himalayan Cataract Project	Emily Newick
Himalayan Cataract Project	Job Heintz
International Eye Foundation	John Barrows
International Eye Foundation	Victoria Sheffield
International Rescue Committee	Nyunt Naing Thein
International Rescue Committee	Milka Choge
International Rescue Committee	Jerry Vincent
KCCO	Paul Courtright
Orbis International	Kerry Stalonas
Orbis International	Danielle Bogart
Orbis International	Joan McLeod-Omawale
Perkins School for the Blind	Mary Burdick
Perkins School for the Blind	Steve Perrault
Perkins School for the Blind	Deborah Gleason
Seva Cambodia	Ek Sarou
Seva Foundation	Amanda Marr
Seva Nepal	Raghunandan Byanju
SightSavers International	Ben Male
USAID	Stacey Maslowsky
USAID	Emily Wainwright
USAID	Frances Davidson
VisionSpring	Miriam Stone
VisionSpring	Arunesh Singh
Total Participants:	**33**

APPENDIX. C

A2Z CHILD BLINDNESS PROGRAM
SPECIALIZED INFORMANT SURVEY SUMMARY & FINDINGS
OCTOBER 2009

SUMMARY

Objective: To increase understanding of the field experience of organizations delivering pediatric eye care services under the USAID-funded A2Z Child Blindness Program. This activity aimed to collect in-depth information regarding organizations' perceptions of project successes, challenges, and priority areas.

Methods: The research activity consisted primarily of a web-based specialized informant survey deployed in February 2009. Informants included implementing project staff coordinating eye care services addressing refractive error and cataract in children under fifteen years old. Both content and descriptive analysis techniques were utilized to review the data collected from 41 respondents. The researcher identified common trends and themes, which will contribute to future A2Z Child Blindness Program planning and priority-setting.

Findings: Participating organizations overwhelmingly deliver services in rural communities with low awareness of eye conditions, treatment options, and available services. Moreover, eye care organizations identified three main challenges to implementing activities as originally proposed: 1) partnerships; 2) accessibility; and, 3) human resources development.

Conclusion: The survey was a useful tool for increasing understanding of the context in which eye care organizations are operating. Respondents provided valuable information regarding program challenges and areas which deserve increased financial and technical support.

SPECIALIZED INFORMANT SURVEY

Research Approach

The purpose of the survey exercise was to increase understanding of grant recipient organizations' field experiences in delivering eye care services for children. The A2Z Child Blindness Grantee Experience Survey aims to answer the following questions:

- How do grantees describe the context in which they coordinate activities?
- How do grantee organizations define project success?
- What are the common challenges in delivering pediatric eye care services?
- Based on their field experiences, what do these organizations consider priority areas for the future of pediatric eye care?

These questions intend to find common themes and experiences in intervention experiences. Existing program materials and activities guided the overall framework for the survey. As such, the questionnaire was developed along the following major thematic areas which emerged from the program documents.

- **Community awareness of eye conditions and available services**: What type of community awareness has the grantee found in their implementing site? What has contributed to low awareness or increased awareness?

- **Community eye care services**: Where do families generally take their children for eye care services? This provides some contextual information regarding the available services in the community in which the grantee is delivering or coordinating services.

- **Project Successes**: What does the respondent consider as the project's greatest success thus far? While the regular reporting forms indicate 'success' toward quantitative targets (i.e. number of children screened), this section inquires about the grantees' perspective of 'success' in their own intervention.

- **Implementation Challenges**: What project activities have been the most difficult to implement? Through site visits and regular communication with these organizations, it is apparent that each group has encountered different challenges in implementing activities as originally planned in their proposals.

- **Service Delivery Challenges**: Even if the activity is implemented as planned, there are often challenges in delivering the services or uptake of services by the targeted beneficiaries.

- **Overcoming challenges**: How did the grantee organization overcome the challenges experienced? When faced with implementation or service delivery challenges, it is expected grantees adapt their approaches. This section inquires on some of those responses to challenges.

- **Way forward**: A2Z grantees represent some of the current leaders in pediatric and community-based eye care services. As such, the questions within this section attempt to tap into their knowledge, expertise, and experiences to identify priority areas for child eye care interventions. Grantees are asked to not only identify priorities, but also indicate how their organization and USAID could respond to these priorities.

