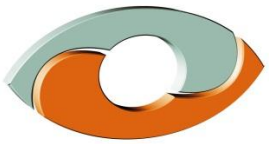

The Fred Hollows Foundation

PAKISTAN - AUSTRALIA
PREVENTION OF AVOIDABLE BLINDNESS
PROJECT

June 2013- June 2017

Project Design Document
20 April 2013, Draft Version 1.9

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EXECUTIVE SUMMARY

Background
Since 1998, The Fred Hollows Foundation (FHF) has been working with the Government of Pakistan (GoP) and other partners towards the goal of eliminating avoidable blindness by the year 2020. FHF is a key stakeholder in the National Programme for Eye Health in Pakistan and has made major contributions to the development of eye care services in the country. The four major projects that FHF worked through are:

- *Micro surgical training program (1998-2001)* - Through this project cataract services were initiated/strengthened in 110 districts across the country.
- *Pakistan Australia District Eye Care (PADEC) Phase I (2002-2007)* - Comprehensive eye care services were developed in 25 eye units at secondary level across Pakistan.
- *Pakistan Australia District Eye Care (PADEC) Phase II (2007-2013)* - The inputs of PADEC Phase I were consolidated through this project. In addition a few initiatives like provision of services at community level were piloted.
- *Pakistan Australia Subspecialty Eye Care (PASEC) Project (2008-2013)* - Through this project efforts have been made to address childhood blindness and diabetes related blindness by partnering with 17 eye institutes/hospitals across the country.

FHF has also been supporting development of an eye health workforce through training of mid-level eye care personnel, ongoing capacity building of community ophthalmologists and support to the Comprehensive Eye Care Cells throughout Pakistan.

As a result of the projects mentioned above, FHF along with other partners was able to demonstrate a successful district based comprehensive eye care model to the Ministry of Health (MoH) in response to which Rs. 2.7 billion (AUD 54 million) were allocated to the National Eye Care Program 2005-2010 to replicate the district model across the country in all public sector eye units. In addition hundreds of Mid-Level Eye Care Personnel (MLECP) who were trained through FHF and other INGOs support, have been recruited by the provincial health departments and placed in permanent positions. These developments have greatly strengthened eye care delivery at all levels. The combined impact of all these inputs was the reduction of blindness prevalence from 1.78% to 0.9%[1].

Despite the allocation of significant funds to the last five year National Eye Care Program by the Government of Pakistan in 2005-2010[2], there are still several deficiencies in eye care services that need to be addressed. The proposed project seeks to address those deficiencies mainly through consolidating the gains made in the PADEC and PASEC projects, strengthening general health management at selected hospitals, strengthening training programmes especially of mid-level eye care personnel and focus on prevention and treatment of high priority eye diseases.

The Australian Agency for International Development (AusAID) has been one of the major supporters of the FHF initiatives in Pakistan. The above mentioned four major projects have been funded by AusAID. The eye care sector in Pakistan owes a lot to the AusAID support and partnership.

[1] Jadoon MZ et al. Prevalence of blindness and visual impairment in Pakistan: the Pakistan National Blindness and Visual Impairment Survey. Investigative Ophthalmology & Visual Science, 2006, 47(11):4749–4755
[2] The Federal Government has extended the programme to 2015 (with allocation of remaining unspent program funds between 2005-2010 as a devolved programme to the provinces.

Main Project Partners

The Project will be implemented in close collaboration with the respective Provincial Departments of Health through the National and Provincial Committees for Eye Health, and respective NGO partners. Some of the major organisations that FHF has partnered with in the past and will continue to partner with under the proposed new project include the following:

College of Ophthalmology & Allied Vision Sciences (COAVS) Lahore - COAVS is one of FHF's long-standing partners in the country. It was established as a joint venture of the Department of Health Punjab, private donors and a couple of eye INGOs in 2004. This institute is affiliated with King Edward Medical University (KEMU). COAVS also has the role of CEC Cell Punjab.

Pakistan Institute of Community Ophthalmology (PICO) Peshawar - PICO is one of the leading community ophthalmology institutes in the country. It was established as a joint venture of the Department of Health KPK and couple of eye INGOs in 1998. It is affiliated with the eye unit of Hayatabad Medical Complex. PICO also has the role of CEC Cell KPK.

Comprehensive Eye Care (CEC) Cell Balochistan - CEC Cell Balochistan was established as part of the National Programme for Prevention and Control of Blindness 1999 – 2003. Its establishment was supported by INGOs. It was set-up at the Helpers Eye Hospital in Quetta and its main role was to plan, implement and coordinate prevention and control of blindness activities in the province. Helpers Eye Hospital is a government tertiary teaching hospital.

Comprehensive Eye Care (CEC) Cell Sindh - CEC Cell Sindh (known as the Prevention and Control of Blindness (PCB) Cell) was established as part of the National Programme for Prevention and Control of Blindness 1999 – 2003. Its establishment was supported by INGOs. It was set-up at Civil Hospital in Karachi and its main role was to plan, implement and coordinate prevention and control of blindness activities in the province.

Comprehensive Eye Care (CEC) Cell Gilgit Baltistan - CEC Cell Gilgit-Baltistan was established as part of the National Programme for Prevention and Control of Blindness 1999 – 2003. Its establishment was supported by INGOs. It was set-up at the District Headquarter Hospital in Skardu and its main role was to plan, implement and coordinate prevention and control of blindness activities in the province.

Al-Shifa Trust Eye Hospital, Rawalpindi - Al-Shifa Trust Eye Hospital (Al-Shifa) is a non-political, non-governmental, and not-for-profit organization involved in delivering eye care services for the last 20 years as well as being a tertiary training centre for all cadres of eye health workers including clinical and non-clinical. Al-Shifa is a World Health Organization (WHO) Collaborating Centre for prevention of blindness in Pakistan. Al-Shifa runs 4 eye hospitals and has various community eye care projects.

Khyber Eye Foundation (KEF) Peshawar - KEF was founded by the Khyber Lions Club in 1996. It is still being managed and supported mainly by the club members and local industrialists. The hospital has grown to a significant level and is renowned for the services it has been rendering to the communities.

Al-Ibrahim Eye Hospital (AIEH) Karachi - This hospital started from a meager community center in the suburbs of Karachi in 1994. In less than 18 years, the facility has attained the status of tertiary level with over 70 beds for inpatients. It has also emerged as a hub for teaching and training for ophthalmologists and paramedics nationally and internationally. FHF plans to support eye care service provision to vulnerable communities in selected locations in Balochistan and KPK through its partnership with AIEH.

Layton Rahmatulla Benevolent Trust (LRBT) Karachi - LRBT is one of the leading national NGO working for prevention and control of blindness since 1984. It has a countrywide spread with 39 Community Eye Health Centers, 15 secondary level hospitals, 2 tertiary level hospitals and a number of community level projects. It has the capacity for treating patients from simple cataract extraction to more complex sub-specialty surgeries. FHF plans to support eye care service provision to vulnerable communities in selected locations in Balochistan and KPK through its partnership with LRBT.

Situation Analysis

Pakistan's estimated population in 2011 was over 187 million making it the world's sixth most-populous country, behind Brazil and ahead of Nigeria. The population growth rate now stands at 1.6%. The overall health status in Pakistan has improved since 1990 albeit at a much slower pace in relation to its neighbouring countries. The increase in life expectancy at birth from 64 years to 67 years in 10 years has not been substantial; it is however, more than the life expectancy at birth for India and Bangladesh, but significantly lower than the level in Sri Lanka, Indonesia and Malaysia.

Pakistan continues to spend less on health than other countries at similar levels of economic development. The total expenditure on health in Pakistan in 2008 was estimated to be USD18 per capita, of which the public sector expenditure was USD4 per capita. This is far below the figure of USD34 proposed by the Commission on Macroeconomics and Health to provide an essential package of health services[3].

Eye Health Situation

Based on the last national blindness survey conducted in 2003-2004, the prevalence of blindness is 0.9%. The main causes of blindness are cataract, corneal opacity, uncorrected aphakia and glaucoma. Diabetic retinopathy and age related macular degeneration are emerging causes of blindness.

FHF has supported the comprehensive up-gradation of 26 and partial up-gradation of 27 district eye units through PADEC Phase I and II. Other INGOs like Sightsavers and Cbm have also supported the districts eye care model. This collective support of INGOs played a major role in the advocacy to the government to invest in eye health.

Subsequent to district based program FHF addressed blindness due two priority eye diseases through its PASEC project. This has been the first initiative in the country to formally and comprehensively address subspecialty eye care in the country. The initiative has been a great success however the gains need to be consolidated to ensure continuing efficiency and effectiveness. The proposed project is a logical progression to consolidation of PASEC, investment in governance, management & information systems in addition to addressing other emerging priority eye diseases. The detailed situation regarding the priority diseases to be addressed in the proposed project and current human resources situation is mentioned in attachments 5 and 6.

Alignment

The project is aligned with the following policies and strategies:

- AusAID's Aid Policy, "An Effective Aid Program for Australia"
- AusAID's Draft Health Strategy
- Australia – Pakistan Development Partnership
- The Fred Hollows Foundation Strategic Framework (2011 – 2014)

[3] Country Cooperation Strategy for Pakistan 2011-2017. World Health Organization

- AusAID and The Fred Hollows Foundation Gender Policies
- AusAID and The Fred Hollows Foundation Child Protection Policies
- AusAID and The Fred Hollows Foundation Counter-Terrorism Policies
- AusAID and The Fred Hollows Foundation Anti-Corruption Policies
- The Fred Hollows Foundation Disability Inclusive Strategy
- AusAID's Disability Policy "Development for All: Towards a disability-inclusive Australian aid program (2009-2014)
- AusAID's Environment Management Guide for Australia's Aid Program 2012
- Millennium Development Goals
- VISION 2020: The Right to Sight

Proposed Project Description

Project Title:
Pakistan-Australia Prevention of Avoidable Blindness (PAPAB) Project

Duration:
1 June 2013 – 30 June 2017 (4 years)

Goal:
To improve the quality of life of people in Pakistan; especially vulnerable groups such as women and children, by reducing avoidable blindness and visual impairment by the year 2020

Purpose:
To strengthen eye health services within the health systems framework of Pakistan

Objectives:
The project objectives are as follows:

Objective 1:
Strengthen paediatric and diabetes related eye care delivery within existing health system

Objective 2:
Strengthen the Governance and HMIS for Eye Health through integration in the existing health system

Objective 3:
Strengthen selected MLECP training institutes to deliver improved training programs

Objective 4:
Prevent and control avoidable blindness due to five high priority eye diseases (glaucoma, RoP, corneal opacities, cataract and refractive errors)

Objective 5:
Develop an evidence base for eye care service delivery approaches that can be scaled up by governments and potential partners

Monitoring and Evaluation (M&E)
An M&E framework for the project has been prepared that has indictors and targets with timelines for each specific output and objective. The progress of the project will be determined by using this framework through annual reviews. FHF periodic progress reports to

AusAID will cover reporting against this M&E framework. Gender-disaggregated data will be generated wherever possible.

Management and Coordination
Contractually, FHF will be responsible to AusAID for the management of the Project. FHF's objective will be to effectively and efficiently manage the Project. The project is designed in collaboration with all partners based on needs assessment conducted by FHF and at the request of the national and provincial eye health committees. Each partner has a defined set of roles and responsibilities. FHF will in turn sign MoUs with the respective Provincial CEC Cell/institutes and individual eye units which will specify their roles and responsibilities. Each year the planned activities within the PDD would be examined and if the situation warrants activities may be reviewed keeping within the broader objectives of the project.

Sustainability
In order to ensure the sustainability of interventions, the project focuses on systems strengthening of both public and private sector organizations engaged in eye health through capacity building in the areas of skills, knowledge and technologies. The project has adopted various strategies such as local capacity building, alignment with local health strategies, integration into devolved structures etc to ensure sustainability of project interventions.

Risk Management
A Risk Matrix has been developed that has identified key risk areas with mitigating strategies. These include areas like provincial ownership of interventions, service delivery, infrastructure development, capacity development, programme management and security concerns.

Feasibility
The current phase (2013-2017) of the project will be focusing on multiple interventions to strengthen eye care within the health care systems. It will consolidate the already used technologies and processes with the partners in PASEC. FHF will continue to utilize the existing settings and systems developed for eye health management in Pakistan through collaboration and partnership development. Following the promulgation of 18th constitutional amendment, the role of CEC Cells headed by provincial coordinators has become vital for successful implementation of the programmes. The project will contribute at the national level through reducing visual disability leading to improved quality of life. The Project will strengthen existing health systems and not create parallel systems.

Budget
The project budget is AUD5.5 million and is being proposed for AusAID funding. The following table presents the breakdown by type of input together with management costs.

	Values in AUD					
Description	**Grants Budget**	**Percentage of total budget**	**YR1**	**YR 2**	**YR 3**	**YR 4**
A-Project Support Costs Total	781,612	14.2	117,318	221,431	221,431	221,431
B-Project Management Costs Total	438,191	8.0	111,345	108,949	108,949	108,949
1- Strengthen health systems by improving capacities for eye care service delivery Total	908,798	16.5	284,404	305,037	186,321	133,035

	Values in AUD					
Description	**Grants Budget**	**Percentage of total budget**	**YR1**	**YR 2**	**YR 3**	**YR 4**
2- Strengthen the Governance and HMIS for Eye Health through integration in the existing health system Total	128,469	2.3	41,299	39,074	29,293	18,803
3- Strengthen selected MLECP training institutes to deliver improved training programs Total	1,395,053	25.4	138,854	864,055	257,902	134,243
4- Prevent and control avoidable blindness due to five high priority eye diseases Total	1,732,589	31.5	399,064	597,284	472,088	264,152
5- Develop an evidence base for eye care service delivery approaches that can be scaled up by governments and potential partners Total	115,415	2.1	28,854	28,854	28,854	28,854
Grand Total	**5,500,127**		**1,121,138**	**2,164,683**	**1,304,838**	**909,467**

MAP

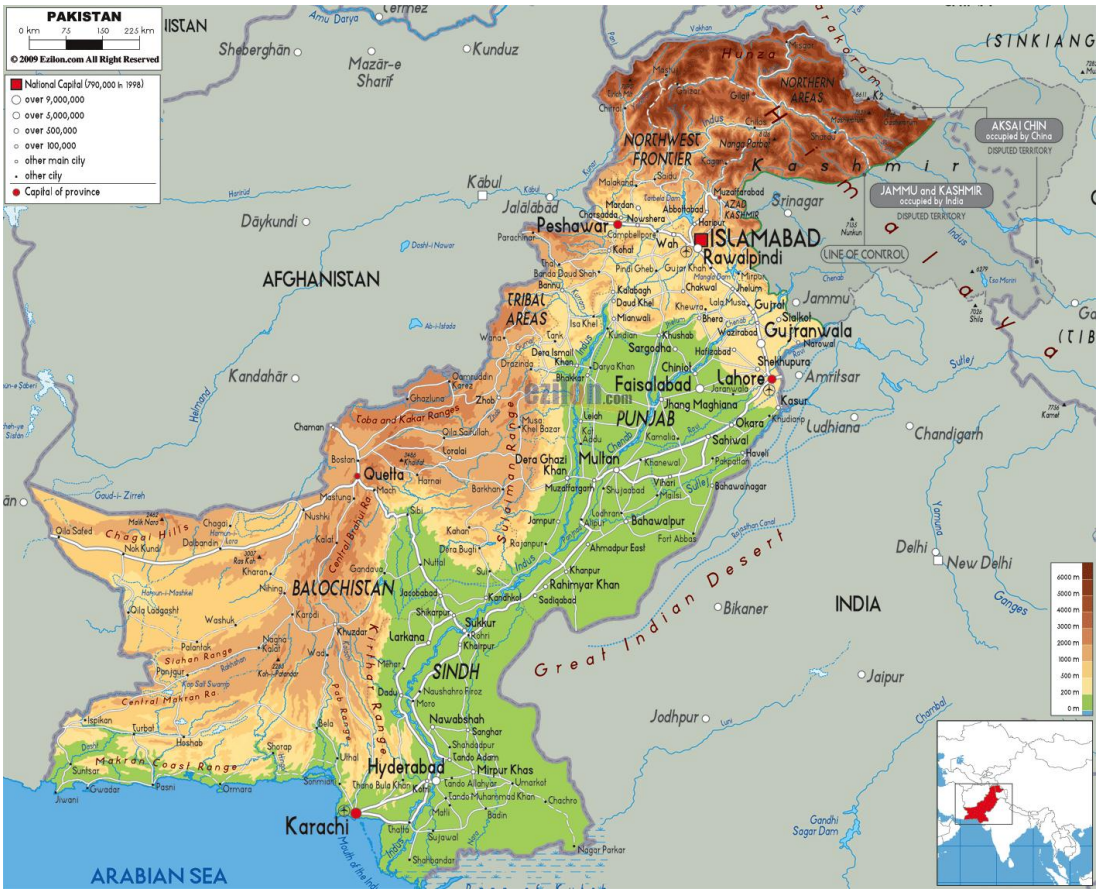

Figure 1 - Physical Map of Pakistan

1.0 BACKGROUND

1.1 Project Origin

Since 1998, FHF has been working with the Government of Pakistan, INGOs and local NGOs towards the goal of ending avoidable blindness by the year 2020.

FHF has been supporting the National Blindness Programme, based on VISION 2020 - The Right to Sight to develop demonstrable and scalable approaches. FHF has been a catalyst along with other eye INGOs working in Pakistan to develop a strong and robust National Eye Health Programme that resulted in a significant reduction in blindness from 1.8 million people in 1989/1990 to 1.3 million in 2003/2004[4] (from 1.78% to 0.9%). This demonstrates commendable success. However, with demographic transitions in Pakistan, especially a growing young population and changing life style, there are now other emerging eye problems that need to be addressed so as to sustain the performance and progress made by the national program for reducing avoidable blindness in Pakistan. The cataract surgical (CSR) rate, which addresses a major treatable cause of avoidable blindness, has increased significantly due to joint efforts of all INGOs and government partners, and this too needs to be sustained to maintain gains made in the last 10 years.

So far, FHF and AusAID have supported four successful projects in Pakistan. In its first project that lasted from 1998 to 2002, the focus was on developing cataract services at all the secondary level eye health facilities across the country. The next project that followed from 2002-2007 was the model of district comprehensive eye care, Pakistan – Australia District Eye Care (PADEC) project in selected districts of four provinces of Pakistan in line with VISION 2020. This was taken forward by the National Programme of Prevention and Control of Blindness 2005-2010 for replication across the country. The National Programme was supported and followed through by a third project that runs through 2007 to 2013. This project mainly supported the gaps in the National Eye Care Program (2005-2010).

The fourth project, Pakistan – Australia Sub-specialty Eye Care (PASEC) that FHF and AusAID started in 2008 with an expected end in 2013 focused on developing subspecialties in the areas of Paediatric Ophthalmology and Vitreo Retina to reduce diabetes and childhood blindness. The project comprehensively strengthened necessary infrastructure at selected centres of excellences and tertiary units across the country for the development of dedicated paediatric and vitreo retina subspecialty units in 17 selected hospitals. As part of human resource development, entire teams for each subspecialty have been trained in long and short-term fellowship. In this project indigenous subspecialty fellowship programs have also been started for the first time in the public sector. The programme also provided limited support to MLECPs in short and long-term courses while effectively engaged with national committee for eye health for improved governance.

With a paradigm shift of health policy and planning at the provincial levels in Pakistan after enactment of 18th constitutional amendment, the role of provincial eye care cells and eye health boards have become pivotal for development of sustainable eye health services in their respective provinces. There is growing recognition of the need to introduce standardized curricula and quality standards especially in MLECP training programs in Pakistan. In addition, there is need for addressing the challenge of uniform reporting of eye health indicators across the country. More importantly, there is need for pilot initiatives to add on glaucoma and retinopathy of prematurity (RoP) services and a few community-screening approaches for learning and adoption by the government and other INGOs. There is need for

[4] Jadoon MZ et al. Prevalence of blindness and visual impairment in Pakistan: the Pakistan National Blindness and Visual Impairment Survey. Investigative Ophthalmology & Visual Science, 2006, 47(11):4749–4755

enhancing the capacities of partners in research for generating sufficient evidence to interface with development issues like poverty, Millennium Development Goals (MDGs), gender, new innovative approaches for service delivery etc.

The national committee for eye health Pakistan, which has provincial representation through provincial coordinators, developed a strategic vision of the future National Eye Health Plan in its meeting held in August 2012. The new national eye health plan is still in the process of being developed in the light of strategic vision. Presently, the unspent funds from the national eye health plan 2005-2010 have been devolved to the provinces after the 18th Constitutional Amendment. The National Committee for Eye Health will now have to align the next eye health plan with the WHO Global Action Plan for Universal Eye Health 2014-2019 that was endorsed by the WHO Executive Board in January 2013[5] and is due to be presented to the World Health Assembly for adoption. This may require the new national eye health plan to be phased between 2014-2019 to align with the WHO Global Plan.

The proposed project, the Pakistan-Australia Prevention of Avoidable Blindness Project (PAPAB), will be the fifth project delivered by FHF with AusAID funding. The project is based on strengthening eye health systems within a health systems framework of Pakistan, as mentioned in strategic options for the next national eye health plan. The focus will be around consolidating the sub-speciality training programme, modelling the impact on quality of MLECP training by strengthening few selected MLECP training institutes, integrating eye health into Provincial HMIS, addressing emerging high priority diseases, enhancing leadership development with improved governance and promoting evidence based programs in Pakistan.

1.2 Project Preparation

- The project is based on the request made by the Government of Pakistan, through the national committee for eye health to support the strategic vision of a revised national eye health programme 2014-2019 (that incorporates the national program 2005-2010 now devolved to 2015) in line with the WHO Global Action Plan 2014-2019 for universal eye health

- The FHF team reviewed the current policy and strategic planning documents of Punjab, KPK, and Sindh provinces. It also reviewed the current heath strategy of AusAID, its Effective Aid Programme for Australia document and the more recently adopted Australia – Pakistan Partnership for Development to align project approaches with respective policies, strategies and plans

- Initial consultations were organized with existing and potential partners to determine their areas of interest and collaboration. Based on those needs, the FHF Pakistan office submitted a concept note to the FHF Sydney office. Following the approval of the concept brief through FHF internal project appraisal process, it was then submitted to AusAID

- After the approval of the concept note by AusAID, FHF initiated the project proposal development through Avicenna Consulting and FHF country office team

- FHF conducted a detailed situation analysis of eye care services in all provinces to determine the current situation for service delivery and human resource development

[5] Towards universal eye health: a global action plan 2014–2019. EB132.R1. 22 January 2013

- Based on the situation analysis, the consulting firm and FHF organized meetings with the National and Provincial coordinators to obtain their perspectives in light of the 18th Amendment

- FHF requested project proposals from the existing and potential partners

- A detailed project document has been prepared based on the documents reviewed including FHF and AusAID strategic documents and feedback received from partners and other stakeholders. The design was reviewed and recommended by the FHF Peer Review Panel based in Sydney Australia and submitted to AusAID.

- A revised detailed project document was resubmitted to AusAID after incorporating AusAID's review feedback.

1.3 Partners

The Foundation commenced its operations in Pakistan in 1998. The modus operandi of FHF is to work with and through local partners. The Foundation adopts participatory approaches, which involve stakeholders in all stages of program development, and building linkages between professionals and people. FHF directed its interventions in capacity building of the existing government health system to address some of the gaps through its various interventions.

From 1998 to 2007, FHF partnered mainly with the Public sector and had its agreement with the MoH and four Provincial Departments of Health. Its partnership ranged from the Provincial CEC Cells to major teaching hospitals and the DHQ hospitals across the country. FHF has formed partnerships with the major national eye care NGOs in addition to working with the public sector. These partnerships have improved FHF's reach into areas that are otherwise inaccessible due to remoteness, security issues or lack of government presence. Local NGOs also bring their particular expertise to further develop and improve models developed by FHF. In the proposed project, FHF shall continue its partnership with the public sector and major NGOs

A brief description of some of the major organisations that FHF has partnered with in the past and shall continue to partner with under the proposed new project can be found at Attachment 3.

1.4 Successes and Lessons Learnt

FHF has long worked in Pakistan demonstrating significant success through its various projects. Many of its initiatives like the training of Lady Health Workers, the district based comprehensive program was taken up by the government through its National Eye Care Program 2005-2010. Similarly, through the PASEC project FHF has demonstrated the significance of setting up of sub-specialty fellowship in the country. Government institutes and local NGO partners now have accredited fellowship programs for pediatric and diabetic eye care disease management. This is the first time to have happened in Pakistan. The below table shows key results from previous projects funded by AusAID and FHF, demonstrating Australia's contribution towards reducing avoidable blindness in Pakistan.

Table indicating FHF achievements through Australian contribution since 1998

	No of persons screened	No. cataract operations	No. other sight saving operations	No. surgeons trained clinically	No. surgical support staff trained (clinically)	Persons attending other courses	No. attending continuing education/mentoring	No. community health workers trained	No. facilities built or rehabilitated	Value of equipment supplied (AUD)
1998-2001	1,057,500	105,750	-	110	-	-	-	-	-	90,400
2002-2004	407,184	13,692	-	-	17	-	-	3,784	19	1,794,095
2005	309,414	11,615	22,120	53	3	2,019	11	820	3	525,768
2006	412,599	16,580	8,223	4	8	1,016	6	154	5	309,020
2007	455,710	19,306	18, 807	11	15	135	18	53	2	63,731
2008	400,722	17,823	2,441	29	23	309	12	2	11	129,739
2009	406,230	18,843	13,121	15	30	90	5	0	8	706,833
2010	411,485	25,157	12,464	11	32	0	4	0	6	966,024
2011	303,869	24,253	18,412	3	24	9	0	0	4	55,943
2012	233,196	19,330	11,118	11	93	2,691	1	0	9	545,629
Total	**4,397,909**	**272,349**	**87,899**	**247**	**245**	**6,269**	**57**	**4,813**	**67**	**5,187,182**

Some of the key lessons derived from the past FHF projects in Pakistan have been incorporated into this project and include the following:

- FHF started in Pakistan by piloting one district for implementing a comprehensive eye care project. Through this project training was provided to the ophthalmic team, infrastructure was developed and equipment was installed as well as provision of data collection systems. The pilot demonstrated successfully that a comprehensive approach was feasible at the district level. It was only then that FHF implemented the project in another 25 districts through the PADEC project. However in the case of PASEC, FHF set itself out to develop 26 sub-specialty eye units. Taking up such a large number in one go without piloting turned out to be very challenging. For the proposed project FHF, has only planned to pilot a few units/institutes of strategic importance and greatest need for new disease specific areas such as ROP, glaucoma and corneal opacities.

- FHF has learnt that by working vertically it is not easy to achieve sustainable development. It is therefore imperative that we work horizontally across a health care system and integrate eye and general health care where possible. This is easier said than done, however FHF is piloting working within a few units for strengthening management and governance along with working in their eye care systems.

- Over the years with the political and security situation in the country, completion of some activities within the stipulated timeframes was not possible at all times. It is recommended that the phasing of the project should be based on realistic timeframes keeping in mind the prevailing conditions in the country. It is also important that all involved in the implementation of projects in countries like Pakistan be aware of this limitation and be ready for alternative plans of action.

- FHF has implemented initiatives taking a comprehensive longer term approach rather than short term ad hoc inputs. This yields good outcomes for both FHF and the partners.

- Working through existing country health systems and building local capacity has proved to be highly sustainable and cost effective. FHF has worked with local partners through PADEC and PASEC namely, the GoP and more recently also through local NGOs rather

than creating FHF owned independent vertical service delivery programs. The sustainability of such models of partnership is much higher than otherwise.

