INDIA CHILDHOOD BLINDNESS INITIATIVE (ICBI)

Manual of Procedures

Abbreviations

ASHA – Accredited Social Health Activists

ANM – Auxillary nursing midwives

AWW – Anganwadi worker

CBO – Community based organization

CEC - Children's Eye Centers

DISE - District Information System for Education

GIS – Geographic Information System

GPS – Geo positioning system

HM – Head master / Head mistress

HRM – Human resource management

IAPB - International Association for Prevention of Blindness

ICBI – India Childhood blindness initiative

ICDS – Integrated Child development services

IEC – information education and communication

IPD – Inter pupillary distance

IP – Inpatient

IT – Information technology

KAP – Knowledge attitude and practices

NGO – Non-governmental organization

NPCB – National Program for prevention and control of blindness

VA – Visual Acuity

VC – Vision center

VI – Visual impairment

VLEG - Vision Loss Expert Group

QA – Quality Assurance

WHO – World Health Organization

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Foreword

Dr. Rishi Raj Borah, Country Director, Orbis India

In 2001, Orbis initiated discussions on eye care needs in India- identifying existing gaps and developing strategy on its way forward to strengthen quality eye care. Childhood and corneal blindness were identified as the most critical areas of work in the long-range strategic plan for Orbis in India. This led to the launch of India Childhood Blindness Initiative (ICBI) in 2002, which is today one of the flagship programs of Orbis in the country.

ICBI focused on identifying tertiary hospitals in the country, and work with these hospitals to develop child friendly infrastructure, and more importantly, build pediatric ophthalmology department, identify the right team, and build capacity of the team to provide quality eye services to children. Orbis has been instrumental in creating and promoting the idea of a pediatric ophthalmology team consisting of the pediatric ophthalmologist, optometrist/orthoptist, pediatric anaesthetist, pediatric nurse and other support staff such as pediatric patient counsellors and outreach coordinators. Orbis initiated training programs for doctors, nurses, other eye health professionals, community outreach teams and medical technicians. We also support local hospitals and clinics with infrastructure and systems to provide primary and tertiary care, as well as improve public awareness around eye health. Over the years, Orbis has successfully established 33 Children's Eye Care Centers across 17 states in India. The availability of pediatric ophthalmology service care was 1 for 400 million in India in 2000 and with Orbis's contribution it has improved to 1 for 20 million across these states. 20 years since the launch of ICBI initiative, today, Orbis is considered as a leader in contributing to the establishment of pediatric ophthalmology as a distinct sub-specialty in the Indian ophthalmology landscape.

This Manual is a step towards celebrating the success of ICBI and sharing our processes and systems while implementing the initiative. I would like to thank all my colleagues at Orbis to support and guide the India team in implementing ICBI. We sincerely hope that the manual brings in a depth of information for each one of us, so we can not only replicate some of the best practices adopted in ICBI, but also improve the initiative further.

Dr. Rishi Raj Borah,
On behalf of Orbis India team

Acknowledgements

A BIG THANK YOU to all the partners we have collaborated with in the last 20 years, for supporting us in strengthening child eye care through ICBI.

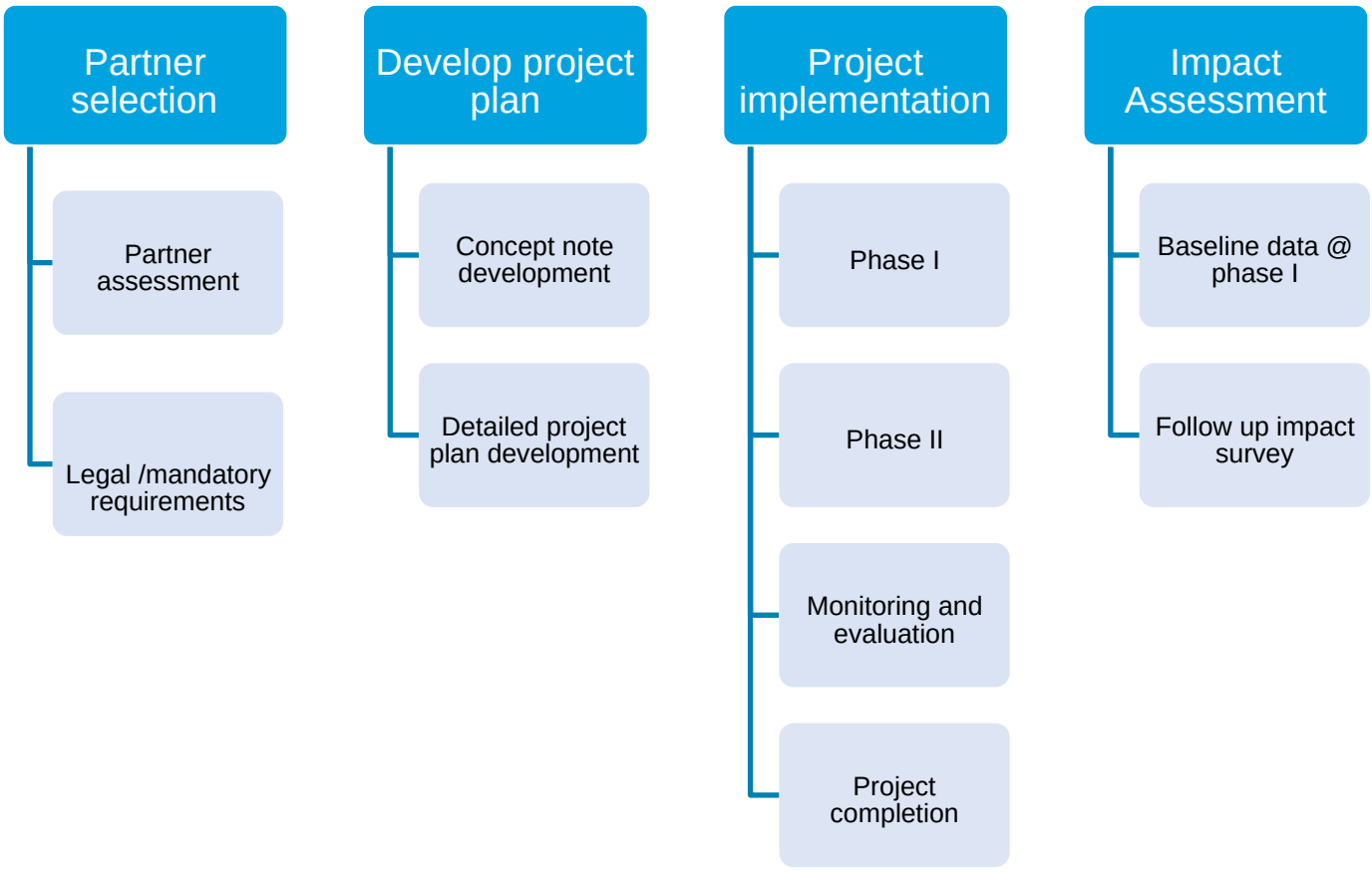
Partner Name	Location
Alakh Nayan Mandir	Udaipur
Akhand Jyoti Eye Hospital	Mastichak
Bangalore West Lions Super Specialty Eye Hospital	Bangalore
Christian Medical College and Hospital	Ludhiana
Choithram Netralaya	Indore
C.L. Gupta Eye Institute	Moradabad
Drashti Netralaya	Dahod
Dr. R.P Centre for Ophthalmic Sciences (AIIMS)	Delhi
Dr. Shroff's Charity Eye Hospital	Delhi
Gandhi Eye Hospital	Aligarh
Global Hospital Institute of Ophthalmology	Mount Abu
Himalayan Institute Health Trust	Dehradun
H.V. Desai Eye Hospital	Pune
Kalinga Eye Hospital and Research Centre	Dhenkanal
Khairabad Eye Hospital	Kanpur
Lions NAB Eye Hospital	Maharashtra
Little Flower Hospital and Research Centre	Angamaly
Lotus Eye Hospital	Mumbai
MGM Eye Institute	Raipur
M. M. Joshi Eye Institute	Hubli
Ramakrishna Mission Hospital	Itanagar
Regional Institute of Ophthalmology	Kolkata
Sankara Eye Hospital	Guntur
Sadguru Netra Chikitsalaya	Chitrakoot
Sadguru Sankalp Netra Chikitsalaya	Anandpur
Sahai Hospital & Research Centre	Jaipur
Shri Ganapati Netralaya	Jalna
Siliguri Greater Lions Eye Hospital	Siliguri
Srikiran Institute of Ophthalmology	Kakinada
Sri Sankaradeva Nethralaya	Guwahati
Suraj Eye Institute	Nagpur
Susrut Eye Foundation & Research Centre	Kolkata
Vivekananda Mission Asram-Netra Niramay Niketan	Haldia & Amtala

Background

In 2000, Orbis International established its office in India. Soon after that, it identified childhood blindness as a priority area of work. The India Childhood Blindness Initiative (ICBI) was subsequently launched in 2002 with the aim of ensuring that the children of the country would have access to affordable, high-quality and comprehensive pediatric eye care for generations to come. ICBI is the flagship program of Orbis International in India and has successfully developed the largest national network of Children's Eye Centers (CEC) in the world. This network consists of 33 CECs across 17 states and reaches out to more than a million children annually, providing comprehensive and tertiary child eye health services. In addition, three Pediatric Ophthalmology Learning and Training Centers (POLTCs) were developed to support the training requirements of the network. It is a matter of pride that some CECs developed through ICBI can now train staff of other CECs and hospitals, beyond the ICBI network. The objective of this manual is to provide a guide to program managers for:

1. The process involved in developing a partnership with eye hospitals.
2. The process of project planning and implementation.
3. Understanding the overview on children eye care centres.
4. Assessing the impact of the intervention.
5. Collaborating and developing future partnership strategies.

The ICBI Process – An Overview



Partner selection

Partner Assessment

Partner Identification and selection:

India is home to more than 20 percent of the world's blind population and the largest number of blind children in one country. However, since children constitute only 3 percent of the world's blind population, childhood blindness has not been given its due importance as compared to other causes of blindness and visual impairment. In 2000, there were only four comprehensive tertiary pediatric eye care centers in India. At that time, with a population of 1 billion, India needed 100 CECs as per the World Health Organization (WHO) guidelines of one center per 10 million population. Over the last two decades, Orbis has established 33 CECs across 17 states.

Orbis continues to partner with eye hospitals in the country and maintains a list of potential hospitals, identified through team interactions at various occasions. While finalizing the location of new CEC, priority or preference is given to those states or regions which lack CECs. For instance, the Northeast region has only two CECs which is highly inadequate, considering the challenges the region faces in terms of difficult terrain and accessibility. The idea is to establish CECs across the country and not just in a few pockets of the country.

This section attempts at capturing the workflow that will be followed for forging new partnerships and to reach out to a wider population across the country.

Mandatory Requirements/ Legal Documentation for Partnership:

1. A society registered under the India Societies Registration Act, 1860 (Act XXI of 1860 or any such act resolved by the State) or a hospital established by the Government of India or Indian Trust Act Registration as a public charitable trust.
2. Permanent Registration under Foreign Contribution Regulation Act, 1976.
3. Experience in providing eye care services for a minimum of three years and no record of misappropriation of grant.

If the organisation's answer to any of the above points is "no", it will immediately disqualify it from entering into a partnership with Orbis, and the next steps like assessment visit will not be planned.

Partner Assessment Process

Orbis will look for new partner hospitals to work with in its endeavour to decrease the prevalence of visual impairment in India. When a request comes in from a new organization or hospital, Orbis will send them the 'Initial Assessment Form for Potential Orbis Partner' Annexure 1 by email and request the concerned groups to respond within a month. A reminder for their response would be sent at the end of three weeks.

An alternate scenario could be approaching a prospective organisation to explore the possibilities for a partnership. This will be done through emails/calls between the senior leadership at Orbis and the organisation. Even under this scenario, the 'Initial Assessment Form for Potential Orbis Partner' will be shared following the initial emails/calls.

'Initial Assessment Form for Potential Orbis Partner' is a Word document containing sections like organisation contact details, vision, mission, level of care and services provided, details of the catchment area, external collaborations, financial status of the last three years, current interest in partnering with Orbis, etc.

Once the response is received from the organisation, the Orbis India Team, consisting of the Country Director, Assistant Director – Programs and Director – Finance, Compliance and Legal Affairs, will review the document, and a decision will be made, based on whether the organisation meets the basic requirements or not.

In addition to the above requirements, it is important that the hospital's or organisation's ideology aligns with the Country Strategic Plan (CSP) to a large extent. CSP is a document made by the country office and is regularly updated and aligned with the Global Strategy Plan of Orbis.

If either the mandatory requirements and/or the ideology do not align with the CSP, then the partner is informed of the same by a letter from the Country Director or by email. Once the hospital/organisation meets the mandatory criteria, next steps like sharing the partner assessment forms will be initiated. Sharing an assessment form and meeting the mandatory requirements does not mean that the organization has been selected, or Orbis will enter into a partnership.

Partner Assessment Forms

If the mandatory requirements are met and the organisation's ideology is aligned to the CSP, Orbis will email the Detailed Partner Assessment Form (PAF) – (Annexure2) to the organisation. The mail will be sent by a member from the Program Development team and a call will be scheduled with the person responsible for filling the form to brief him/her on various sections of the form.