Data Collection

Recognizing both the need for in-depth qualitative data and the sensitivity regarding some of this information, a web-based key informant survey was developed with the online service, *SurveyMonkey,* www.surveymonkey.com. Respondents entered their own responses into the survey, which consisted of nine close-ended questions and 12 open-ended questions. The close-ended questions were primarily background questions, (with space for additional comments), to collect information on the type of respondent: program manager, support staff, participating ophthalmologist or other health care worker. Information regarding the type of activities (screening, communication, training, or other) was also recorded. The survey was first deployed on February 4, 2009 and a Spanish version was deployed on February 17, 2009. For approximately one month, grantees received weekly reminders about the active survey and were encouraged to complete the module.

Sample

Purposive sampling was employed to ensure that respondents included individuals with specialized knowledge of the A2Z Child Blindness Program, grantee project implementation experience, as well as service delivery activities and the beneficiary population. Respondents included program managers (based in organizational headquarters and field offices), other project support staff, participating ophthalmologists, as well as eye and health care workers. The initial communication containing the survey access information was sent to a total of 45 recipients. These recipients serve as the main points of contact between each grantee

organization and A2Z.

Data Analysis

Duplicate and incomplete responses were removed from the dataset. The revised total of respondents was 41. The open-ended responses were converted into MS Word documents. These files were then downloaded for coding with qualitative research software, NVivo 8. Codes (nodes) were created under each major theme of the questionnaire, as highlighted earlier. Sub-codes were then developed after review of the responses. Each individual respondent file was reviewed and coded with the software in order to identify common themes and trends under the major categories. After initial coding, some of the original codes were renamed to better describe the coded content and other codes were combined to minimize redundancy. Both content and descriptive analysis techniques were utilized to identify common themes and emerging trends.

Findings

Grantees generally reported low community awareness

Community awareness of eye conditions and available eye care services impacts service utilization. Respondents were asked not only to characterize the general level of awareness, but also to identify factors which contribute to awareness levels. Overall, awareness levels fell into two categories: 'low awareness' and 'increased awareness'. Three respondents did not report on awareness levels in their community. However, of the 38 respondents that reported on community awareness, 71% categorized awareness as low. When asked about factors contributing to low awareness, the following were mentioned:

Table 1. Factors contributing to low awareness of eye conditions and services Among all respondents (multiple responses possible)

Factors identified	%
Low literacy	38.5%
Lack of eye health education	20.5%
No eye care or health services in community	15.4%
Not a government priority	10.3%
Cultural beliefs	7.6%
Lack of training for personnel in community	2.5%

Respondents who reported an 'increased awareness' in their communities attributed it specifically to their own or previous eye care interventions. Respondents noted that various project efforts led to an increase in community awareness related to available eye care services.

> *'Key informant training, teacher training, meeting with community and government authority, workshops, and advocacy contributed to awareness…'*
>
> *'The attention from schools and local authorities through communication activities such as counseling, propaganda messages on television and radio…'*

The contrast in replies regarding awareness levels could be attributed to variations in interpretation of the question. However, it also potentially reflects that some organizations are seeing a change in awareness in their target communities because of their own efforts. Meanwhile, other groups are challenged by low awareness and their projects may not consist of communication activities to target awareness.

Project Successes: Expanded services and Capacity Building

Despite the brief implementation period for most grantees (two years), all groups identified multiple successes under their initiatives. The two most mentioned successes were 'expanding direct eye care services' (58.5%) and 'capacity building' (39%). Expanding direct services included increasing the availability of pediatric vision services (screening, referrals, and medical treatment); bringing services to underserved populations in rural areas; providing subsidized or free service to low-income families; and, increasing inclusive education opportunities for blind and low vision children.