- Involvement of all stakeholders is highly important for the success and sustainability of any project. FHF has always consulted partners from the initial planning phases through to implementation and review. This ensures that inputs are owned up and implemented by partners well beyond FHF presence.

- There needs to be strong coordination, cooperation and information sharing between all stakeholders and other INGOs working in the eye care sector. Formal forums like INGO coordination forum, national and provincial eye health committees are important to promote this sort of coordination and consultation. It avoids any duplication of efforts and also provides a basis of good peer review.

- FHF has been in a fortunate position to have received consecutive funding from AusAID for eye care activities. AusAID has always displayed flexibility to review activities and allowed introduction of new ideas in response to the changing needs in the country. This has proved highly encouraging for the best planning and utilization of resources.

- Diversity in partnerships enables greater reach, better outcomes, efficient use of resources and efforts. For example national eye care NGOs are excellent partners where there are no public health services available and these NGOs are the only service providers. These NGOs have local linkages and mechanisms to deliver projects that FHF would have not been able to do so otherwise. NGOs also have better management systems and specific mission of reaching the poor and disadvantaged segments of the society. This highly complements FHF and AusAID philosophy of catering the needs of the poor.

- Respect and trust of partners is critical to achieving successful outcomes for the project. Diffusion of innovation and good relationship building with partners takes time. FHF works closely with partners to understand their ideas and to share with them our innovative approaches for the development and implementation of eye care services. Through PADEC and PASEC implementation, FHF recognizes that logical timeframe and a lot of interaction is needed to take partners onboard for accepting new inputs rather than forcing upon them.

- Through work in PADEC 1 and 2, FHF has identified that building capacity of provincial boards and investigating effective service delivery models will have more impact and continue the momentum of the work at all levels rather than FHF contributing to ongoing inputs like HRD, equipment provision etc. FHF does not want to be seen as carrying on with doing the government's job.

2.0 SITUATION ANALYSIS

Details of the general situation are shown in Attachment 4.

2.1 Eye Health Sector

2.1.1 Eye Health Situation

In 1980, at the request of the Ministry of Health, WHO conducted a situation analysis of eye health services in the country. The analysis revealed that over two-thirds of the district (secondary level) hospitals had no eye care services. The report further added that there were an insufficient number of ophthalmologists and that there was no paramedic cadre to assist the ophthalmologists. They observed that the cataract surgical output was very low and insufficient to address the backlog of cataract in the country. Based on these recommendations, the Ministry of Health constituted a national team in 1982 to address this issue. This team was called the National Cataract Committee, which later in 1988 was changed to the National Eye Camp Planning Committee, as the general approach to reducing the burden of cataract blindness in South Asia at the time was through eye camps.

It was in 1989-1990 when the first National Blindness Prevalence Survey was conducted with support from WHO. The results of the survey were so staggering that the Ministry of Health took a very serious note of the prevailing situation of blindness in the country, with the effect that the National Eye Camp Planning Committee rapidly evolved into the National Committee for Prevention of Blindness in 1991. This committee formulated the first National Plan for Prevention of Blindness 1994-1998. Subsequently, two further National Plans were developed – second National Plan 1999-2003, and third National Plan 2005-2010. In 2008, this committee was re-constituted as the National Eye Health Committee. Following the 18th Amendment, the provinces now have to develop their individual Provincial Eye Health Plans. The amalgamated Provincial Eye Health Plans shall constitute the National Eye Health Plan.

The second National Survey on Prevalence of Blindness and Low Vision was undertaken in 2003-2004. After almost 15 years of joint intervention, this survey revealed that the prevalence of blindness had been halved to 0.9%.

Table 1 - Causes of blindness in Pakistan obtained from two population based surveys

Main cause of blindness	National blindness survey 1988-1989		National blindness survey 2002-2004		Odds Ratio (95% CI)
	N	%	n	%	
Cataract	342	66.7	289	51.5	1.83 (1.42-2.36)
Corneal opacity	66	12.6	66	11.8	1.10 (0.75-1.60)
Uncorrected refractive errors*	60	11.4	15	2.7	0.97 (0.70-1.35)
Uncorrected aphakia	NSR	NSR	48	8.6	
Glaucoma	21	3.9	40	7.1	0.55 (0.31-0.98)
Macular degeneration	NSR	NSR	12	2.1	
Diabetic retinopathy	NSR	NSR	1	0.2	
Others	29	5.4	90	16.0	
Blindness Sample Total	518**	100%	561***	100%	
Survey Sample Total	29,157		16,507		

**Includes uncorrected aphakia; **This gives a prevalence of blindness of 1.78%*

****This gives a prevalence of blindness of 3.4%. However, when it is adjusted for all ages, the prevalence is 0.9%; NSR – Not separately reported* [6]

Table 1 illustrates the key results of two national blindness surveys undertaken about 15 years apart. The surveys revealed that while cataract still remained the commonest cause of blindness, its proportion as a blinding cause had reduced from two-thirds to about half of all causes. This corroborated with the eye health workforce development and simultaneous strengthening of static facilities for eye care at the secondary level, which took place during this period. Furthermore, the second survey identified diabetic retinopathy and macular degeneration as emerging causes of blindness. The first survey may have identified these conditions but these were not reported separately.

Further details about the eye health situation and specific priority diseases are shown in Attachment 5.

2.1.2 Eye Health Human Resources

One of the key successes of the national plans for eye health has been the development of provincial and national centers for training an eye health workforce. To address the paucity of eye health professionals, the National Committee for Prevention of Blindness prioritized the establishment of at least one training centre in each province. The national strategy also developed the concept of an eye care team with allied health professionals supporting ophthalmologists. Two of the critical factors in this regard were the identification of eye health workforce development needs and the establishment of training institutions in the public sector in all the four provinces.

National plans have invested in four main levels of the eye health workforce. Each level went through a process of piloting, followed by a demonstration phase before scaling up to each province.

Firstly, it strengthened ongoing training of ophthalmologists through up-gradation of training facilities in teaching hospitals. In 1993 there were 1500 ophthalmologists. Based on data from the Pakistan Medical and Dental Council, there were an estimated 2000 or more ophthalmologists in the country by 2009. By 2012, the number had risen to 2,200.

The second area of attention was curriculum development and launch of training programmes for allied health professionals (like optometrists, orthoptists and ophthalmic technologists) and ophthalmic medical assistants (called ophthalmic technicians). All courses and training centres have been approved by the relevant accrediting authorities. However, curriculum standardization and establishment of quality standards remains to be addressed.

Thirdly, a new cadre of eye health managers was created in the form of Community Ophthalmologists. They obtain training that is equivalent to a Masters degree in Public Health and attend to the preventive and promotive aspects of eye health.

The fourth vital cadre is that of the Lady Health Worker who provides primary health care to the communities. This cadre has been trained in eye health promotion, detection and referral of seven priority eye problems to the next level of care. This cadre is already deployed as a primary health care worker – integration of eye health activities enhances their task shifting options and ensures horizontal strengthening of health systems.

[6] A.A. Khan, N.U. Khan, K.M. Bile and H. Awan. Creating synergies for health systems strengthening through partnerships in Pakistan – a case study of the national eye health programme. EMHJ Vol. 16 Supplement 2010

Details of the eye health workforce are shown in Attachment 6.

General Ophthalmology Training Program
Currently, thirty centres provide training in general ophthalmology. 71% of the centres are government institutions, while 29% are NGO or private. The training programmes offered include residency training of 2 years and of 3-4 years. Presently, there are 1051 students in the programme with a total teaching faculty of 165. There is an ophthalmologist to midlevel eye care personnel (MLECP) ratio of about 1:1 indicating insufficiency of MLECPs in the country.

Subspecialty Services and Training
There are 150 ophthalmologists delivering subspecialties. Out of this number only 20 have undergone two years accredited subspecialty fellowship training in pediatric and vitreo-retina through FHF supported PASEC project. In the other subspecialties about 10 Ophthalmologists have received 12 months or lesser formal training in their respective subspecialties in the entire country. Others are practicing in different subspecialties areas through their interest and experience.

Currently, 18 centers are providing subspecialty services and 7 centers subspecialty training. There are nationally approved subspecialty curricula for community eye health, pediatric ophthalmology and vitreo-retina.

2.1.3 Eye Health Structure and Services

Table 2 demonstrates a rising trend in eye care interventions every five years. The period between 1988 – 1993 serves as a baseline before any formal National Programme for Prevention of Blindness was launched. As static facilities were upgraded and new eye hospitals established in the non-government sector, a corresponding decrease in eye camps is noted.

Table 2 - Eye care interventions carried out in Pakistan during 1988 to 2003

Year	Type of service	Estimated annual number of interventions carried out		Total
		Institutionalized	Non-Institutionalized*	
1988-1993 (Pre-National Programme)	Eye Outpatients	1,600,000	500,000	2,100,000
	Refractive Error examinations	160,000	100,000	260,000
	Cataract surgeries	88,000	52,000	140,000
1994-1998 (1st 5 year Plan)	Eye Outpatients	3,768,120	753,624	4,521,744
	Refractive Error examinations	565,218	113,044	678,262
	Cataract surgeries	120,000	70,000	190,000
1999-2003 (2nd 5 year Plan)	Eye Outpatients	6,782,616	1,356,523	8,139,139
	Refractive Error examinations	1,017,392	271,304	1,288,697
	Cataract surgeries	208,204	102,548	310,752

**This includes eye camps, outreach and private practices* [7]

Table 3 indicates the operational outcome of interventions and up-gradation of district hospitals in the public sector. There was a threefold increase in outpatient attendance rates and the number of cataract surgeries increased by almost four times. Even in areas of heightened security situation, there were modest increases. In Balochistan, 10 districts were not upgraded due to lack of staff. A similar situation was found in two districts each in Punjab and Khyber Pakhtunkhwa (previously North West Frontier), and one each in Sindh and Azad Jammu and Kashmir. Data from districts that were not upgraded was not reliable as no systematic reporting was being followed.

Table 3 - Three year operational outcome of up-gradation of district eye care services

Province	Number of facilities upgraded	Eye outpatients seen in upgraded district eye units			Eye surgeries performed in upgraded district eye units		
		2006	2007	2008	2006	2007	2008
Federal	2	19702	40971	18576	719	1934	1610
Punjab	34	45461	132917	259385	1584	9757	13898
Sindh	14	91095	133890	263971	1072	4349	16024
North West Frontier Province*	22	68192	87043	146440	3448	8839	8706
Balochistan*	11	31600	37,309	44,585	6079	5617	7,145
Northern Areas	2	2055	2122	4440	179	187	351
AJK	3	21081	22495	41151	498	1047	3148
Total	**88**	**281192**	**458,754**	**780,556**	**15585**	**33737**	**52,890**

Source[8]

The approach taken by the National Committee for Prevention of Blindness was to adopt a district based comprehensive eye care strategy. This provided a steady unit of population with basic health infrastructure. The aims of the strategy were to conduct a district needs assessment with regards to eye health and determine gaps that existed; strengthen the infrastructure and technology needs of the eye unit at the district hospital; skills up-gradation of the district ophthalmologist especially in micro-surgery; training and provision of ophthalmic assistants for the ophthalmologist and develop an eye care team approach; refurbishment of eye clinic, eye ward and eye theatre; provision of essential consumables for surgery; training of primary health care workers in eye health promotion and setting up a referral system. An initial situation analysis of district eye care services revealed gross deficiencies[9].

The district based comprehensive eye care strategy was piloted in one district in 1996 and after a successful evaluation, expanded to 63 districts between 2000-2005 with support from international partners, and then scaled up to another 63 districts in the country by the

[7] A.A. Khan, N.U. Khan, K.M. Bile and H. Awan. Creating synergies for health systems strengthening through partnerships in Pakistan – a case study of the national eye health programme. EMHJ Vol. 16 Supplement 2010

[8] A.A. Khan, N.U. Khan, K.M. Bile and H. Awan. Creating synergies for health systems strengthening through partnerships in Pakistan – a case study of the national eye health programme. EMHJ Vol. 16 Supplement 2010

[9] Situation analysis of the existing ophthalmic resources of DHQ hospitals Sind, Baluchistan and Punjab (1998-1999). Report, Results and Recommendations. Fred Hollows Foundation, 1999

government in the 2005-2010 national plan. The district programme not only demonstrated the feasibility of the approach even in the most difficult districts, it also revealed that there was a demonstrable increase in the number of women attending the district eye units for treatment and eye surgery. FHF have supported the comprehensive up-gradation of 26 and partial up-gradation of 27 district eye units through PADEC Phase I and II, which played a major role in the advocacy to the government to invest in eye health. The gains were consolidated through PADEC Phase II and later by adoption of eye care program by the MoH.

The proposed project is a logical progression for FHF and its partners after collective efforts have been made at district level strengthening through PADEC. It is hoped that the efforts will be further consolidated by the provincial governments and FHF has set out to support the provincial boards to do so. At the tertiary level FHF has been instrumental in tackling sub-specialty eye care services through PASEC project and hence the gains need to be consolidated by creating awareness at the community level. FHF has therefore proposed community level screening for paediatric and diabetes related blindness.

According to VISION 2020: Right to Sight, each ophthalmologist should be supported by 4 mid level eye care personnel. As is evident from above that there is a shortage to this ratio, FHF has proposed in the project to strengthen this cadre of eye care workers by developing institutional capacity of the mid level eye care personnel training institutes.

Through the project FHF is also looking to invest in strengthening management and governance of eye care to ensure its proper integration into the health system. As part of the strategy, FHF will also work with partners to strengthen eye health management systems to ensure eye care data collection is streamlined in the proposed location. This will enable partners to collect essential data for it planning as well as generate evidence base for advocacy.

2.2 Alignment with Existing Strategies and Policies

AusAID Draft Health Strategy
The project is aligned with and meets the six pillars of AusAID's investment in health by:

- Supporting partner countries to deliver more and better-quality health services for poor and vulnerable people – by focussing on partnerships with government and NGO partners in eye care; by supporting provision of cataract surgical services to the poor especially women
- Closing the funding gap to provide essential health services for all – by partly meeting eye health financing gaps and strengthening eye health systems through infrastructure development, provision eye health technology, training of eye health workforce so that eye health services are available and accessible
- Empowering poor and vulnerable people to improve their health – by supporting community mobilization initiatives especially for awareness about child eye health, diabetes and diabetic retinopathy to improve early detection, timely screening and treatment
- Working with other sectors, such as education, water and sanitation, and rural development, to address the causes of poor health – by working with education sector in school health programs to screen for refractive errors in school children
- Reducing the impact of global and regional health threats, particularly in Asia and the Pacific – by developing partnerships with organizations that can provide emergency eye health services during emergencies and disasters, and eye disease transitions due to climate change

- Maximising the impact of Australia's total health ODA investment in partner countries – by strengthening governance and management mechanisms for the delivery of the provincial eye health plans, and monitoring to ensure aid effectiveness and efficiency
- The project is aligned to contribute towards and meet AusAID outcome of 'increased use and improved quality of affordable health services, underpinned by stronger country health systems, through increased funding and mobilising community demand'

Further details are shown in Attachment 7.

Australia – Pakistan Development Partnership

The Australia – Pakistan Development Partnership is underpinned by a *Memorandum of Understanding (MoU) on Partnership for Development between the Government of the Islamic Republic of Pakistan and The Government of Australia* signed on 28th October 2011. The partnership is based on a shared commitment to pursuing a stable, secure and democratic Pakistan through broad-based social and economic development and poverty reduction in line with the MDGs. The Australian aid program in Pakistan will support activities that focus on health, education and technical training amongst others such as rural development, agriculture, etc. The project to support prevention of blindness falls within the priorities for the Australian aid program to Pakistan.

The Fred Hollows Foundation Strategic Framework (2011- 2014)

The project conforms to the Country Program Strategy for Pakistan 2013-2017 and is aligned with the following strategic objectives:

- End avoidable blindness
- Strengthen decentralized management of eye health services at provincial level
- Strengthen local institutes to train mid level eye health workforce
- Advocate for allocation of resources in the country by strengthening research capacity in eye health and provide evidence for advocacy and policy development.

AusAID and The Fred Hollows Gender Equality and Development Policies

An analysis of blindness prevalence surveys conducted in Africa, Asia and Industrialized countries[10] estimate that women account for approximately two-thirds (64%) of the world's blind population. Similarly, several surveys[11] of blindness in Pakistan have reported higher rates of blindness for women[12].

Recent studies in Pakistan have demonstrated that there is an inextricable link between blindness and poverty. The Pakistan national blindness and visual impairment survey revealed that the prevalence of total blindness in poor clusters was more than three times of that in affluent clusters[13].

The following key steps would be taken for gender equality, gender equity and gender mainstreaming.

[10] Abou-Gareeb I, Lewallen S, Bassett K, Courtright P. Gender and blindness: A meta-analysis of population-based prevalence surveys. Ophthalmic Epidemiol. 2001;8:39–56

[11] Mohammad Z. Jadoon, Brendan Dineen, Rupert R. A. Bourne, Shaheen P. Shah, Mohammad A. Khan, Gordon J. Johnson, Clare E. Gilbert, Mohammad D. Khan and on behalf of the Pakistan National Eye Survey Study Group. Prevalence of Blindness and Visual Impairment in Pakistan: The Pakistan National Blindness and Visual Impairment Survey. Invest. Ophthalmol. Vis. Sci. November 2006 vol. 47 no. 11 4749-4755

[12] Anjum KM, Qureshi MB, Khan MA, Jan N, Ali A, Ahmad K, Khan MD. Br J Ophthalmol. 2006 Feb;90(2):135-8.

[13] Gilbert CE et al. Poverty and blindness in Pakistan: results from the Pakistan national blindness and visual impairment survey. British Medical Journal, 2008, 336(7634):29-32

- The project lays emphasis on strengthening the services at the primary and secondary levels by making them more accessible and affordable to the local communities nearer to their homes. This will encourage women to visit the hospitals by virtue of less distance, time and reduced cost & language barriers
- The project will work with primary health care workers especially LHWs who are women. This will add on to their capacities in identification of the cases of women and children in the communities and refer them to the nearest health facility and eye care centres for treatment
- The project will provide training to the ophthalmic community and MLCEP students in gender equality and equity
- Under MLCEP training programme, the scholarships would be given to the girls from marginalized areas
- The hostel facility constructed at COAVS will provide immense benefit to the girls students ensuring their safety and protection
- The gender-segregated data will be collected at all levels where possible. The ophthalmic community will be encouraged to report sex disaggregated data from their units
- The female staff of the partner organization will be encouraged to participate in review meetings
- Advocacy will be maintained at all relevant forums for the protection and equal rights of women
- Partners will be supported in developing their gender and social protection policies
- Program planning and design that incorporates needs for services for women and girls especially in childhood blindness, diabetic retinopathy, and refractive errors
- The MoU signed between all partners will include a commitment to gender equality and no discrimination based on gender
- Community mobilization that is gender sensitive
- Evaluation criteria shall emphasize impact on gender equity

AusAID and The Fred Hollows Child Protection Policies

The project activities of service delivery and human resource development are aligned with the FHF organizational policy on child protection as follows:

- Ensure that partners understand FHF has zero tolerance of child abuse.
- Partner organizations, especially those providing services for paediatric ophthalmology shall be sensitized on child protection issues
- Subspecialty development training centres supported by FHF in paediatric ophthalmology shall be oriented in child protection
- Collection of photos and case studies of children shall conform to child protection policy principles
- Community mobilization interventions shall ensure that child protection issues are not overlooked
- The involvement of children in the project will be through screening and provision of services that will be provided by staff employed and managed by the provincial governments.
- FHF will work with partners and ensure that when children are being screened or services are provided that a relative accompanies them, which is often the case culturally in Pakistan.

AusAID and The Fred Hollows Counter-Terrorism Policies

The proposed project is aligned with the FHF organizational policy on counter-terrorism as follows:

- The partners shall be selected on the basis that they meet security requirements included in the policy

- On a six-monthly basis, project partners will be screened by FHF against the Australian Government's listing of terrorist organizations and individuals.
- The partners selected shall be made aware of the organizational policy
- All MoUs or other Agreements with Program Partners will include a clause requiring them to use their best endeavors to ensure that the program will not provide any direct or indirect support or resources to individuals or organizations associated with terrorism
- Funds transferred will be through appropriate banking channels with follow up monitoring and reporting by partners

AusAID and The Fred Hollows Foundation Anti-Corruption Policies

FHF will work with the hospitals to strengthen data collection, registration, and audit and conduct advocacy in relation to access by the underprivileged. Moreover, in collaboration with National and PCs, FHF will do the following to reduce the risk of corruption in the Project:

- Sound selection criteria for trainees based on merit applied by a broad based selection panel including FHF, concerned PC and the unit in charge
- Strengthen internal controls and audits in relation to financial management and procurement
- Conduct external audits in relation to financial management
- Directly manage the procurement and distribution of physical inputs; tenders will be sought from suppliers and payments will be made directly to suppliers from the FHF country office by designated staff
- Ensure when equipment is installed that it is taken onto the hospital stock register and that the rooms storing the equipment have appropriate security arrangements; and monitoring to check there have been no thefts or misuse of the equipment
- Support the anti-corruption policies and plans of the GoP and promote the application of the relevant rules and regulations of key counterparts.
- Build the capacity of counterparts to take anti-corruption measures
- Apply a communication strategy that delivers consistent messages on fraud and corruption.

Disability Inclusive Strategy

FHF is committed to ensuring that people with disabilities are included in planning, implementation and monitoring and evaluation processes. FHF will seek to do the following:

- The MoU signed between all partners will include a commitment to disability inclusive development in relation to the project implementation through non-discrimination of disabled persons and provision of eye care services to all.
- FHF will ensure disability access is provided to all buildings at the eye units being renovated and the construction of MLECP girl's hostel.
- FHF will also work with partners and eye unit authorities to allow for internal disability access in screening areas, wards, toilets etc.
- FHF will encourage partners to collect data on people accessing eye care services with additional disability other than vision impairment and blindness. However this may not be possible at the beginning of the project but may be introduced after working in close collaboration with partners for some time and once the data collection capacity has been developed.

AusAID Environment Management Guide for Australia's Aid Program 2012

FHF recognizes that environmental degradation, whether as a result of direct or indirect links to human induced accelerated climate change, is closely linked with other development issues. While 'ensuring environmental sustainability' is in itself a specific MDG, it is commonly acknowledged that a failure to secure this has the potential to undermine all efforts

to achieve other MDGs. In order to be consistent as an organization committed to such development goals FHF will introduce environmental initiatives specific to its own practices within the project. FHF will work with partners to ensure that their respective government guidelines and practices regarding environmental sustainability will be followed.

VISION 2020
Pakistan signed the VISION 2020 - the Right to Sight Declaration in February 2001, thereby adopting the global initiative as the strategy for controlling blindness in Pakistan.

The VISION 2020 Global Initiative put on its agenda several priority diseases, which are among the leading causes of blindness worldwide and can be either prevented or treated. The initial list of five, included cataracts, trachoma, Onchocerciasis (river blindness), childhood blindness and refractive error/low vision. The increase of diabetes has caused DR to be added to the VISION 2020 priority list. Cataracts have been the focus of the AusAID funded PADEC projects. Cataracts will still be addressed under the proposed project because of rising poverty and marginalized communities that still need this surgery but cannot access it due to distance, cost (even in the public sector patients need to purchase a pack of consumables), perceptions etc. The project is aligned with VISION 2020 priorities.

Millennium Development Goals
Several of the MDGs depend on measures linked to the implementation of VISION 2020. The proposed project is underpinned by the following MDGs:

- MDG 1: Eradicate Extreme Poverty and Hunger
- MDG 2 and 3: Achieve universal primary education, promote gender equality and empower women.
- MDG 4: Reduce child mortality

3.0 PROJECT DESCRIPTION

3.1 Title

Pakistan – Australia Prevention of Avoidable Blindness (PAPAB) Project

3.2 Duration

Five years from 1 July 2013 to 30 June 2017

3.3 Goal

To improve the quality of life of people in Pakistan, especially vulnerable groups such as women and children, reducing avoidable blindness and visual impairment by the year 2020

3.4 Purpose

To strengthen eye health services within the health systems framework of Pakistan

Please refer to the Project Logframe of this PDD for more detail at Attachment 8.

3.5 Objectives

PROJECT SUMMARY

Goal: To improve the quality of life of people in Pakistan; especially vulnerable groups such as women and children, by reducing avoidable blindness and visual impairment by the year 2020				
Purpose: To strengthen eye health services within the health systems framework of Pakistan				
Objective 1: Strengthen paediatric and diabetes related eye care delivery within existing health system	Objective 2: Strengthen the Governance and HMIS for Eye Health through integration into the existing health system	Objective 3: Strengthen selected MLECP training institutes to deliver improved training programs	Objective 4: Prevent and control avoidable blindness due to five high priority eye diseases (glaucoma, RoP, corneal opacities, cataract and refractive errors)	Objective 5: Develop an evidence base for eye care service delivery approaches that can be scaled up by governments and potential partners
Output 1.1 Capacities of primary and secondary / tertiary health care cadres in selected districts strengthened to improve referral pathways for the effective uptake and delivery of paediatric ophthalmology services	Output 2.1 Increased effectiveness of national committee for eye health and five provincial boards	Output 3.1 Capacity of selected institutes strengthened to deliver high quality training of mid level eye care personnel for improved delivery of comprehensive eye care services	Output 4.1 Control of avoidable visual loss due to glaucoma piloted and tested at selected centres of excellence and tertiary institutions	Output 5.1 Evidence based project planning and review introduced in selected project interventions
Output 1.2 Capacities of primary and secondary / tertiary health care cadres in selected districts strengthened to improve referral pathways for the effective uptake and delivery of vitreo-retinal services	Output 2.2 The provincial and district Eye Health Information System (EHIS) investigated in a selected project district in collaboration with respective provincial HMIS	Output 3.2 Hostel for mid level eye care students constructed at a selected centre of excellence	Output 4.2 Screening for retinopathy of prematurity piloted and practiced at selected centres of excellence / tertiary eye units.	Output 5.2 Improved advocacy for eye health through increased linkages with regional forums
Output 1.3 Selected gaps in technology addressed in the paediatric ophthalmology	Output 2.3 An Eye Health Information System (EHIS) piloted as part of the Tertiary		Output 4.3 Screening for diabetic retinopathy strengthened in selected tertiary	

and vitreo-retinal services developed through PASEC	Health Information System (THIS) in selected centres of excellence and tertiary centres		centres	
Output 1.4 Selected gaps in human resource development addressed in the paediatric ophthalmology and vitreo-retinal services developed through PASEC	Output 2.4 Effective linkages and coordination established between eye and general health structures at selected tertiary and district levels through capacity building initiatives		Output 4.4 Coverage and access of cataract surgical services enhanced especially to marginalized and poverty stricken populations in selected districts	
			Output 4.5 School eye health screening for refractive errors institutionalized by developing capacities of local stakeholders especially teachers	
			Output 4.6 Control of avoidable visual loss from cornea related blindness piloted and tested at a selected tertiary eye unit	

Objective 1:
Strengthen paediatric and diabetes related eye care delivery within existing health system

The PASEC project mainly addressed control and prevention of childhood and diabetes related blindness. This was achieved through the following key initiatives:

- Comprehensive development of pediatric and vitreo retinal subspecialty eye units. This involved human resource development (team approach), technology support, physical infrastructure refurbishment and systems support
- Screening of known diabetics for diabetic retinopathy
- Screening of school going children for refractive errors

In 2012, FHF conducted a needs assessment of the COEs and tertiary eye units through its PASEC project. The needs assessment revealed the following:

- Some minor gaps in the technology provision to a very few units

- HRD has been one of the main components of PASEC. It has however been quite challenging in terms of getting the right candidates for training, getting no-objection certificates (NOCs) for the identified candidates for the two year training, securing training slots of the identified trainee in-country and abroad. As a result, a few candidates started their training late and so would continue for at least a year after the completion of PASEC

- Some of the eye units were up-graded in the last year of PASEC and would require follow-up for at least next two years to ensure effective utilization of the project inputs

The PASEC project mainly focused on tertiary level eye care services in the two subspecialties. However, now that the clinical services are well in place, there is a strong need to create awareness and mobilize communities for the uptake of these services. This would ensure optimal uptake of services developed. The project will strengthen the capacities of primary health care workers especially Lady Health Workers (LHWs) in identifying the cases of childhood blindness and diabetic retinopathy at selected districts. A lady health worker is appointed for coverage of 125- 200 households with a monthly visit to each household of her area. She is responsible for health promotion and preventive care; including eye health, in the community especially for the women and children. With the devolution of health in Pakistan, the National Programme of LHWs has been devolved to the provinces. The LHWs are provided monthly stipends, and very recently the Federal Cabinet has approved regularization of the cadre of LHWs under government services for which final modalities are under process.