Prior to selection of a partner for any given project/partnership, it is essential to do a detailed assessment of the partner. The assessment will ensure that the selection of the partner is as informed and objective as possible. The PAF has 10 sections for which the organization must provide information: Basics, Governance, Human Resource, Service Delivery, Infrastructure, Data Management, Financial Management, Academics, Research, and Advocacy.

The organisation will get a maximum of two months to respond. At the end of one and a half months, a reminder will be sent to the organisation, if required. When the PAF is sent to the organisation, a team will be formed – Project Team – which will work with the organisation for future communications and associations. This team will consist of the Country Director, Assistant Director – Programs, Senior Program Manager/ Program Manager, Director – Finance, Compliance and Legal affairs, and Manager – Program Development. The Manager – Program Development will be the point person, and he/ she will be in touch with the organisation and address any queries regarding the completion of the format during the period.

Once the PAF is shared, it will be analysed on whether the form is filled completely, and adequate information is shared or not. The Manager – Program Development will get in touch with the organisation in case of any ambiguity or lack of information.

Assessment Visit to Potential Partner Hospital

The Orbis team will consult the organisation and plan a visit. The agenda of the visit will be communicated in advance so that the organisation can plan the meeting and work on a convenient date and detailed schedule. All communication with the organisation will be done through emails by the Manager – Program Development. Other ''Project Team'' members will be marked in the mails.

Prior to the visit, the organisation must be informed about the key aspects of the visit, including the following:

- Information about the visiting Orbis team members
- List of members from the organisation whose presence is a must during the visit
- Any specific logistical requirements like travel and accommodation arrangements for the visiting team
- Any facility visits beyond the main/base hospital or field visits.

The objectives of the visit are:

- To introduce Orbis and its work to the organisation
- To meet the leaders and decision-makers of the organization
- To validate the information in the assessment forms shared by the organisation (by touring different departments of the facility and interacting with staff members)
- To educate the organization on the process of involvement with Orbis
- To prioritize the areas of involvement for this partnership
- To develop the concept note and collect relevant information

Orbis Team composition for the visit

- Country Director
- Director – Finance, Compliance and Legal Affairs
- Associate Director – Program
- Senior Program Manager/ Designated Program Manager
- Manager - Program Development

During the visit, the presence of certain people from the organization is a must, and it includes:

Board Chair	Head of Ophthalmology Section

Director	Medical Director
Finance Manager/Treasurer	IT Section Head
CEO	In-charge of Laboratory services

A sample agenda of the visit is detailed below

Meeting the top management of the organization like the board members/ trustees, medical director, head of management/ administration, head of ophthalmology team and other key staff members of the organisation. The organisation should be encouraged to make a presentation about the facility and services provided, catchment area, etc.

- Touring the hospital
  - Patient registration
  - Patient waiting areas
  - Patient flow from registration, doctors visit and follow up (spectacles /investigations/ pharmacy)
  - Physical layout of the services
  - Examination of the patient – assess the comprehensiveness of the examination
  - Operating room
  - In-patient facility
  - Standard operating protocols
  - Support services
  - Data management system
- Meeting the staff – doctors, paramedical staff, support staff, outreach manager/ coordinator, IT management team and finance team
- If relevant, observing an outreach camp/ school screening site/ vision center (not mandatory)
- Reviewing SWOT analysis with the organisation's team to prioritise areas of involvement based on Orbis team's assessment of the organisation
- Closing meeting with the entire team – administrative and medical team – to brief on the highlights of the visit, areas of involvement that have been prioritised, the process of further collaboration, if possible, with the organisation

The duration of the visit will be of two days. It could be three days only if there's a field visit (school screening site, outreach camp, secondary facility/ vision centers).

Partner Assessment Tool (PAT) and Scoring

After the visit, PAT will be used to arrive at a score for the organisation.

- PAT (Refer Annexure 3) is a system of weighted scoring that will enable the Project Team to objectively assess the capabilities of the potential partner and prioritize the areas of need.
- The information for completing PAT will be taken from PAF and onsite visit.
- PAT is an excel sheet with a worksheet for each of the 10 sections and a summary sheet. Each section will be scored on the scale of 1 to 5, with 1 being poor and 5 being excellent. This will populate the summary sheet scores and generate an overall weighted score for the partner.
- Quality, an extremely important criterion, has been embedded within the other sections due to its all-pervasive nature and, hence, does not have a distinct score of its own.
- Using individual headings, the areas of need will be identified and listed out, irrespective of the overall PAT score. These will be addressed, in part or whole, while developing the project plan.

Orbis considers that the final score will not be a contributing factor in deciding whether to go ahead with a project or partnership with a particular organisation, but the PAT score will guide Orbis in identifying the possible areas for intervention. In fact, it is believed that lower the score, the higher would be the need for intervention by Orbis. In the case of multiple facilities or organisations being assessed simultaneously, the organisation having the lowest score will be given priority. Certainly, other factors like availability of services in the area, socio-economic status and location will also play a role before a final decision is taken.

Summarization tool

A summarization tool has also been developed wherein each organization is assessed on six parameters – 5A + Q:

- Availability
- Affordability
- Accessibility
- Acceptability
- Awareness
- Quality

Refer to Summarization Tool in Annexure 4

Mandatory requirements/legal documentation for partnership

- A society registered under the Societies Registration Act, 1860 (Act XXI of 1860), Not-for-profit company incorporated under Section 8 under Companies Act, 2013 (Act 18 of 2013), organization registered as a public charitable trust under relevant act, organization established by the Government of India or incorporated under any such act resolved by the State.

- Registration under Foreign Contribution Regulation Act, 2010.

- Experience in providing eye care services for a minimum of 3 years and no record of misappropriation of grant.

Once the response is received from the organization, the Orbis India team - Country Director, Associate Director – Programs, Director - Finance and Compliance, and Senior Program Manager will review the document and assess the organization for a potential partnership.

If the organization does not meet the mandatory or legal pre-requisites for partnership, Orbis will immediately disqualify the organization for partnership and a ‘Regret Letter’ will be sent to the organization detailing the reason.

Develop Project plan

Concept Note Development

A concept note should contain outline of the project and must be developed as per the Orbis standard concept note template, which cannot exceed one page. The initial draft concept note must be developed along with the partner hospital team. The project's budget estimation, including contribution from the partner, should also be worked out before developing the concept note.

The draft concept note will be circulated among relevant team members of Orbis for their inputs. The revised version will be shared with Associate Program Director/ Program Director and Country Director for their review and approval. Once finalised by the Country Director, the concept note will be shared with the partner for comments and consent. Any comments from the partner would be addressed. Though it's not necessary to include all the suggestions given by the partner, a proper explanation will be given to them for the non-inclusion.

Following the consent from the partner, the concept note will be shared with Orbis International's (OI) development team. Once approved by the OI team, the concept note will be uploaded on Indicata. If the global team requests for a revision, then the concept note will be amended by the Orbis India Team. The partner will be kept informed of the changes via email and telephonic communication. Once all stakeholders agree to the changes, the concept note will be amended on Indicata and sent for approval again. If the concept note is approved, the team will move on to planning the project in detail. The concept note template has the following sections:

Disease focus: There are eight Orbis clinical categories and one needs to choose the focus area from the categories listed below. A project can also focus on more than one disease category.

1. Cataract
2. Retina
    - DR
    - ROP
    - Uveitis
    - Trauma
3. Pediatric Ophthalmology
    - Strabismus
    - Anterior segment - Cataract, Glaucoma, Cornea
    - Retinoblastoma
    - ROP
4. Glaucoma
5. Cornea
    - Trachoma
    - Eye banking
    - Dry eye/ocular surface

6. Oculoplastics
    - Trichiasis
    - Trauma
    - Ocular oncology
7. Optometry
    - Refractive error
    - Low vision
8. Neuro Ophthalmology

Pitch: This part must contain 1-2 sentences that describe the project.

Problems: This section should list the problems that directly relate to the project and, thereby strengthen the case of why the project is necessary. Global or national statistics should not be part of this section.

Orbis solution: This section of the concept note should describe the solutions that address the issues outlined in the problems section. The solutions described must be from the eight Orbis solution categories which are listed below:

1. Child Eye Health
    - School screening
2. Human Resources for Eye Health (HReH)
    - Access to medical education
    - Assessment of human resource allocation in eye care
    - Capacity building
    - Education, school health education
    - Emphasize eye care team approach
    - Health education
    - Improve training models (also, training program development)
    - Training (also, clinical training, basic eye health training)
    - Training (FEH, HBT, fellowships, wet labs): Ophthalmology, nursing, anaesthesia, BME, community eye health and optometry
    - Technology and Innovation: Training methods, Cybersight, distance learning, blended learning, simulation and virtual reality
    - HBT
    - FEH
    - Wet Labs
3. Primary Eye Care
    - Community outreach, outreach services
    - Screening (camps)

- Vision centers

4. Trachoma elimination and the SAFE strategy
5. Advocacy
    - Advocacy and government linkages
    - Enabling environment
6. Creation of Eye Health Referral Networks
    - Referral Network
7. Demand Generation
    - Awareness (also, community awareness program)
    - Behavioural change communication
8. Developing Sustainable Eye Care Services and Systems
    - Equipment (also, prevision of equipment, provision of equipment, equipment and supplies)
    - Health insurance scheme
    - Institutional strengthening (also, strengthen institutional capacity)
    - Leadership
    - Quality assurance
    - Quality management system
    - Strengthen infrastructure
    - Access (also, public awareness, increase access, health education)
    - Availability of the service
    - Quality in eye care
    - Technology and innovation: diagnostic and service delivery such as all grading, non-medical graders, low-cost ophthalmic imaging devices, etc.
    - Construction
    - Renovation

Sample activities: This section should include some major and/ or innovative activities for each of the solution categories mentioned.

Impact statements: This should be a powerful statement that clearly states the expected impact of the project. Different than a result or outcome statement, the impact should inspire and demonstrate the influence this project may have in behaviour and/ or institutional change related to Orbis's mission and vision.

Concept Note template in Annexure 5

Detailed project plan development

Project Plan Development

The project plan will require sections to be filled both by the partner and the Orbis India Office. This template must always be used, unless responding to a funder's request for bids with a specified proposal template. When using this template, the project plan should not exceed 12 pages (excluding appendices). The template will consist of the following sections:

Basic Information

This section gives a brief overview of the project name, partners, duration, and the estimated budget.

Proposed Project

1. **Executive summary** (1 page only): This section includes the project plan's summary, with a description of the project objectives, geographic location, intended beneficiaries, partner institutions, key activities and intended results.

2. **Problem statement and rationale** (2-4 paragraphs): Describe the following with citations for any figures and quotes (insert the full citations in footnotes at the bottom of the page):
    - What are the main eye health problems/ needs that the project will address (prevalence or incidence of problems and their distribution in the population)?
    - What are the main service delivery problem(s) the project will address (for example, lack of particular capacities in a partner institution)?
    - Why is it important to address these problems?
    - Are there existing resources available, such as other organisations or initiatives active in addressing different aspects of the problem in the local context? If so, how would our work complement those initiatives?

3. **Goals and objectives** (up to 1/3 page): In a bulleted list, state the project goal and objectives:

    - Typically, a goal is a broad statement of desired accomplishment – something the project will contribute to – frequently in the long term and not intending to be measured during the project.
    - Objectives represent more specific achievements during the lifetime of the project. We would, generally, expect projects to have 2-4 objectives. While objectives are written in a variety of ways, it is best not to draft overly specific objectives. The specificity will come in the performance monitoring plan (PMP) in the appendix with the inclusion of specific indicator(s) with targets that measure progress towards achieving each objective. Example of objective statements are listed below:

- To expand community-based pediatric eye services that increase access to care in X province.
- To increase public awareness of pediatric eye care services in X district
- To achieve high-quality ROP services in tertiary eye hospitals in X Region

4. **Contribution to the MYP or country strategy plan** (up to 1 short paragraph): Describe how this project fits within Orbis's country strategic plan (CSP). If it does not, explain why the project still merits being considered.

5. **Contribution to broader development agenda** (up to 1 paragraph): Describe how this project fits within the broader global and country development agendas (for example, SDGs, Vision 2020, poverty alleviation and gender equity). This is an opportunity to suggest angles that our business development team may use to seek external funding for the project.

6. **Target population and location** (up to 3 sentences): State who the intended beneficiaries are (for example, adults/children, rural/urban etc.) and in which locations (region, district)

7. **Project sites** (up to 1/3 page): Indicate the types and names of health facilities (or networks of facilities) or community sites where the project will be located.

8. **Project strategy/approach** (up to 3 pages including project logic framework): First, provide a narrative description of approach(es) that will be used to achieve project objectives. This section will, typically, be more in-depth than the description in the concept paper.

9. **External factors that could adversely affect project implementation** (recommended length: 1-4 sentences): Indicate if there are any external factors that have a medium to high potential to impede the project from being implemented as planned (for example, national/ state/ local body elections, natural disasters etc. that could delay project activities and prevent staff from visiting partner facilities). Also note how you would address them. If you do not feel there are any such factors likely to affect project implementation, simply state that in one sentence.

10. **Institutional Capacity (Orbis, Partners)** (up to 1.5 pages): Describe the capacity of Orbis and partner(s) to conduct the proposed work. This will include previous experience in the proposed field of work (may discuss key lessons learned), leadership, technical expertise, personnel availability, infrastructure, as well as previous work in the geographic location. Also, discuss any previous experience that Orbis has had working with partner(s).