> *'Children with cataracts get foldable intraocular implants irrespective of their capacity to pay. Child needing spectacles do get them immediately on the day of screening. The beneficiaries are increased many fold. Low economic group get the surgeries done in both eyes without much delay with the available subsidy through the project. Child attending the regular outpatient department if found credible are given free spectacles.'*
>
> *'This has provided the platform for enhancing our services both at the base hospital and in outreach activities, especially on conducting camps exclusively for children.'*
>
> *'Project enabled us to introduce new areas in service delivery, primary child eye care at village level which is sustainable and low vision screening at vision center level.'*
>
> *'Development of comprehensive eye care facilities including children eye care services through partnership with local partners. Program is based in community and providing services to poor rural population.'*
>
> *'Taking services to the doorstep.'*

The second most mentioned project success was capacity building and training, which are closely linked to expanding direct services. Grantees training activities target a wide spectrum of community members. These initiatives include teachers to screen for basic eye conditions and measure visual acuity of their students. Teachers in other sites were trained in special education techniques to support their work with low vision, blind, and deafblind children. Several interventions also trained community members as 'key informants' to identify children in their communities with visual impairments and provide referrals to the nearest eye care center or hospital. Lastly, longer-term training initiatives were also coordinated to increase local surgical capacity to treat pediatric cases of cataract, strabismus, or other conditions which require specialized skills to ensure positive surgical outcomes and follow-up care.

> *'Training community workers from rural areas.'*
>
> *'Capacity of child eye disease treatment of trained health personnel strengthened.'*
>
> *'Motivated teachers; accomplishing action plans to incorporate eye care into general curriculum.'*

Combined, expanded direct services and training activities were mentioned more than any other areas of success. Following these two areas, 'increased community awareness' was the third most mentioned area of success (29.3%).

Partners posed project implementation challenges

When asked about project implementation challenges, respondents surprisingly named one or more local partners. This was an interesting finding as this particular challenge was not previously highlighted in quarterly reports or site visits. Grantees work with various local stakeholders, including government officials, teachers, parents, and health care workers to

successfully implement activities according to their anticipated timeline. While multiple responses were possible, the most often provided response was related to government partners.

> *'Working across two government departments – department of health and the department of education.'*
>
> *'Working with government authorities.'*
>
> *'Working with government health care providers.'*

The other implementation challenges mentioned included a combination of external and internal factors. In terms of external factors, grantees noted community misperceptions and cultural beliefs as a challenge to achieving project targets for screening, referrals, and/or treatments. Some families believe visual impairment is a curse or deemed by God. Parents may not realize which conditions are treatable. Families are also hesitant to subject young children to surgery and elect to wait until they are older. However, delaying treatment actually worsens conditions and reduces sight further.

> *'Cultural barriers make it impossible for all children identified to be operated on…'*
>
> *'Parents and the community people had wrong beliefs about blindness and cataract surgery, especially in rural areas.'*

As for internal challenges, grantees identified project management capacity as a challenge. This was also considered a candid response since grantees are reluctant to reveal their own organization's potential weaknesses.

Table 2. Project implementation challenges identified by grantees
Among all respondents (multiple responses possible)

Challenges identified	%
Working with local partners	34.1%
Community misperception or cultural beliefs related to vision	30.0%
Limited resources among community (i.e. families cannot afford service fees)	9.8%
Procurement of equipment	7.3%
Management	7.3%
Expanding model	7.3%
Spectacle compliance	4.9%

These factors are important to identify so projects can adapt their strategies and approaches to overcome these challenges.

Reaching beneficiaries and limited human resources are substantial challenges to delivering eye care services

In addition to project implementation challenges, which are related to launching various activities (communication, procurement, advocacy, etc), grantees were also asked to provide information on their experience delivering eye care services. This section intended to increase understanding of some of the potential barriers to bringing services to underserved populations. The most mentioned service delivery challenge was 'accessibility.' This includes difficulties in reaching target populations, due either to geography, cost, or transportation difficulties.

> *'Access to children: Transportation of vision screeners to schools…'*
>
> *'Environmental challenges that affect travel or ability to host a training.'*

'It is difficult to connect to communities due to distances of the schools and communities.'

Rural communities are a priority for the majority of the organizations. However, accessing these communities poses financial and planning difficulties. Furthermore, the lack of sufficient human resources also impacts service delivery to these areas. There simply are not enough people trained in eye care (primary or tertiary) to meet the vision needs of populations.