FHF has piloted the above initiatives in the last year of PASEC in one district. It will now work with the provincial coordinators of LHWs program to implement the developed strategy for community screening in other selected districts. The module developed for the training of LHWs will be used and training will be provided to Lady Health Supervisors (LHS). The LHS will provide training to LHWs in their respective areas. These LHWs will be informed about basic identification and referral of cases to the nearest health facility and district eye units. FHF will be closely involved in the training of LHSs and LHWs. Joint monitoring and periodic reviews of the work done by LHWs in eye health will be conducted with the support of LHWs program coordinators.

The LHWs trained will screen patients during their home visits and refer them to the designated primary eye centers. A project team having an optometrist, social organizer and driver will be deployed at the selected tertiary unit to visit the health facility to examine the

screened cases. These cases would either be treated on the spot or referred to the nearby subspecialty eye units for further treatment/management.

The district ophthalmologists in the vicinity of the selected tertiary centers will also be involved in this program and would be trained to enhance their skills in eye care management of the relevant eye condition.

Output 1.1 Capacities of primary and secondary health care cadres in selected districts strengthened to improve referral pathways for the effective uptake and delivery of paediatric ophthalmology

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Organize meeting with provincial PHC programs and all other stakeholders to develop strategy for LHWs training in PEC 2. Formalize the relationships with all relevant stakeholders 3. Develop the training curriculum and process for training in childhood blindness identification 4. Finalize the reporting mechanisms and referral systems along the referral chain 5. Procurement of equipment and vehicle for the field 6. Deployment of project staff including optometrist, social organizer and driver 7. Training and orientation of staff about childhood blindness project 8. Prepare project related IEC materials. 9. Organize the training of trainers for LHS 10. Organize training of LHWs by LHS 11. Orientation of district/sub district ophthalmologists in childhood blindness from the pilot district 12. Support the monitoring of trainings of LHWs and their work 13. Seminars and world sight day at	No of Master Trainers trained No of PHC workers trained in identification of pediatric cases No of district / subdistrict ophthalmologist oriented No of referrals made along the chain No of cases treated disaggregated by sex	One district in KPK, Sindh and Punjab each. The CEC Cells of the respective Provinces/ the district administration of the respective districts, the district eye unit of the selected district and FHF country office.	Activity 1-4 July-December 2013 Activity 5-11 August-December 2014 Activity 12-14 ongoing till the end of activity December 2016

the district level 14. Organize periodic review meetings with LHWs programs			

Output 1.2 Capacities of primary and secondary health care cadres in selected districts strengthened to improve referral pathways for the effective uptake and delivery of vitreo-retinal services

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Organize meeting with provincial PHC programs and all other stakeholders to develop strategy for LHWs training in PEC 2. Formalize the relationships with all relevant stakeholders 3. Develop the training curriculum and process for training in DRB identification 4. Finalize the reporting mechanisms and referral systems along the referral chain 5. Procurement of equipment and vehicle for the field 6. Deployment of project staff including optometrist, social organizer and drive 7. Training and orientation of staff about DRB project 8. Prepare project related IEC materials. 9. Organize the training of trainers for LHS 10. Organize training of LHWs by LHS 11. Orientation of district / sub district ophthalmologists in DRB from the pilot district 12. Support the monitoring of trainings of LHWs and their work 13. Seminars and world sight day at the district level 14. Organize periodic review meetings with LHWs programs	No of Master Trainers No of PHC workers trained in DRB identification No of district / subdistrict ophthalmologists oriented in DRB No of mid-level staff trained No of referrals made along the chain No of cases treated disaggregated by sex	One district in KPK, Punjab and Sindh each. The CEC Cells of the respective Provinces The district administration of the respective districts, The district eye unit of the selected district and FHF country office.	Activity 1-4 July – December 2013 Activity 5-11 August-December 2014 Activity 12-14 ongoing till the end of activity December 2016

Output 1.3: Selected gaps in technology addressed in the pediatric ophthalmology and vitreo-retinal services developed through PASEC

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Consultation and planning with selected upgraded units for further strengthening 2. Procurement of equipment 3. Installation of equipment 4. Strengthen the reporting system in the selected units 5. Quarterly review reports	Technology gaps addressed in No of units upgraded No OPD cases of CBL and DRB at selected centers disaggregated by sex No of surgical treatments for DRB and CBL disaggregated by sex	The CEC Cells of the respective Provinces Selected training institutes FHF country office.	Activity 1 July-December 2013 Activity 2-5 January - December 2014 Activity 5 ongoing during project life

Output 1.4 Selected gaps in human resource development addressed in the paediatric ophthalmology and vitreo-retinal services developed through PASEC

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Human Resource Development in the selected eye units amongst existing partners 2. Extend HRD support in the selected VR and Paediatric Ophthalmology units upgraded through PASEC	No of paediatric and VR sub-specialists trained No of medical officers trained No of Mid-level eye care personnel trained in each subspecialty	The selected training institute and FHF country office	Activity 1 January - December 2014 Activity 2 January 2014 December 2015

Objective 2:
Strengthen the Governance and HMIS for Eye Health through integration into the existing health system.

Historically ophthalmology has been seen as minor specialty in health care as compared to specialities like M & CH, surgery, medicine etc. Therefore there has been less investment in eye care as compared to these areas of health. Due to this perception ophthalmology faced a lot of neglect. So when in the early eighties the alarming situation of blindness in the country was revealed, efforts were put into place to address the situation. These efforts became more organized and focused in late nineties when different eye INGOs got together with the MoH. While we need to continue the focal efforts to develop eye care, one of the lessons learnt from FHF's past experience is to avoid purely vertical program and strive for horizontal linkages of eye care with general health care where possible. While the current project proposes to continue specific initiatives like supporting forums like eye health committees, it also proposes to develop integration of eye health management into general health management where possible.

The National Committee for Eye Health in Pakistan has been the custodian of the National Programme for Prevention and Control of Blindness and VISION 2020 in the country. The committee under the leadership of the National Coordinator is responsible for providing strategic guidance and supervision to the eye health activities undertaken in Pakistan. With the devolution of Federal Ministry of Health, the committee has been placed under the Department of Interprovincial Coordination Division. Presently, the National Committee for Eye Health has developed its national strategic vision in line with the national health system framework of Pakistan. The role of the National Committee has become more strategic especially when there are vast differences in capacities and opportunities in the provinces. The forum provides an opportunity for learning and advocacy with precedents set by different provinces with certain changes and achievements. The committee also provides a forum for consensus building and joint positioning for external representation of Pakistan. FHF will support the national committee through this project to increase coordination among the provincial eye health actors, and develop consensus about key issues like quality standards, curriculum, job descriptions, etc.

The role of provincial eye health boards has become pivotal with a paradigm shift of health policy and planning at the provincial level after the 18th Constitutional Amendment. Before the 18th Amendment, FHF and other INGOs have worked with provincial coordinators, and had been successful in creating the formation of provincial boards/committees for eye health in five provinces however these forums now need more focus and clarity about their roles and responsibilities with terms of references (ToRs). Thus, support from the project is planned for all five provincial boards to review their current structure and develop strategic plans where needed in line with national strategic vision, VISION 2020 and the WHO Global Action Plan. FHF will extend support in organizing the six monthly meetings of the provincial boards to review the progress of the project and approval for any strategic deviations needed to meet the objectives of the project. In the current economic conditions prevailing in Pakistan and deficiencies in public health spending, FHF sees a critical need for supporting the six monthly meetings.

COAVS in Punjab and PICO in KPK provinces have the mandate to implement and monitor the eye health activities in their respective provinces including partnerships with INGOs. Both institutes have been successful in achieving tasks like creating the positions necessary for effective implementation and monitoring. The other three provinces i.e. Sindh, Balochistan and Gilgit Baltistan CECs are at a relatively lower stage of development. The project will strengthen the capacities of these committees for effective and efficient role in planning, implementation and monitoring of eye health activities in their respective provinces.

The project will investigate the provincial HMIS programs in the selected provinces to ascertain the current data streams working at the district level and how the eye health indicators can be integrated into the existing system of information flow. The project will explore the possibilities of integrating eye health reporting within existing health reporting streams especially working at the district and tertiary levels. The district Eye Health Information System (EHIS) will be piloted at one selected district level.

Similarly, FHF will work with one selected tertiary unit and two centers of excellence to develop a Tertiary Hospital Information System (THIS) reporting arrangement to integrate with provincial HMIS reporting. FHF will support the development of necessary infrastructure and data management support with periodic review. Further, FHF will work with the same selected tertiary hospital health administration to improve their understanding and support for eye health. This will include management training and awareness raising for their knowledge building and integration of eye heath into general health systems.

Output 2.1 Increased effectiveness of National Committee for Eye Health and five provincial boards

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Support the national and provincial eye health structures to develop eye health plans and coordination mechanisms 2. Support the national and provincial eye health structures to conduct six monthly performance review meetings 3. Enhance the capacity of committee member by exposure visits to relevant eye care forums.	Minutes of Six monthly meetings of the national and provincial committees / boards Provincial Strategic Eye Health Plan Documents Number of exposure visits.	Each provincial CEC Cell in five provinces FHF Country office National committee for eye health	An ongoing activity during the project life July 2013- December 2017

Output 2.2 The Provincial and District Eye Health Information System investigated in a selected project district in collaboration with respective provincial HMIS

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Hold consultations to conduct situation analysis and identify gaps in the selected district EHIS and provincial HMIS 2. Review the results of EHIS within existing DHIS	No of consultations held Report on the status of Provincial and District HMIS	CEC Cells of the selected province and FHF country office	June 2014- July 2015

Output 2.3 An Eye Health Information System (EHIS) piloted as part of the Tertiary Health Information System (THIS) in selected centre of excellence and tertiary centre in collaboration with respective provincial HMIS

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Needs assessment and consultations to re-verify suitability and needs of the proposed partners for pilot project 2. Prepare a pilot project for integrating eye health information system into tertiary health information system for the selected partner 3. Implement the pilot project in selected centre of excellence and tertiary unit 4. Develop linkages with provincial HMIS for collaboration 5. Review the results of EHIS within existing THIS	No of units supported with THIS No of units that generated THIS reports No of eye health indicators included in THIS	DoH Baluchistan, KPK and Punjab The respective ECE Cells, DoH and FHF Country office	Activity 1 June – December 2013 Activity 2-4 January 2014- December 2015 Activity 5 on going till December 2017

Output 2.4 Effective linkages and coordination established between eye and general health structures at selected tertiary and district levels through capacity building initiatives

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Needs assessment of the identified tertiary administration unit 2. Identification of capacity building opportunities in the selected tertiary unit for connectivity and improved understanding of governance issues. 3. Arrange a customized training/ visits for the managers from the selected provincial, tertiary and district administration within Pakistan 4. Facilitate the participation of the management / administrative personnel in partners' review meetings of the programme	No of trainings /attendance No of exposure visits Program review meetings attended	Selected provincial health partners	Activity 1 –2 Jan- June 2014 Activity 3-4 July 2014- June 2016

Objective 3:
Strengthen selected MLECP training institutes to deliver improved training programs.

VISION 2020 strongly advocates team approach for eye services delivery. Pakistan is one of the few developing countries which has accepted the cadre of MLECP as an important part of the eye care team. All the INGOs working in Pakistan have supported and advocated the MLECP training and their inclusion in the eye care team. The government has established MLECP training institutes in all their CoE across the country. The INGOs have since 1998 been helping these institutes to train hundreds of MLECP. The government have also created permanent positions for these trained personnel and as such they are now seen as important permanent resources of the eye care team. Although the MLECP training is now happening on regular basis in multiple training institutes across Pakistan, addressing the quality and standardization of these training institutes have been identified by the National Eye Health Committee as a strong need.

Some of the training institutes are also delivering training to candidates from regional countries and as such Pakistan is emerging as regional training centre. The strengthening of the quality of MLECP training is therefore seen extremely important.

FHF will provide support to seven mid level eye care personnel training institutes in Pakistan especially in the areas of curriculum review and developing quality standards for training. The support will include needs assessment of these training institutes to identify infrastructural and technology gaps. Three Government and four NGO partners will be provided financial and technical support in running the MLECP courses in line with national approved criterion and approach. These seven training institutes have been selected based on the National Mapping exercise that was conducted by FHF and the National Committee in 2012. The main considerations in the selection have been, the existing capacity of the institute to up take the project inputs effectively, the number of students that are being trained each year, prospects of sustainability of the project inputs and the motivation and desire of each institute to develop further. It has also been ensured that each province benefits from this activity.

Through the National Committee, FHF will facilitate a curriculum review by organizing the meetings of training institutes to standardize the approach and topics to be covered in the MLECP courses i.e. BSc Vision Sciences, Ophthalmic Technician, Ophthalmic Nursing, etc. Moreover the institutes will be supported to develop their quality standards for their training courses. FHF will also provide technical assistance to both processes through experts and sharing good practices. FHF will organize periodic review of these training institutes to learn the progress and follow up to the implementation of quality standards in these training institutes. This would create uniformity and quality enhancement to the MLECP courses.

Presently, COAVS is the main MLECP training institute in the Punjab province in the public sector. Ideally an institute of the level of COAVS should have dedicated students living accommodation to facilitate students; especially female students from remote parts of the country. In recent years, the enrollment of girls in MLECP courses has increased significantly not only from within the country but from the EMR (coming from Sudan, Yemen, etc) and other countries. However, the security situation in Pakistan has been particularly challenging in the recent years and this is liable to impact female enrollment and retention. COAVS has been hiring local buildings, which are usually situated in crowded and distant locations due to cost limitations. The contracts have to be renewed for these accommodations every year with increase in rent. These local buildings are neither safe nor comfortable especially for the girl students. Interaction with the students has clearly highlighted this issue and repeated requests for safer accommodation have been made at different levels.

The project will construct a residential hostel facility for the students of COAVS to solve this problem. The project shall conduct an environmental impact assessment before construction, and shall incorporate accessibility guidelines of the Government of Pakistan in the design[14]. COAVS has a commitment to secure land, funding for the running costs and creation of regular positions of hostel staff through government. Historically, COAVS has been successful in meeting its commitment for job creation and taking up running costs of institutes supported by donors. FHF will work closely with COAVS in procurement of a quality conscious contractor in line with AusAID and FHF procurement policies. It will deploy dedicated staff to monitor the project construction work.

In 2011, the Government of Pakistan passed the 18th constitutional amendment, which resulted in devolution of the Federal Ministry of Health to the provinces – providing more autonomy to the provinces in allocation and approval of resources. Although provincial eye health partners have already been proactively engaged at the provincial level, this new administrative change at the provincial level requires a review of its existing capacities and how best these can be developed considering the long term strategic perspectives of eye health at provincial and national level. This requires the organizational capacity assessment of the partners to define their way forward in light of new administrative set ups.

FHF will provide specific focus on organizational assessment and development of training institutes under key areas of partnership development to make them more vibrant and robust. In addition, FHF will develop a sustainability index for each partner at the start of the project. Then, these training partners will be assessed in the MTR and final evaluation against the sustainability index. This index underpins the organizational effectiveness with emphasis on developing organizational policies and procedures, financial controls, programme management, leadership development, connectivity and networking etc. In order to enhance the motivation and teaching capacities of training faculty of MLECP, the project would support a training of trainer's events for teaching faculty to share the experience and presentation skills.

Output 3.1 Capacity of selected institutes strengthened to deliver high quality training of mid-level eye care personnel for improved delivery of comprehensive eye care services

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Develop quality standards for allied eye health training programs 2. Advocacy and consultation workshop for curriculum & quality standardization with major MLECP training institutes. 3. Advocate implementation of the quality standards with all MLECP institute partners 4. Conduct detailed needs assessment of infrastructure and equipment of the selected	Quality standards developed Quality standards implemented in No of institutes No of Institutes supported for capacity development. No and type of	The selected training centers, FHF Country office	Activity 1-2 January-December 2014 Activity 3 ongoing Activity 4-5 July 2014 - December 2015 Activity 6 -7 ongoing till

[14] Design Manual and Guidelines for Accessibility for Creation of Barrier Free Environments to make Buildings and Facilities Accessible to People with Disabilities. Government of Pakistan. Ministry of Social Welfare and Special Education. Directorate General of Special Education, Islamabad. 2007

partners 5. Support four NGOs and three Government institutes in training programs 6. 70 MLECP training supported in the government and NGO partners 7. Support the partners in developing necessary operational manuals and implementation procedures 8. Training of Trainers workshops in teaching methodology for the teachers/faculty 9. Conduct periodic reviews of the training programs with feedback from the students	courses supported No of trained professionals		the end of project.

Output 3.2 Hostel for mid-level eye care students constructed at the selected centre of excellence

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Support the institute to develop the initial lay out and preliminary cost estimates 2. Discussions with the government for joint ownership and concept approval 3. Undertake an environmental impact assessment of the hostel construction project 4. Detailed designing of the building and work plan for the construction that incorporates accessibility 5. Preparation of the project proposal and PC-1 for government approval 6. Procurement call for the construction of the building 7. Awarding of the contract to the qualified firm 8. Extend and facilitate support to the institute in supervision and	Construction work completed No of students living in hostel Percentage of girls students in hostel	Mayo hospital Lahore COAVS and FHF Pakistan	January 2014- December 2015

performance review to the quality of the construction 9. Procurement and Installation of accessories in the building 10. Project completion report 11. Inaugural ceremony of the hostel building			

Objective 4: Prevent and control avoidable blindness due to five high priority eye diseases (glaucoma, Retinopathy of Prematurity (RoP), corneal opacities, cataract and refractive errors)**.**

The project will build the capacities of selected partners both in government as well as NGO sectors in addressing three new high priority eye diseases namely glaucoma, retinopathy of prematurity and corneal opacities. Diabetic retinopathy and childhood blindness would be addressed at community level to complement PASEC inputs. The project would continue to address refractive errors among school going children and cataract in underserved areas.

Limited diagnostic capacities to identify glaucoma at the early stages cause irreversible vision loss to the affected people. The project will develop two centres of excellence and one tertiary teaching eye unit for sub-specialty services in glaucoma. The centre will also train district ophthalmologists in screening and detecting glaucoma among high risk groups at the early stage to overcome vision loss and refer complicated cases to the tertiary centres.

RoP is not a huge issue in Pakistan at the moment however; considering the number of premature births and improving situation of their survival this problem is bound to surface very soon. The services of RoP are not widely available. The project will equip two tertiary facilities in RoP services. The ophthalmic team and paediatric unit of the selected hospital will be provided necessary orientation and training in RoP services. The project will fund the position of counsellor/occupational therapist for an initial period of two years to demonstrate their impact. The partners will be supported to develop RoP protocols, which can be used at other places in the country.

Corneal opacities account for 14% of total burden of blindness in Pakistan (blindness prevalence survey 2003-2004). The main causes of corneal opacities in Pakistan are vitamin A deficiency, trauma, traditional eye care practices, trachoma, measles etc. The biggest deficit for corneal opacities treatment is the unavailability of human cornea and lack of cornea grafting services in Pakistan. Until 2007 organ donation was illegal in Pakistan. Also illiteracy, lack of awareness regarding possible treatment, wrong religious perceptions and cultural practices makes the acceptance of cornea donation highly unacceptable. In 2007 the "Transplantation of Human Organs and Tissues Bill" was passed by the National Assembly. This has made possible the production of indigenous corneas in Pakistan. However multiple barriers have to be crossed and a lot of awareness and advocacy needs to be done to achieve this monumental task. Simultaneously eye care services for corneal opacities also have to be developed. In the proposed project only one pilot will be undertaken with a public sector tertiary hospital. This project would be undertaken in collaboration with civil society, media and the government. Due to the close relationship of FHF Australia with Tilganga Eye Institute Nepal and the highly developed corneal grafting services in Nepal, FHF will support the HRD and protocols development part of the project. The technology and other components of the project will be supported by two other partners.

Nearly 10% population of Pakistan suffers from Diabetes Miletus and a quarter of these have potential threat from sight threatening diabetic retinopathy. FHF has piloted the screening of known diabetics at diabetic units of three major hospitals through the PASEC project. In the said pilot over 30,000 known diabetics were screened through a Non Mediatric Fundus Camera for any possible retinal complications. The evaluation of the project revealed huge health cost benefits. On an average, by just utilising 2 USD, we can achieve early detection, awareness and timely management of diabetic retinopathy (which causes irreversible blindness if not diagnosed and treated in time). The blindness averted and the cost of treatment of advanced DR through this initiative would sum up to millions of dollars. FHF proposes to replicate this model in a few strategic locations to complement the PASEC initiatives. The project will focus on strengthening the screening capacities both at tertiary and district levels at selected places by using the latest technology, refurbishment and linkages

development with medical units. The project will support the developing of screening protocols in the hospitals, and operational research to identify the key patterns among DR cases. The ophthalmologists and other staff in the hospital would be oriented about DR.

Pakistan has significantly developed comprehensive eye health services across the country both in public and NGO sectors. There are however, pockets where services are either unavailable / non-functional due to security situation or non-availability of trained human resources. Across Pakistan there are segments of society unable to afford services even when they are available. FHF will work with partner organizations to organize to reach remotely placed cataract patients for cataract surgical services with the support of NGO partner's and/ or government agencies.

The project will strengthen the school eye health services at selected places by developing the skills of teachers in vision screening. The project will use national school screening guidelines in line with WHO Regional School Eye Health Guidelines. Formal relationship will be established with education department to institutionalize eye health screening in schools. Awareness and knowledge building regarding eye health would be disseminated among students and teachers. Spectacles will be provided to the students identified with refractive error (RE), and children in need of surgical treatment would be referred to the nearest paediatric ophthalmology unit.

Output 4.1 Control of avoidable visual loss from glaucoma piloted and tested at selected centres of excellence and tertiary institutions

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Training of key staff of identified training partners in advanced glaucoma management 2. Development of technology and infrastructure to establish a glaucoma unit at a selected centre of excellence / teaching hospital 3. Orientation of district ophthalmologists in glaucoma screening and management 4. Celebrate the Glaucoma awareness days	No of ophthalmologists & support staff trained Necessary technology provided Required infrastructure developed Clinical data collection system strengthening support No of Glaucoma patients screened disaggregated by sex No of Glaucoma awareness / orientation days carried out	Selected eye units/ FHF Pakistan Country office/ respective provincial CEC Cells.	Activity 1 January 2014- December 2015 Activity 3 Jan –June 2016 Activity 4 Jan 2016 – December 2017

Output 4.2 Screening for retinopathy of prematurity piloted and practiced at selected centre of excellence /tertiary eye unit.

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Consultation with selected CoE/Tertiary center for RoP services 2. Consultation with neonatal ICUs for support and development for the prevention of RoP. 3. Develop and sign an MoU for start of RoP services 4. Orientation of ophthalmic team in RoP screening and management 5. Deployment of counsellor 6. Up gradation with necessary equipment and refurbishment for RoP services in an existing paediatric eye unit. 7. Finalize and review the RoP protocols to be used in screening and management 8. Support & coordination with Paediatrician for referrals and awareness raising	No of medics & paramedics trained Necessary technology developed Required infrastructure developed No of awareness raising sessions conducted for staff dealing preterm babies and patients. Linkages developed with the attached maternity units No of preterm babies recorded in the selected neonatal units disaggregated by sex No of RoP cases screened disaggregated by sex No of RoP cases managed disaggregated by sex	One unit in KPK and Punjab each Selected eye units/ FHF Pakistan Country office/ respective provincial CEC Cells.	Activity 1-5 January – December 2015- Activity 6-7 January 2015 December 2016

Output 4.3: Screening for diabetic retinopathy strengthened in selected tertiary centers

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Identification of tertiary diabetic units for DR screening services 2. Up-gradation of the selected units with necessary equipment and refurbishment where needed 3. Develop the screening protocols and mechanisms for patients recording 4. Link the eye units established through PASEC with medical units for improved DR patients management. 5. Orientation sessions for ophthalmologists and medical practitioners working in hospital 6. Follow up for reviewing progress and technical support	No of screening facilities developed No of diabetic patients screened disaggregated by sex No of lasers done disaggregated by sex	Two centers in Punjab	Activity 1-5 Jan-July 2014 Activity 5-7 July 2014 December 2016 Activity on going till the project end.

Output 4.4: Coverage and access of cataract surgical services enhanced especially to marginalized and poverty stricken populations in selected districts

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Identify the vulnerable pockets across country 2. Develop a strategy for static / outreach activities with local partners i.e. Al-Shifa, Al Ibrahim, DoH etc 3. Engage all relevant local partners in organizing eye camps 4. Screening and surgical camps organized in the communities and government facilities respectively	No of cataract surgeries supported through mobile units disaggregated by sex	Selected disadvantaged areas across Pakistan Respective partners organization and FHF Country office	January 2014 December 2017

Output: 4.5: Children from selected schools screened for eye diseases and those with refractive errors rehabilitated

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Review screening guidelines to align with WHO EMRO regional guidelines for school screening 2. Develop linkages with education department- Formalize arrangements between health and education for school screening 3. Deployment of teams in selected districts i.e. optometrist, social organizer and driver 4. Cascade training of school teachers in screening 5. Provision of spectacles and referral of children to nearest eye unit for complicated eye conditions. 6. Regular review meetings 7. Collection of data from schools and reporting 8. Periodic assessment and follow ups	No of school children screened for refractive errors by school teachers disaggregated by sex No of children referred disaggregated by sex No of children provided spectacles disaggregated by sex No of school teachers trained	1-2 Districts in KPK, AJK and Sindh Balochistan subject to security CEC Cells in AJK, Punjab and KPK province	January 2014- December 2016

Output 4.6 Control of avoidable visual loss from cornea related blindness piloted and tested at selected tertiary eye unit.

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1 Training of key staff of identified training partners in cornea related blindness prevention 2 Advocacy in communities for indigenous corneal donations 3 Protocols development for corneal donation storage and grafting	No of ophthalmologists & support staff trained No of cornea patients treated disaggregated by sex	Selected eye units/ FHF Pakistan Country office/ respective provincial CEC Cells.	Activity 1-3 January 2014- December 2015

Objective 5:
Develop an evidence base for eye care service delivery approaches that can be scaled up by government and potential partners.

Generally speaking the culture of research and evidence based initiatives is lacking in countries like Pakistan. FHF has been involved in many new initiatives and interventions through its various projects in Pakistan. The proposed project is designed to conduct pilots and innovative approaches for eye care delivery models. It is seen extremely important that the work done, the results achieved and the lessons learnt be effectively documented for future programing.

FHF mainly works through partners it is also seen important that the capacity of partners in conducting evidence based approached be supported. In the proposed project evidence building will be encouraged among the partners through promoting a culture of research and advocacy. FHF will organize consultation meetings with its partners and other stakeholders to identify research priorities preferably operational research in community related approaches. Partners will also be supported in developing their capacities and conducting research in certain project interventions. FHF will work with policy researchers to collect evidence for linking eye health intervention with other development work. The commissioned research will be published and disseminated in the development and public health spheres. Advocacy plans of the partners will be underpinned with evidence collected through research supported.