    Orbis: [Recommended length: 1-2 paragraphs]
    Partner(s): [Recommended length: 1–2 paragraphs. If there are many partners you can do this as a narrative, a bulleted list or a table]

11. **Project Management Structure** (up to 1-2 paragraphs): Briefly describe key roles played by Orbis and the partner(s) in managing the project. Include key positions/ individuals and their responsibilities in this project. This can be done in a bulleted list or a narrative format.

    In the appendix, provide a project organogram diagram, illustrating the project structure. Include key entities at Orbis and partner organisation(s) that are directly engaged in the project.

12. **Monitoring and Evaluation** (1/2 to 3/4 page): Describe the system of data collection, reporting and analysis in narrative form. This should include information on who will conduct it, how data quality will be assured, how data will be used during project implementation, and any specific assessments that will be conducted such as baseline assessments and quality of care assessments.
    In the appendix, include a performance monitoring plan (PMP) with performance indicators, targets and reporting frequency. Note: the PMP is not included in this section's recommended page length or in the 12 pages limitation for the project plan.

13. **Post-Project Plan for Sustaining Results** (up to 1 paragraph): Briefly describe how the project will continue to sustain even after it ends.

14. Appendix

Include the following:

- Performance Monitoring Plan (Annexure 6)
- Project Organogram (Annexure 7)
- Budget Spreadsheet (Annexure 8)
- Project Work Plan (Annexure 9)
- Project Staff Structure - Orbis (Annexure 10)

Optional:

- Preliminary training plan (should be included if training is a key project strategy)
- If you have other material related to project, you can include the same. However, it will be at the discretion of reviewers to read or not read those optional attachments.

Logframe

Purpose of Logframe:
The Logical Framework is a tool to help strengthen project design, implementation and evaluation. This means that you use it throughout the project cycle. The Logical Framework is a simple tool which helps you

- Map a clear link between what a project is proposing to do/ achieve and the results it can report.
- Communicate information on the project concisely and unambiguously.

Refer Annexure 11 for Orbis standard Logframe Template

Logframe Example

In the standard Orbis Logframe template, the project design is drafted by the designated Project personnel (Manager/ Officer), Project Development personnel and M&E personnel. This exercise is done in alignment with the development of the project concept. It is particularly important to define the goals of the project at this stage. The potential indicators of the project are listed based on the global indicator bank available on Indicata and those that are specific to project-related requirements. Along

with the concept note, the Logframe template is used as a tool to hold discussions with the partner. These discussions are either done off-site (e-mail/ skype/ zoom) or through face-to-face meetings. This helps in finalizing the project concept and establishing a common understanding of project activities, objectives and deliverables. Based on these discussions, the final concept note is shared further with the project team at the partner hospital and Orbis. It is also sent to the project development team at OI and all inputs are incorporated. The final concept note is uploaded on Indicata for official review and approval by the Country Director and Chief of Programs.

Taking the approved concept note as the base document, the project work is initiated. The draft Logframe is refined with inputs incorporated from all the stakeholders – partner, Orbis India project team, Orbis India leadership and OI project development team. Key project activities are listed and their logical flow towards accomplishing the objectives of the project is defined. Objectives should be the same as in Section 3 of the project plan template and should be written exactly in the same way. The second round of inputs are taken from the Orbis project team and shared further with the global M&E team for review. The Logframe is finalised and incorporated into the project plan template. The project plan and the budget are uploaded on Indicata for approval by COP/ CFAO/ CEO.

Goal*: Typically, a goal is a broad statement of a desired accomplishment – something the project will contribute to in the long term and not intended to be measured during the project.*

Objective *1*	Outcomes (Results)	Output	Activities
Objectives represent achievements during the lifetime of the project. We would generally expect projects to have limited objectives (2-4). ***Examples of objectives:*** • ***To expand community based pediatric eye services that increase access to care in X province*** • ***To increase public awareness of pediatric eye care services in X district*** • ***To achieve high quality ROP services in tertiary eye hospitals in X region***	*An outcome represents a specific result a project is intended to achieve. An outcome is not what the program produced itself (the output), but the consequence of those products, services, or assistance. Outcome statements must be developed carefully so that they clearly identify the type of change that will be measured and ensure that the proposed outcomes are achievable.* *Examples of outcomes:* • *A high-quality training model on cataract service delivery is established in each province* • *Enhanced understanding and adoption of US best practices among local ophthalmic community*	*Key outputs are the main interventions supported or directly provided by the project to achieve the outcomes they are associated with.* *Examples of outputs:* • *Increase in uptake of screening in schools and communities* • *Work with primary and secondary care facilities to recruit rural women*	*Actions taken or work performed through which resources such as funds, technical assistance and others are mobilized to produce specific outputs.* *Examples of Activities:* • *Avail Zithromax from the International Trachoma Initiative (ITI) at the district level* • *Train and organise teams to conduct Mass Distribution of Antibiotics (MDA)* • *Conduct annual mass drug administration*
	Indicators • *Percent of eye doctor trainees who complete the training and can perform small incision cataract surgery independently by the end of training* • *Percent with postoperative IOP within 6-20 mmHG, six weeks after the surgery*	**Indicators** *An indicator is a quantitative metric that provides information to monitor performance, measure achievement and determine accountability*	

		• *Number of children screened during school screenings*	
		• *Number of school teachers trained in school screening on children eye health*	

Refer Budget template in Annexure 12

Project Implementation

Phase I

Establish Quality Management System (QMS)

The need to improve quality is gaining importance in health care systems across the world. Quality management systems give hospitals a framework through which they can continuously improve all the aspects of health care service delivery. By implementing a comprehensive and systematic Quality Assurance system in the eye care sector, the quality of eye care can be enhanced and made available to everyone. Quality management is a formalised system that documents the processes, procedures, and responsibilities for developing quality policies and objectives.

Orbis established a fully functional Quality Resource Center (QRC) in 2014 at Dr. Shroff's Charity Eye Hospital (SCEH), Delhi.

Roles of Institutions:

Orbis

- Identify a partner who must undertake a quality phase.
- Conduct gap assessment with support of QRC.
- Provide support to partner based on the gap assessment recommendations.
- Provide continuous support to partners for implementing quality management systems in their hospital.
- Help partners to achieve their quality vision through available data and MIS.
- Help the partner hospital to develop a growth plan for individuals post their training, as part of the institutional HR retention strategy.

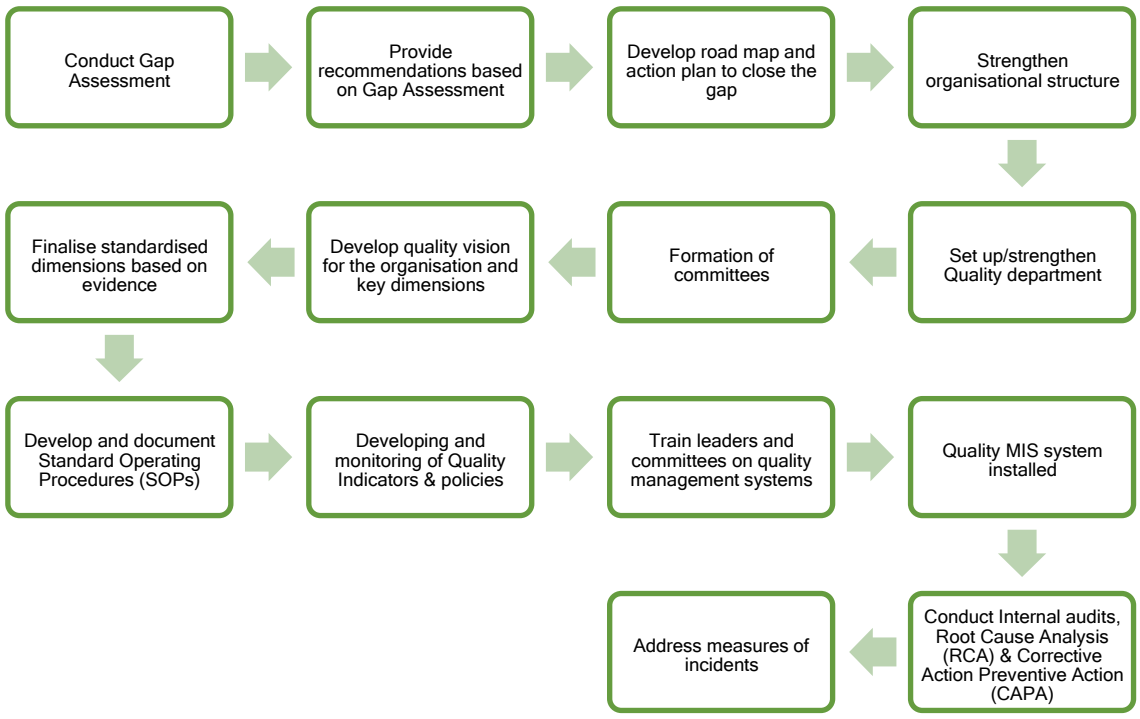
Partner

- The partner should be interested in taking up the quality phase.
- The partner should be open for assessments and recommendations.
- The partner should provide full cooperation and support to QRC.
- The partner will consider a mechanism in place to retain trained staff and formulate a plan to develop a second line of human resources to continue pediatric ophthalmology service delivery, beyond the life of the project.
- The partner will regularly update their documents, services, and capacity to improve quality
- The partner will provide reports and data to QRC and Orbis on a monthly basis.

Quality Resource Center (QRC):

- QRC will handhold Orbis partners to achieve Comprehensive Institutional Quality Improvement (CIQI).
- QRC will conduct gap assessment/ analysis of the partner hospital and provide recommendations.
- Based on the recommendations, trainings and workshops will be conducted to strengthen systems, patient care, human resources and financial management.
- Technical support will be provided to partner hospital for a minimum period of 24 months (Phase I). The QRC's involvement will taper off over the next four years (Phase II).
- Various templates, tools and strategies will be adopted to ensure quality into the organisation.
- A comprehensive skill mapping exercise will be undertaken with the help of QRC to develop an institutional training plan.
- QRC and partner hospitals will jointly develop a roadmap to formulate and implement the Quality Management System.

Here is a step-by-step process to establish Quality Management System:



Phase II

- QRC collects the monthly data and reports of the organisation every half year and analyses them to correlate with quality outcomes.
- Ensures frequent and consistent communication with the employees to understand whether they have imbibed the quality vision and are working accordingly or not.
- Engages with everyone to create a more sustainable and quality work culture.
- Conducts refresher training, if required.
- Support the partner in applying for accreditation.
- Conducts weekly review meetings and monitors remotely.

Timeline

Sl. No.	Particulars	Timeline
	Phase – I	
1	Gap Assessment/ Analysis	Y1Q1
2	Recommendations of Gap Assessment/ Analysis	Y1Q2
3	Develop road map to close the gap	Y1Q2
4	Strengthen organisational structure	Y1Q3
5	Set up/ strengthen quality department	Y1Q3
6	Formation of committees	Y1Q3
7	Develop quality visions	Y1Q3
8	Standardisation and development of SOPs	Y1Q4
9	Develop and monitor indicators	Y2Q1
10	Train leaders and committees	Y2Q2-Q3
11	Develop online MIS	Y2Q3
12	Conduct internal audits and address measures	Y2Q4
	Phase – II	
13	Collect monthly reports and data from partners to review intermediate outcomes through concurrent monitoring	Half-yearly from Y3 till the project ends
14	Conduct refresher training, if required	Y4Q2
15	Facilitate the partner to apply for accreditation and provide support in getting the same	From Y5Q2 onwards

Training Details

Sl. No.	Trainings	No. of days	Outcome	People to attend
1	Orientation on quality assurance	5	Draft quality assurance policy formulated	Leadership team (3 days) and staff (2 days)
2	Gap Assessment/ Analysis - observation & interview in various clinical and non-clinical areas	1	Gap identified and top-level findings listed	Leadership team
3	Training on RCA, CAPA and audit mechanism	3	RC, CAPA and audit training workshop conducted, practice audit conducted.	Quality management committee
4	Development and finalisation of SOP workshops	5	Clinical and non-clinical SOPs finalised and signed off	Different committee heads
5	Quality indicators' development workshop	3	Development of quality indicators, data collection parameters	Leadership team
6	Training to quality management team, leadership team and committee members	3	Develop vision, finalise standardisation and facility management and safety training	Quality management team, leadership team and committee members
7	Develop Quality parameters and MIS	3	Finalise MIS in the organisation, basic data management training and library management course	Quality management team and project management team
8	Course on implementation of NABH standards and ISO	3		Leadership team

Appendix

List of committees (may be suggested based on gap assessment)	• Steering committee • Medical records committee • Hospital infection control committee • Safety committee • Teaching and training committee • Quality management committee
List of SOPs (may be suggested based on gap assessment)	**Non-clinical** • OPD non-clinical (registration and other processes) • Emergency services • Lab (pathology, microbiology) • Pharmacy • Counselling and pre-surgical assessment • IPD • Optometry (including contact lens) • Safety manual (patient safety, staff safety, facility and disaster management) • Diagnostics • Eye bank • IT • Community outreach • OT • HIC manual • HR and administration • Maintenance (facility and equipment) • Outsourced services (housekeeping, laundry, canteen, security) • Teaching and training • Medical records department • Corporate and TPA • Finance and accounts • Purchase, stores and inventory • Quality manual (control of documents)
	Clinical • Oculoplasty • Cataract • Pediatric (squint and other specialities) • Retina • Glaucoma • Refractive surgery (Lasik etc.) • Anaesthesia • Cornea
HR – Quality Department	• Quality manager • Safety officer • Hospital infection prevention and control nurse

Pediatric Team Training

Examining children needs special skills and treatment requires specific training, knowledge and equipment. The development of infrastructure and systems were the easier part. The challenging part was identifying staff and creating teams at a time when pediatric ophthalmology was not recognised as a distinct sub-specialty in India. This resulted in limited career options and, therefore, not many individuals were willing to undergo training initially.