'Critical shortage of ophthalmologists, optometrists, and eye care technicians.'

'Lacking qualified human resources in child eye care.'

'*There is a shortage of general medics, so it is a challenge to get new trainees for eye care program.'*

While accessibility and human resources were the most often mentioned challenges, a variety of other responses were also recorded. These ranged from 'follow-up' to 'case detection' and 'credibility.'

Table 3. Service delivery challenges
Among all respondents (multiple responses possible)

Challenges identified	%
Accessing communities (especially rural areas)	44.0%
Compliance with follow-up care	30.0%
Limited human resources to deliver services	26.8%
Low community awareness	9.8%
Limited resources to meet community need	7.3%
Staff turnover (staff are reluctant to work long-term in rural regions)	7.3%
Working with local partners	7.3%
Case detection (finding children that most need care)	7.3%
Translating project activities into results	2.4%
Low literacy levels in community	2.4%
Credibility of non-medical personnel delivering basic services	2.4%

Training and communication activities are the strategies most used to address challenges

Besides identifying various challenges, respondents were asked to provide information on how they have overcome implementation or service delivery challenges. Overwhelmingly, the most mentioned responses fell under the categories of communication (interpersonal and mass media) and training activities (46.3% and 41.5% respectively).

'Health education: Awareness programs at community level, block level, district level and state level with different stakeholders.'

'Awareness activities: local F.M. radio, pamphlets, school children and community leaders.'

'Awareness, education, and making sure each family has plenty of time with the ophthalmologist for questions to be answered and fears assuaged.'

'Training of community health workers in primary eye care carried out in order to enhance community screening of the eye diseases.'

To address external barriers posed by geographic distance or service fees, grantees are also increasing various supports to beneficiaries and/or bringing services closer to the beneficiary. For instance, grantees are providing transport subsidies, reduced price or free spectacles, or funding for transport and food for follow-up visits. Several grantees also noted an increase in their outreach activities whereby a team of eye care specialists (both primary and tertiary) travel to remote communities for large-scale campaigns.

Table 4. Strategies for overcoming challenges
Among all respondents (multiple responses possible)

Strategies or activities to address challenges	%
Communication activities (inter-personal or mass media)	46.3%
Training workshops (health care workers and policy-makers)	41.5%
Strengthen support to community members (subsidies)	19.5%
Outreach activities	19.5%
Collaboration with local partners	14.6%
Increased advocacy efforts	7.3%
Improved evaluation of project activities and progress	2.4%

Grantees identified a variety of medical conditions and program needs as priorities areas in child eye care

The greatest variety of responses was received to the question, 'What do you consider priority areas for child eye care in the next five years?' The initial intention of this question was to inquire about specific eye conditions, similar to the priority areas of VISION2020 or emerging eye trends. During site visits, several ophthalmologists mentioned strabismus and retinopathy of prematurity as conditions that need increasing attention. However, responses to this open-ended question included programmatic priorities as well.

Table 5. Priority areas in child eye care
Among all respondents (multiple responses possible)

Priority areas	%
Awareness raising	29.2%
Refractive error	29.2%
Human resource development	22.0%
Scaling-up current projects	22.0%
Low vision	17.0%
Early case detection	14.6%
Improved public education for blind or low vision children.	12.2%
Integration into overall health network	12.2%
Cataract	9.8%
Other eye conditions (strabismus, trauma, conjunctivitis)	9.8%
Trachoma	7.3%
Organizing parents for group therapy and advocacy	4.9%
Rural services	4.9%
Retinopathy of prematurity	4.9%
Equipment	4.9%
Policy/Advocacy to increase government support for eye care	2.4%
Knowledge sharing	2.4%
Prevention	2.4%
Follow-up	2.4%

The most mentioned priority areas reflect the areas of concentration of the majority of grantee organizations. It was also interesting to find that provision of essential ophthalmology equipment was only mentioned two times. For several years, a component of the A2Z Child Blindness Program has been providing funding for organizations to procure essential equipment. Through anecdotes and meetings with grantees, the program had been informed of

the urgent need for certain types of equipment to support pediatric services. Nonetheless, this was not reflected in the survey responses.