FHF will also make an effort to share its programs and lessons learnt with national and regional organizations / institutes. It will try to create technical linkages with forums WHO, IAPB, OSP etc. to maximize its blindness prevention efforts.

Output 5.1: Evidence produced from selected project interventions and reports available for planning and review.

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Develop research plan and strategy for FHF Pakistan 2. Identify the research themes in consultation with partners 3. Provide technical support to the partners in developing research proposals 4. Fund the identified research topics 5. Monitor the implementation of research proposals 6. Provide guidance and support to the partners through external linkages and experts 7. Finalize the research reports 8. Publish the reports	No of research projects initiated No of research project completed	All the five provinces The provincial CEC Cells and FHF Country office	Ongoing till December 2017

Output 5.2 Improved eye health profile through increased linkages with regional and national forums

Proposed Activities	Output Targets	Project Locations and Responsibility	Time Frame
1. Attend the regional WHO, IAPB and EMR meetings 2. Develop formal linkages with OSP 3. Support OSP to update their website with knowledge/papers 4. Facilitate the selected strategic partners to attend regional events. 5. Support joint studies and workshops for learning and knowledge dissemination	No of linkages developed at regional level No of people visited eye health blogs for information collection No of papers / guidelines added on the website of OSP	FHF Country office	January 2014 June 2017

3.6 Outcomes

The core outcome expected from the proposed project is to strengthen eye health service delivery within the health systems framework of Pakistan to respond to prevention and control of avoidable blindness and visual impairment. A key assumption and dependency for achieving the outcomes is the commitment of the provincial governments to allocate resources for eye care services, and to provide a supportive policy framework for the whole health system. The main outcomes of the proposed project in collaboration with proposed partners are as follows:

- Improved access for the general population, with special emphasis on vulnerable, marginalized groups such as women and girls, children and people with disability, to high quality, cost effective eye care services in the program areas
- Increased awareness in the population regarding available eye care services leading to increased demand and uptake of services in the program areas
- Referral pathways from primary and district level to tertiary eye care services established and functioning in program areas
- Increased numbers and well-trained mid-level eye care personnel delivering improved quality of services
- Effective, evidence-based eye care strategies and programs developed and implemented by Departments of Health and INGOs within each province
- Eye care data collection systems integrated into the national HMIS system and providing evidence regarding coverage of eye care services and progress toward VISION 2020 and the Global Action Plan for universal eye health

4.0 WORKPLAN

Annual project work plans will be prepared and agreed upon by all project partners in December each year in conjunction with the development of annual budgets and partnership agreements.

Please refer to the Project Work-plan as Attachment 9.

5.0 MONITORING AND EVALUATION

A dedicated M&E framework of the project has been developed and attached as Attachment 10.

The project aims to develop and strengthen participatory monitoring and evaluation mechanisms that will define the indicators of performance at different levels and the frequency at which they need to be collected. The project evaluation will focus on higher-level indicators while regular monitoring will cover process and output levels.

Baseline Data/ Need Identification
Pakistan Social Living Measurement (PSLM) survey and Multiple Indicators Cluster Survey (MICS) do not provide sufficient information to establish a baseline or any benchmark for eye health interventions. This necessitates the need of a population based blindness survey or rapid assessment at the selected locations to determine the impact of interventions however this is beyond the scope of the proposed project.

The project focuses on ending avoidable blindness and emphasises strengthening eye health as part of health system strengthening while underpinning all priority diseases of VISION 2020 Pakistan, as identified in population based National Blindness Survey of Pakistan 2003-2004. The population based cross sectional surveys are very expensive and cannot be organized annually because of resource constraints and level of effort required. A new national blindness survey may be held in 2017-2018 and that would provide the basis to inform the prevalence of blindness in Pakistan.

Moreover, establishing baseline for prevalence of blindness especially for children and diabetic cases has been more difficult owing to paucity of information in both areas. In the current phase, the project emphasises operational research, which is anticipated to contribute to establishing certain benchmarks/baseline in the areas of childhood blindness, diabetic related blindness, and refractive errors among children. However baseline information about MLECP-HRD trainings in Pakistan has already been established through a situation analysis conducted by FHF. Similar information about the level of access to eye health at the community and district level will also be established before the start of interventions at the selected districts and community levels where possible.

Aim/Goal: Assessment of Impact

The overall aim of the project is on improving the quality of life of vulnerable groups in Pakistan especially children and women through the reducing avoidable blindness by 2020. A population based national blindness survey is planned in 2017-2018 that will inform levels of blindness in Pakistan. The current project plans on consolidating the previous phases and supporting multiple interventions to address priority issues in eye health. Thus, attribution and inference would be established against the results of a future blindness survey.

The project will contribute at the national level by eliminating visual disability that reduces productivity. A study[15] on the economic burden of blindness in Pakistan showed that the per annum productivity gains of rehabilitating the entire blind population represents 0.74% of the current gross domestic product of Pakistan, which is higher than the total public spending on health. Hence, it is envisaged that the level of reduction in blindness through the project interventions shall provide a basis to determine its broader economic gain by preventing blindness in those suffering from avoidable causes of blindness.

Purpose: Assessment of Achievement

Please refer to the M&E framework for details

Evaluation will take the following forms:

- **Annual Reviews**
  FHF and each CEC Cell will, along with individual implementing partner, conduct joint annual reviews to learn from the interventions while describing the challenges and implications. AusAID will be a part of the annual reviews. These reviews will underpin the level of achievements and progress made under different components of the project. This will also include identification of solutions and approaches to address the challenges and implications. The annual review will also provide the basis for developing annual work plans by the partner organizations and FHF. The stakeholders of the annual review will be the implementing partners including the provincial CEC Cell, Tertiary Institutes, NGO partners, HMIS and Provincial Departments of Health and FHF staff. These implementing partners will share their progress and update performance of their work

[15] Awan H, Malik SM, Khan N: The economic burden of blindness in Pakistan: A socio-economic and policy imperative for poverty reduction strategies. Indian Journal of Ophthalmology Vol 60 (5):358-361

against the agreed indicators. The findings and revisions arising from the Annual Reviews will be incorporated into the Annual Plans. The annual project cycles will be January – December.

The annual reviews may not be conducted collectively but may take the form of individual reviews with respective partners due to security situation in the country.

- **Mid-Term Evaluation**
  A Mid-Term Review of the Project is proposed to inform the progress of the project in line with project approaches and expected outcomes outlined in this project proposal. It is expected that the evaluation will highlight key successes and suggest any necessary changes required in the project design to achieve the intended results. AusAID would be a part of the said review and all the findings and reports of the review will also be shared with AusAID. In case AusAID desires to conduct a third party / external Mid Term Review, FHF will facilitate the process.

- **End of Project Evaluation**
  FHF will organize an internal end of project evaluation / completion review. The evaluation will assess progress and achievement against all components of the project. The evaluation will include a comparison of targets and achievements (both in terms of outputs and outcomes), an assessment of likely impact, significant constraints, lessons learned and recommendations for further support.

- If AusAID desires to conduct an Independent Completion Review (ICR), FHF will fully facilitate the process.

Monitoring of project outputs and quality assurance

An M&E framework (Attachment 10) of the project has been prepared that has indictors and targets with timeline for each specific output and objective. The progress of the project will be determined by using this framework, and annual review and FHF periodic progress reports to AusAID will cover reporting against this M&E framework. Sex-disaggregated data will be generated wherever possible.

Overall, monitoring of the project will be done at two levels
Process Monitoring: This will revolve around the completion of activities as given in the project proposal along with provision and procurement of necessary infrastructure as envisaged. This will focus around the processes, and what steps had been taken to ensure compliance to the policies and procedures as agreed. The required inputs and finances for each activity have been given in the project framework. The learning will enable future activities and procedures to be refined.

Output Monitoring: This will be around the achievements of project interventions. For each specific output, key performance indicators have been given in the M&E framework. These indicators can be refined and modified depending upon the local context and feedback received from partners in the annual reviews and field visits. The key performance indicators (KPIs) will be agreed with each implementing partner for reporting on a regular basis to inform the achievements.

Overall FHF and implementing partners will jointly own responsibility for monitoring project interventions. An independent MOU and annual partnership agreements (APAs) will be signed with each partner outlining the needs and requirement of reporting with its frequency. Primary responsibility of the data collection from the field level and its regular monitoring

will rest with implementing partners. This would be collated and reviewed by the provincial coordinators and CEC cells where possible. The project team of FHF will provide technical support to the partners in developing and conducting systematic monitoring. The team of FHF will make regular field visits including to the clinical eye units and meeting with local stakeholders to validate the progress reports submitted by the partners. Moreover, FHF will provide guidance in identifying plausible solutions where issues arise.

AusAID will be involved in the monitoring of the project on a regular basis through quarterly meetings with FHF, annual reviews and field visits in addition to monitoring through reports received from FHF.

There will be need for strengthening the capacities of partners in order to ensure effective monitoring at the provincial and community levels especially in data collection and reporting. The project will conduct an appropriate needs assessment of the partners in the areas of M&E, and will provide training and accessories to the staff deputed for M&E. Moreover, the partners will be encouraged to share their quarterly work plans with targets to FHF. An appraisal and feedback to the quarterly work plans by FHF will improve quality of reporting and capacities of partner's staff through mentoring. The project will also explore the reporting mechanisms to strengthen the existing arrangement with quality enhancement where possible. There would be determined efforts to overcome the duplication in parallel reporting and data collection.

FHF will conduct a needs assessment to find out the current data streams and data collection system under health sector reforms at primary, secondary and tertiary levels. This will enable FHF to know the gaps in strengthening the health management information system in relation to eye health indicators. The project envisages providing necessary technical and financial support to establish a uniform approach to reporting for integration into existing health system arrangements where possible. The project will also support strengthening of information systems at the tertiary levels for integration with tertiary reporting arrangements while adding on value of data to be used at provincial level for policy planning and advocacy.

FHF would ensure that monitoring is much more about learning and finding the plausible solutions in consultation with partners. The Country Manager of FHF in Pakistan will provide leadership to her team in providing effective and efficient M&E support to the partners. The field visits of the FHF staff will have clear ToRs, and these will be shared with the partners before the start of each visit to ensure transparency, accountability and partnership development. The findings of the visits would be shared with the partners, and next action steps would be agreed mutually. During the follow up visits, FHF staff will update about action plans, and what steps would be needed to address issues. The FHF Project Officers, Country Manager, CO and PCs as needed, will also conduct ad hoc field visits. The Sydney based Program Coordinator will also conduct regular desk based and in-country monitoring of the project. FHF will organize joint periodic reviews with operational and senior management of partner's organizations in their offices to develop adaptable and flexible solutions for the problems and issues identified in the implementation process.

Based on the quarterly work plans of partner organization, FHF will organize its monitoring visits. FHF will also make some spot checks but in every case will have clear ToRs as discussed with partners. Periodic patient satisfaction surveys will be undertaken in the eye units to ascertain the satisfaction and response of the communities towards the services provided in these units. Similar sessions would be organized with the communities to understand their knowledge, practice and attitude towards newly upgraded or services introduced in the communities. Besides the scheduled monitoring there will be on-going telecommunications, e-mail exchange and need based visits which would be a source of constant interaction with stakeholders at both the provincial and district levels.

Reporting:

Annual reports
Annual Review reports and Annual Plans would be submitted in January each year. This would include both quantitative and qualitative data for sharing with AusAID and FHF Sydney office. This report will also have financial information about receipts and expenditures.

In addition to the above period reports two other reports will take the form *of Mid Term* and *Project Completion Reports.*

6.0 PROJECT MANAGEMENT

6.1 Partner Roles, Responsibilities and Contributions

The Fred Hollows Foundation:
- Plan, coordinate and liaise with partners
- Provide technical assistance to the project and partners
- Periodically monitor, supervise and evaluate the project activities
- Administer funds for all agreed activities
- Purchase all agreed equipment and consumables
- Maintain all financial records
- Review and revise annual plans with partners each year
- Report to AusAID, FHF Sydney and the national & provincial committees

Provincial Departments of Health:
- Appoint a focal person to represent the DoH at the provincial eye health committee/board level and to plan, coordinate and liaise with partners
- Provide the necessary facilitation and support in the planning and implementation of the project
- Provision of appropriate personnel for training
- Provision of appropriate personal for mid-level training
- Provide space for all the agreed activities
- Provide running costs of eye units where agreed

National Eye Care Committee:
- Facilitate the development of policies and national guidelines
- Plan, coordinate and liaise with partners and provincial committees
- Provide technical assistance to the project and partners
- Periodically monitor, supervise and evaluate the project activities
- Provide an advocacy forum for the project and eye health in general

Provincial CEC Cells:
- Provide a leadership role for all the eye care activities for their respective provinces
- Provide a focal person to effectively coordinate the project
- Provide full facilitation in planning and implementation of the project
- Coordinate with all relevant partners for effective project implementation
- Monitor and evaluate the Project activities
- Provide access to FHF personnel to program and financial records for monitoring and evaluation
- Maintain sound financial records and their onward transmission to FHF where funds are transferred to partners

- Provide regular reports to FHF Country office regarding the progress of the project according to their needs and requirements

NGO and Public sector Partners:

- Provide a focal person to effectively coordinate the project
- Plan and implement all project activities along with other partners
- Provide all support needed for all the agreed activities
- Provide all the necessary personnel needed for the project
- Ensure adoption of all measures to run the project effectively and develop quality training program
- Provide access to FHF personnel to clinical and financial records for monitoring and evaluation
- Maintain sound financial records and their onward transmission to FHF where funds are transferred to partners
- Provide regular reports to FHF Country office regarding the progress of the project according to their needs and requirements

HMIS Divisions at Provincial and District Level:

- Provide a focal person to effectively coordinate the project
- Provide necessary information, support planning of all project activities.
- Provide support for all the agreed activities

6.2 Management and Coordination Strategies

Contractually, FHF will be responsible to AusAID for the management of the Project. FHF's objective will be to effectively and efficiently manage the Project.

The project is designed in collaboration with all partners based on needs assessment conducted by FHF and at the request of the national and provincial eye health committees. Each partner has a defined set of roles and responsibilities. FHF will in turn sign MoUs with the respective Provincial CEC Cell / institutes and individual eye units which will specify their roles and responsibilities followed by an annual partnership agreement (APA) each year. FHF will guide the project while all partners will have specific responsibilities. The management and supervision of all the work would be the responsibility of provincial eye health boards with administrative support extended by CEC Cells.

Focal persons from each partner will liaise with each other on the management of the project and for maintaining ongoing communications. The work plan is devised and shared between all partners. Quarterly meetings will be held between FHF and CEC Cells and other partners will participate on a needs basis. Communication flow will be between all partners. A quarterly progress report will be submitted to the FHF country office by CEC Cells and other partners, which will be communicated to FHF in Australia through the quarterly progress report.

The national eye health committee and provincial eye health committee/boards will meet on a regular basis with FHF and other partners for sharing information and learning.

FHF will maintain its existing office in Peshawar to manage the Project, and continue to be supported by the Sydney office. FHF will provide the following personnel inputs:

- In Pakistan - a Team Leader (the Country Manager), 1 Administration and Financial Officer, 1 Finance Assistant, 2 Project Coordinators, 4 Project Officers, 1 Research and

communication officer, 1 Office and IT Assistant and 5 support staff.

- In Australia – an International Program Coordinator, who will provide coordination support to the program and visit twice a year, and
- In Australia – the Finance Division will support/assist the Pakistan office in financial and other reporting requirements. Management will occasionally be involved in advice and oversight of the Project.

6.3 The Annual Planning Process

Annual Partnership Agreements and budgets will be developed in consultation with the relevant partners in the month of December each year for the next year. The annual planning process will be based on participatory approach with all partners being part of the review meeting and discussions. The annual review will underpin the level of achievements and progress made under different components of the project. This will also include identification of solutions and approaches to address any challenges and implications identified. The review will also provide the basis for developing annual work plans by the partner organizations and FHF. The stakeholders of the annual review will be the implementing partners including the provincial CEC Cells, Tertiary Institutes, NGO partners, HMIS and Provincial Departments of Health and FHF staff. The partners will share their progress and update performance of their work against the agreed indicators. The review will invite external experts to share learning and insights of different approaches adopted or being adopted by the project. The findings and revisions arising from Annual Reviews will be incorporated in Annual Plans.

6.4 Budget and Financial Management

Please refer to the Project Budget at Attachment 11 of this PDD.

The total Project budget over 4 years is AUD 5.5 million. An annual budget and work plan will be developed collaboratively by partners in December each year and submitted to AusAID for approval.

The project budget is proposed for AusAID funding. If approved, AusAID and FHF will enter into a Funding Order in relation to this Project, which will sit under the overarching Head Agreement between FHF and AusAID. The Funding Order will outline FHF's responsibilities in relation to managing the funding of the project and will include schedules for funds transfer and reporting to AusAID. Upon signing of the Funding Order, project funds will be sent to the FHF Australia bank account where they will be held until FHF Pakistan makes a request for these funds on a quarterly basis.

AusAID funds will only be used for the purpose of this project, except where a variation to the project is agreed to in writing with AusAID. FHF will maintain sound financial and activity management systems including proper financial records and internal controls to substantiate all declarations of expenditure and activity progress. FHF's financial records will be audited on an annual basis by a global accounting company. The Audit reports would be shared with AusAID.

The specific financial management arrangements between FHF Pakistan and program partners will be clearly articulated in project MoUs. The MoUs will specify the arrangements for financial reporting and transferring funds to partner bank accounts based on the annual project plan and budget and regular expenditure reporting.

Program expenditure will be recorded by FHF Pakistan in Monthly Expenditure Reports (MERs) and submitted to the FHF Sydney Office. FHF will report project expenditure to AusAID on an annual basis in accordance with the Funding Order reports schedule and guidelines.

7.0 SUSTAINAIBILITY AND RISK

7.1 Sustainability

In order to ensure the sustainability of interventions, the project focuses on systems strengthening of both public and private sector organizations engaged in eye health through capacity buildings in the areas of skills, knowledge and technologies. Following strategy is planned to ensure the sustainability of the project interventions, and these will be reviewed and updated under an annual review and planning process.

Integration and Alignment with the provincial health strategies
In Pakistan, the policy, planning and execution have been handed over to the provinces after the enactment of 18th constitutional amendment. The provinces have either developed, as in Punjab and KPK provinces, or are under the process of developing their health strategies in line with health systems strengthening approach. The priorities and areas given in the project proposal are in line with provincial health strategies. FHF is working with its provincial partners to develop their eye health strategic plans in line with provincial health strategies. This has been achieved in KPK province, and is under process in Punjab and Sindh provinces. The interventions are aligned with government priorities as identified in their health strategies.

Devolved National Eye Health Program
The government has devolved the components of the national programme of eye health to the provinces with a commitment to fund their share until end June 2015, after which the provinces will be responsible for further resource allocations. The provinces are empowered with certain discretions about the use of those funds. As part of this project, FHF shall aim to strengthen the planning and coordination capacities of the national and provincial eye health structures, so that they are aware of planning and budgeting mechanisms at provincial level. The general aim is to support provincial eye health boards to design their respective eye health strategies and plans, cost the plans and for timely submission of project proposals to the planning sections in the departments of health for incorporation in the Annual Development Programmes (ADP) and medium-long term health sector strategies, plans and budgetary frameworks.

Adding on the existing capacities of the partners
All interventions in the proposed project have been designed or developed with the intention of adding value to services or capacities already existing among the partners. The innovations in the project are incremental steps towards enhancing the effectiveness; efficiency and coverage of eye care services that would lead towards sustainability. During the project design, FHF has been careful to select interventions where partners have certain minimum capacities / expertise or human resources in that specific area with a commitment from the partner organizations to carry on once the support from FHF supported projects ends.

Participatory Consultations

The project has been prepared in consultation with government and NGO partners including provincial coordinators, head of tertiary institutes, eye health experts, community ophthalmologist, and health managers. The needs have been identified and defined through problem analysis approach and evidence generated by the partners through situation analysis or data available on their part. This has created the ownership on the part of the partners by taking their voices on board but also enabled FHF to make them accountable.

Institutional Development

In order to strengthen the institutional capacities of training and implementing partners, FHF has started to support the organizational assessment and strategic planning of the implementing partners. In KPK province, PICO has developed its five years strategic plan while in Punjab COAVS has done its organizational assessment. Now, FHF is providing necessary technical and programmatic support to these partner organizations to achieve their strategic plans and needs. FHF is committed to provide similar kind of support in other provinces and NGO partners under a partnership development approach. This approach is helpful to develop strong and robust provincial eye health institutes in Pakistan along with identification of leadership succession as well as strategic visioning.

Capacity Enhancement in Eye Health

The proposed Project is designed to integrate into and build the capacity of the public and NGO health system for reduction of avoidable blindness. By providing infrastructure, equipment, training inputs and strengthening data collection and audit systems, the Project will promote the sustainability of partner organizations. The partners both in the public and NGOs sectors have made a commitment for fulfilling operational costs of necessary human resources and running of eye units. All staff to be trained in this Project are already in place in the public health system or NGO sector. FHF is not committed to providing any financial support for the creation of positions on the part of the partner organizations except for a minimum support staff for fixed minimum period of time with the undertaking from the partner organization to absorb those positions after the agreed support ceases.

Skill Development and Transfers

The current phase of the Project is based on consolidation of PASEC project initiatives in paediatric ophthalmology and VR subspecialties while adding on skills and orientation in the areas of health information and community adopted approaches. Thus, major emphasis of the project is skill development and technology transfers with ownerships at the local levels. All of the trainees involved in the proposed Project will be selected from well reputed public and NGO sector organizations and there is commitment on the part of trainees and institutions to continue their working with their parent institutes after the completion of training. Constant monitoring and annual reviews of the proposed Project will ensure issues arising, potential delays etc. are identified for Project managers to respond to appropriately.

Operation and Maintenance of Equipment

As the Project involves provision of sophisticated equipment, FHF will support the partner organization to strengthen their operation and maintenance (O&M) protocols. During field visits, FHF staff will review whether those protocols are being followed by the partner organizations. All equipment provided will be added on the stock register of hospital and government/partners record to shift the onus of their O&M to the running budget of partner organizations.

Strengthening the information system

In the current phase, the project will invest in strengthening the eye health information system through supporting the pilot initiatives at two places both at tertiary and district levels. This will help eye health to integrate with other health reporting but knowing the trends and patterns of diseases. This will save time in policy planning and reporting of the partner organizations. The learning of the project will provide the basis of scaling up across the

country. The biannual National Steering Committee and provincial boards meetings will be an ideal forum for implementing partners and other stakeholders to share information and network. It will build support and understanding as to the Project's intentions and progress.

Research and Evidence based Advocacy
The project will provide support to integrate operational research and generate necessary evidence through research in different intervention/ program areas of the project to be used for lobbying and advocacy with policy makers and political leadership. By strengthening the capacities for research among partner organizations, FHF will be promoting the culture of collecting and generating the evidence that would enable partner organizations to explore new frontiers in eye health. More importantly, the policy research studies funded under this project will be useful to provide the link between eye health and its importance to achieving the MDGs, reducing poverty, and implementing good governance.

Networking with other Institutes
The project lays emphasis on enabling its partner organizations to work with regional and international institutes through collaborations and partnerships. Audio-Visual Aids for videoconferencing will be provided to those partner organizations that do not have such facility. As many experts are not able to travel to Pakistan, these facilitites will be useful to gain the benefit from their experiences and insights. Even within Pakistan, FHF will explore to linking up MLECP institutes for video-conferencing for teaching and experience sharing.

Exit Strategy
During the design phase of the project, the partners have been oriented about scope and potential of the support to be extended by FHF and AusAID. There will be dedicated MoUs with partners explaining the ownership and sustainability of the interventions once the project support ends. Although AusAID support may end after four years, FHF in its own capacity is committed to work with local partners for eye health. By working with multiple local large scale NGOs, FHF envisages building their capacity to be able to support and develop eye health in Pakistan well into the future. It is also through these local NGOs that FHF hopes will carry the advocacy work at both national and international levels. Depending on the situation of eye health sector in Pakistan in a few years time, FHF may be in a position to assist local partners to leverage other international support in addition to the INGOs they are already working with.

7.2 Risk Management and Feasibility

7.2.1 Risk Management

In order to achieve its aims, purpose and objectives, the project may face a number of risks, which have been explained in detail under the Risk Management Matrix with mitigation strategies. Details can be found at Attachment 12.

The security situation in Pakistan is often unpredictable and some of the proposed project locations especially in Baluchistan and KPK are high risk security areas. FHF works closely with CEC Cells who will be responsible for and continue monitoring regardless of FHF's ability to travel to all areas. Additionally FHF proposes to work with local NGOs that have good local linkages and presence even in high risk communities where public systems are not present or are non functional. These local NGOS will continue to implement and monitor the project at all times.

At the program level, FHF will make determined efforts to create ownership of the programme to the Government of Pakistan by working with the provincial boards for eye health and national committee for eye health. Moreover, all projects signed with NGO partner organizations will have backing of their respective boards. For technical backstopping, FHF Australia has international experience and expertise in the areas of eye heath, which will be made available to the project through lessons learnt and experience sharing. Further, FHF Australia networking at the regional and international level will provide additional support to overcome the risks in the areas of technical knowledge. During implementation FHF will monitor risks and will identify practical and plausible solutions to respond to them quickly. The project has been designed on robust grounds but the risks would be reviewed annually as a new Government in Pakistan may come into power after the May 2013 General Election.

The MoUs to be signed with partners will articulate clear roles and responsibilities of the partner organizations, and these have been discussed with key partners during the consultation process. For each output specified under an objective, project activities have been defined. An annual detailed implementation plan will be prepared and agreed with implementing partners. Any gaps and challenges that emerge during the implementation of the project will be addressed with the support of provincial eye health boards and provincial coordinators/head of NGOs. Risks in relation to the assumption of the costs of salaries, maintenance of equipment etc have been addressed in the sustainability section above. Risks in relation to corruption have been addressed in the context of AusAID and FHF's anti-corruption policies. FHF country office has financial control policies safeguarding against any financial corruptions.

Below are a few key measures to overcome risks associated with quality:

Service Delivery: Strengthen the system of identified eye units for disease controls especially in DR, childhood blindness, glaucoma, corneal opacities, cataract and refractive errors through capacity development of human resources, facilitation in the preparation of protocols for screening and surgical treatments at tertiary and district levels. Involvement ophthalmologists in planning and support in improved data collection mechanisms including introduction of computerized software.

Infrastructure Development: Close supervision and monitoring of the selection of contractors for the construction of the building and provision of equipment, assurance to compliance to the rules laid and agreed with in FHF policies AusAID. Technical experts to be hired when needed to seek advice on the quality of construction and equipment.

Capacity Development: Promote the development of quality standards for MLECP training programme to improve efficiency and effectiveness of MLECP courses. Standardize curriculum development for Pakistan through consensus building.

Management: Work with National PHC and HMIS programmes to learn and develop eye health integration to make PEC and eye reporting sustainable. Provide administrative support to the CEC cells in project monitoring to build their capacities in management. Pilot the integration of general management into eye care management and advocate the lessons learnt. Six monthly meetings of the national and provincial eye health committees supported by FHF and other INGOs will support learning and leadership development.