Considering the challenge, we decided to build the infrastructure for service delivery, support community work and develop human resources. In 2002, the India Childhood Blindness Initiative (ICBI) was launched by Orbis to ensure that children have access to quality eye care, and eye care teams have access to quality training and advisory services (provided by Dr. Shroff Eye Hospital, New Delhi).

Comprehensive Capacity Building

The program began by identifying tertiary level eye hospitals where CECs could be established. Further, a country-wide survey was undertaken to generate evidence for human resource and infrastructure requirements for elimination of avoidable childhood blindness. This was the first time that such an extensive survey was undertaken in India.

Pediatric Ophthalmology Team

A pediatric eye care team, typically, comprises of at least six people: an ophthalmologist, anaesthesiologist, optometrist, nurse, counsellor and outreach coordinator who have undergone specific training in the management of eye diseases among children. Furthermore, other clinical, non-clinical and support staff are trained or oriented to complement the core team.

Pediatric ophthalmologist: The ophthalmologist is trained to conduct a comprehensive ophthalmic evaluation of children, keeping in mind the nuances of a child's eye. They should be able to identify pediatric eye conditions and manage them appropriately to achieve the best possible outcome. The pediatric ophthalmologist will work closely with his/ her colleagues in other departments -- cornea, glaucoma, retina etc. -- and be aware of community pediatric eye care, vision screening and awareness initiatives.

Anaesthesiologist: Unlike adults, children undergoing eye surgery will nearly always require general anaesthesia. A pediatric-trained anaesthetist makes it possible for children to safely undergo sight restoration surgeries, even a few days after birth.

Optometrist: Optometrists are trained in the diagnosis and management of routine and complex eye conditions, including refractive error, amblyopia (lazy eye), strabismus and more. They also travel outside CEC to deliver services to children in the community.

Pediatric nurse: The management of drugs, drawing blood, counselling patients and families, supervising sterilisation, managing the operating room, and assisting surgery are some of the responsibilities of nurses. Very often, they become a child's best friends during their stay in hospital, during and after a surgery.

Counsellor: Patient education and counselling are integral parts of both medical and surgical management of a disease. Among children, the eye is still developing so the information required on any intervention, especially surgery and care, before or after a surgery is quite different as compared to

what is required for adults. The counsellor assists parents in decision-making by giving detailed information about the management plan. The counsellor also alleviate anxiety among parents by providing a detailed description of pre-operative evaluation, including pre-anaesthesia check, post-operative care, discharge, and the necessity of long-term follow-up.

To address the training needs of 'where and how', **Pediatric Ophthalmology Learning and Training Centers (POLTCs)** were identified. Three existing tertiary-level pediatric facilities in the country were identified and developed to provide training, consultation and research support to the partner hospital.

Besides the currently structured training, there will be custom-packaged training opportunities for all ophthalmic professionals involved in the project activities, through Multidisciplinary Hospital Based Programs (MDHBPs), Flying Eye Hospital (FEH) Program(s), and consultation and ongoing learning through Cybersight. This will increase the clinical and surgical abilities of the team. If the training slots are not available at POLTCs, the training will be conducted in other accredited/ reputed training institutions in India, including Orbis Regional Resource Centers. There will be opportunities for the project team members to attend conferences (national/ international), get exposed to latest trends and share their experiences at appropriate platforms.

Appendix:

Trainings conducted for pediatric ophthalmic team in Phase I:

Trainee	No.	Training course	Training center	Duration
Ophthalmologist	1	Fellowship in Pediatric Ophthalmology	Aravind Eye Hospital, Madurai/ Sankara Nethralaya, Chennai/ SCEH, Delhi/ LVPEI, Hyderabad	1 year
Anaesthetist	1	Pediatric Anaesthesia	Aravind Eye Hospital, Madurai	2-4 weeks
Optometrist	1	Pediatric Optometry & Orthoptics	Aravind Eye Hospital, Madurai/ Sankara Nethralaya, Chennai/ SCEH, Delhi/ LVPEI, Hyderabad	6 months
Optometrist	1	Low Vision & Rehabilitation	LVPEI, Hyderabad	3 months
Vision Technicians	3	Vision Technician Course	LVPEI, Hyderabad/ Susrut Eye Foundation, Kolkata	1 year
Hospital Administrator	1	Hospital Systems Management	LAICO, Madurai	1 month
Project Manager	1	Project Management for Eye Care	LAICO, Madurai	1 month
Training of Quality Team		QMS	SCEH, Delhi	

Training of Human Resources for Phase II:

Training of the pediatric ophthalmology team will be completed through appropriate training for other cadres, including nurses, counsellors, equipment maintenance technicians, outreach coordinators, and vision technicians at the Orbis POLTCs.

Trainee	Training course	Training center	Duration
Vision Technicians	Vision Technician Course	LVPEI, Hyderabad/ Susrut Eye Foundation, Kolkata	1 year
Ophthalmic Nurse	Pediatric Nursing (OR, OPD & Ward)	Sankara Nethralaya, Chennai	3 months
Patient Counsellor	Pediatric Counselling	LAICO, Madurai	2 months
Outreach Coordinator	Community Outreach and Social Marketing of Eye Care Service	LAICO, Madurai	4 weeks
Equipment Maintenance Technician	Equipment Maintenance Course	LAICO, Madurai	1 month

The partner hospital will consider putting a mechanism in place to retain its trained staff and formulate a plan to develop a second line of human resources to continue pediatric ophthalmology service delivery, beyond the life of the project.

A global survey conducted in 2010 and 2015 by the International Council of Ophthalmology illustrated that this burden is unfairly distributed towards low and middle-income countries (LMICs), which severely lack ophthalmologists and health care workers. Considering the scenario, Orbis International introduced a “sandwich” fellowship, which combines a series of training modalities to overcome the common barriers ophthalmologists working in LMICs face in accessing medical education, including costs, lack of infrastructure and supportive mentoring. This model also addresses barriers faced by the health system in LMICs by reducing the risk of brain drain and minimising the amount of time spent away from an ophthalmologist’s home institution and family to no more than a few months at a time. This fellowship consists of four three-month rotations. At the training institution, fellows have the opportunity for traditional fellowship training with clinical observation and management, wet lab training and hands-on surgical training. At their home institution, they complete online courses in theory, anatomy, pathology and patient care; do monthly live tele-rounds, where they present cases for discussion; receive clinical and surgical tele-mentorship where they are observed and mentored through two-way audio-visual connectivity with their mentor and participate in regular webinars on key learning topics.

Simulation training is a well-recognised modality that augments traditional education. Simulation allows training in new techniques and competencies, refreshing existing skills, management of complications and improvement of patient safety. The Orbis approach to training is one of Blended Learning (also known as hybrid or mixed mode courses). Simulation provides a safe and stable environment with repeatable scenarios that allow trainees to develop necessary competencies before managing patient care, reducing the risk of patient harm and improving the quality of care. FEH has been used as a simulation center, which will enhance our traditional training models and add to the strategic value of the MD10. As a simulation center, the plane will have three main simulation models that will cover ophthalmology, anaesthesia, nursing and biomedical.

Orbis will help the partner hospital to develop a growth plan for these individuals post-training as part of the institutional HR retention strategy. A comprehensive skill mapping exercise will be done with the help of QRC to develop an institutional training plan. To have a clear succession plan, required training and exposure will be given to the leadership to drive future growth and sustainability of the organisation in Phase I of the project.

Continuous Medical Education (CME) is organized each year for four years during the service delivery phase of project. The objective of the CME is to orient teams on child eye care and the importance of early referral. These CMEs are organized as standalone and combined with the HBTs. 200 professionals, which includes general ophthalmologists, pediatricians and registered medical practitioners (RMPs) are invited to participate in the CMEs combined with HBTs. The CMEs are usually up to one day duration. The hospital staff (including the clinical team from base hospital, vision center and outreach) also participate during the CME.

Outreach Activities

Early Identification of Eye Problems

Children can be reached out to at Schools and Anganwadi centers (AWC). Community volunteers, including school teachers and Anganwadi workers (AWW) are involved to identify and refer the children for treatment. Other potential community volunteers can be ASHAs, ANM etc. Community volunteers play a crucial role in conducting outreach activities. Engagement of different community volunteers is important for sustaining the project.

Process of Engagement of Community Volunteers

Permission for training school teachers is taken from the District Education Officer/ Block Education Officer. Training for school teachers is scheduled for less than a day on primary eye screening and referral of school aged children (>6-18 years). Dates of training are fixed in consultation with the school headmaster. The location of training is a block office, base hospital or community space. Refer Annexure 13 for Attendance sheet of School Teacher. A teachers' training handbook is used to train the teachers for conducting screening in schools. Teachers are trained in a batch of 25-30 in one session. The role of school teachers will depend on the school screening model followed by the partner.

Anganwadi workers/ ASHAs/ ANMs are oriented to primarily identify and refer children within the age group 0-6 years. Permissions are taken from the Child Development Project Officer (CDPO)/District

Programme Officer (DPO)/Block Development Officer (BDO). The orientation is done at CDPO office or base hospital in a batch size of 25-30 per session. Refer the attendance sheet for orientation in Annexure 14. These community volunteers also identify and refer children with eye ailments who are out of school. They also play a major role in community mobilisation as they work closely with the community. The content of orientation includes common eye complaints in 0-6 years of age, signs and symptoms and preventive measures. A standard orientation material is to be developed for focussing on children in the age group of 0-6 years.

School Screening

The school teachers who are trained for conducting primary screening will screen the children. Children identified with an eye problem will undergo detailed examination by a hospital team during a confirmatory visit. The time given to teachers to screen school varies from 7-10 days. Children who require further treatment will be referred to the nearest vision center or base hospital. Children attending the adult camp in the project catchment are to be reported as part of the outreach camps.

Steps for conducting school screening by the teacher:

Step 1 - Choose a well-lit room

Step 2 - Draw two lines 6 metres away

Step 3 - On one side, hold the E-chart

Step 4 - Make student stand on the other side

Step 5 - Start with the right eye, without pressing the left eye. It is advisable to use the occluder

Step 6 - Make the student indicate the orientation of the arms of the letter E

Step 7 - Repeat step 5 and 6 with the other eye

→If the child is able to indicate correctly, the vision is normal.

→If not, report the list of identified children to the hospital for confirmatory screening.

Another way of doing school screening is by following the REACH protocol, under which the primary and detailed examinations are done by the hospital team.

Team composition for school screening:

1. Optometrist/ vision technician
2. Community health worker
3. Counsellor

Anganwadi Screening

Before The Screening Day: AWW will be informed before the camp. Dates are decided in coordination with AWW to organise the camp. Anganwadi workers inform the community about the upcoming eye screening activity in the AWC, with or without the IEC material given by the outreach coordinator. This helps in community mobilisation for the screening day.

On The Day of Screening: The team visits the Anganwadi center and the area covered by the center for comprehensive eye examination for enrolled children. AWW supports the outreach team for organising the camp. It is advisable to have a senior optometrist or optometrist trained in pediatrics in the team for screening children in the age group of 0-6 years. A comprehensive eye examination is needed in this age group, as early identification of childhood blindness conditions such as cataract, squint etc. will lead to better prognosis.

The team composition for the screening:

1. Senior optometrist/ vision technician
2. Community health worker
3. Counsellor

Equipment/Instruments

- Handheld slit lamp
- Handheld auto refractometer
- Lea chart
- Ophthalmoscope
- Retinoscope

After The Screening: Anganwadi workers will follow up with the identified children to ensure that the treatment is completed. Anganwadi workers remain in contact with the vision center/ hospital after the camp is over to make referrals to the nearest vision center or base hospital.

Phase II

Planning and Establishment of Children's Eye Center (CEC), Vision Center and Outreach

Introduction

In 2002, Orbis launched the India Childhood Blindness Initiative (ICBI) to ensure that India's children have access to quality eye care for generations to come. A country-wide survey was undertaken to generate evidence for human resource and infrastructure requirements for the elimination of avoidable childhood blindness along with Dr. R P Center for Ophthalmic Sciences, New Delhi.