Way forward in child eye care: Responding to priorities

Since the A2Z Child Blindness Program has worked with many of the implementing organizations for several years, the survey asked about the type of continued support grantees would like to receive from USAID and the overall program. Not surprisingly the most mentioned type of support was financial. Respondents emphasized the need for continued financial support to strengthen and expand current interventions.

> *'Continue to fund a wide range of providers, small clinics and large institutions.'*
>
> *'Expanding support to strengthen capacity of existing comprehensive eye facility including children eye care services.'*

Besides continued financial support, grantees also called for additional technical assistance and knowledge-sharing so that best practices and lessons learned can be applied across the variety of projects.

> *'Re-convene technical advisory group for input and continued support for monitoring and evaluation.'*
>
> *'Organize workshops to share experiences/technical support.'*
>
> *'Sharing of information and models utilized in other regions.'*

These are types of support which A2Z and USAID are beginning to explore. Hearing directly from grant recipients underlines the need for the A2Z Child Blindness Program to evolve even further.

Conclusion

The overall research objective of the Grantee Experience Survey was accomplished. The qualitative data provided by respondents depicted the complex settings in which organizations are attempting to successfully implement pediatric eye care services. Grantees largely work in communities with low awareness of eye health and available treatment options. While government support and collaboration is essential for service delivery, it is often an impediment. Increased advocacy, communication, and human resources development are needed to address these challenges.

APPENDIX. D A2Z Child Blindness Program Partners Meeting Presentations

On November 2, 2009, 33 representatives from 15 eye care, health, and education organizations, as well as advisors from USAID, met in Washington, DC to participate in theA2Z Child Blindness Program Partners Meeting. The goal of the two-day meeting was to convene stakeholders of the A2Z Child Blindness Program to review project experiences, achievements and challenges. Participants also discussed emerging priorities in pediatric eye care service delivery and how the A2Z Child Blindness Program could respond to these needs. Meeting presentations and materials are available for download at http://www.a2zproject.org/~a2zorg/node/76.

A2Z Child Blindness Program 2004-Present
Roshelle Payes- A2Z Child Blindness Program

Eye Care Services for Refugee Populations, Thai-Burma Border Findings from 2009 Documentation Activities
Dr. Nyunt Thein- International Rescue Committee (Thailand)

Tackling Avoidable Blindness through Partnerships- Medical/Surgical Interventions
Dr. Paul Courtright - Kilimanjaro Centre for Community Ophthalmology

A2Z Child Blindness Program Refractive Error Case Study
Amanda Marr- Seva Foundation

Restoring sight and the quality of life of children in Tanzania and Madagascar
Dr. Paul Courtright - Kilimanjaro Centre for Community Ophthalmology

Giving Sight to Children of Busoga, Bunyoro & Teso Regions of Uganda
Ben Male- Sightsavers International

Kenya Program A2Z Child Blindness Program
Milka Choge- International Rescue Committee (Kenya)

Sustainable Vision and Eye Care for Rural Malawi
John Barrows- International Eye Foundation

Pediatric Ophthalmology Project, Hawassa University, Ethiopia
Joan McLeod- Orbis International

SEVA Foundation Cambodia
Ek Sarou- Seva Foundation Cambodia

SEVA Foundation Nepal
Dr. Raghunandan Byanju- Seva Foundation Nepal

Himalayan Child Blindness Alleviation and Eye Health Initiative
Emily Newick- Himalayan Cataract Project

The Child Eye Care Support Project in Quang Nam and Quang Ngai Provinces of Vietnam November 2008- December 2009
Phan Bao- Fred Hallows Foundation

Eye Care Services for Refugee Populations, Service Delivery Experiences
Dr. Nyunt Thein- International Rescue Committee-Thailand

VisionSpring
Arunesh Singh- VisionSpring

Active screening and management of cataract, refractive errors and ROP
Dr. P. Vijayalakshmi- Aravand Eye Hospital

Haiti: an experience
Karen Heinicke- Motsch- Christian Blind Mission

Perkins Possibilities for Children: The Philippines and Latin America
Steven Perrault and Deborah Gleason- Perkins School for the Blind

Sharing Sight through Transplantation
Ellen Heck- Eye Bank Association of America