7.2.2 Feasibility

With enactment of the 18th amendment in Pakistan that empowered the provinces of Pakistan to take lead on health policy, planning and management, the proposed approach of the project seems feasible and viable within the context of Pakistan and FHF. The purpose of the project

is strengthening eye health within health systems framework of Pakistan to achieve reduction in avoidable blindness. The health systems framework of Pakistan also recognizes the role and ownership of both government as well as private sector organizations. Overall, the project is in line with national and provincial health strategies of Pakistan for system strengthening and lays emphasis on avoiding the duplication or creation of parallel services for eye health by involving stakeholders at the provincial and national levels.

The planned intervention of the project at the tertiary, secondary and primary levels are simple and have been designed within the established settings of the Government of Pakistan. Infrastructure development and refurbishment of eye units, training of professionals and development of HMIS will not require any difficult arrangements. The backup support from the national committee for eye health and provincial eye health boards will pave the way to achieve the desired goals/objectives. Below is a detailed description of feasibility.

Manageability of the Project

The leadership and staff of FHF Pakistan office have already demonstrated successful implementation of three AusAID supported projects in Pakistan. Dr Rubina Gillani, the Country Manager, established the country office of FHF Pakistan in 1998. She is a highly qualified public health professional with expertise in the areas of eye health, community development, reproductive health, etc. She is well positioned in the circles of development and civil society in Pakistan. In addition to her position of Country Manager, there is dedicated staff in Peshawar and Sydney offices to support the management of the project.

The National Steering Committee and Provincial Eye Health Boards will provide necessary support to FHF in facilitating the coordination and connectedness. With the support of the provincial coordinators, there is unlikely to be any difficulty in maintaining effective and efficient working relationships at the hospital and eye unit level.

Technical feasibility

The current phase of the project will be focused on consolidating the technologies and processes already used by partners. All the equipment to be procured under the project is already tested either in Pakistan or elsewhere in the world, and is being reported as viable for Pakistan. The VR and paediatric surgeries are complicated for which necessary protocols have been developed and training is provided to the staff involved in such surgeries. FHF will interact with national programme of PHC and HMIS for eye health integration as a pilot intervention within the existing settings and technologies already being used in Pakistan. Similarly, the training program with PHC workers will be straightforward.

Institutional feasibility

FHF will continue to utilize the existing settings and systems developed for eye health management in Pakistan through collaboration and partnership development. The promulgation of the 18th constitutional amendment, the role of CEC Cells headed by provincial coordinators has become vital for successful implementation of the programmes. For public sector development initiatives, the provincial coordinators nominated by the provincial government will be on board to provide leadership in their respective province in identification of tertiary units, secondary hospitals and community screening. FHF will directly interact with tertiary institute once the project is principally started. The PCs will take advice and approval from their provincial boards for strategic direction and FHF is also member all provincial boards. For NGO partner, after strategic approval from the Provincial Eye Health Boards, FHF will discuss the modalities directly to their management.

The management and supervision of all the work will be the responsibility of provincial eye health boards with administrative supported extended by a tertiary training institute. In Punjab, COAVS will be key implementing partner while PICO will be in KP province. The CEC Cell in Sindh is under transition of leadership for which guidance would be sought from

provincial eye health board. Support to the CEC Baluchistan will be provided to strengthen its management system as currently it is well below to all other cells. New provincial board for Gilgit Baltistan has been created and FHF will work PC Gilgit Baltistan to explore the possibilities in the areas of PEC and outreach services.
The proposed partner NGOs, Al-Shifa, LRBT and AL-Ibrahim, are regarded as leading national eye care NGOs. Their contribution to blindness prevention has been significant. They have strong systems and the proposed inputs will improve their capacity and performance significantly.

Financial and economic feasibility
The project will contribute at the national level by rehabilitating the population by eliminating their visual disability that reduces their productivity. A study of economic burden of blindness in Pakistan showed that the per annum productivity gains of rehabilitating the entire blind population represents 0.74% of the current gross domestic product of Pakistan, which is higher than the total public spending on health. Further, significant productivity gains accumulated over 10 years, range from Rs. 61 billion (US$ 709 million) to Rs. 421 billion (US$ 4.9 billion) depending upon whether the entire blind population or only those affected by a specific cause are rehabilitated[16].

The Project will strengthen existing health systems and not create parallel systems. This is an efficient use of Australian aid. The increased public sector capacity in terms of HR, infrastructure, equipment and quality control and management systems will be utilized well beyond the life of the Project. The proposed Project represents very good value for money. The devolution of eye care services to the district level will result in increased access to affordable eye care for poorer individuals.

[16] Awan H, Malik SM, Khan N: The economic burden of blindness in Pakistan: A socio-economic and policy imperative for poverty reduction strategies. Indian Journal of Ophthalmology Vol 60 (5):358-361

8.0 ATTACHMENTS

Attachment 1: Acronyms
Attachment 2: Glossary
Attachment 3: Project Partners
Attachment 4: Situation Analysis
Attachment 5: Eye Health Situation of Selected Diseases
Attachment 6: Human Resource Development for Eye Health
Attachment 7: Alignment with Policies and Strategies
Attachment 8: Project Log frame
Attachment 9: Project Work plan
Attachment 10: Monitoring and Evaluation Plan
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Attachment 12: Risk Matrix

ATTACHMENT 1: ACRONYMS

AusAID	Australian Agency for International Development
ACFID	Australian Council For International Development
AIEH	Al Ibrahim Eye Hospital
APA	Annual Partnership Agreement
APAO	Asia Pacific Academy of Ophthalmology
AUD	Australian Dollar
CBL	Childhood Blindness
CBM	Christoffel Blinden Mission
CEC	Comprehensive Eye Care
CO	Community Ophthalmologist (based in provincial CEC Cell)
COAVS	College of Ophthalmology and Allied Vision Sciences
CoE	Centres of Excellence
CPSP	College of Physicians and Surgeons Pakistan
CR	Cataract
DHQ	District Headquarters
DO	District Ophthalmologist (based in DHQ Hospital)
DoH	Department of Health
DRB	Diabetic Retinopathy Blindness
DR	Diabetic Retinopathy
EDO	Executive District Officer
EHIS	Eye Health Information System
FHF	Fred Hollows Foundation
GoA	Government of Australia
GoP	Government of Pakistan
HMC	Hayatabad Medical Complex
HMIS	Health Management Information System
HR	Human Resources
HRD	Human Resource Development
IAPB	International Agency for the Prevention of Blindness
ICD	International Classification of Diseases
IEC	Information Education Communication
INGO	International Non Government Organisation
KPK	Khyber PakhtunKhawa
LHS	Lady Health Supervisor
LHW	Lady Health Worker
LRBT	Layton Rahmatullah Benevolent Trust
LTF	Long Term Fellowship
MDG	Millennium Development Goals
MEACO	Middle East-Africa Council of Ophthalmology
MLECP	Mid-Level Eye Care Personnel
MO	Medical Officer
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTR	Mid-Term Review
NGO	Non-Government Organisation
NOCs	No Objection Certificates
OPD	Out Patients Department
OSP	Ophthalmological Society of Pakistan
OT	Operating Theatre
PADEC	Pakistan Australia District Eye Care Program
PC	Provincial Coordinator

PCR	Project Completion Report
PEC	Primary Eye Care
PDD	Project Design Document
PHC	Primary Health Care
PICO	Pakistan Institute of Community Ophthalmology
PKR	Pakistan Rupee
PMDC	Pakistan Medical and Dental Council
Q	Quarter
RHC	Rural Health Centre (equivalent to a health centre)
SSI	Sight Savers International
STF	Short Term Fellowship
TEC	Tertiary Eye Centres
THIS	Tertiary Hospital Information System
USD	United States (American) Dollar
VR	Vitreo-Retinal
WHO	World Health Organization

ATTACHMENT 2: GLOSSARY

Anaesthetist / Anaesthesiologist - a Medical Doctor trained to administer anaesthesia and manage patients medically before, during, and after surgery.

Blindness -central visual acuity of 20/200 or less in the better eye with corrective glasses or central visual acuity of more than 20/200 if there is a visual field defect in which the peripheral field is contracted to such an extent that the widest diameter of the visual field subtends an angular distance no greater than 20 degrees in the better eye.

Capacity building activities - relevant activities include development of the necessary infrastructure, provision of equipment and development of the human resource and supporting systems.

Cataract - opacity of the lens of the eye; more common with increasing age.

Centre of Excellence - an important tertiary referral centre for provincial hospitals, which provides a standard of care comparable to that of the best medical institutions in the region. CoEs would be expected to deliver appropriate and quality services to patients and act as training and research centres for the training of all cadres necessary for the delivery of paediatric and diabetes related eye services.

Childhood blindness - a group of diseases and conditions occurring in childhood or early adolescence, which, if left untreated, result in blindness or severe visual impairment that are likely to be untreatable later in life.

Clinical audits - a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

Coordinating Agency - the international non-government organisation authorised to enter into a MoU with the Implementing Agency to coordinate and fund development projects.

Diabetes – a result of the pancreas not producing enough insulin, or the body not effectively using the insulin produced. Insulin is a hormone made by the pancreas that helps 'sugar' (glucose) to leave the blood and enter the cells of the body to be used as 'fuel'.

Diabetic retinopathy (eye disease) - damage to the blood vessels in the retina of the eye, which can lead to vision loss. The incidence of blindness is 25 times higher in people with diabetes than in the general population.

Disability Adjusted Life Years (DALY) - a method of calculating the global disease burden in terms of the reported or estimated cases of premature death, disability and days of infirmity due to illness from a specific disease or condition. The DALY takes into account both the reduction in life span caused by the disease as well as the loss of healthy years. DALYs are the sum of the years of life lost (YLL) due to premature mortality in the population and the years lost due to disability (YLD) for incident cases of the health condition. The DALY is a health gap measure that extends the concept of potential years of life lost (PYLL) due to premature death to include equivalent years of healthy life lost in states of less than full health, broadly termed disability. One DALY represents the loss of one year of equivalent full health.

Executing Agency - the agency that is responsible for the day-to-day operations of the development projects. The executing agency is responsible to, and works closely with, the Implementing Agency.

Implementing Agency - a host agency authorised by law or by their charter to enter into a MoU to undertake development projects.

Low vision - visual activity less than 6/18, but equal to or better than 3/60, with best possible correction in the better eye (ICD - 10 visual impairment categories 1 or 2 in both eyes). A

person with 'low vision' is also defined as one who – after treatment and refractive correction – has impairment of visual function but who uses or is potentially able to use vision for planning and/or execution of a task.

Onchocerciasis or river blindness – the result of an infection by the nematode worm Onchocerca Volvulus.

Ophthalmic Technician - Ophthalmic technicians are midlevel health workers trained for two years to help ophthalmologists in their clinical and other work. Their duties often include: performing simple eye exams, explaining diagnostic and treatment procedures to patients, collecting data and measurements to allow the correct diagnosis and treatment of eye diseases, and assisting in eye surgeries.

Optometrist – a person who has undergone at least 2 to 3 years of formal training in Optometry in an established Optometry unit/department within Pakistan or abroad.

Orthoptist – a person who has undergone at least 3 to 4 years of formal training in Orthoptics in an established Orthoptics unit/department within Pakistan or abroad.

Paediatric Anaesthetist - an anaesthetist who has received formal sub-specialty training in paediatric anaesthesia.

Paediatric Ophthalmic Nurse – a person who has a general nursing qualification with specialty training in paediatrics and has been attached to a paediatric ophthalmology and squint unit/department within Pakistan or abroad for a period of at least 3 months.

Paediatric Ophthalmologist - an Ophthalmologist who has a Fellowship or equivalent qualification, and who has at least 12 months or more training in an established paediatric ophthalmology and squint unit/department within Pakistan or abroad.

Paediatric Ophthalmology - a broad and varied sub-specialty, spanning the whole of ophthalmology. Primarily, dealing with the care of the child's eye and visual system

Paediatric Oriented Ophthalmologist - an Ophthalmologist who has a Diploma or Fellowship or equivalent qualification, and who had at least 3 months or more training in an established paediatric ophthalmology and squint unit/department within Pakistan or abroad.

Refractive error -an optical defect of the eye that prevents effective focus of images. Most visual impairment due to refractive error is correctable with the use of spectacles.

Retinopathy of prematurity - occurs in premature babies with immature retinal blood vessels. Low birth weight and hyperoxia (due to use of inadequately-monitored supplemental oxygen in neonatal intensive-care units) are important risk factors.

School screening – a school-based activity to identify children with eye problems. Early detection of problems like lazy eye and squint reduces their complexity as the child ages.

Teaching Hospitals - provide medical / clinical training to medical students under the supervision of specialist doctors. These hospitals have links with medical colleges and are associated with universities.

Technical Support Agency - the agency providing technical support as required.

Visual impairment - includes low vision and blindness (ICD-10 visual impairment categories 1,2,3,4, and 5).

Vitreo-Retinal Surgeon - an Ophthalmologist who has a Fellowship or equivalent qualification, and who has at least 12 months or more training in an established Vitreo-Retinal ophthalmology unit/department within Pakistan or abroad.

ATTACHMENT 3: PROJECT PARTNERS

College of Ophthalmology & Allied Vision Sciences (COAVS) Lahore

COAVS is one of FHF's long-standing partners in the country. This institute is attached to King Edward Medical University (KEMU). The College of Ophthalmology and Allied Vision Sciences (COAVS) started as the Comprehensive Eye Care Cell Punjab in 1999 to eradicate preventable and curable blindness from the country and from the province of Punjab, in particular. Based on its tremendous achievements, the Government of Punjab upgraded it to the Punjab Institute of Preventive Ophthalmology (PIPO) in 2004 and subsequently upgraded it further to the present status of College of Ophthalmology and Allied Vision Sciences in 2007.

Prof Dr Asad Aslam Khan is head of COAVS. He has been associated with the institute since 1998 first in the capacity of provincial coordinator and now as the National Coordinator for Prevention of Blindness in Pakistan. He has been instrumental in the success of the eye care sector in Pakistan. COAVS has the responsibility to oversee the planning, implementation and monitoring & supervision of the blindness prevention activities in the Punjab province. It is conducting different postgraduate program for doctors in ophthalmology, continuous medical education for in service district ophthalmologists, community ophthalmology and the only institute recognized by the primer medical education bodies like Pakistan Medical and Dental Council (PMDC) and College of Physicians and Surgeons Pakistan (CPSP) for subspecialties fellowship in pediatric ophthalmology and Vitreo Retina. It is also one of the major training institutes for MLECP.

Pakistan Institute of Community Ophthalmology (PICO) Peshawar

PICO is one of the leading community ophthalmology institutes in the country. It was established as joint venture of the Department of Health KPK and couple of INGOs in 1998. It is affiliated to the eye unit of Hayatabad Medical Complex; the center of excellence for KPK. PICO has the responsibility to oversee the planning, implementation and monitoring & supervision of the blindness prevention activities in the KPK province. It conducts different postgraduate program for doctors in affiliation with the ophthalmology unit in ophthalmology, continuous medical education for in service district ophthalmologists, community ophthalmology. It is also one of the major training institutes for MLECP and it offers quality education to the medics and paramedics from the country and the region.

Comprehensive Eye Care (CEC) Cell Balochistan

CEC Cell Balochistan was established as part of the National Programme for Prevention and Control of Blindness 1999 – 2003. Its establishment was supported by INGOs. It was set-up at the Helpers Eye Hospital in Quetta and its main role was to plan, implement and coordinate prevention and control of blindness activities in the province. The Cell facilitated the development of an ophthalmic technicians training programme at the Multi-Purpose Training Centre for allied health professionals. The ophthalmic technician course is accredited by the Balochistan Medical Faculty of the provincial government.

Prof. Nasim Panezai was the first head of the CEC Cell and the provincial coordinator for the prevention & control of blindness in Balochistan. After his retirement in 2008, three provincial coordinators have been appointed in a span of four years. The CEC Cell was supported with appointment of a Community Ophthalmologist.

Comprehensive Eye Care (CEC) Cell Sindh

CEC Cell Sindh (known as the Prevention and Control of Blindness (PCB) Cell) was established as part of the National Programme for Prevention and Control of Blindness 1999 – 2003. Its establishment was supported by INGOs. It was set-up at Civil Hospital in Karachi and its main role was to plan, implement and coordinate prevention and control of blindness activities in the province. The Cell facilitated the development of the Vision Sciences Centre (VISC), which then developed and conducted training programmes for optometrists and ophthalmic technicians. The optometry training programme was then shifted to Dow University in 2006. Presently, the PCB Cell only runs training for ophthalmic technicians. The ophthalmic technician course is accredited by the Sindh Medical Faculty of the provincial government.

Prof. Zia Shaikh was the head of the PCB Cell. After his retirement in 2008, he was succeeded by Prof Idrees Adhi. In 2012, Prof Shahid Wahab was appointed as head of the eye department, while Dr Minhaj was appointed as Project Director of the PCB Cell and continues in that role to date. The PCB Cell was supported with appointment of a Community Ophthalmologist. Previously, the head of the eye department was also the Project Director for the PCB Cell. In the current situation, the appointment of two separate heads may require streamlining of management arrangements. Presently, Dr Zahid Hussein works as the Community Ophthalmologist in the Cell.

Comprehensive Eye Care (CEC) Cell Gilgit Baltistan

CEC Cell Gilgit-Baltistan was established as part of the National Programme for Prevention and Control of Blindness 1999 – 2003. Its establishment was supported by INGOs. It was set-up at the District Headquarter Hospital in Skardu and its main role was to plan, implement and coordinate prevention and control of blindness activities in the province. The Cell facilitated the identification of potential candidates for training as ophthalmic technicians at various training centres in other provinces like KPK and Punjab etc.

Dr Niaz Ali was the head of the CEC Cell and continues in that role to date. Dr Niaz Ali is also a trained clinical and Community Ophthalmologist.

Al-Shifa Trust Eye Hospital, Rawalpindi

Al-Shifa Trust Eye Hospital (Al-Shifa) is a non- political, non-governmental, and not-for-profit organization involved in delivering eye care services for the last 20 years as well as being a tertiary training centre for all cadres of eye health workers including clinical and non-clinical. Al-Shifa runs 4 eye hospitals and has various community eye care projects. Over 70% of patients are treated free of cost. Al-Shifa is also a World Health Organization (WHO) Collaborating Centre for prevention of blindness in Pakistan. FHF has been working in partnership with Al-Shifa through the PASEC Project for training sub-specialists in pediatrics and vitreo-retina. Al-Shifa is working in partnership with FHF for the training different cadre of MLECP.

Khyber Eye Foundation (KEF) Peshawar

KEF was founded by the Khyber Lions Club in 1996. It is still being managed and supported mainly by the club members and local industrialists. The hospital has grown to the significant level and renowned for the services it has been rendering to the communities. KEF and FHF are also long standing partners and have been working jointly on many hospital based and community level projects.

Al-Ibrahim Eye Hospital (AIEH) Karachi

This hospital started from a meager community center in the suburbs of Karachi in 1994. In less than 18 years, the facility has attained the status of tertiary level with over 70 beds for inpatients. It has also emerged as hub for teaching and training for medics and paramedics nationally and internationally. It offers basics ophthalmology courses to the subspecialty training to the ophthalmologists. It also offers ophthalmic technician training and BSc vision sciences to the paramedics. It is a well-placed learning facility for students from Pakistan in general and Sindh province in particular. FHF plans to support eye care service provision to vulnerable communities in selected locations in Balochistan and KPK through its partnership with AIEH.

Layton Rahmatulla Benevolent Trust (LRBT) Karachi

LRBT is one of the leading national NGO working for prevention & control of blindness since 1984. It has a countrywide spread with 39 Community Eye Health Centers, 15 secondary level hospitals, 2 tertiary level hospitals and a number of community level projects. It has the capacity for treating patients from simple cataract extraction to more complex sub-specialty surgeries. LRBT operated upon 130,000 cataract patients free of cost during the last year alone.

In the recent past, the organization has established its paramedic school affiliated with Sindh Medical Faculty (body recognizes paramedic schools and awards degree to the students after examination). FHF is currently providing services in remotes districts/locations through LRBT where FHF presence would have not been possible otherwise. Terrorism in Swat, (district in KPK) prevented any kind of service delivery to the people but FHF was able to continue cataract surgical campaign through LRBT. FHF plans to support eye care service provision to vulnerable communities in selected locations in Balochistan and KPK through its partnership with LRBT.

ATTACHMENT 4: SITUATION ANALYSIS

Current Situation

Political and Administrative
Pakistan is a populous country with a land area of around 800,000 kilometres. It gained its independence in 1947. The country is divided into five provinces namely Punjab, Sindh, Balochistan, Khyber PakhtunKhawa (formerly North West Frontier Province) and the relatively smaller Gilgit-Baltistan, as well as three territories, namely Federally Administered Tribal Areas (FATA); Azad Jammu & Kashmir (AJK) and the Islamabad Capital Territory (ICT).

The political system in Pakistan takes place within the framework of a federal republic, where the system of government has at times been parliamentary, presidential, or semi-presidential. In the current parliamentary system, the President of Pakistan is the largely ceremonial head of state, the Prime Minister is head of government, and there is a multi-party system. Executive power is exercised by the government. Legislative power is largely vested in the Parliament.

Economic growth and development
Pakistan is currently going through the worst economic crisis of its history as reflected by economic indicators. In the 1990's and specifically in the late half of the decade Pakistan observed low economic growth. On the contrary 2000 to 2005 exhibited some economic recovery but owing to a weak basis it was short-term since the economic recovery was based on the service sector rather than the production sector.

Due to the fluctuating economic recovery in the period 2000-2005, GDP growth reached as low as 1.2% by 2009. In 2010, the government envisaged a growth rate of 4.1%. Inflation on the other hand increased sharply during 2008 and 2009 i.e. 12% and 20.8% respectively. Higher inflation and low economic growth rates increased poverty and food insecurity in the country[17].

The economy was also deeply affected by the war on terror. There was a huge decline in foreign and local investment. According to the government's conservative estimates, Pakistan has suffered an estimated loss of US $45 billion as a result of the current war. The war has also caused damage to the country's infrastructure including government buildings, some of the product markets and schools. In Khyber Pakhtunkhwa alone, hundreds of schools were destroyed. Since schools were the prime victim of this war on terror, a huge threat was posed to human skills development[18].

The economy was also affected due to other effects of the war on terror in other provinces. Local unrest in Baluchistan and Karachi, the economic hub of the country with a seaport has been impacted adversely. Moreover natural resources have also been depleted in certain areas of the country where they are the main source of livelihood leading to unemployment and poverty in the country.

Economic growth was further impacted by the floods in 2010, 2011 and more recently in 2012. The floods not only destroyed the infrastructure in the country but also destroyed

[17] Shakeel Ahmad Ramay. A Profile of Pakistan's Development Status and Green Economy in Pakistan. Sustainable Development Policy Institute, 2011
[18] Shakeel Ahmad Ramay. A Profile of Pakistan's Development Status and Green Economy in Pakistan. Sustainable Development Policy Institute, 2011

livelihoods of millions of people. The World Bank and Asian Development Bank calculated that Pakistan suffered about 10 billion US$ which remains a conservative estimate[19].

Post Devolution scenario in the Health Sector of Pakistan

The unanimous adoption by Pakistan's Parliament of the 18th Amendment to the Constitution of Pakistan during April 2010 was a highly popular move that devolved a lot of responsibilities from the federation to its federating units or provinces. As a result, as of 30th June 2011, seventeen ministries had been totally abolished at the federal level including the Ministry of Health. Furthermore, certain critical health functions that constitutionally vest with the Federal Government, whose most careful handling is incontrovertible, have been assigned to six ministries/divisions of the Government of Pakistan[20].

There are, however, concerns that certain critical oversight functions requiring federal role and involvement may be compromised. These functions include health policy formulation; human resource planning; enabling policies on medicines, vaccines and biologicals; responding to public health emergencies; compliance with domestic and International Health Regulations (IHR); fulfilling international commitments including the three health-specific MDGs, coordination and monitoring resource mobilization through health development partners including United Nations (UN) agencies, multilateral and bilateral donors[21].

Furthermore, while the benefits of decentralization cannot be denied, particularly in the context of a large country like Pakistan, certain inherent dangers resulting from inequities in distribution of health resources in the absence of national redistributive policies, with an increase in inefficiency, insufficient managerial capacity of local institutions, escalation of political pressures on lower tiers, and a possible lack of coherence of district and provincial plans with national goals and policies will require careful handling.

With the dissolution of the Ministry of Health, the residual federal functions have been assigned to the Planning Commission (PC), Cabinet Division, Economic Affairs Division (EAD), Inter-Provincial Coordination Division (IPCD), States and Frontier Regions Division (Saffron) and Capital Administration and Development Division (CADD), which may lead to a certain degree of fragmentation with no clustering under a single entity. This is despite the existence of any constitutional barrier for establishing such an arrangement at the federal level in the form of a national commission or task force for coordination.

Health and development challenges

The overall health status in Pakistan has improved since 1990 albeit at a much slower pace in relation to its neighbouring countries. The increase in life expectancy at birth from 64 years to 67 years in 10 years has not been substantial; it is however, more than the life expectancy at birth for India and Bangladesh, but significantly lower than the level in Sri Lanka, Indonesia and Malaysia.

Other contributing factors to disease burden and health system challenges include some of the major social determinants of health such as poverty, gender inequality, low levels of literacy and lack of public service facilities such as proper sanitation and safe water, food safety regulations, hygiene improvement and solid waste management. Pakistan's under-five mortality is the second highest in South Asia, after Afghanistan. Although a decline has occurred from 150 in the 50s to 94/1000 live births in 2007, this decrease has, however, not been matched by a proportional decrease in the neonatal mortality, which constitutes more

[19] Shakeel Ahmad Ramay. A Profile of Pakistan's Development Status and Green Economy in Pakistan. Sustainable Development Policy Institute, 2011

[20] Country Cooperation Strategy for Pakistan 2011-2017. World Health Organization

[21] Country Cooperation Strategy for Pakistan 2011-2017. World Health Organization

than half of the infant mortality. The matter needs to be viewed in relation to the societal barriers on women while seeking healthcare[22].

Malnutrition remains widespread with few significant or positive outcomes achieved in the last two decades. Acute malnutrition levels have been consistently above the emergency threshold posing a serious public health problem, with stunting reaching 37% and severe wasting 13%[23].

Human Development Index

Pakistan's Human Development Index (HDI) for 2011 was reported as 0.504 ranking it at 145 out of 187 countries. If Inequality-adjusted HDI is taken, then the index falls even further to 0.346 (a loss of 31.4%). Fig 1 illustrates districts according to HDI using 2005 data.

Fig 2 depicts the districts by HDI. Most districts lie in the medium range of 0.6 and above, while several districts in Balochistan and some in south Sindh lie in the low HDI range of less than 0.5. However, most of these districts also tend to have lower population densities.

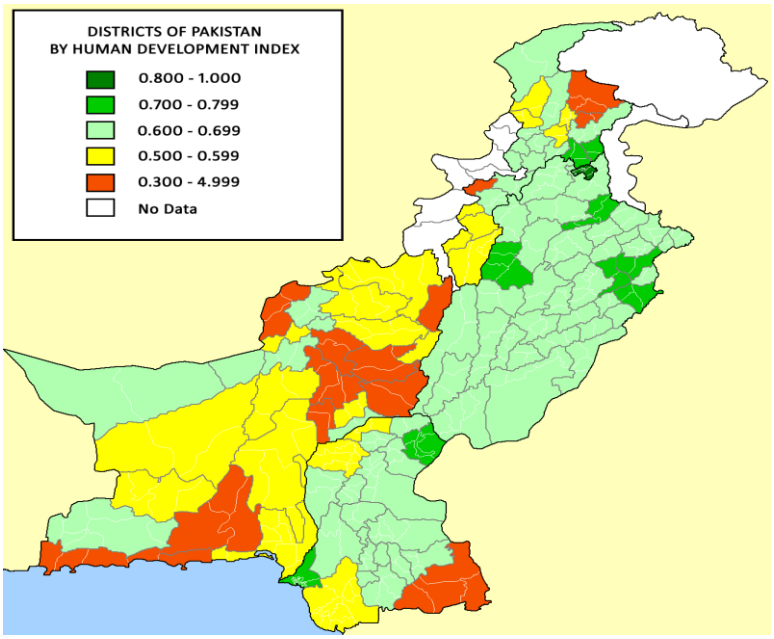

Figure 2 - Districts of Pakistan by Human Development Index

Table 4 indicates that Pakistan's major contributors to low HDI are inequality in education and health, which therefore implies that they should be the development prerogatives for the country.