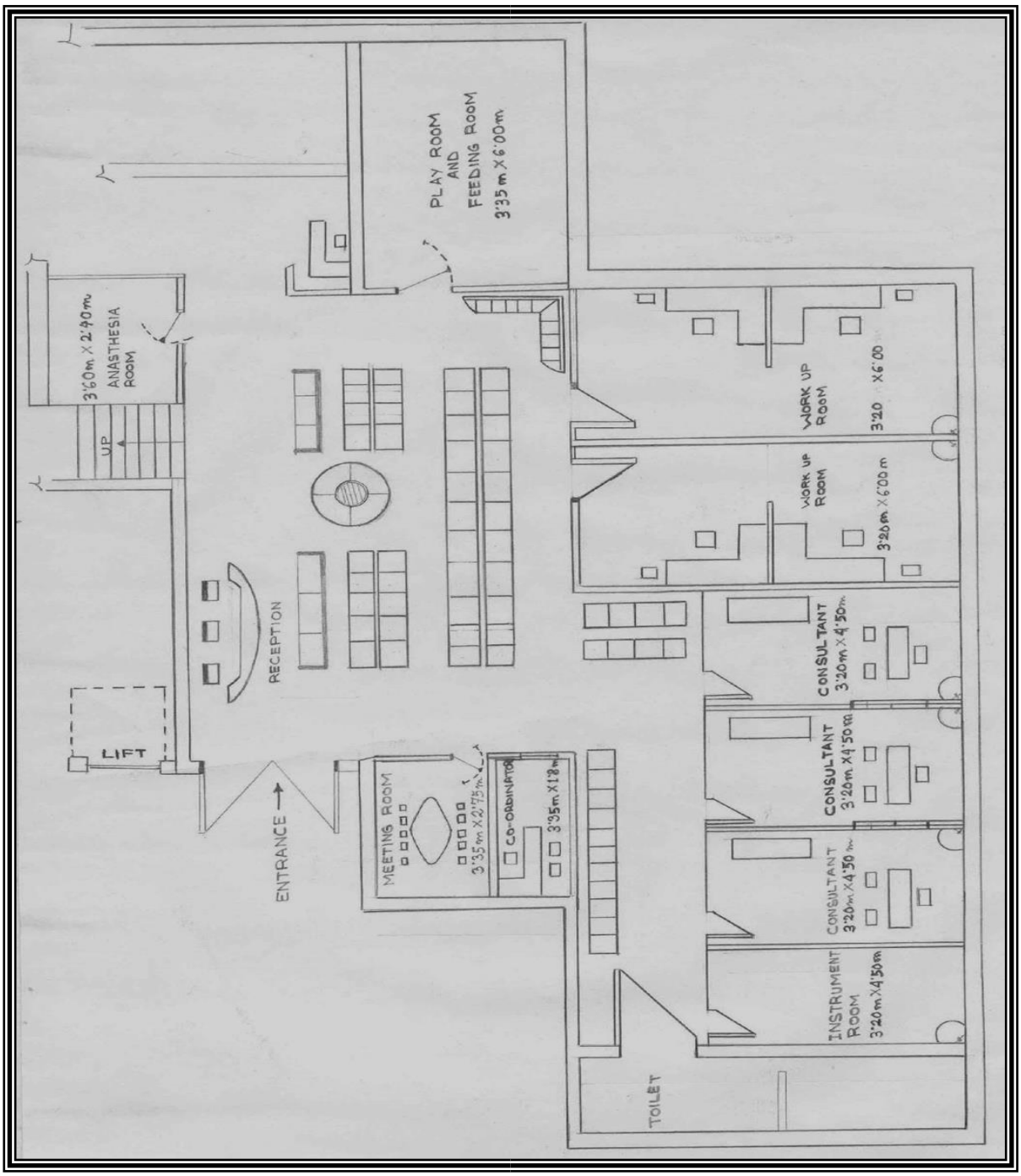
A step-by-step process on planning for CECs are shown below:

- Following facilities are required in pediatric ophthalmology units like an examination room, orthoptic room, waiting area for dilatation, play area for kids and pediatric beds (minimum five).
- Examination rooms for optometrists/ ophthalmic technicians. The pediatric ophthalmologist unit should be 3.5 meters by 2.5 meters. All windows should be fitted with blinds. Each examination room should have two visual acuity charts -- LEA symbols and LEA letters. LEA symbols illuminated stand must be kept at the eye level of the child.
- Orthoptic room: Patient recovery room should be adjacent to the operation theatre.
- A separate feeding room to feed babies.
- Procurement of appropriate equipment and refurbishing the pediatric ophthalmology department.

- Ensuring the department is child friendly i.e. there is a colourful waiting area, accessible examination room, friendly counselling room, play area for kids (with toys, child's books and safe play items), beds with cartoon characters, walls having colourful pictures/ cartoons, accessible toilets (low toilet seats and low wash basins), child friendly furniture, no sharp edges in the buildings, etc.
- Development of minimum required human resources i.e. pediatric ophthalmologists, anaesthesiologists, optometrists, pediatric nurse, counsellor, community eye care/ outreach coordinator, program manager/ coordinator for community eye center for running a CEC.
- Training of the pediatric ophthalmic team to deliver comprehensive care for children with support from POLTCs. The details of the training and needs can be gained from the pediatric ophthalmic team training chapter.
- Recommending organisations to have a comprehensive child protection policy with clear guidelines to ensure a safe environment for children.

Annexure 15 on Infrastructure Requirements for Pediatric Ophthalmology Units

A Model Floor Plan of a Pediatric Ophthalmology Department



Vision Center

A vision center (VC) is a small, permanent facility set up to provide primary eye care services to semi-rural and rural communities. In the XI Five year plan the Government of India, made the establishment of primary eye care centers, an integral strategy of the overall national plan. The non-government sector since then has developed this concept of primary eye care centers under the name of Vision Centers (VCs). Ideally, there must be a vision center for a population of 50,000, but there is a considerable gap

with communities forced to travel 50-100 km to access basic services. The country requires an additional 20,000 VCs to make primary eye care accessible to the communities. The need was felt for permanent structures to provide primary eye care services regularly in the community. The purpose of VC is to increase the uptake of eye care services among rural population, offer comprehensive primary eye care to the targeted population, offer on going care to those with chronic eye conditions, raise awareness and educate the target community about eye health and establish a population-based eye care monitoring and support system.[1]

Guidelines for setting-up a Vision Center

1. **Selecting the location:** The criteria for selecting the locations for the Vision Centers can be-
    - Rural town or village with a population of 15,000 and above
    - Good transport connectivity and a market hub for nearby villages
    - No eye care services available locally
    - Nearest eye hospital within 40 to 50 kms
2. **Infrastructure and other facilities:** The Vision Center needs adequate space (400 square feet) for reception, refraction, patient examination and tele-consultation.
3. **Equipment/Facilities:** The Vision Center will be equipped with the following equipment.

Medical Equipment

- Trial sets
- Digital Vision Chart
- Retinoscope 4. Direct Ophthalmoscope
- Slit Lamp
- Applanation Tonometer
- Autorefractor
- Low vision Charts
- Basic sterilizer
- BP apparatus
- Glucometer with Strips
- Weighing & Height scale
- Digital camera and adapters for digital retinal imaging

Small Equipment

- Computer system
- Non-Mydiatric Camera
- Webcam
- Speaker/mic
- Printer

[1] Aravind Vision Center Manual

Human Resource: One Optometrist/Vision Center Technician will be appointed in each center. She/ he will carry out comprehensive eye examination, handle tele-consultations and refer patients when indicated. One community health worker or counsellor will also there. Once in fortnight/month an ophthalmologist can visit the VC.

Tele-Medicine

Availability of broadband connectivity at an affordable cost has enabled leveraging IT applications in various areas to bridge urban – rural divide. All the Vision Centers will be linked to the Secondary center/ tertiary center through a broadband to carry out real time patient consultations with a specialist. This would enhance the quality of diagnostic services and treatment advised in the Vision Centers. The connectivity will also be used for data exchange, communication, and to update the Optometrist/ Vision technician's skills on a regular basis.

Services provided at Vision Center

- Patient examination will include visual acuity measurement, refraction, slit lamp examination and fundus examination. Intra-ocular pressure (IOP) and random blood sugar will be measured for all patients above 40 years. In addition, blood pressure, height and weight will also be measured to offer general health counselling to the patients. Diabetic Retinopathy screening and post operative cataract follow-up will also be done.
- Dispensing of spectacles and sunglasses.
- Necessary first aid services will be given to people found with minor ailments like conjunctivitis and for patients with corneal ulcers, corneal abrasion, and trauma.
- Those patients who need further procedural or surgical interventions like cataract, laser for diabetic retinopathy and management of corneal abrasion, corneal ulcers, trauma, glaucoma; childhood blindness etc. will be referred to the tertiary hospital.
- Eye health education- Technical education for Vision technicians and orientations for AWW, ASHAs etc.

Green Vision Center (GVC)

Features of GVCs are-

- Use of Solar energy
- Use of software for data management
- Energy efficient appliances

GVCs will be established in the underserved rural areas manned by well-trained paramedical personnel. GVCs would create permanent access to primary eye care services for the communities at an affordable cost. These GVCs will be networked with a secondary facility or a tertiary facility within 50 km range for taking care of referrals. Since most eye problems can be addressed locally at GVCs, only a small number of patients will be referred to either a secondary or a tertiary level hospital for further management. Due to their convenient location within the community, GVCs provide an optimal platform for screening for eye diseases at an early stage and providing remedial measures and timely referrals.

The following guidelines will be followed for setting up a GVC:

- The GVC will be set up in a semi-urban place or a village with a population of 10,000 to 15,000

- The place should have good transport connectivity and a market hub for nearby villages
- A population of around 100,000 must be residing within a radius of 10 – 15 km
- The area should not have eye care services available locally
- Referral facility (Secondary/ tertiary eye hospital) must be available within 40-50 km
- The building identified for GVC should be centrally located and easily accessible with adequate shade-free roof space to accommodate the solar panels.

Use of solar energy:

One of the vital infrastructure gaps that have been observed at the primary service delivery level is that of reliable energy availability. For a VC to function to its full potential requires uninterrupted energy supply to run its various equipment, computers, and appliances. In general, VCs are powered by conventional power, which includes the combustion of fossil fuels, which emit greenhouse gases and results in air pollution. Moreover, there are still pockets of rural India, which are not connected to the grid and a large number of vision centers face fluctuations in energy supply. Energy access in vision centers is also imperative to facilitate communication services, telehealth applications and to retain skilled health workers.

The GVCs will be powered by renewable solar energy to ensure continued services irrespective of the availability of grid electricity. Alternative solutions for augmenting the energy needs of health facilities combined with efficient health equipment can transform the delivery of eye care services by making it affordable and accessible to the poor. Sustainable energy options like solar will not only help phase out the more expensive diesel generators being used as power backup with a cleaner source of electricity but also contribute towards sustainability of GVCs. Access to a functional VC also goes a long way in reducing costs for patients who have undergone cataract surgery, as they can have their follow-up visits at the VC rather than travel to the city every time.

Digital data management and Tele-health services:

The manual data collection system relies on paper, which has a tremendous environmental impact in terms of energy consumption in production, cutting of trees, transportation, paper waste generation.

The GVCs will be deployed with digital data management software – Integrated Community Outreach Module (ICOM) enabling better management of patient data as well as improve continuity of care when patients move between the GVC and referral facility. ICOM software was developed by Orbis and is designed for all outreach activities and has been used successfully at VCs, vision vans as well as community screening camps across different Orbis partner hospitals. This feature significantly reduces the use of paper in the GVCs and contribute towards environmental sustainability. In addition to environmental benefits, the use of the software will ensure better flow of information and clinical decisions apart from data accuracy and security of information. ICOM can provide continuity of care; data can be saved, retrieved and seen by all care providers along this patient journey. The software also makes available disaggregated data that allows analysing the performance and track trends of each GVC individually or the network as a collective. Digitization also supports more streamlined processes, reducing unnecessary travel for patients and creates environmental awareness among staff and patients. These GVCs could also be connected to a referral facility, and this makes it possible for the patients to have direct consultation and interaction with the ophthalmologist.

Energy-efficient appliances:

Energy initiatives are currently limited to tertiary or secondary facilities and had not percolated to the primary level. The GVCs will have 5 star rated appliances, equipment that is highly energy efficient like LED bulbs, super fans. All equipment functioning will be ensured as specified and designed. The GVC management team of the hospital will work closely with the energy service provider to help manage and improve energy performance. Staff and patients will be educated on how their behaviours affect energy use.

Community engagement through Vision Center

VC plays an important role in developing community networks. Celebration of various awareness days in the VC helps in engaging community. Schools and Anganwadi centers in the catchment area can be involved to increase community engagement. Orientation of community volunteers can also be done in the Vision center.

Sustainability of Vision Center

Sale of spectacles is the major source of revenue generation. A nominal registration fee can also be charged. By end of three years, VC should generate revenue to bear its operational cost. Part of surgery cost (10-30%) can go to VC account if the referral is done through VC.

Outreach

Outreach camps will be conducted based on the project and in some cases, the partner decides the minimum number of camps per month. The camp covers comprehensive eye screening and dilatation to examine the posterior segment, wherever required and possible. Children who require further treatment would be referred to the base hospital. Those who require support for low vision rehabilitation services will be referred to the low vision department/services at base hospital.

To increase access to pediatric primary eye care services in underserved and unreached areas, services will be provided through vision centers, mobile vans, community-based screening and awareness activities.

Under REACH, the outreach activities are limited to school screening, with a major focus on identifying and correcting refractive error. Under ICBI projects, Anganwadi workers are engaged in primary screenings at Anganwadi centers. Through vison centers and mobile vans, community-level screening activities were aimed at identifying children with refractive error, blind or visually impaired children and those who need surgical intervention.

Plan for Outreach

Outreach camps are always a part of project activity to reach children.

The partner hospital plans for outreach activities through the baseline data undertaken before the project planning.

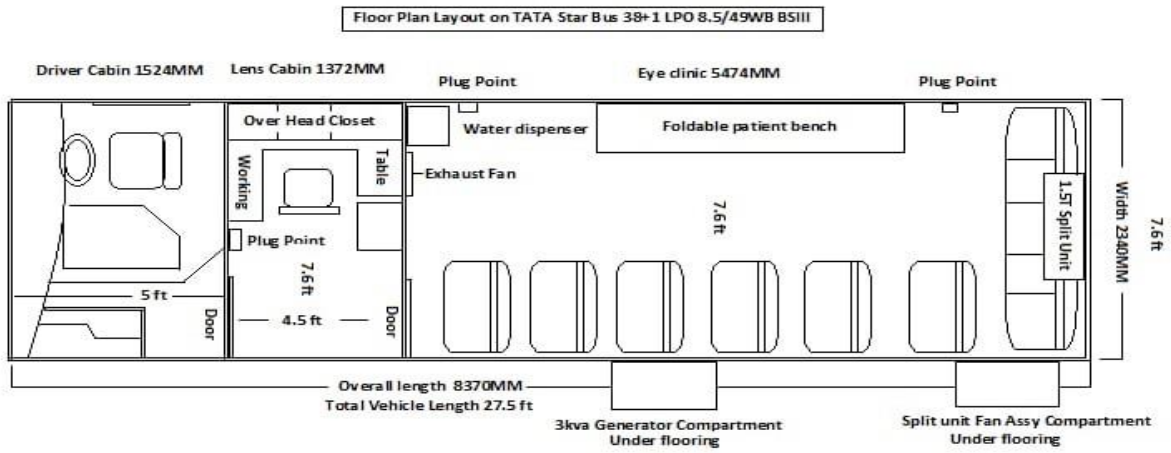
In the baseline document, the partner studies the staff requirements, availability of services, potential population with eye care problems, number of schools for screening children, etc.

Various approaches adopted for outreach include awareness programs for the public on childhood blindness; information dissemination through posters and leaflets, group discussions, and orientation of Anganwadi workers/ community to identify and refer children with eye ailments.

The details of outreach activities include in Annexure 16

Vision Van

Vision Van is a fully equipped fabricated vehicle, deployed in the outreach for primary eye care services at the doorsteps in underserved and unreached areas. This helps in improving the accessibility and affordability by reducing the patients cost of travel and loss of wage in visiting a fixed facility for eye care services. This also helps in increase of the spectacle uptake as they are readily available and delivered in the van. The vision van provides visual acuity assessment (primary screening), refraction, slit lamp examination, tonometry, and fundus examination - detailed examination. Provision is also made inside the vision van for spectacle dispensing unit for spectacle preparation and on-the-spot delivery of spectacles. Below is the sample blueprint of vision van.



Planning of Vision Van: The budgetary allocation for procurement, fabrication of a van and equipment [this includes medical and IT equipment (Table 1, 2 & 3)] is done when the project plan is developed. An amount of INR 25,00,000 to 30,00,000 (approximately) is budgeted for the procurement and fabrication of the van.

As the Vision Van will be functioning by the end of the first year of service delivery, planning for procurement of the van should begin in the initial months of the service delivery phase or by the end of the quality phase to avoid any delay in procurement and fabrication. The partner hospital will also identify the fabricator while the procurement of the vehicle is in progress. When the vendor for fabrication is identified and finalised, the partner hospital will further discuss the requirements and obtain the blueprint for fabrication. The blueprint is discussed with the Orbis team and finalised for the fabrication. While this is in progress, the medical equipment for the Vision Van is procured and sent for mounting. The procurement and fabrication of the Vision Van will take six to nine months. While the fabrication of the Vision Van is completed to an extent, the exterior designs and the brand visibility will be discussed and finalised by the partner hospital and Orbis Communications team. Once the fabrication is done and the Vision Van reaches the base hospital, trials must be done to check for the operational challenges. The changes/modification based on operational challenges will be addressed before the launch is planned. For the launch, the partner hospital will invite a government official or local community leader to increase the visibility.

The operational schedule for the Vision Van will be pre-determined and will cover the peripheral area of catchment for conducting project activities, which include screenings in a school, Anganwadi center and in the community for a minimum of three days in a week. A plan should be developed for operating the Vision Van, exclusively for three days a week for pediatric camps and the other days for adult outreach camps in the community. Apart from providing primary eye care services, the Vision Van can be also used for doing follow-ups with patients who have undergone surgery at the base hospital to improve post-op follow-up compliance and to reduce the loss of wages. The Vision Van also serves as a medium for raising awareness in the community.

The following are the steps to be followed for planning the implementation activities through Vision Van.

Pre-planning for screening:

- Create a list of underserved and inaccessible areas in the project catchment.
- Identify local camp organisers to take care of community-based arrangements (camp venue, publicity, local volunteers, local liaising, medical team hospitality etc).
- Develop a quarterly calendar with earmarked destinations which the Vision Van will visit. Intimation of the schedule to the district health authorities.
- Approach local pediatricians/ general physicians/ rural medical practitioners in advance to mobilise children with eye conditions to attend the camp.
- Approach local childcare centers, maternity clinics and primary health centers to mobilise children with eye defects to attend the camp.

The camp activity with the Vision Van is planned as per the module of ICOM. This enables the use of technology in the outreach.

For any camp with a Vision Van, the team composition (HR) needs to consist of at least a driver, vision screener, optometrist/ vision technician, community health/ social worker for registration, optician, counsellor and outreach coordinator, when required.

On the day of screening:

- The vision van will be used for conducting comprehensive eye examination by the outreach team for children in schools, Anganwadi centers and community; provide necessary prescriptions; and deliver the spectacles on the spot. The Vision Van can also be used for conducting confirmatory camp in schools.
- Based on the type of camp planned in ICOM, an average of 300-500 screenings per day will be conducted in the Vision Van.
- Counselling to the parents of children who require surgical intervention, follow-up and compliance to spectacle wear will be done by the counsellor in the Vision Van. Appropriate referrals will be done to the vision center/ secondary center and base hospital for children who require further examination, treatment or surgery. Data is captured in the Vision Van module in ICOM for screening, spectacles prescribed, spectacles delivered and referrals.
- Log details of the vehicle are maintained for every visit using the Vision Van. The details include travel, fuel etc. This information can be entered in ICOM in the vehicle module. This helps to track the performance of the Vision Van.

Sustainability of Vision Van

By conducting other camps such as corporate/ institutional camps and screening in community outreach, the partner hospital will be able to generate the operational cost. The source of revenue can be generated from the spectacles provided to adults. This further provides an option for sustaining the Vision Van.

The details of the equipment to be procured for vision van is as follows:

Table: 01 Medical Equipment for vision van

MEDICAL EQUIPMENT
E Chart, Lea Chart
Distance Vision Chart – Monitor
Near Vision Chart
Trial set with adult & pediatric trial frames
Streak Retinoscope
Direct Ophthalmoscope
Fundus Camera & Auto Refractometer combined
Hand-held slit lamp
Indirect Ophthalmoscope – wireless
Non-Contact Tonometer (hand-held)

Table: 02 Equipment for Optical Dispensing Unit in vision van

OPTICAL DISPENSING EQUIPMENT
Semi-automatic edging & cutting machine
Lensometer
Frame warmer
Fitting tools set
Supra-groover
Drilling machine

Table: 03 Other Equipment for vision van

OTHER EQUIPMENT
LED TV 32"
Audio System
Scrolling display board
Que Manager
Generator 5KVA

Hospital Based Training

The HBTs are an integral part of the ICBI projects as they help in enhancing the skills of the pediatric eye care team and are conducted during the service delivery phase of the project, as a part of the long-term strategy for capacity building, which requires continuous reinforcement and follow-up. The HBTs are designed to address specific training needs (clinical and non-clinical) and support a clear, deliverable outcome identified by the partner hospital. They play a critical role in the transfer of skills or knowledge and focuses on human and institutional capacity building. The HBTs should aim to improve the overall quality of patient care, while providing necessary skill transfer and are not a standalone tool for skill or knowledge transfer. Based on the needs of the partner hospital and the trainees, one or more sub-specialities or disciplines are covered in the training. It is best to choose a multidisciplinary approach, which includes ophthalmologists, nurses, anesthesiologists, biomedical engineers, and/or other cadres as identified in local contexts.

The multidisciplinary HBT is a specially designed Orbis capacity development event where Orbis Volunteer Faculty, an expert (and/or a team) comes to the local (partner) hospital and works together with the local eye care professionals to transfer skill(s) in specific techniques and specialities. It is a five-day training conducted at the partner hospital and the duration can be adjusted based on the partner's needs.

From the available pool of volunteer faculty (VF) across the globe, the Faculty Relations and Clinical Services team (FRCS) from Orbis selects the VF based on the specialty and requirement of the HBT. The key members involved in conducting HBT from the country office are Program Officer/ Manager (PO/ PM), Senior Program Manager (SPM), Associate Director - Programs, Communications Officer/ Manager and Office Manager.

The planning tools such as HBT Training Form and Partner Hospital Checklist allows the Program Officer/ Program Manager to plan and develop each HBT. These tools are designed to capture detailed information about the background data on the sub-speciality or the discipline chosen, level of training

and program required, detailed training objectives, identifying available and/or needed equipment, instrumentation, and consumable medical supplies and outline specific VF requirements.

The Program Officer/ Program Manager may seek advice from the Associate Director of Clinical Training and/ or Vice President of Clinical Services during the HBT planning and design process. (Refer Annexure 17 HBT Planner for Orbis India)

Blended Training Approach is a combination of in-person and online activities. A comprehensive list of courses, lectures and webinars which are available on Cybersight serve as useful resources for a blended training approach. Please refer to the course catalogue available on Cybersight for more information on the courses available.

In-Country Temporary Registration

It is important to consider the credentialing requirement of the ophthalmologist and anesthetist licence while planning for HBT. The Program Officer/ Program Manager (PO/ PM) is responsible to check for updates on these changes as per the government guidelines and provide information to the Senior Manager of Faculty Relations & Clinical Services (FRCS) to fulfil the requirements of temporary registration.

Consumables and Supplies for HBTs

It is encouraged that all supplies are made available and procured locally to ensure the sustainability of training and service delivery. In case an equipment is required by the VF but cannot be procured locally, the same can be communicated to the Associate Director of Clinical Training, Vice President of Clinical Services and VFs, when submitting the HBT forms. These personnel will then work with the Faculty Relations and Supply Chain Teams to arrange for the VF to bring the equipment along with them if it is required for the HBT. Consumable supplies should be obtained locally when possible and only minimal supplies and instrumentation should be shipped from the Orbis warehouse or transported by VF.

Communication With VF

After the recruitment of VF is complete, the global faculty relations team will introduce the PO/ PM responsible for communicating with the VF about the HBT. The communication will include the program details, objectives of the training, and local logistics such as daily schedules, translations services (if required), lecture venues, and operating theatres.

An introduction document of the host hospital will be shared with the VFs to provide general information about the hospital's location, activities undertaken by the hospital, other information such as climatic condition during the HBT dates and recommended things to carry during the visit.

Teleconference calls

For HBTs involving direct patient care, two teleconference calls will be arranged to discuss HBT objectives and clinical details. The FRCS team will work with the PO/ PM and VF to schedule and set up the teleconference. (Refer Annexure 18: Objective of the teleconference calls)

Cybersight Pre-screening

Cybersight plays an important role during HBT to help the trainees to communicate with the VFs before HBT. The trainees must register on Cybersight and upload individual patient cases on Cybersight for VFs to review. This process allows VFs to pre-determine which patients will be appropriate for surgery

during the program. To streamline screening day and to provide more time for hands-on skill training, it is important that the reviewing of patients is done beforehand which allows VFs to focus on the planned teaching objectives.

Logistics and Travel (this is country specific)

Once the VF is recruited, the PO/ PM needs to work with the partner, faculty relations team, and the VF's appropriate travel team to obtain a letter of invitation for the VF, which is generally needed for obtaining travel visas. The letter of invitation is also needed by the VF to request time off from his/ her employer. The travel team in OI will coordinate with the VF to make flight and visa arrangements. The travel team will also coordinate with the responsible PO/ PM (or responsible country office operations/ logistics personnel) to book local accommodation, airport transfers and ground transportation.

Shortly before the VF's departure, the Orbis Travel Team will compose a summary email with all practical information (hotel, emergency contact, schedule, ground transport details, etc.) and send it to the VF.

During the HBT

Communication: The PO/ PM is responsible to communicate with the FRCS team and the VP clinical services about the arrival of VF(s) and share daily updates about the HBT.

Patient records: The PO/ PM will also work with the VF and partners to complete the HBT patient records (Orientation to HBT Patient Record Form).

Emergencies: In case a VF or Orbis staff member gets sick or needs medical attention while on an HBT, seek immediate and appropriate medical attention. If care is needed, Orbis's Global Travel Assistance Program MedAire can be consulted to support the staff, volunteers, and visitors while travelling on behalf of Orbis (MedAire's contact information is available on Orbis portal: HBT Planning Guidelines).

Reporting After HBT

The PO/ PM (or Orbis clinical staff member) should conduct a debrief session with the VF at the end of the HBT to obtain their thoughts and recommendations and include them in the HBT Post-Training Evaluation form. The PO /PM and the VF should complete certain sections of the evaluation form (sections 2 and 3) together at the end of the HBT. The completed forms are then submitted to the Director of Program Development & Quality and the FRCS team within two weeks of the HBT's conclusion. The HBT Patient Records are sent by courier through FedEx to the Program Associate in New York Headquarters office (while leaving one copy with the partners) immediately after the HBT.