[22] Country Cooperation Strategy for Pakistan 2011-2017. World Health Organization

[23] Country Cooperation Strategy for Pakistan 2011-2017. World Health Organization

Table 4 - Pakistan's Inequality Adjusted HDI for 2011 relative to selected countries and groups

	IHDI value	Overall loss (%)	Loss due to inequality in life expectancy at birth (%)	Loss due to inequality in education (%)	Loss due to inequality in income (%)
Pakistan	**0.346**	**31.4**	**32.3**	**46.4**	**11.0**
India	0.392	28.3	27.1	40.6	14.7
Bangladesh	0.363	27.4	23.2	39.4	17.7
South Asia	0.393	28.4	26.9	40.9	15.1
Low HDI	0.304	33.3	35.6	39.2	24.2

(Source: Human Development Report 2011)

Table 5 indicates that about 50% of the population is in a state of multidimensional poverty, and about 23% lives below the income poverty line.

Table 5 - Multidimensional Poverty Index in selected countries

	MPI value	Head count (%)	Intensity of deprivation (%)	Population vulnerable to poverty (%)	Population in severe poverty (%)	Population below income poverty line (%)
Pakistan	**0.264**	**49.4**	**53.4**	**11.0**	**27.4**	**22.6**
India	0.283	53.7	52.7	16.4	28.6	41.6
Bangladesh	0.292	57.8	50.4	21.2	26.2	49.6

(Source: Human Development Report 2011)

Table 6 illustrates the variation in HDI in the different provinces, with lower HDIs in the rural areas.

Table 6 - Human Development Index by region in Pakistan

Region	Human Development Index	Comparable Country
Urban Pakistan	0.656	Equatorial Guinea
Rural Pakistan	0.496	Togo
Punjab	0.670	Tajikistan
Urban Punjab	0.657	Equatorial Guinea
Rural Punjab	0.517	Sudan
Sindh	0.628	India
Urban Sindh	0.659	Equatorial Guinea
Rural Sindh	0.456	Eritrea

Khyber Pakhtunkhwa	0.607	Solomon Islands
Urban Khyber Pakhtunkhwa	0.627	India
Rural Khyber Pakhtunkhwa	0.489	Zimbabwe
Balochistan	0.556	Ghana
Urban Balochistan	0.591	Solomon Islands
Rural Balochistan	0.486	Mauritania

(Source: Human Development Reports 2003 and 2006)

Health Financing

Pakistan continues to spend less on health than other countries at similar levels of economic development. The total expenditure on health in Pakistan in 2008 was estimated to be US$ 18 per capita, of which the public sector expenditure was US$ 4 per capita. This is far below the figure of US$34 proposed by the Commission on Macroeconomics and Health to provide essential package of health services. Over the last 15 years public health expenditures have increased by 50% in nominal terms, however taking into account population increase and inflation, real expenditure as a percentage of GDP has remained below 0.6%. Between 2001/02 and 2006/07 public sector investment increased by 90% in real terms compared to 5% over the previous 5 years, but this increase did not meet the targets set under Poverty Reduction Strategy Paper (PRSP)-I and Fiscal Responsibility Act 2005[24].

There is a general lack of information on private health expenditure in Pakistan; despite estimates that out-of-pocket spending contributes to 75% of the total health expenditure in Pakistan. In the absence of social protection mechanisms this puts a large number of families at risk of poverty because of illness.

A total of 2.9% of the GDP is spent on health with 1.16% by public sector and a larger share of 1.17% by private sector. Public sources on health expenditure account for 33.3% of expenditure, semi-government agencies 5.1%, donor assistance 1.7%, while private sources make up the largest share of 59.8%. Within the private spending, out of pocket payments account for 57.3% of total health expenditure, private employees 1.6% while philanthropy accounts for around 0.9%[25]. About 26% of the country's population has either partial or comprehensive financial cover paid by employers, while 0.32% is covered by government safety nets.

Foreign assistance has played a critical role in developing Pakistan's health sector and the country has historically received large volumes of aid. In 2007, Pakistan received more than US$ 2.2 billion in Official Development Assistance (ODA), ranking the country as the sixth largest recipient of official aid in the world.

While the United States of America's development assistance historically constituted the bulk of the aid to Pakistan, the major multilateral development banks now provide more than half of all donor assistance to Pakistan. Of the $4 billion in development assistance recorded by the State Bank of Pakistan in 2009, $2.6 billion came from multilateral organizations and development banks. Several non-OECD countries, most significantly China and Saudi Arabia, are currently providing significant amounts of aid. Some bilateral donors and nearly all of

[24] Country Cooperation Strategy for Pakistan 2011-2017. World Health Organization

[25] Country Cooperation Strategy for Pakistan 2011-2017. World Health Organization

Pakistan's major multilateral partners have drastically increased their funding to Pakistan in recent years.

The overall investment in the health services sector during 2009 was US$ 4.853 billion, with the government providing 24%, donors 6%, the military 4%, and 1% through social security. The remaining 65% has been paid by people as out-of pocket medical expenses. It is estimated that US$ 19.51 billion are currently required to maintain the health services on track for a 3-year period. The Government has increased its investment in health by an additional 34% from 2005-2009 (US$3.4 billion as compared with US$4.6 billion in 2010-2012). Despite this increase, however, there is a huge gap of almost US$15.0 billion. As regards the attainment of MDGs, the PRSP-II has estimated an overall funding gap of US$ 1.3 billion. In view of a short fall of US$ 481 million from Government sources in 2009-2010 for meeting the health MDGs, the future funding gap is expected to be even greater[26].

The estimated global cost of eliminating avoidable blindness (adapted from The Price of Sight - PWC 2011)[27]

Based on this approach and the costing framework, the cost of eliminating avoidable blindness was estimated. The key results include:

- The direct health cost/investment required to treat the backlog of avoidable blindness over ten years (2011 to 2020) is estimated to be $26.7 billion.

- The estimated additional investment required to eliminate avoidable blindness (in addition to costs already incurred) is $397.8 billion over the ten year period from 2011 to 2020.

    - The estimated additional investment required in the primary health care sector is the largest component of this cost, at $308.4 billion, followed by the secondary health care sector at $62.7 billion over the ten year period
    - Expressed another way, the additional investment required to eliminate global avoidable blindness is an average of $5.80 per person per year over this ten year period
    - Excluding high income countries, the additional investment required to eliminate avoidable blindness is estimated to be $127.4 billion

Drawing on these estimates, the total global direct health cost of avoidable blindness including recurrent primary and secondary eye care service costs is estimated to be $6.3 trillion (USD 2009) over the ten year period from 2011 to 2020. This estimate includes both the direct health costs that are already incurred and the additional investment required. This data is not available to a level of breakdown for Pakistan but provides a good indication that the additional investment required to eliminate global avoidable blindness is an average of $5.80 per person per year over the ten year period.

On the other hand a study of economic burden of blindness in Pakistan showed that the per annum productivity gains of rehabilitating the entire blind population represents 0.74% of the

[26] Country Cooperation Strategy for Pakistan 2011-2017. World Health Organization

[27] The Price of Sight. The global cost of eliminating avoidable blindness. PWC and Three Rivers Consulting, 2011

current gross domestic product of Pakistan, which is higher than the total public spending on health[28].

Funding for the eye health sector is in a similar position as is the case with the general health sector in the country. The provincial governments are funding operational costs of all public sector eye units at the tertiary, district and sub district levels. The main costs that the departments of health are supporting includes the salaries of the ophthalmologists, ophthalmic support staff, utilities of the eye units, essential technology and maintenance & repairs etc through regular annual budgets. However the financial allocation of the departments of health to the above mentioned categories is grossly deficient. Also the level of expenditure is different in different provinces depending upon the economic capacity and ownership / motivation of the respective provincial government. For example, in Punjab, in addition to the tertiary level, new posts of optometrists have been created and funded by the provincial government in all districts. In Khyber Pakhtunkwa, Punjab and Sindh provinces, the government has created of positions of community ophthalmologists in the provincial CEC cells, which are still to be created in Balochistan.

In addition to the regular provincial support in 2005, the Federal Ministry of Health; responding to the work done by INGOs through the national committee for the prevention of blindness, approved a 5 years project on prevention and control of blindness of Rs. 2.7 billion from 2005-2010. The national committee for prevention of blindness oversaw the implementation of the project. A project steering committee was headed by the Federal Secretary Health with representation of provincial health secretaries. A procurement committee set up by the Ministry also included the national and provincial coordinators for prevention of blindness. Approximately 60% of the project funds were disbursed. In 2005, project funds were diverted to the earthquake relief and rehabilitation activities, in 2009 funds were again diverted to meet the crisis of Internally Displaced persons, while in 2010 another cut was placed due to the massive floods that swept over two-thirds of the country. In 2011, the cabinet approved the 18th Constitutional Amendment for devolution of various ministries including health to the provinces. The national programme for prevention of blindness 2005-2010 was also devolved to the provinces and has received a no-cost extension from financial year 2012-2013 to end June 2015. During this time, provincial shares pending as per the project document shall be disbursed directly to the respective provinces for completion of pending activities.

Geography and Demography

Pakistan's estimated population in 2011 is over 187 million making it the world's sixth most-populous country, behind Brazil and ahead of Nigeria. During 1950–2011, Pakistan's urban population expanded over sevenfold, while the total population increased by over fourfold. In the past, the country's population had a relatively high growth rate that has been changed by moderate birth rates. The population growth rate now stands at 1.6%.

Dramatic social changes have led to rapid urbanization and the emergence of megacities. During 1990–2003, Pakistan sustained its historical lead as the second most urbanized nation in South Asia with city dwellers making up 36% of its population. Furthermore, 50% of Pakistanis now reside in towns of 5,000 people or more.

Pakistan has a multicultural and multi-ethnic society and hosts one of the largest refugee populations in the world as well as a young population.

[28] Awan H, Malik SM, Khan N: The economic burden of blindness in Pakistan: A socio-economic and policy imperative for poverty reduction strategies. Indian Journal of Ophthalmology Vol 60 (5):358-361, 2012

The majority of southern Pakistan's population lives along the Indus River. Karachi is the most populous city in Pakistan. In the northern half, most of the population lives about an arc formed by the cities of Faisalabad, Lahore, Rawalpindi, Islamabad, Gujranwala, Sialkot, Nowshera, Swabi, Mardan, and Peshawar (Fig 3).

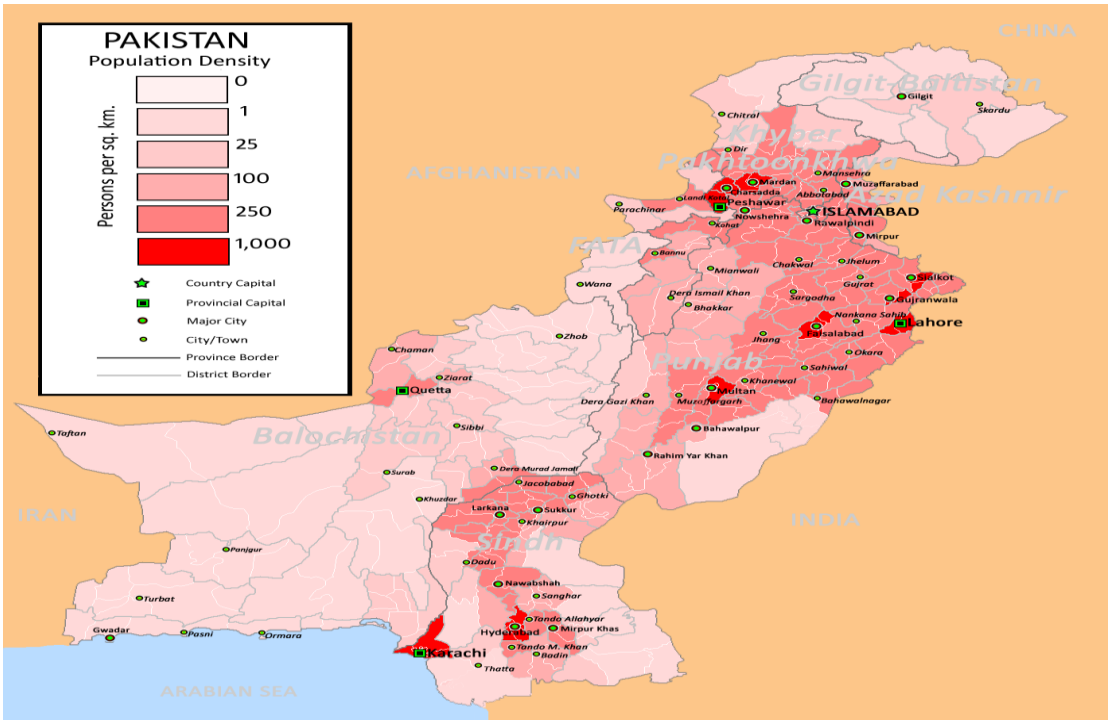

Figure 3 - Population density in Pakistan

Pakistan is divided into three major geographic areas: the northern highlands; the Indus River plain, with two major subdivisions corresponding roughly to the provinces of Punjab and Sindh; and the Balochistan Plateau. Some geographers designate additional major regions. For example, the mountain ranges along the western border with Afghanistan are sometimes described separately from the Balochistan Plateau, and on the eastern border with India, south of the Sutlej River, the Thar Desert may be considered separately from the Indus Plain.

Nevertheless, the country may conveniently be visualized in general terms as divided in three by an imaginary line drawn eastward from the Khyber Pass and another drawn southwest from Islamabad down the middle of the country. Roughly, then, the northern highlands are north of the imaginary east-west line; the Balochistan Plateau is to the west of the imaginary southwest line; and the Indus Plain lies to the east of that line.

Owing to the mountainous terrain, and more recently the security situation, parts of Balochistan to the south-west, Gilgit-Baltistan to the north and Federally Administered Tribal Areas to the north-west are not so accessible.

ATTACHMENT 5: EYE HEALTH SITUATION OF SELECTED DISEASES

Conducted in the mid-1990s, the National Diabetes Survey of Pakistan was a phased nationwide prevalence study of Diabetes; this survey documented prevalence of Diabetes and Impaired Glucose Tolerance (IGT) in four provinces of the country utilizing similar study protocols and standardized WHO definitions for diagnosis. The results of these provincial surveys were recently amalgamated. Overall prevalence in women was found to be 3.5% in urban and 2.5% in the rural areas, whereas overall prevalence of Diabetes in men was 6% in urban and 3.3% in rural areas. IGT in urban versus rural areas was 6.3% in men and 14.2% in women against 6.9% in men and 10.9% in women, respectively. Overall glucose intolerance (DM +IGT) was 22.04% in urban and 17.15% in rural areas[29].

More recent data suggests that the prevalence of diabetes is high ranging from 7.6 to 11% in Pakistan. Variations according to age, sex, location and urbanization have been noted. Reports from National diabetes survey and National health survey differ in observations regarding prevalence of diabetes and in relative burden of diabetes in various provinces and among males and females. According to the International Diabetes Federation (IDF) Diabetes Atlas 5th Edition, 2012 update, the prevalence of diabetes in Pakistan is about 7.89%, while the prevalence of IGT is 8.53%[30].

The total number of diabetics is estimated to increase from 10.2 million in 2012 to 17.6 million in 2030 at the present prevalence rate. Furthermore, with increasing urbanization, the number of diabetics in urban centres is likely to increase from 2.8 million to 6 million by 2030[5]. By 2030, at least 1.8 million people in Pakistan will be afflicted by sight threatening diabetic retinopathy, which is about the same as the 1.7 million in 2012 who are blind from all causes.

In a four year DR screening program implemented by FHF through its local partners, over 30,000 known diabetics have been screened for DR. Out of this number 28% of the screened diabetics were found to be positive for DR. Since this screening is hospital based for known diabetics it is anticipated that the DR positive ratio would be much higher in diabetics at community level.

FHF has undertaken a major subspecialty development project to upgrade the vitreo-retinal and pediatric ophthalmology services in 17 major tertiary and teaching hospitals.

Children constitute about a third of the population of Pakistan. There are an estimated 65 million children. Several studies have been conducted to determine the common causes of blindness and visual impairment in children in schools for the blind. The National Committee for Prevention of Blindness commissioned a nationwide situation analysis of all schools for the blind in the country[31]. The study team examined 1000 children enrolled in 46 schools in 2003. They found a male:female ratio of 1.8:1. There was a positive family history in 56.1% and consanguinity was found to be high in 68.9%. Retinal disease, mainly due to dystrophies emerged as the major cause of blindness in 51.2%. These were followed by Whole Globe problems (20.3%) mainly Microphthalmia 13.2%, Phthisis Bulbi 4.2% and Buphthalmos 3.3% and Glaucoma 4.7%. Cataract and related conditions accounted for 10.0%, while Corneal problems were seen in only 3.7%. Optic nerve disorders especially Optic Atrophy was present in 6.1% children.

[29] Nishtar 2007. Health Indicators of Pakistan. Gateway Paper II. Heartfile

[30] IDF Diabetes Atlas, 5th Edition, 2012 Update. International Diabetes Federation

[31] Current status of the aetiology, prevalence and distribution of childhood blindness in Pakistan – a report. National Committee for Prevention of Blindness, Sightsavers International, 2003

Retinopathy of Prematurity (ROP), which is often thought to be a disease that affects transitional economies where neonatal services are just beginning to develop but do not have sufficient experience to prevent ROP from occurring, is an emerging cause of blindness and visual impairment in children in Pakistan.

According to a report published by WHO in 2012; *Born Too Soon: The Global Action Report on Preterm Birth,* Pakistan stands at a ranking of 4 in the number of preterm births/year at a rate of 15.8% preterm births in the population each year. A preterm baby is classified as one having a birth weight of less than 1,500 grams. With an annual growth rate of 1.8% quoted in the WHO country statistics, Pakistan having a population of over 187 million, there are 3,366,000 babies born each year. Of these born there will be over 531,828 babies born at preterm. Using the study conducted by Tuqui et al[32] it can be estimated that each year in Pakistan there will be over 172,312 children that will develop ROP (inclusive of all stages).

Based on current estimates of prevalence of severe visual impairment and blindness in children of 7 per 10,000, there are an estimated 45,000 children who are blind or severely visually impaired, and about twice that number have low vision. Children with visually disabling eye problems require specialist care in the form of trained paediatric ophthalmologists and support teams of orthoptists and optometrists. FHF has taken an initiative of developing pediatric units to cater for this problem however, more work is needed, to organize primary eye care health services and their linkage with the tertiary eye care services to raise the awareness of the communities regarding childhood blindness and community based screening of kids for early diagnosis and referral.

Glaucoma as a blinding eye disease presents serious challenges in Pakistan. The results from the two blindness surveys reveal that the prevalence of glaucoma as a cause of blindness has effectively doubled from 3.9% to 7.1% in all causes of blindness (Table 4). Recent guidelines on public health control of glaucoma were published by the WHO Regional Office for the Eastern Mediterranean[33]. There is a pressing need to strengthen subspecialty services for glaucoma at selected tertiary centres and build capacities for its management.

Corneal opacities account for 14% of total burden of blindness in Pakistan (blindness prevalence survey 2003-2004). The main causes of corneal opacities in Pakistan are vitamin A deficiency, trauma, traditional eye care practices, trachoma, measles etc. The biggest deficit for corneal opacities treatment is the unavailability of human cornea and lack of cornea grafting services in Pakistan.

A countrywide situation analysis of refractive error services conducted in 2006 gathered data from over 2000 optical outlets and from all the districts in the country[34]. They found that at least 6.2 million refractions were being done annually (2.2 million by ophthalmologists in the private sector, 1.6 million at hospitals (eye hospitals and eye departments within general hospitals) and 2.4 million by opticians. As part of a community based study, the prevalence of visually disabling refractive errors was found to be about 3.5% to 4.5% in children and 4% in all ages. Refractive errors are the commonest cause of visual impairment worldwide. A national study found that overall spectacle coverage (6/12 visual acuity cut-off) was 15.1% indicating that refractive error services were not covering the majority of the population in need.

[32] Taqui AM, Syed R, Chaudhry TA, Ahmad K, Salat MS: Retinopathy of prematurity – frequency and risk factors in a tertiary care hospital in Karachi, Pakistan. J Pak Med Assoc 2008 Apr; 58(4):186-90

[33] Summary Report of the Regional workshop on the development of public health control strategies on glaucoma. WHO-EM/CPB/007/E

[34] Situation analysis of refractive services in Pakistan. Ministry of Health, National Committee for Prevention of Blindness, Sightsavers International, 2006

Pakistan is highly vulnerable to the adverse effects of climate change, particularly those resulting from rising temperatures, increased variability of monsoon, melting of Himalayan glaciers, and an increase in the frequency and intensity of extreme weather events and natural disasters. This will have significant repercussions on human health in Pakistan not only in terms of rise in the incidence of infectious diseases – that are already inflicting a substantial proportion of its population – but also in terms of shortages in food and water that are vital to maintain good health.

The potential health consequences of increase in temperature are Heat Stroke; Dengue; Cataract Blindness; Respiratory Diseases; and Cardiovascular diseases. The health consequences of floods in the context of Pakistan include diarrhoea and gastroenteritis; skin infections; eye infections; acute respiratory infections; malaria; and mental illnesses. Droughts on the other hand, increase the risk of food insecurity and malnutrition; anaemia; night blindness; and scurvy[35].

[35] Malik S, Awan H, Khan NU. Mapping vulnerability to climate change and its repercussions on human health in Pakistan. Globalization and Health 2012, 8:31 doi:10.1186/1744-8603-8-31

ATTACHMENT 6: HUMAN RESOURCE DEVELOPMENT FOR EYE HEALTH

Human resource development for eye health in Pakistan

Table 7 - Subspecialty two year fellowship training

Name of Province	VR Specialist	Peads Specialist	Cornea specialist	Glaucoma Specialist	Oculplastic Specialist
	Formal Fellowship for 2yrs				
Punjab	5	4	0	0	0
Sindh	2	2	0	0	0
KPK	3	2	0	0	0
Baluchistan	1	1	0	0	0
Total	**11**	**9**	**0**	**0**	**0**

(Source: Fred Hollows Foundation Country Office, 2013)

Table 8 - Subspecialty six months training

Name of Province	VR Specialist	Paedtric Ophthalmologists	Cornea Specialist	Glaucoma Specialist	Oculoplatics Specialist
	Formal trained 6 months training				
Punjab	11	6	3	2	2
Sindh	1	2	1	2	1
KPK	2	4	1	1	1
Baluchistan	0	0	0	0	0
Total	**14**	**12**	**5**	**5**	**4**

(Source: Fred Hollows Foundation Country Office, 2013)

Table 9 - Subspecialty three months training or on-the-job training

Name of Province	VR	Peads	Cornea	Glaucoma	Oculplastic
	3 months training or on the job training				
Punjab	20	4	3	3	3
Sindh	2	2	1	2	1
KPK	1	2	1	2	1
Baluchistan	1	0	0	0	0
Total	**24**	**8**	**5**	**7**	**5**

(Source: Fred Hollows Foundation Country Office, 2013)

Table 10 - Mid level eye care personnel training

	Number of training centres running an accredited training program	Total Number of specific cadre produced annually	Total number of specific cadre available in country
B. Sc Degree program (4 year	13	220	293
Ophthalmic Nursing (1 year)	2	29	226
Ophthalmic Technician (1 year)	12	170	1593

(Source: Fred Hollows Foundation Country Office, 2013)

Tables 7 to 10 indicate the status of various eye health professionals obtained from a recent situation analysis of training programmes in the country. This survey was done in collaboration with the National Coordinator for Prevention of Blindness and sponsored by FHF.

Table 11 - Status of eye health workforce in Pakistan

Key Indicators	**Statistics**
Number of Doctors	157,000
Number of Ophthalmologists	2200
Number of Ophthalmic Subspecialists	20
Number of Optometrists	300

Number of Orthoptists	20
Number of Ophthalmic Assistants	450
Number of Ophthalmic Nurses	70
Number of Ophthalmology Training Centres	30
Number of Ophthalmic Subspeciality Training Centres	7
Ophthalmologist Per Total Population Ratio	1:81,818
Ophthalmologist Per 75,000 Population Ratio	0.92:75,000
Ophthalmologist to Total Doctors Ratio	71
Allied Eye Health Professional Per Total Population Ratio	1:214,285

Source[36]

Table 11 provides the results of a situation analysis of human resources for eye health in the country undertaken in 2012 and data collected from 30 tertiary teaching hospitals (including government, private and non-government) and the provincial and national coordinators for prevention of blindness.

[36] Status of ophthalmic education and eye health workforce in SAARC countries. International Council of Ophthalmology, 2012

ATTACHMENT 7: ALIGNMENT WITH POLICIES AND STRATEGIES

AusAID Draft Health Strategy
Australia's overseas aid program aims to help developing countries reduce poverty and achieve sustainable development in line with Australia's national interests. The proposed project will be delivering Australian development assistance in an effective manner making a real difference in people's lives and delivering real results.

AusAID's health policy also encourages the use of local structures for delivering aid rather than setting up parallel structures that place heavy administrative burdens on the partner country. FHF's focus is on strengthening local structures. The health policy also provides that: "When providing assistance to strengthen health systems Australia will seek to complement and, where feasible, directly engage with other donors." FHF's strategy of working through government systems and coordinating with other donors is consistent with the *Paris Declaration on Aid Effectiveness* (OECD DAC 2005) commitments and the *AusAID 2010* vision.

Through AusAID's *Avoidable Blindness Initiative*, Australia's investment in eye health and avoidable blindness aims to improve the quality of life for people with low vision and blindness and to reduce the prevalence of preventable blindness.

AusAID is committed to helping poor people overcome poverty. Through its policy document "*An Effective Aid Program for Australia: Making a real difference—Delivering real results*", AusAID will continue to play its part in efforts to bring development to Pakistan. Blindness and poverty are closely related. Poor people are more vulnerable to becoming and remaining blind, and blind people are more vulnerable to poverty and exclusion. Funding the proposed project will ensure provision of quality eye care services to the poor population in Pakistan enabling them to have better quality lives, earning livelihoods and for visually impaired children to be able to have better chances of development and education.

AusAID will "invest in strengthening the overall health systems in partner countries to deliver services that benefit poor people—for instance, training doctors, nurses and midwives...", an objective to which the proposed project will work to achieve with its partners both public and private sector. By providing general and sub-speciality eye care services across Pakistan the proposed will contribute to AusAID's aid objective of empowering poor communities to improve their health through direct support to reduce the economic and social barriers that prevent the poor accessing critical health services and interventions.

Through the policy document AusAID has a firm commitment to "also help combat avoidable blindness through support for better screening and treatment". Through the proposed project, FHF will be working with its partners to screen at the community level for childhood blindness and eye diseases due to diabetes.

The proposed project will assist AusAID to "promote opportunities for all" by:

- *Enabling more children, particularly girls, to attend school for a longer and better education so they have the skills to build their own futures and, in time, escape poverty* – the screening of children at the community level and through the school program will enable children who are at risk of visual impairment to access eye care services in time to avoid them going blind and therefore achieving normal development and education.
- *Empowering women to participate in the economy, leadership and education because of the critical untapped role of women in development* – making quality eye care services available within the public sector and to remote communities through NGO partners, will

encourage women to seek services rather than to accept blindness as fate. Also as women are primary careers of blind children and disabled adults, prevention of avoidable blindness will free them to participate in employment, education etc.

- *Enhancing the lives of people with disabilities* – the proposed project will focus on treating and preventing avoidable blindness through improved access to comprehensive and quality eye care services, with the aim of reducing the impact of this particular disability on individuals, their families, communities and Pakistan.

Australia – Pakistan Partnership for Development

The Australia – Pakistan Development Partnership is underpinned by a *Memorandum of Understanding (MoU) on Partnership for Development Between The Government of the Islamic Republic of Pakistan and The Government of Australia* signed on 28th October 2011. The partnership is based on a shared commitment to pursuing a stable, secure and democratic Pakistan through broad-based social and economic development and poverty reduction in line with the MDGs. The Australian aid program in Pakistan will support activities that focus on health, education and technical training amongst others such as rural development, agriculture, etc. The project to support prevention of blindness falls within the priorities for the Australian aid program to Pakistan. Prevention of blindness has a positive effect on productivity and income earning opportunities and therefore directly leading to saving in medical costs to individuals and governments. This in turn contributes to reduction in poverty for the individual and society in general. The MoU also states that allocation and disbursement of Australian development assistance may take the form of "support through international organizations and non-governmental organizations". FHF is in a unique position in Pakistan to utilize this development assistance due to its long-standing partnership with Government of Pakistan and presence across the country.

The Fred Hollows Foundation Strategic Framework (2011- 2014)

The project conforms to The Fred Hollows Foundation organizational strategic framework 2011-2014 as follows:

- The project's goal is to eliminate avoidable blindness by the year 2020 in Pakistan. This will be done by focusing on blindness due to cataract, glaucoma, childhood blindness, diabetic retinopathy and refractive errors; by endorsing initiatives in line with VISION 2020; by strengthening comprehensive eye care services especially at secondary and tertiary levels of care; by following a development approach in eye health systems strengthening and capacity building of partners
- The project has a main objective for learning through research, which will not only inform program design, but also be used for advocacy and cross-organizational learning
- The project is underpinned by strong government and NGO partnerships, with an aim to set-up demonstration approaches that can be used for advocacy for scaling up services
- The project conforms to the Country Program Strategy for Pakistan 2013-2017 and is aligned with the following strategic objectives:
    - End avoidable blindness
    - Strengthen decentralized management of eye health services at provincial level
    - Strengthen local institutes to train mid level eye health workforce
    - Advocate for allocation of resources in the country by strengthening research capacity in eye health and provide evidence for advocacy and policy development

AusAID and The Fred Hollows Gender Equality and Development Policies

AusAID's Gender Policy: *Gender equality in Australian aid program – why and how, March 2007* emphasises that all Australia's development work will embrace gender equality.

AusAID's Health Policy states that priority will be given to the health needs of women and children, including reproductive health, nutrition and childhood diseases. The South Asia Strategy provides that the program "will continue to contribute to improved basic service delivery in our partner countries, paying attention to gender in the analysis of needs, particularly to promote the unrealised potential of women in South Asia."

An analysis of blindness prevalence surveys conducted in Africa, Asia and Industrialized countries[37] estimate that women account for approximately 2/3rd (64%) of the world's blind population. Similarly, several surveys[38] of blindness in Pakistan have reported higher rates of blindness for women[39].

Recent studies in Pakistan have demonstrated that there is an inextricable link between blindness and poverty. The Pakistan national blindness and visual impairment survey revealed that the prevalence of total blindness in poor clusters was more than three times of that in affluent clusters[40]. The same study indicates that poverty, measured at household and cluster levels with composite indices, was significantly associated with blindness in Pakistan and there was lower uptake of eye care services. The study highlighted that poorer quality services contribute to the higher rates of blindness among poor people in Pakistan. Through this project FHF envisages to build the capacity of selected local public and NGO partners in delivering quality eye care services that the poor can easily access.

FHF also recognized this fact in its Gender Equality and Development Policy. Women in developing countries have less access to and control of family financial resources to pay for treatment; fewer transport options and less likely to travel outside of their villages, lower female literacy and less decision making power. Similarly, girl children are more vulnerable compared to boys as evident from the fact of higher number of male childhood blindness cases presented in the hospital than girls with an expectation of more economic return to the family from boys

In the context of childhood blindness, poverty inhibits parents bringing their children for treatment and surgery, and in Pakistani society parents make a greater effort to bring boys than girls because they see boys being responsible for their well being in old age as opposed to girls who will be married off.

FHF is fully committed to gender equality and will address the foregoing barriers primarily by improving the accessibility and reducing the cost of public sector eye care services in urban, rural and remote areas. The cost would be influenced by making the services available in the public sector so that patients would not have to seek treatments in the more expensive private sector, and by bringing the services closer to the communities in the districts thus greatly reducing travel. It is noted that in the public sector the consultation, diagnostic and other services are free and the patient only pays the cost of consumables. In some hospitals safety networks for the very poor are also functional.

[37] Abou-Gareeb I, Lewallen S, Bassett K, Courtright P. Gender and blindness: A meta-analysis of population-based prevalence surveys. Ophthalmic Epidemiol. 2001;8:39–56

[38] Mohammad Z. Jadoon, Brendan Dineen, Rupert R. A. Bourne, Shaheen P. Shah, Mohammad A. Khan, Gordon J. Johnson, Clare E. Gilbert, Mohammad D. Khan and on behalf of the Pakistan National Eye Survey Study Group. Prevalence of Blindness and Visual Impairment in Pakistan: The Pakistan National Blindness and Visual Impairment Survey. Invest. Ophthalmol. Vis. Sci. November 2006 vol. 47 no. 11 4749-4755

[39] Anjum KM, Qureshi MB, Khan MA, Jan N, Ali A, Ahmad K, Khan MD. Br J Ophthalmol. 2006 Feb;90(2):135-8.

[40] Gilbert CE et al. Poverty and blindness in Pakistan: results from the Pakistan national blindness and visual impairment survey. British Medical Journal, 2008, 336(7634):29-32

Increased accessibility of public sector services will benefit women and the female child. The proposed Project also includes provision for community based screening for children under the age of five for eye problems and DR in adults, which would contribute towards advocacy, awareness raising and higher uptake of services by the communities.

Moreover, the screening of children in schools will be a way to reaching children and making their teachers and parents more aware of eye care issues and available services. The infrastructure provided to the up-graded units will also take into account the need for the privacy of female patients, which is important in Pakistan.

The proposed Project will be headed by a female leader, Dr. Rubina Gillani who has proven her ability to work effectively within the social and cultural constraints of Pakistan. FHF has so far tried to encourage and include female eye care staff at all level in all its initiatives wherever possible.

Sex-disaggregated data will be collected as part of setting up an effective clinical data collection system for each upgraded unit and this will be analysed on a regular basis to monitor progress on gender equality.

As evident from the research studies above, women of Pakistan are more disadvantaged than men especially in cataract surgery and access to education. The proposed project will explore the opportunities to ensure that interventions are in line with FHF guiding principles for gender equality. Following key steps would be taken for gender equality, gender equity and gender mainstreaming.

- The project lays emphasis on strengthening the services at the primary and secondary levels by making them more accessible and affordable to the local communities nearer to their homes. This will encourage women to visit the hospitals by virtue of less distance, time and reduced cost and language barriers
- The project will work with primary health care workers especially LHWs who are women. This will add on to their capacities in identification of the cases of women and children in the communities and refer them to the nearest health facility and eye care centres for treatment
- The project will provide training to the ophthalmic community and MLCEP students in gender equality and equity
- Under MLCEP training programme, the scholarships would be given to the girls from marginalized areas
- The hostel facility constructed at COAVS will provide immense benefit to the girls students ensuring their safety and protection
- The gender-segregated data will be collected at all levels where possible. The ophthalmic community will be encouraged to report sex disaggregated data from their units
- The female staff of the partner organization will be encouraged to participate in review meetings
- Advocacy will be maintained at all relevant forums for the protection and equal rights of women
- Partners will be supported in developing their gender and social protection policies
- Program planning and design that incorporates needs for services for women and girls especially in childhood blindness, diabetic retinopathy, and refractive errors
- The MoU signed between all partners will include a commitment to gender equality and no discrimination based on gender
- Community mobilization that is gender sensitive
- Evaluation criteria shall emphasize impact on gender equity

AusAID and The Fred Hollows Child Protection Policies

AusAID's *Child Protection Policy* released in January 2013 provides a framework for protecting children from exploitation and abuse in the delivery of Australia's overseas aid program. AusAID's *Child Protection Policy* follows five guiding principles: zero tolerance of child exploitation and abuse; recognition of the best interests of the child; sharing responsibility for child protection; a risk management approach; and procedural fairness.

FHF's *Policy on Child Protection* provides that child abuse is unacceptable in all circumstances and that all children have equal rights to protection from abuse and exploitation regardless of their gender, race, religion, age, disability, sexual orientation, social background and culture considers. FHF is committed to protecting children with/for whom we work and ensuring a child safe culture for all children accessing our programs. When we work through partners, we impose a responsibility to meet minimum standards of protection for children in their programs.

As a signatory to the ACFID Code of Conduct and as an AusAID accredited organisation, FHF is required to implement "policies and procedures to promote the safety and well-being of all children accessing the services and programs, particularly to minimise the risk of abuse of children".

The project activities of service delivery and human resource development are aligned with the FHF organizational policy on child protection as follows:

- Ensure that partners understand FHF has zero tolerance of child abuse.
- Partner organizations, especially those providing services for paediatric ophthalmology shall be sensitized on child protection issues
- Subspecialty development training centres supported by FHF in paediatric ophthalmology shall be oriented in child protection
- Collection of photos and case studies of children shall conform to child protection policy principles
- Community mobilization interventions shall ensure that child protection issues are not overlooked
- The involvement of children in the project will be through screening and provision of services that will be provided by staff employed and managed by the provincial governments.
- FHF will work with partners and ensure that when children are being screened or services provided that a relative accompanies them, which is often the case culturally in Pakistan.

AusAID and The Fred Hollows Counter-Terrorism Policies

According to the AusAID policy *Counter-Terrorism and Australian Aid*, August 2003 the Australian aid program "restricts environments conducive to terrorism" by "assisting countries to develop better quality, cost-effective and community-focused service delivery systems which will support sustainable delivery of services and lead to better health and education outcomes in the long term." The proposed Project will help strengthen the capacity of the public sector to address blindness. The proposed Project will improve children's access to eye care services, giving them a better chance to have an education, break the cycle of poverty and become young citizens contributing positively to society.

FHF's principal partners will be the MoH, DoH and other local NGOs. As recommended in AusAID's counter-terrorism guidelines FHF has undertaken due diligence by checking the two lists on the Department of Foreign Affairs and Trade and National Security websites and ensuring updates to the website have been taken into account. FHF will also ensure no beneficiary provided with direct funding, support or resources is included on either list.

FHF in its Counter-Terrorism Policy 2007 acknowledges its obligations under Australian laws and therefore exercises all reasonable care and makes every reasonable effort to ensure that funds and program activities are not misused to further terrorism or support terrorist activities.

The proposed project is aligned with the FHF organizational policy on counter-terrorism as follows:

- The partners shall be selected on the basis that they meet security requirements included in the policy
- On a six-monthly basis, project partners will be screened by FHF against the Australian Government's listing of terrorist organizations and individuals.
- The partners selected shall be made aware of the organizational policy
- All MoUs or other Agreements with Program Partners will include a clause requiring them to use their best endeavours to ensure that the program will not provide any direct or indirect support or resources to individuals or organizations associated with terrorism
- Funds transferred will be through appropriate banking channels with follow up monitoring and reporting by partners

AusAID and The Fred Hollows Foundation Anti-Corruption Policies

In 2011, *Transparency International* reported a Corruption Perception Index Score for Pakistan of 2.5 and included Pakistan that ranked 139th in 176 countries surveyed. Although no data is available that is directly relevant to the health sector, it has to be presumed that corruption is pervasive, although it is not believed by FHF to be so pervasive in the provision of health services.

FHF is cognisant of AusAID's Anti-Corruption Policy: *Tackling corruption for growth and development - A Policy For Australian Development Assistance On Anti-Corruption,* March 2007 and recognises that public sector service delivery may be vulnerable to "the misuse of entrusted power for private gain from petty corruption, which may include bribes or illicit payments".

FHF through its Anti Corruption Policy, 2010 is committed to promoting and adhering to the highest standards of probity and accountability in its governance and operations and takes a zero-tolerance stance towards cases of fraud and corruption in its activities and operations, both within the organisation and under its projects and programs.

FHF will work with the hospitals to strengthen data collection, registration, audit and conduct advocacy in relation to access by the underprivileged. Moreover, in collaboration with National and PCs, FHF will do the following to reduce the risk of corruption in the Project:

- Sound selection criteria for trainees based on merit applied by a broad based selection panel including FHF, concerned PC and the unit in charge
- Strengthen internal controls and audits in relation to financial management and procurement
- Conduct external audits in relation to financial management
- Directly manage the procurement and distribution of physical inputs; tenders will be sought from suppliers and payments will be made directly to suppliers from the FHF country office by designated staff
- Ensure when equipment is installed that it is taken onto the hospital stock register and that the rooms storing the equipment have appropriate security arrangements; and monitoring to check there have been no thefts or misuse of the equipment
- Support the anti-corruption policies and plans of the GoP and promote the application of the relevant rules and regulations of key counterparts.
- Build the capacity of counterparts to take anti-corruption measures

- Apply a communication strategy that delivers consistent messages on fraud and corruption.

The proposed Project will be working with the Federal level under the inter-provincial coordination division and DoH through National and PCs who provide strong leadership and drive the change process in the eye care sector. According to AusAID policy efforts to combat corruption are most successful when the change is driven internally.

AusAID's Anti-Corruption Policy highlights the fact that the efforts of various donors in any sector should be coordinated to avoid duplication and waste of resources. The proposed Project will work under the umbrella of the National Programme with other local NGOs and international NGOs to avoid duplication of resources.

As a recipient of funds from the Australian aid program, FHF is required to comply with the Code of Conduct of the Australian Council for International Development (ACFID). This code obliges a recipient organisation to 'oppose and not be a willing party to wrongdoing, corruption, bribery or other financial impropriety in any of its activities'. The code binds organisations to comply with Australian and partner government laws and regulations, and AusAID policies, 'in relation to corrupt practices, in particular the bribery of public and foreign officials'.

Disability Inclusive Strategy

FHF is committed to ensuring that people with disabilities are included in planning, implementation and monitoring and evaluation processes in a genuine manner, and that they benefit equally from project activities. However in a country like Pakistan there are inherent limitations to do this. Despite its challenges FHF will seek to do the following:

- The MoU signed between all partners will include a commitment to disability inclusive development in relations to the project implementation through non-discrimination of disabled persons and provision of eye care services to all
- FHF will ensure disability access is provided to all buildings at the eye units being renovated and the construction of MLECP girl's hostel
- FHF will also work with partners and eye unit authorities to allow for internal disability access in screening areas, wards, toilets etc
- FHF will encourage partners to collect data on people accessing eye care services with additional disability other than vision impairment and blindness. However this may not be possible at the beginning of the project but may be introduced after working in close collaboration with partners for some time and once the data collection capacity has been developed

AusAID Environment Management Guide for Australia's Aid Program 2012

FHF recognizes that environmental degradation, whether as a result of direct or indirect links to human induced accelerated climate change, is closely linked with other development issues. While 'ensuring environmental sustainability' is in itself a specific MDG, it is commonly acknowledged that a failure to secure this has the potential to undermine all efforts to achieve other MDGs. In order to be consistent as an organization committed to such development goals FHF will introduce environmental initiatives specific to its own practices within the project. FHF will work with partners to ensure that their respective government guidelines and practices regarding environmental sustainability will be followed.

- The proposed Project is not in any of the environmentally sensitive locations. The proposed Project does not explicitly or implicitly aim to have any negative environmental

impact. The only area identified as a potential concern is the renovation of eye care facilities and construction of the hostel. The hostel is being constructed within the Mayo Hospital Lahore in collaboration with the DoH, Punjab. As per the *AusAID Environment Management Guide for Australia's Aid Program 2012*, "the activity size should be considered against the size of the potential environment impact" and as such hostel construction costing $750,000 does not warrant a huge amount of funds allocated to assessment. However it would have been a different scenario for a $5 million construction project.

- FHF will work with partners to ensure that the hostel construction is environmentally sustainable and the structure fits in with the local landscape.
- FHF will work with partners to ensure the design incorporates accessibility
- FHF will ensure renovations are carried out in accordance with hospital requirements and with standards set by the GoP in line with international commitments.
- Waste management and waste disposal systems are beyond the domain of the proposed Project and beyond FHF control; however no adverse environmental impact is anticipated

Whilst the hostel construction project is a partner initiative to which FHF is contributing, FHF will ensure to make partners understand that there are large benefits to be gained from adopting a more environmentally conscious and sustainable approach at the construction phase. These approaches will require planning and careful management to achieve during the initial design consultation. As per the *AusAID Environment Management Guide for Australia's Aid Program 2012*, FHF will work with partners to make them aware that:

- Partners are responsible to follow the local environment legislation;
- Partners are responsible for assessing and managing the environment impact within their policy frameworks;
- Partners have sought the required construction approvals from their local environment managing authorities;
- Partners will ensure that any waste from the construction project will be disposed off according to the local environment guidelines; and
- Partners will be responsible to ensure that the construction is not on any heritage listed areas.

VISION 2020

VISION 2020 The Right to Sight was launched on 18 February 1999 with the aim of eliminating avoidable blindness by the year 2020. It is a global initiative between the International Agency for the Prevention of Blindness (IAPB), which represents over 70 international and national organisations involved in blindness prevention and control, and the WHO acting on behalf of its 192 Member States. VISION 2020 provides the programmatic framework for planning, developing and implementing sustainable national eye care programs. It is also a partnership that provides guidance, technical and resource support to countries that have formally adopted its agenda to eliminate avoidable blindness by year 2020.

Pakistan signed the VISION 2020 - the Right to Sight Declaration in February 2001, thereby adopting the global initiative as the strategy for controlling blindness in Pakistan.

VISION 2020 is predicated on the three core strategies of disease control, HRD and infrastructure development, incorporating the principles of PHC. WHO's strategy is to address the causes of blindness through integrating eye care into PHC, by training more eye care specialists and health care workers, and by involving donors and INGOs in combating blindness.

At the national, regional and community levels, VISION 2020 fosters strong partnerships among the Ministry of Health, international/national organisations, professional organisations, and civil society groups – brought together in a national prevention of blindness and/or VISION 2020 committee – aiming to facilitate the implementation of effective and efficient eye-care services in all districts.

The VISION 2020 Global Initiative put on its agenda several priority diseases, which are among the leading causes of blindness worldwide and can be either prevented or treated. The initial list of five, included cataracts, trachoma, Onchocerciasis (river blindness), childhood blindness and refractive error/low vision. The increase of diabetes has caused DR to be added to the VISION 2020 priority list. Cataracts have been the focus of the AusAID funded PADEC projects. Cataracts will still be addressed under the proposed project because there is a segment of poor and deserving patients that still need this surgery but cannot access it due to distance, cost (even in the public sector patients need to purchase a pack of consumables), perceptions etc. Trachoma is not a major eye health issue however; trachoma mapping is being addressed and consolidated by FHF and the National Committee for Eye Health through DFID trachoma initiative. FHF is also tackling trachoma through other projects funded by FHF and its donors. Onchocerciasis is not relevant to Pakistan. Refractive error/low vision has been included in the proposed project through school screening initiative. Childhood blindness and diabetes related blindness would also be the focus of the proposed Project.

Millennium Development Goals
Several of the MDGs depend on measures linked to the implementation of VISION 2020.

The proposed project underpins key objectives of MDGs that are agreed by UN state members for achieving sustainable development across the world. The basis of MDGs emerged from Basic Human Rights approach and Sight is one of the basic rights for existence, and thus project is strongly aligned with these MDGs. Below is summary of measures of MDGs linked with proposed project.

MDG 1: Eradicate Extreme Poverty and Hunger
Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day; Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger.
It is estimated 90% of the blind people live in developing countries[41]. The poor vision deprives the people to have an independent life with low participation and restricted income earning opportunities. Evidence from the paper of economic burden of blindness in Pakistan[42] that a productivity gain of PKRs 45 billion can be achieved by rehabilitating the visually impaired people through surgical treatments or rehabilitation support. Thus, the project interventions will enable the visually impaired people to have an improved quality of life with return to their income earning opportunities after sight restoration.

MDG 2 and 3: Achieve universal primary education, promote gender equality and empower women.
Target 3: Ensure that, by 2020, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling; Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.

Pakistan has the highest number of out-of-school children (7.3 million in 2009) in the region, representing 34% of the country's primary school-age population. Girls account for 57% of

[41] Visual impairment and blindness. Fact Sheet No 282. June 2012. World Health organization

[42] Awan H, Malik SM, Khan N: The economic burden of blindness in Pakistan: A socio-economic and policy imperative for poverty reduction strategies. Indian Journal of Ophthalmology Vol 60 (5):358-361

children excluded from primary education[43]. Moreover, nearly 4% of the children in school can have visual disability due to uncorrected refractive errors[44]. Seven to eight out every 10,000 children in Pakistan can have childhood blindness thus restricting their education[45]. The attendance of children in schools is also reduced in cases where elder members are visually impaired because of low income and dependency on children on daily living. The project will focus on developing the capacities of schoolteachers in vision screening thus promoting an early detection and treatment of visually impaired cases. Similarly local health workers would be trained to identify the cases at the early stage and successful integration into schools. Engagement with girl's school will be given focus to increase their access and build their knowledge to bring women of their families for eye screening to the nearest health facilities.

MDG 4: Reduce child mortality

Target 5: Reduce, by two-thirds, between 1990 and 2015, the under-five mortality rate.

It is estimated that six out of ten children in developing countries have high risk of death within first year of their becoming blind due to lack of appropriate screening and treatment services. Thus improving eye care services will contribute to a reduction in child mortality and further strengthening the retinopathy of prematurity services will enable to take necessary steps at the earliest stage.

[43] http://www.uis.unesco.org/Education/Pages/out-of-school-children-data-release.aspx

[44] Situation analysis of refractive services in Pakistan. Ministry of Health, National Committee for Prevention of Blindness, Sightsavers International, 2006

[45] Current status of the aetiology, prevalence and distribution of childhood blindness in Pakistan – a report. National Committee for Prevention of Blindness, Sightsavers International, 2003

ATTACHMENT 8: PROJECT LOGFRAME

Outcome/Objective	Indicator (Data to be collected)	Means of verification (e.g. reports and records)	Annual Targets and Achievements	Assumptions
Project Goal				
Goal: To improve the quality of life of people in Pakistan; especially vulnerable groups such as women and children, by reducing avoidable blindness and visual impairment by the year 2020	Reduction in prevalence of blindness across Pakistan	Rapid Assessment Survey Reports		Political and Geographical Stability in the region
Project Purpose				
Purpose – To strengthen eye health services within the health systems framework of Pakistan	Integration of eye health into provincial health policy and programs % increased sight restoration recorded by gender and type of disease treated by the program units	Provincial Health Policy documents Provincial health reports Provincial eye health plans OPD and surgical statistics		Government of Pakistan is committed for Health System Strengthening Framework
Project Objectives/Outcomes				
1. Strengthen peadiatric and diabetes related eye care delivery within existing health system	Per Cent Increase in the uptake of patients in priority eye diseases with specialized equipment and trained staff	Hospital Records Progress Reports End Project Reports M&E reports on human resources for eye health		
2. Strengthen the Governance and HMIS for Eye Health through integration into the existing health system	No of Eye Indicators reported as part of HMIS Reports	HMIS Data LHW program reports Progress Report		
3 Strengthen selected MLECP training institutes to deliver improved training programs	No of training institutes with improved capacity to deliver MLECP training No of girl students in hostel and their satisfaction with the accommodation arrangement	Independent Quality Assessment Reports Students performance reports Progress Reports of the partners organizations Sustainability report		

Outcome/Objective	Indicator (Data to be collected)	Means of verification (e.g. reports and records)	Annual Targets and Achievements	Assumptions
4. Prevent and control avoidable blindness due to five high priority eye diseases (glaucoma, RoP, corneal opacities, cataract and refractive errors)	No of patients treated in priority eye diseases with specialized equipment and trained staff	Hospital Records Monitoring Reports Hospitals records School Records		
5. Develop an evidence base for eye care service delivery approaches that can be scaled up by governments and potential partners	No of research project completed and published	Research Documents/ List of papers/documents Reports of meetings		

Objectives	Activities	Output Targets	Project location and responsibility	Timeframe
Objective 1: Objective 1: **Strengthen paediatric and diabetes related eye care delivery within existing health system**				

Objectives	Activities	Output Targets	Project location and responsibility	Timeframe
Output 1.1 Capacities of primary and secondary health care cadres in selected districts strengthened to improve referral pathways for the effective uptake and delivery of paediatric ophthalmology	1.1.1 Organize meeting with provincial PHC programs and all other stakeholders to develop strategy for LHWs training in PEC 1.1.2 Formalize the relationships with all relevant stakeholders 1.1.3 Develop the training curriculum and process for training in childhood blindness identification 1.1.4 Finalize the reporting and referral systems along the referral chain 1.1.5 Procurement of equipment and vehicle for the field 1.1.6 Deployment of project staff including optometrist, social organizer and driver 1.1.7 Training and orientation of staff about childhood blindness project 1.1.8 Prepare project related IEC materials. 1.1.9 Organize the training of trainers for LHS 1.1.10 Organize training of LHWs by LHS 1.1.11 Orientation of district / sub district ophthalmologists in childhood blindness from the pilot district CBL 1.1.12 Support the monitoring of trainings of LHWs and their work 1.1.13 Seminars and world sight day at the district level 1.1.14 Organize periodic review meetings with LHWs programs	No of Master Trainers trained No of PHC workers trained in identification of pediatric cases No of district ophthalmologists oriented No of referrals made along the chain No of cases treated disaggregated by sex	One district in KPK, Sindh and Punjab each. The CEC Cells of the respective Provinces/ the district administration of the respective districts, the district eye unit of the selected district and FHF country office.	Activity 1-4 January –July 2014 Activity 5-11 August-December 2014 Activity 12-14 ongoing till the end of activity December 2016

Output 1.2 Capacities of primary and secondary health care cadres in selected districts strengthened to improve referral pathways for the effective uptake and delivery of vitreo-retinal services	1.2.1 1.2.2 1.2.3 1.2.4 1.2.5 1.2.6 1.2.7 1.2.8 1.2.9 1.2.10 1.2.11 1.2.12 1.2.13 1.2.14	Organize meeting with all stakeholders to develop strategy for LHWs training in PEC Formalize the relationships with all relevant stakeholders Develop the training curriculum and process for training in DRB identification Finalize the reporting mechanisms and referral systems along the referral chain Procurement of equipment and vehicle for the field Deployment of project staff including optometrist, social organizer and driver Training and orientation of staff about DRB project Prepare project related IEC materials. Organize the training of trainers for LHS Organize training of LHWs by LHS Orientation of district / sub district ophthalmologists in DRB from the pilot district CBL Support the monitoring of trainings of LHWs and their work Seminars and World Sight Days at the district levels Organize periodic review meetings with LHWs programs	No of Master Trainers No of PHC workers trained in DRB identification No of district /subdistrict ophthalmologist oriented in DRB No of mid-level staff trained No of referrals made along the chain No of cases treated disaggregated by sex	One district in KPK, Punjab and Sindh each. The CEC Cells of the respective Provinces/the district administration of the respective districts, the district eye unit of the selected district and FHF country office.	Activity 1-4 January –July 2014 Activity 5-11 August-December 2014 Activity 12-14 ongoing till the end of activity December 2016 2016