Case Closure on Cybersight

After the HBT is completed, the hands-on trainee will update the information of each case on Cybersight. The information includes the type of treatment provided and follow-up remarks. The information is further reviewed by the VFs. The cases are open on Cybersight till the follow-up information is updated and closed by the hands-on trainee. For more information on HBT, refer: https://portal.orbis.org/Interact/Pages/Content/Document.aspx?id=2904

Cybersight

Cybersight is an online training and mentorship service platform for eye health professionals across the globe. With advanced online training tools and access to international expert faculty and trainers, Cybersight is a global platform that helps eye health professionals improve their skills, collaborate on diagnosis and treatment of their patients and connect with a truly global community which includes technicians, nurses, optometrists and ophthalmologist. Click here to know more about Cybersight

Introducing Cybersight to the partner

After the formal agreement with the hospital partner, Cybersight must be introduced to the partner organization and project staff by the Orbis Project Manager. It can be a 1-2 hr workshop, to be attended by not just the project staff, but the ophthalmologists, partner head (if possible), optometrists, nurses, etc- beyond the program team at hospital.

The workshop will include:

- A virtual tour of the Platform
- Types of services offered by Cybersight
- How to use Cybersight for strengthening the implementation of ICBI
- Registration process

Hospital Based Trainings and Cybersight

All the Hospital Based Trainings (HBTs) can be recorded and uploaded on Cybersight platform, for others to access and gain information. The recording link can also be shared with other ICBI Partners across the country or relevant Orbis partners across the globe.

To record the HBT and share training link with others, here is a step-by-step procedure

- **Internet Test:** The purpose of internet test call is to help the VF become more accustomed and familiar with the platform and check the internet connectivity, audio and video devices used by the VF. The call is also important to discuss and finalize an agenda prior to the HBT. The test call is being organized with support of the technical advisor of Cybersight. The Cybersight team member will schedule the meeting and share the details with the VF directly, keeping Project Manager in loop.
- **Creating registration link:** The Project Manager can provide relevant information to the Cybersight team for creating a registration page. The information required to create registration page include- Title, Brief description of training in about 150 words, and photograph of the VF. The link can then be shared with relevant stakeholders for registering to the Training.
- **Broadcasting the training:** The training can be attended live with everyone who signs up for the training. Details would be shared by the platform on their registered mail id. Cybersight technical support team will provide a host link (which is different from the participation link) to the VF and Project Manager to sign up as per the schedule.
- **Recording:** The recording of session will be made available post the HBT, which can be shared with the participants and others for their reference.

Cybersight webinars

Cybersight platform organizes global, live and free webinars throughout the year. The schedule of the webinars of a particular calendar year is uploaded here

Orbis India also organizes in-country webinars through Cybersight platform. The project manager must share details of the in-country webinar with the Partner hospital on regular basis. Orbis India Communications team will design and provide e-mailers and social media messages for circulation.

Monitoring and Evaluation

Project Initiation

The core deliverable/ objective of Project Initiation phase is to launch project and ensure all partners share a collective understanding of roles, responsibilities, and expectations. It is to ensure effective communication and relationship building with partner for shared ownership of project goals, understanding of work burden and project requirement.

All PM and M&E tools and documentation are prepared at this stage, like Project Operational Plan. Project Operational Plan contain the Baseline Data Collection Tool, Indicator Reference Sheet and Data Flow Chart as per the standard Orbis template.

Baselines are used for comparison with monitoring or evaluation data collected during or after the implementation of a project. They are vital to setting realistic performance indicator targets and for measuring change over time. Baselines and baseline trends can also serve an important comparison function for both impact and performance evaluations by providing a point of comparison for future data collection.

Phase I is used to collect institutional data to create a partner performance baseline prior to the initiation of Phase II; allowing for monitoring progress of the project and comparison of achievements at the end of the project. This baseline will help Orbis in conducting mid-term and final evaluation of the project. Baseline data will also be used to re-examine the targets set for Phase II and subsequent modification of targets and related budget as required.

Baseline data is collected before implementation of an intervention using Baseline Data Collection Tool. If performance indicator baseline data cannot be collected until later during the project, the Project Operational Plan documents when and how the baseline data will be collected.

Baseline data is collected for a baseline timeframe of three years, against all performance indicators. It is measured using the same data collection source and method that will be used to collect data for that indicator throughout the life of the project. Each disaggregate of a performance indicator must also have a baseline. For example, the indicator # eyeglasses prescribed must be disaggregated by gender, and type of service site/ outreach.

Implementing projects involve continuous monitoring – or routine collection of data and information that allows to gauge if activities are being implemented according to expectations, and if barriers or challenges need to be addressed. Developing a comprehensive monitoring tool to define how and what all information from the project will be tracked becomes vital for the said purpose. It is also a foremost requirement for good data quality control. Project management training for data collection, and reporting, ensures integrity of project design and deliverables.

How the data collected from the field/ stakeholders will be recorded? What will be the flow of information within stakeholders? These questions are answered through a comprehensive description of well-defined indicators, monitoring schedules, list of data sources to be used before project activities are implemented. This information is compiled using Orbis standard templates- project's Indicator Reference Sheet and Data Flow Chart.

Monitoring

A standardized IT-enabled data management system, ICOM, is used to manage data and facilitate smooth project operations in outreach (for screenings conducted in Schools, Anganwadi Centers and screenings through Vision Van). Vision Centers are equipped with hospital- owned software/ ICOM, and HMIS for data management. The implementation of ICOM at the partner site reduces the potential for transcription errors. Orbis can access ICOM on the central server directly for analysis and reporting.

Data against most of indicators- #screenings/ examinations, #eyeglasses prescribed, # of children referred from schools, anganwadi centers- (Direct Screening by Clinical staff, Confirmatory Camp), screening done through Vision Van, is accessed on real-time basis from ICOM. This data will be accessible to project staff at Hospital, and at Orbis as well once data will be synced by project staff. Data from screenings done by teachers is captured in paper-based record- *Screening Report by Teachers* and collected by project staff on bi-monthly/ monthly basis. *Post Camp Report Collection Template* is maintained for pediatric screening and referral data captured in Adult Outreach Camps is submitted to project staff at the end of the month.

Data for trainings conducted at base hospital is maintained by project staff in *Quality Training Attendance Template* and *Staff Training Template*. Children referred to base hospital from vision van, outreach, are identified through referral slips issued to children.

Data for orientation of Anganwadi Workers (AWW) on eye health and training of teachers on eye health and conducting primary screening is maintained by project staff in *AWW Orientation Attendance Report*, and *Teachers Training Attendance Report*.

The data of patients' visits to vision center is maintained in hospital- owned software/ ICOM. The consolidated report is sent to hospital on monthly basis from Vision Center in excel template- *Monthly Program Report.* At the end of every month, project staff compiles data from all primary data source for reporting to Orbis in excel template 'Monthly Program Report' (going forward this data would be entered and reported to Orbis in MIST database). Data is extracted from HMIS (eg. #surgeries); from paper-based records '*Training Attendance Record'* for training events held in the month at hospital; from '*Monthly Communications Checklist*' for IEC material data; *Vehicle Logbook* for vision van operations, data for child screening in adult outreach camp- *Post Camp Report Collection Template* along with data from ICOM.

The compiled report is reviewed by project staff at partner site and shared with Orbis by 5th of every month along with *Monthly Cost Booking Sheet* through the MIST platform.

The Program Officer/ Manager at Orbis cross-checks data points in *'Monthly Program Report'*. For eg., #eyeglasses provided with # eyeglasses booked in Cost Booking Sheet. Also, data from ICOM is cross-checked with data reported in '*Monthly Program Report'*. Follow-up with project staff at partner site is done to review monthly progress against targets. Also, any query on data reported is resolved.

The Program Officer/ Manager at Orbis presents the *report* updated in MIST in Monthly Review Meeting at Orbis. Project status is reviewed against set targets and budget in comparison with achievements and budget utilization. Follow up implementation plans are also discussed in the meeting.

Data is submitted in Orbis Global M&E System, Indicata every quarter by the 15th of every month post quarter end. The Program Officer/ Manager compiles and presents *Quarterly Progress Reports* (narrative and Excel spreadsheet for results reporting) in the Monthly Review Meeting at Orbis. The Program Officer/ Manager incorporates the suggestions based on the discussions and submits the report to the Associate Director- Programs for approval after it is reviewed by the M&E Manager and Senior Program Manager. The case stories are reviewed by the Communications Manager/ Senior Officer- Communications Manager & Senior Program Manager, before submitting it for approval to the Associate Director- Programs. These approved project's quarterly progress reports and case stories are entered in Indicata by the Program Officer/ Manager.

Quarterly Progress Reports are reviewed and endorsed by Country Director before submission in Indicata. Project monitoring is carried out regularly by the Orbis Program Officer/ Manager responsible for the project through quarterly site visits as well. During these visits, progress of all key activities of the project are monitored. In addition, at least once a year, the Program Officer/ Manager is accompanied by the Grants Manager to review financial reporting by the partner and assess their financial practices. Post-monitoring visit reports are sent to the partner by the Program Officer/ Manager highlighting key findings of the visit, discussions held and any action items.

Orbis's M&E Manager and Program Officer/ Manager visit the partner hospitals and its sub-reporting entities (Vision Centers) to check data quality using Orbis's Project Rapid Data Quality Assessment (RDQA) template.

The Program Manager, Senior Program Manager, Associate Director - Programs, Director – Finance, Compliance and Legal Affairs and Country Director, provide support with internal reviews of the project, including finances.

Evaluations

Interim Evaluation: This evaluation is done at the end of Phase I with the aim of assessing the outcome of interventions during the first two years of the project. This independent evaluation is done by an external Quality Consultant. This will also lead to any modifications that may be required in the strategy, activities and targets of Phase II implementation. The experiences of both the partner and Orbis concerning this project are also noted. The final report with recommendations is shared with the partner. Subsequently, discussions are held with the management and project team of the partner on the evaluation findings and recommendations to plan the remainder of the project, including any corrective action(s) that may be required.

Mid-Term Evaluation: This evaluation is carried out at the end of second year of Phase II implementation by an internal/ external team to critically evaluate the progress as per project plan. Any key successes or failures/challenges will be recorded. The experiences of both the partner and Orbis about the project are also noted. The final report with recommendations is shared with the partner. Subsequently, discussions will be held with the management and project team of the partner on the evaluation findings and recommendations to plan the remainder of the project, including any corrective action(s) that may be required.

End-Term Evaluation: The evaluation will be conducted at the end of the project, by a team of consultants with ophthalmology, management and public health expertise for an in-depth analysis of the entire project. These findings will be shared with the partner as well as Orbis to allow both parties to learn from the experience and incorporate the same into future activities. It will also pave the way for conducting impact assessment of the project intervention.

Following key areas will be covered during evaluation:

- To what extent have the project objectives and results against targets (outputs, outcome) been achieved?
- What are the factors that contributed to these results or achievements?
- How effectively and efficiently has the project been implemented and managed?
- Has the project been relevant in terms of adopting the most appropriate strategy for the problem and context? What are the missing gaps in the strategy adopted?
- What have been the strengths, gaps/challenges and lessons learned within the project?
- To come up with strategy and implementation level recommendations for the benefit of project in terms of what has worked, what has not worked and what are the areas of reconsideration for Orbis, partner hospital(s) and other stakeholders.

These findings will be shared with the partner as well as Orbis to allow both parties to learn from the experience and incorporate the same into future project activities. It will also pave the way for conducting an impact assessment to assess changes in the community as a result of project interventions.

Project completion

Project completion involves taking stock of the final deliverables of the project, handing over of the project related assets, settling of finances and formal communication about end of the project with the partner.

On the completion of the project, the following documents are developed:
Program: A project ending report (including program and finance) is developed by the partner hospital, documenting the success and failure, challenges faced during implementation of the project and submitted to Orbis Program Manager. This is then finalized internally within Orbis office and then submitted to the donor as required. The report is uploaded in Indicata and all the achievements till end of the project are entered.
After this, the project is marked ‘Closed’ in Indicata.

Finance: Based on the project report, Orbis Finance team at the country office will reconcile the project expenses with MIP. Final entries will be made in the MIP to reflect total project expenses. Along with this, the partner hospital is required to submit the details and locations of all assets given to the partner for the project. At the completion of the project, the assets are donated to the partner and a letter stating the same is provided to the partner. The Program Manager will send a ‘No Dues’ declaration template to the partner organization to receive confirmation that there are no outstanding financial support requirements or pending claims against Orbis. With receipt of signed letter from partner organization the project is financially closed.

Impact Assessment

Baseline data @ Phase I

To establish evidence on the existing prevalence of blindness and visual impairment in the project area, Rapid Assessment of Avoidable Blindness (RAAB) studies is planned and implemented before the project implementation. The results from these surveys are used to plan the project strategy and serve as a baseline to compare the achievements after a few years from implementation.

Rapid Assessment of Avoidable Blindness (RAAB) and Diabetic Retinopathy (DR)

RAAB is a rapid survey methodology using a population-based survey of blindness and visual impairment and eye care services among people aged 50 years and above. RAAB can provide data on the prevalence of blindness and visual impairment, its main causes, the output and quality of eye care services, barriers, cataract surgical coverage and other indicators of eye care services in a specific geographical area.