Output 1.3 **Selected gaps in technology addressed in the pediatric ophthalmology and vitreo-retinal services developed through PASEC**	1.3.1 Consultation and planning with selected upgraded units for further strengthening 1.3.2 Procurement of equipment 1.3.3 Installation of equipment 1.3.4 Strengthen the reporting system in the selected units 1.3.5 Quarterly review reports	Technology gaps addressed in No of units upgraded No OPD cases of CBL and DRB at selected centers disaggregated by sex No of surgical treatments for DRB and CBL disaggregated by sex	The CEC Cells of the respective Provinces/ Selected training institutes.	Activity 1 July-December 2013 Activity 2-5 January - December 2014 Activity 6 ongoing during project life
Output 1.4 **Selected gaps in human resource development addressed in the pediatric ophthalmology and vitreo-retinal services developed through PASEC**	1.4.1 Appraisal of Human Resource Development in the selected targeted eye units of existing partners 1.4.2 Extend HRD support in the selected VR and Paediatric Ophthalmology units upgraded through PASEC	No of paediatric and VR sub-specialists trained No of medical officers trained No of Mid-level eye care personnel trained in each subspecialty	The selected training institute and FHF country office	Activity 1 July-2013 December 2014 Activity 2 July 2013 December 2015

Objective 2: **Strengthen the Governance and HMIS for Eye Health through integration into the existing health system**				
Output 2.1 Increased effectiveness of national committee for eye health and five provincial boards	2.1.1 Support the national and provincial eye health structures to develop eye health plan and coordination mechanisms 2.1.2 Support the national and provincial eye health structures to conduct six monthly performance review meetings 2.1.3 Enhance the capacity of committee member by exposure visits to relevant eye care forums.	Minutes of Six monthly meetings of the national and provincial committees / boards Provincial Strategic Eye Health Plan Documents M&E reports from CEC Cells	Five provinces Each provincial CEC Cell and FHF Country office.	An ongoing activity during the project life
Output 2.2 **The Provincial and district Eye Health Information System (EHIS) investigated in a selected project district in collaboration with respective provincial HMIS**	2.2.1 Hold consultations to conduct situation analysis and identify gaps in the selected district HMIS and provincial HMIS 2.2.2 Provide necessary equipment support to provincial HMIS and partners in piloting the district EHIS 2.2.3 Review the results of EHIS within existing DHIS	No of consultations held Report on the status of Provincial and District HMIS	CEC Cells of the selected province and FHF country office	June 2014- July 2015

Output 2.3 **An Eye Health Information System (EHIS) piloted as part of the Tertiary Health Information System (THIS) in selected centres of excellence and tertiary centres in collaboration with respective provincial HMIS**	2.3.1 2.3.2 2.3.3 2.3.4 2.3.5	Needs assessment and consultations to re-verify suitability and needs of the proposed partners for pilot project Prepare a pilot project for integrating eye health information system into tertiary health information system for selected partners Implement the pilot project in selected centre of excellence and tertiary units Develop linkages with provincial HMIS for collaboration Review the results of EHIS within existing THIS	No of units supported with THIS No of units that generated THIS reports No of eye health indicators included in THIS	DoH Baluchistan, KPK and Punjab The respective ECE Cells, DoH and FHF Country office	Activity 1 June – December 2013 Activity 2-4 January 2014-December 2015 Activity 5 ongoing till December 2017
Output 2.4 **Effective linkages and coordination established between eye and general health structures at selected tertiary and district levels through capacity building initiatives**	2.4.1 2.4.2 2.4.3 2.4.4	Needs assessment of the identified tertiary administration units Identification of capacity building opportunities in tertiary units for connectivity and improved understanding of governance issues Arrange a customized training/ visits for the managers from the selected provincial, tertiary and district administration within Pakistan Facilitate the participation of the management / administrative personnel in and the partners' review meetings of the programme	No of trainings /attendance No of exposure visits Program review meetings attended	Selected provincial partners from health department	Activity 1 –2 Jan-June 2014 Activity 3-4 July 2014- June 2016

Objective 3: **Selected MLECP training institutes strengthened to deliver improved training programs.**				
Output 3.1 **Capacity of selected institutes strengthened to deliver high quality training of mid-level eye care personnel for improved delivery of comprehensive eye care services**	3.1.1 Develop quality standards for allied eye health training programs 3.1.2 Advocacy and consultation workshop for curriculum & quality standardization with major MLECP training institutes. 3.1.3 Advocate Support implementation of the quality standards with all MLECP institute partners 3.1.4 Conduct need assessment of infrastructure and equipment of the selected partners 3.1.5 Support two NGOs and three Government institutes in training programs 3.1.6 70 MLECP training supported in the government and NGO partners 3.1.7 Conduct periodic reviews of the training programs with feedback from the students	Quality standards developed Quality standards implemented in No of institutes No of Institutes supported for capacity development. No and type of courses supported No of trained professionals	The selected training centers, FHF Country office	Activity 1-2 January-December 2014 Activity 3 ongoing Activity 4-5 July 2014 - December 2015 Activity 6 -7 ongoing tills the end of project.

Output 3.2 **Hostel for mid-level eye care students constructed at a selected center of excellence**	3.2.1 Support the institute to develop the initial lay out and preliminary cost estimates 3.2.2 Discussions with the government for joint ownership and concept approval 3.2.3 Undertake an environmental impact assessment of the construction project 3.2.4 Detailed designing of the building and work plan for the construction that incorporates accessibility 3.2.5 Preparation of the project proposal and PC-1 for government approval 3.2.6 Procurement call for the construction of the building 3.2.7 Awarding of the contract to the qualified firm 3.2.8 Extend and facilitate support to the institute in supervision and performance review to the quality of the construction 3.2.9 Procurement and Installation of accessories in the building 3.2.10 Project completion report 3.2.11 Inaugural ceremony of the hostel building	Construction work completed No of students living in hostel Percentage of girls students in hostel	Mayo hospital Lahore COAVS and FHF Pakistan	January 2014-December 2015

Objective 4: **Prevent and control avoidable blindness due to five high priority eye diseases (glaucoma, RoP, corneal opacities, cataract and refractive errors)**				
Output 4.1 **Control of avoidable visual loss from glaucoma piloted and tested at selected centres of excellence and tertiary institutions**	4.1.1 Training of key staff in advanced glaucoma management 4.1.2 Development of technology and infrastructure to establish a glaucoma unit at a selected centre of excellence / teaching hospital 4.1.3 Orientation of district ophthalmologists in glaucoma screening and management 4.1.4 Celebrate Glaucoma Awareness Days	No of ophthalmologists & support staff trained Necessary technology provided Required infrastructure developed Clinical data collection system strengthening support No of Glaucoma patients screened disaggregated by sex No of Glaucoma awareness / orientation days carried out	Selected eye units/ FHF Pakistan Country office/ respective provincial CEC Cells.	Activity 1 January 2014- December 2015 Activity 3 Jan –June 2016 Activity 4 Jan 2016 – December 2017

Output 4.2 **Screening for retinopathy of prematurity piloted and practiced at selected centre of excellence/ tertiary eye unit**	4.2.1 Consultation with selected CoE/Tertiary center for RoP services with a neonatal ICU 4.2.2 Develop and sign an MoU for start of RoP services 4.2.3 Orientation of ophthalmic team in RoP screening and management 4.2.4 Deployment of counsellor 4.2.5 Up gradation with necessary equipment and refurbishment for RoP services in an existing paediatric eye unit. 4.2.6 Finalize and review the RoP protocols to be used in screening and management 4.2.7 Support and Coordination with Paediatrician for referrals and awareness raising	No of medics & paramedics trained Necessary technology developed Required infrastructure developed No of awareness raising sessions conducted for staff dealing preterm babies and patients. Linkages developed with attached maternity units. No of preterm babies recorded in the selected neonatal units disaggregated by sex No of RoP cases screened disaggregated by sex No of RoP cases managed disaggregated by sex	One unit in KPK and Punjab each Selected eye units/ FHF Pakistan Country office/ respective provincial CEC Cells.	December 2015- Activity 6-7 January 2015 December 2016

Output 4.3 **Screening for diabetic retinopathy strengthened in selected tertiary centers**	4.3.1 4.3.2 4.3.3 4.3.4 4.3.5 4.3.6	Identification of tertiary diabetic units for DR screening services Up-gradation of the selected units with necessary equipment and refurbishment where needed Develop the screening protocols and mechanisms for patients recording Link the eye units established through PASEC with medical units for improved detection Orientation sessions for ophthalmologists and medical practitioners working in hospital Follow up for reviewing progress and technical support	No of screening facilities developed. No of diabetic patients screened disaggregated by sex No of lasers done disaggregated by sex	Two centers in Punjab	Activity 1-5 Jan-July 2014 Activity 5-7 July 2014 December 2016 Activity 8 - ongoing till the project end.
Output 4.4 **Coverage and access of cataract surgical services enhanced especially to marginalized and poverty stricken populations in selected districts**	4.4.1 4.4.2 4.4.3 4.4.4	Identify the vulnerable pockets across country Develop a strategy of static / outreach activities with local partners i.e. Al-Shifa, Al Ibrahim, DoH etc Engage local government officials in organizing eye camps Screening and surgical camps organized in the communities and government facilities	No of cataract surgeries supported through mobile units disaggregated by sex	Selected disadvantaged areas across Pakistan Respective partners organization and FHF Country office	January 2014 - December 2017

Output: 4.5: Children from selected schools screened for eye diseases and those with refractive errors rehabilitated	4.5.1 Review screening guidelines to align with WHO EMRO regional guidelines for school screening 4.5.2 Develop linkages with education department- Formalize arrangements between health and education for school screening 4.5.3 Development of IEC materials and guidelines for school screening 4.5.4 Deployment of teams in selected districts i.e. optometrist, social organizer and driver 4.5.5 Cascade training of school teachers in screening 4.5.6 Provision of spectacles and surgical support to the children in need 4.5.7 Regular review meetings 4.5.8 Collection of data from schools and reporting 4.5.9 Periodic assessment and follow ups	No of school children screened for refractive errors by school teachers disaggregated by sex No of children referred disaggregated by sex No of children provided spectacles disaggregated by sex No of school teachers trained	1-2 Districts in KPK, AJK and Sindh Balochistan subject to security CEC Cells in AJK, Punjab and KPK province	January 2014-December 2016
Output 4.6 Control of avoidable visual loss from cornea related blindness piloted and tested at selected tertiary eye unit.	4.6.1 Training of key staff in advanced cornea management 4.6.2 Protocols developed for corneal management 4.6.3 Awareness and advocacy raised among communities regarding cornea donation	No of ophthalmologists & support staff trained No of cornea patients treated disaggregated by sex	Selected eye units/ FHF Pakistan Country office/ respective provincial CEC Cells.	Activity 1-3 January 2014-December 2015

Objective 5: **Develop an evidence base for eye care service delivery approaches that can be scaled up by governments and potential partners**				
Output 5.1 **Evidence based project planning and review introduced in selected project interventions**	5.1.1 Develop research plan and strategy for FHF Pakistan 5.1.2 Identify the research themes in consultation with partners 5.1.3 Provide technical support to the partners in developing research proposals 5.1.4 Fund the identified research topics 5.1.5 Monitor the implementation of research proposals 5.1.6 Provide guidance and support to the partners through external linkages and experts 5.1.7 Finalize the research reports 5.1.8 Publish the reports	No of research projects initiated No of research project completed	All the five provinces The provincial CEC Cells and FHF Country office	Ongoing till December 2017

Output 5.2 **Improved eye health profile through increased linkages with regional and national forums**	5.2.1 Attend the regional WHO, IAPB and EMR meetings 5.2.2 Develop formal linkages with OSP 5.2.3 Support OSP to update their website with knowledge/papers 5.2.4 Facilitate the selected partners to attend regional events. 5.2.5 Support joint studies and workshops for learning and dissemination	No of linkages developed at regional level No of people visited eye health blogs for information collection No of papers/guidelines added on the website of OSP	FHF Country office	January 2014 June 2017

ATTACHMENT 9: PROJECT WORKPLAN FOR FIVE YEARS

Yearly project work plans would be prepared on the following format each year after detailed consultation with individual partners. The broad scheduling for the next five years has been done however it is not possible to do the detail activity scheduling at this point; please refer to the cost schedule for this.

The work plan for the first six months has been given below as a sample work plan.

Work plan for the period from July to December 2013

#	Activity	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
1.1.1	Organize meeting with provincial PHC programs and all other stakeholders to develop strategy for LHWs training in PEC												
1.1.2	Formalize the relationships with all relevant stakeholders												
1.1.3	Develop the training curriculum and process for training in childhood blindness identification												
1.1.4	Finalize the reporting mechanisms and referral systems along the referral chain												
1.2.1	Organize meeting with provincial PHC programs and all other stakeholders to develop strategy for LHWs training in PEC												
1.2.2	Formalize the relationships with all relevant stakeholders												
1.2.3	Develop the training curriculum and process for training in childhood blindness identification												

1.2.4	Finalize the reporting mechanisms and referral systems along the referral chain												
1.3.1	Consultation and planning with selected upgraded units for further strengthening												
2.1.1	Provide administrative support to provincial boards and national committee in organizing six monthly meetings												
2.1.2	Provide administrative and financial support to CEC cells for effective M&E and follow ups												
2.3.1	Needs assessment and consultations to re-verify suitability and needs of the proposed partners for pilot project												

ATTACHMENT 10: MONITORING AND EVALUATION PLAN

Outcome/Objective	Indicator (Data to be collected)	Means of verification (e.g. reports and records)	Frequency for data collection	Responsibility for data collection
Project Goal				
Goal: To improve the quality of life of people in Pakistan; especially vulnerable groups such as women and children, by eliminating avoidable blindness by the year 2020	Reduction in prevalence of blindness across Pakistan	National Blindness Survey (expected in 2017-2018) Rapid Assessment Reports	Planned in 2017-2018	National Committee for Eye Health INGOs
Project Purpose				
Purpose – To strengthen eye health services within the health systems framework of Pakistan	Integration of eye health into provincial health policy and programs, Xx% increased sight restoration recorded by gender and type of disease treated by the program units	Provincial Health Policy documents Provincial health reports OPD and surgical statistics	Annual Annual Annual	FHF FHF FHF
Project Objectives				
1. Strengthen paediatric and diabetes related eye care delivery within existing health system	No of eye health personnel trained % of trainees applying new skills No of children with vision impairment had preserved useful vision (gender and age disaggregated data) No of patients with DRB with useful vision preserved (gender and age disaggregated data)	Monitoring Reports Statistics of Children from hospitals PHC records Progress Reports	Annual Annual Annual Quarterly	FHF and Partners FHF and Partners FHF and Partners
2. Strengthen the Governance and HMIS for Eye Health through integration into the existing health system	Provincial Strategic Eye Health Plan Documents developed No of eye health indicator included in the provincial and district HMIS	Minutes of Meetings National and provincial eye health plan documents HMIS reports Progress /Monitoring reports	Six Monthly Reports Annual Annual Quarterly	National Committee CEC Cells and FHF HMIS and FHF HMIS and FHF

Outcome/Objective	Indicator (Data to be collected)	Means of verification (e.g. reports and records)	Frequency for data collection	Responsibility for data collection
3 Strengthen selected MLECP training institutes to deliver improved training programs	No of training institutes with improved capacity to deliver MLECP training No of girl students in hostel and their satisfaction with the accommodation arrangement	Independent Quality Assessment Reports Students performance reports Progress Reports of the partners organizations Sustainability report	Biannual Annual Six monthly Quarterly Annual	Third party FHF and partners FHF FHF and partners FHF
4. Prevent and control avoidable blindness due to five high priority eye diseases (glaucoma, RoP, corneal opacities, cataract and refractive errors)	No of people screened disaggregated by sex No of cataract surgeries disaggregated by sex No of patients with diabetic retinopathy with useful vision preserved disaggregated by sex No patients with glaucoma with useful vision preserved disaggregated by sex No pre-terms/low birth weight successfully treated for ROP disaggregated by sex No school children treated for refractive errors disaggregated by sex	Hospital Records Monitoring Reports Hospitals records Monitoring Reports Hospitals records Monitoring reports Progress Reports Record of beneficiaries School Records	Annual Six Monthly Annual Six monthly Annual Six monthly Six Monthly Annual Annual	Partners and FHF FHF Partners and FHF FHF Partners and FHF FHF FHF FHF and partners FHF and partners
5. Develop an evidence base for eye care service delivery approaches that can be scaled up by governments and potential partners	No of research projects initiated and completed No of linkages developed at regional level No of papers published and presented in regional forums	Research Documents/ Research Published No of new projects List of papers/documents Reports of meetings	Annual Annual Annual	FHF FHF FHF

ATTACHMENT 11: PROJECT BUDGET

	Values in AUD				
Description	**Grants Budget**	**YR1**	**YR 2**	**YR 3**	**YR 4**
A-Project Support Costs					
ADP - Project-related advocacy (e.g. launches) - 2ADP410	152,330	21,761	43,523	43,523	43,523
DCL - Other treatment - 2DCL390	75,881	10,840	21,680	21,680	21,680
HRD - Other HRD Activities - 2HRD910	66,594	9,513	19,027	19,027	19,027
IND - Construction of Eye Facilities - Primary - 2IND110	47,468	6,781	13,562	13,562	13,562
PAG - Office Running Costs - 3PAG230	122,739	17,534	35,068	35,068	35,068
PAG - Organisational Development - 3PAG340	7,336	0	2,445	2,445	2,445
PAG - Personnel - 3PAG110	301,440	43,063	86,126	86,126	86,126
PCX - Capital Expenses - 3PCX110	7,825	7,825	0	0	0
A-Project Support Costs Total	**781,612**	**117,318**	**221,431**	**221,431**	**221,431**
B-Project Management Costs					
PAG - Office Running Costs - 3PAG230	222,222	55,556	55,556	55,556	55,556
PME - Monitoring & Coordination - 3PME210	133,266	53,453	26,604	26,604	26,604
PME - Review & Evaluation - 3PME310	82,703	2,337	26,789	26,789	26,789
B-Project Management Costs Total	**438,191**	**111,345**	**108,949**	**108,949**	**108,949**
1- Strengthen paediatric and diabetes related eye care delivery within existing health system					
ADP - Project-related advocacy (e.g. launches) - 2ADP410	21,518	11,737	9,781	0	0
DCL - Cataract treatment - 2DCL310	114,495	10,534	38,371	37,960	27,631
DCL - Refractive error correction - 2DCL360	8,803	880	2,934	2,934	2,054
DCL - School screening - 2DCL220	344,190	30,282	113,556	115,317	85,035

	Values in AUD				
Description	**Grants Budget**	**YR1**	**YR 2**	**YR 3**	**YR 4**
DCL - Service Institution Strengthening - 2DCL410	12,226	3,057	3,057	3,057	3,057
HRD - Ophthalmology Short Courses - 2HRD140	1,345	734	611	0	0
HRD - Primary Eye Care Training - 2HRD310	23,768	13,468	10,299	0	0
HRD - Sub Speciality education and training - 2HRD110	76,007	31,631	43,144	1,232	0
IND - Equipment – Medical - Secondary - 2IND212	40,610	24,227	16,383	0	0
IND - Equipment – Medical - Tertiary - 2IND213	94,718	94,718	0	0	0
IND - Equipment – Non Medical - Secondary - 2IND222	78,981	37,901	41,080	0	0
IND - Equipment – Non Medical - Tertiary - 2IND223	14,671	14,671	0	0	0
PME - Monitoring & Coordination - 3PME210	77,465	10,563	25,822	25,822	15,258
1- Strengthen paediatric and diabetes related eye care delivery within existing health system Total	**908,798**	**284,404**	**305,037**	**186,321**	**133,035**
2- Strengthen the Governance and HMIS for Eye Health through integration in the existing health system					
ADP - Government V2020/PBL Engagement - 2ADP220	106,951	19,781	39,074	29,293	18,803
IND - Equipment – Non Medical - Secondary - 2IND222	4,890	4,890	0	0	0
IND - Equipment – Non Medical - Tertiary - 2IND223	16,628	16,628	0	0	0
2- Strengthen the Governance and HMIS for Eye Health through integration in the existing health system Total	**128,469**	**41,299**	**39,074**	**29,293**	**18,803**
3- Strengthen selected MLECP training institutes to deliver improved training programs					
HRD - In-service Training and Continuing Prof Dev - 2HRD120	176,056	0	117,371	58,685	0
HRD - Mid-Level Eye Care Training - 2HRD210	357,981	44,748	89,495	89,495	134,243
HRD - Training Institution Strengthening - 2HRD810	29,343	0	29,343	0	0
IND - Construction of Eye Facilities - Tertiary - 2IND113	733,568	94,106	529,741	109,721	0
IND - Equipment – Medical - Tertiary - 2IND213	49,053	0	49,053	0	0
IND - Equipment – Non Medical - Secondary - 2IND222	49,053	0	49,053	0	0

	Values in AUD				
Description	**Grants Budget**	**YR1**	**YR 2**	**YR 3**	**YR 4**
3- Strengthen selected MLECP training institutes to deliver improved training programs Total	**1,395,053**	**138,854**	**864,055**	**257,902**	**134,243**
4- Prevent and control avoidable blindness due to five high priority eye diseases					
ADP - Project-related advocacy (e.g. launches) - 2ADP410	12,226	2,445	4,890	4,890	0
DCL - Cataract treatment - 2DCL310	576,795	82,399	164,799	164,799	164,799
DCL - Diabetic retinopathy treatment - 2DCL330	513	73	147	147	147
DCL - Other treatment - 2DCL390	12,676	0	4,225	4,225	4,225
DCL - School screening - 2DCL220	398,698	60,088	131,595	131,595	75,420
HRD - In-service Training and Continuing Prof Dev - 2HRD120	7,825	0	7,825	0	0
HRD - Sub Speciality education and training - 2HRD110	136,150	29,343	24,061	63,185	19,562
IND - Construction of Eye Facilities - Secondary - 2IND112	4,401	4,401	0	0	0
IND - Construction of Eye Facilities - Tertiary - 2IND113	11,982	2,201	9,781	0	0
IND - Equipment – Medical - Secondary - 2IND212	315,297	163,146	110,309	41,843	0
IND - Equipment – Medical - Tertiary - 2IND213	192,938	40,786	110,309	41,843	0
IND - Equipment – Non Medical - Secondary - 2IND222	7,825	7,825	0	0	0
IND - Equipment – Non Medical - Tertiary - 2IND223	1,956	1,956	0	0	0
IND - Renovation of Eye Facilities - Secondary - 2IND122	23,963	4,401	19,562	0	0
IND - Renovation of Eye Facilities - Tertiary - 2IND123	29,343	0	9,781	19,562	0
4- Prevent and control avoidable blindness due to five high priority eye diseases Total	**1,732,589**	**399,064**	**597,284**	**472,088**	**264,152**
5- Develop an evidence base for eye care service delivery approaches that can be scaled up by governments and potential partners					
REH - Prevalence Studies – Other - 2REH120	115,415	28,854	28,854	28,854	28,854
5- Develop an evidence base for eye care service delivery	**115,415**	**28,854**	**28,854**	**28,854**	**28,854**

	Values in AUD				
Description	**Grants Budget**	**YR1**	**YR 2**	**YR 3**	**YR 4**
approaches that can be scaled up by governments and potential partners Total					
Grand Total	**5,500,127**	**1,121,138**	**2,164,683**	**1,304,838**	**909,467**

ATTACHMENT 12: RISK MATRIX

Log Frame Reference	Risk Event	**L**	**I**	**Strategy to address risk**	**Timing**
1.1, 1.2	Capacities of LHWs are limited in identification of eye diseases, they have restricted mobility. LHWs have other programme priorities especially family planning, vaccination, etc. Motivation of LHWs becomes low when referrals are not given attention or priority in the hospitals.	M	M	Training of LHWs will be organized in areas of primary eye care with a focus on childhood blindness and diabetic related blindness. LHWs will be provided phone contact numbers of the screening unit for advice and guidance if there are challenges in referral of cases. The project activities will be well planned and coordinated with the primary health care coordinators to avoid any over load or clash with other activities. Incentives for the best performing LHWs would be announced.	Continuous
2.1	Meetings of National Committee and Provincial Boards are not held on time and delays in the implementation of decisions taken in the board	M	M	Administrative and programme support extended to the national committee and provincial boards to organize the meeting on time with follow-ups by FHF. Development of national and provincial strategic plans will be supported to develop the direction of eye health in Pakistan. Secretaries & D. G health are members of National / Provincial committed in the respective provinces to help approve and implement the decisions of the boards.	Continuous
2.2, 2.3	Delays, under reporting and missing data of eye health to be	H	M	Capacity development of the staff engaged in HMIS	Continuous

	collected at the community, district and tertiary levels			reporting will be arranged. Effective engagement through MoU and periodic review meetings will be maintained to feedback on HMIS reporting.	
2.4	Government organizations are less inclined to implement and review its organizational effectiveness strategy			Engagement through open dialogues and feedback is maintained. Periodic review of organizational effectiveness review reports is organized with partners. FHF provides technical assistance through experts, equipment and technology to enhance the effectiveness. Coordination is improved through connectivity and linkages development	Continuous
3.1	Quality Standards for Eye Health Training Programme at MLECP are difficult in implementation by the partner training organizations	H	H	FHF and other INGOs work together in facilitating the consensus building among training partners for national standards of MLECP training. The periodic reviews of training programme are supported by FHF and INGOs for sharing among training institute for learning and replicating good practices. Effective advocacy and lobbying is maintained for creation of faculty positions in the training institute through provincial boards and provincial coordinators.	Continuous
3.2	Administrative Delays in the approval and construction of hostel facility at the CoE	M	M	Necessary administrative approval is in place for space and provincial government will provide approval to PC-1 with assurance to meet operational costs. Detailed construction plans will be prepared for quality assurance, and track record of the contractors will be thoroughly assessed.	2013-2016
3.3	Challenges of Leadership successions at the partner training institute for quality assurance and sustainability especially in the context of faculty development	M	H	Support training partner organization to strengthen their linkages training institutes. Training of trainers workshops for faculty and career counseling for students to increase their interest and motivation in the course	Continuous
4.1, 4.2, 4.3	Trained and experienced faculty for Mid Level Eye Care Personnel is available and motivated	M	M	The faculty members are provided training and exposure opportunities. Appreciation mechanism likes awards; certificate and exposure visits will be arranged for high performing staff working in difficult and hard areas.	Continuous
1.1, 1.3, 3.1, 3.4, 4.1, 4.2,	Operation and Maintenance of the equipment provided by the project can be challenging	M	M	Under procurement arrangements, service contracts with suppliers will be part of the procurement. MoUs and	Continuous

4.2				APAs will clearly outline the responsibility of recipients.	
5.1	There may be limitations in skills and expertise needed for Research and Advocacy initiatives	M	H	The partners will be provided support in developing capacities in research through training workshops and linkages development with international institute. Technical experts and organizations will be engaged in executing the research and advocacy initiatives with mentoring to the partner organizations.	Continuous
	Insecurity and Instability hampers programme activities in KPK and Baluchistan. The war on terrorism reduces the public spending on development initiatives especially health, education and disability	H	H	Update travel intelligence frequently; Enhance the capacities of partners in need identification and M&E, and improve phone and conference calls Enhanced advocacy and visibility of the programs to attract donors and government with evidence; Encourage and train the partners in resource mobilization	Continuous
	The performance based M&E system may be challenging	L	H	Necessary base line will be established M&E framework agreed with partners and followed rigorously	Continuous

Key: L = Likelihood H = High, M = Medium, L = Low I = Impact H = High, M = Medium, L = Lo