There are two main reasons to collect RAAB survey data on blindness and visual impairment in a community.

- To help eye health managers develop programmes for control of blindness based on a community's needs.
- To help monitor existing blindness control programmes and adjust these programmes, as and when required.

RAAB survey data provides only some of the information needed to plan interventions.

Limitations of RAAB

- RAAB is not a case-finding exercise: It will not provide a list of names and addresses of all the people who are blind or visually impaired in an area.
- RAAB is not a detailed blindness survey: It provides a reasonably accurate estimate of the prevalence of blindness, and the proportion that is avoidable in a geographic area. RAAB is not designed to give accurate estimates of the prevalence of specific causes of blindness and does not measure posterior segment eye disease in detail.
- RAAB focuses on people aged 50 years and above and so it does not give an estimate of childhood blindness, which is better measured through the Key Informant Method. RAAB provides data on uncorrected refractive errors, spectacle coverage and uncorrected presbyopia in people aged 50-plus. It does not provide data on refractive errors in people younger than 50 years.

Carrying out RAAB survey for the project:

- It is neither easy nor straightforward to undertake.
- Advised to coordinate with a CEH-certified RAAB trainer when planning a RAAB survey.
- Chances of biased results if not carried out with high quality.
- Will involve a huge amount of funds and time to complete.

- Recruiting survey personnel.
- Developing the sampling frame for the survey with the support of RAAB trainer.
- Carrying out a baseline needs assessment.
- Selecting the clusters to be examined
- Arranging transport and equipment logistics.
- Organising and ensuring the quality of the staff training.
- Managing the data - collecting survey records, managing data entry, analysis and report writing.

Diabetic retinopathy module in RAAB

Globally, the prevalence of diabetes is rapidly increasing and left us with little information on the prevalence of diabetic retinopathy (DR) particularly in low- and middle-income countries. The DR module for RAAB (RAAB+DR) was developed as a relatively rapid method for estimating the prevalence of diabetes and DR in the population aged 50 years and above. This module follows two additional components i.e., assessment of the diabetes status of survey participants and assessment of DR among survey participants identified with diabetes.

Limitation of RAAB+DR module

- Includes people aged 50 years and older and cannot estimate the prevalence of diabetes and DR in younger age groups.
- Keep the survey relatively rapid. RAAB+DR uses simplified examination procedures that can be conducted at the household, which has implications for the degree of clinical detail collected.
- Diabetes diagnosis is based on history of diabetes or elevated RBG rather than a fasting blood glucose or oral glucose tolerance test.
- DR assessment is by dilated examination by direct and indirect ophthalmoscope using a simplified grading system.
- RAAB+DR therefore does not provide comprehensive detail on the level of DR.

Carrying out RAAB+DR survey:

DR component in RAAB adds significantly to the time, resources, cost, and complexity of the survey. It should only be undertaken if

- The prevalence of diabetes is expected to be high (e.g.>15% among people aged 50+ years),
- There are enough resources, experienced DR graders and time
- Diabetic and DR services are available and accessible

The information will be used for planning DR services. If available, a standard RAAB should be undertaken. (http://raabdata.info/about-the-raab-repository/what-is-raab/, n.d.)

Orbis, carried out RAAB among two partners i.e., Akhand Jothi Eye Hospital (AJEH) and Susrut Eye Hospital (SEH). The main purpose of conducting RAAB in partner location, was to identify the prevalence of blindness in the partner's service location and develop the intervention programmes

accordingly. It is recommended to implement RAAB studies minimum twice, one in the beginning of the project to establish baseline data on the burden of various avoidable eye problems and after 5 years to assess the impact of the intervention in the service area.

The team from the partner hospital will be identified and will be trained to implement the study as per the protocol. Research capacity building activities will be undertaken for partner's team to plan, implement, document, analyse and publish the findings in conferences and in peer reviewed journals.

Knowledge Attitude and Practices assessment (KAP)

Generate baseline data during Phase I (years 1 and 2) of the project

During Phase I, along with RAAB & RARE, a Knowledge Attitude and Practice (KAP) study is also conducted (as appropriate) to create a baseline dataset required to assess knowledge gaps about eye care, attitude towards eye care services and ongoing practices related to eye care in the community (project catchment area), prior to project commencement. This is usually known as a pre-project KAP study. Based on the findings from the study, a strategic communication plan is developed, part of which is the development of Information Education Communication (IEC) activities that are executed/ implemented/ disseminated during the life of the project. Other than the IEC activities, a media outreach plan for partners is also devised based on the available resources to increase visibility for Orbis's work in the community. Impact of IEC interventions need to be assessed through a post-project KAP study to generate end line data and complete the circle.

Definition

A KAP survey usually is conducted to collect information on the knowledge (i.e., what is known), attitudes (i.e., what is thought), and practices (i.e., what is done) about eye health, eye care services, and it's availability among a particular population.

KAP Survey: Process

Information is to be collected by interviewers through a structured, standardized questionnaire that may include both quantitative and qualitative data.

The KAP survey should include (but not limited to) data that can be used for the following purposes:

- To identify knowledge gaps, cultural beliefs, and behavioural patterns that may identify needs, problems, and barriers to help plan and implement interventions.
- To deepen the understanding of commonly known information, attitudes, and factors that influence behaviour.
- To generate baseline levels and measure changes that result from interventions.
- To assess and identify communications processes and sources important for program implementation and effectiveness.
- To help set program priorities and make program decisions.

As mentioned earlier, a KAP survey, ideally, should be conducted before and after a project, if possible. A pre-project KAP survey will provide data that may help with the communication planning and provide baseline data to help measure impact of campaign-related activities. A post-project KAP survey will provide data that will help evaluate the campaign-related activities. Should there be insufficient time and resources to conduct a complete KAP survey (pre- and/or post-project), the communications and

program teams may consider using a rapid assessment questionnaire to determine whether certain campaign activities/processes should be modified in real time. These assessments may be conducted at any time during a communication campaign.

KAP Surveys: Who Can Conduct Them?

Survey staff must have knowledge of survey methodology, eye disease prevention and control measures. Assistance from the Orbis Technical Advisor and even Orbis technical partners with relevant expertise also may be requested, and external interviewers with survey experience may be hired.

Survey Protocol and Questionnaire Development

The following is an outline and brief discussion of practical steps for survey protocol and questionnaire development. In general, a survey protocol should include the following items:

- A statement of the problem or its background
- Survey goals and objectives
- Survey methodology including the survey population, survey design, survey sampling plan, enrolment and consent procedures, data collection procedures, data management and analysis plans
- Plan for use and dissemination of survey results
- Ethics review
- Budget (allocation)
- Project schedule
- Questionnaires and interview forms as annexes

General Steps for KAP Surveys

Step 1: Review existing information
Step 2: Determine survey goals
Step 3: Define survey objectives
Step 4: Outline survey methodology
Step 5: Develop the survey questionnaire
Step 6: Determine the requirements for ethics approval

Budget and logistics

Budget allocation for KAP survey should be made during project planning phase to ensure availability of resources for conducting the same. Final budget calculations should be made in adherence to the allocated budget while outlining survey timeline and logistical plans. Main funding categories to include in the budget line are the following:

- Training
- Personnel
- Transportation and per diems
- Equipment and supplies
- Data collection, management and analysis.

Translating Findings into Action

In general, upon completion of the data analysis, a summary report should be drafted and findings should be translated into action. The survey coordinators and field teams should be the primary authors of the report, with help from Orbis, any other collaborators and technical experts involved in the survey. The report should include a 'project background, the survey objectives, methods, and results, a discussion of the results, conclusions and recommendations. The survey questionnaire and summary data tables and figures should also be included as annexes. The final report should be made available to all stakeholders, and results should be presented at relevant meetings to encourage discussion and inform program planning.

Implementing Partner(s) Orientation for Devising Communication Plan

Once the KAP findings are available, the implementing partner(s)' teams, with guidance (where applicable) from Orbis communications team, should assess, analyze and lay down the key findings from survey report during Phase I of the project. Throughout the life of the project, interventions will be supplemented with the communication tools designed to carry key messages to address the findings from the KAP survey report. To develop the tools, the Orbis communications team will engage with the implementing partner(s) in an interactive orientation to discuss the ground level experiences faced in relation to the findings and prioritization of the key findings to be addressed.

Based on the discussion, communication tools and messages will be developed by the implementing partner(s)' project teams. Development of posters, flyers, leaflets, brochures, booklets, messages for health education sessions, radio broadcast or TV spots, etc. as a means of promoting desired, positive behaviours in the community are carried out as part of IEC activities. These activities are part of the communication plan discussed during the orientation along with devising a comprehensive dissemination strategy.

Information Education Communication (IEC)

An operational definition of "IEC" refers to a public health approach aiming at changing or reinforcing health related behaviours in a target audience, concerning a specific problem (in this case, an eye care related problem) and within a pre-defined time period, through communication methods and principles.

The communication orientation and IEC activities should also be conducted with the following in mind:

- have a clear objective (the specific behaviour to change or reinforce);
- target a specific audience (e.g., parents of children, Anganwadi workers, school personnel, healthcare workers);
- prioritize "specific problems" (e.g., accepting advise of local quacks to treat child's eye problem), rather than attempt to address multiple problems at the same time;
- set a timeframe within which the results ("change in behaviour") are expected to occur.

The "problem" must be well defined, as that is what the IEC intervention aims to address. Thorough understanding of what people do, what prevents them from following the desired practices ("barriers") and what facilitates them ("enabling factors") is essential before designing a communication intervention. Refer Annexure 19

This requires a detailed plan, the implementation of which needs to be closely monitored and evaluated, based on pre-set indicators.

Development of IEC.

The implementing partner(s) can develop the IEC or hire an agency/consultant to develop the IECs as per budget availability. Community based organizations with ample experience in generating awareness locally can be engaged as per project budget allocation.

Pre-test of IEC
After developing the IECs, a pre-test of all materials is necessary to understand whether the messaging, look and feel are resonating with the community. Refer Annexure 20

Dissemination of IEC
Once you have finalized your IEC materials based on the pre-test, you'll need a dissemination plan. Refer Annexure 21

Monitoring the progress, usage and impact of IEC
Control group is engaged during Phase II of the project to see target audience response to the IEC activities. The project team at partner hospital also logs the monthly dissemination of each IEC material. Refer Annexure 22

Revisiting IEC mid-term of project based on TA response
Based on the response received, the IEC can be further revised to produce desirable results

KAP Study to Generate End line Data for Assessment of Impact of the Communication Plan
As the project comes to a close, an end line KAP survey needs to be conducted to measure the impact of the communication plan devised in Phase I and implemented throughout Phase II. Questionnaires should complement the ones used during the pre-project KAP to see measurable change in eye health seeking behaviour, knowledge, attitude and practices amongst the community. Since the communication plan would not cover all key findings from the pre-project KAP survey, it is imperative to devise the questionnaire as per the findings addressed through the communication plan alone. For instance, the pre-project KAP survey has reported 10 findings of which merely four were integrated in the communication plan throughout the project. The post-project KAP survey questionnaire should encompass questions/ interviews around the select four findings aimed to be addressed through the plan.

Measurable outcomes
One can measure outcomes of an IEC dissemination plan by devising a feedback mechanism for direct and indirect beneficiaries. Refer to Annexure 23

Follow up impact assessment

It is ideal to conduct a follow up impact assessment after the project implementation period to create evidence on the impact and the changes contributed due to this project. However, due to resource constraints this activity will not be included as part of the initial implementation plan and is left to the partner to assess the impact after few years of project completion. At times, this kind of activity is planned as separate research to create the evidence on the impact created in the region.

Post Project Activities

Post project activities

A broad exit strategy will be built in the design of the program which would include a roadmap to sustainability and reduction in external support. An end-term evaluation will be conducted which will be a more in-depth analysis of the entire project duration. These findings will be shared with the partner as well as Orbis to allow both parties to learn from the experience and incorporate the same into future activities.

Program Sustainability: will be achieved by improving availability, accessibility and affordability of service provided by the partner hospital. This will be ensured by incorporating the following strategies in the program design:

- Establishing the image of a high-quality service provider through quality services as well as IEC to increase community awareness, thereby attracting paying patients and increase revenue generation.
- Increase in involvement of local doctors, NGOs and health workers in the initiative so that they can continuously refer cases to the hospital
- Establish the referral linkages by continuously engaging the school teachers and the community health intermediaries as the Anganwadi workers, during the project duration and beyond

Financial Sustainability: For ensuring financial sustainability it is important that the hospital further increases its revenue to sustain the pediatric eye care unit. With more outreach camps being done as part of the project and introduction of services at the vision centers, there will be an increased footfall in the hospital, thus increasing revenue from patient services. To ensure sustainability of the project, the partner will share a part of the total project cost from the paying patient's revenue and grants. It would be nearly a quarter of the total project cost and partially support capital costs in terms of disbursement of spectacles and cost of surgeries. Orbis will initially support the cost of some of the project staff as project manager, one outreach coordinator and one data entry operator, and this will be reduced gradually on an annual basis. The partner will support all other salaries.

Human Resource strengthening: To retain eye care and management personnel, management at partner hospital will continue its efforts to retain their trained staff as well as develop second line human resources in order to continue pediatric ophthalmology service delivery beyond the life of the project. This will include continuous skill development through training, competitive remuneration, and establishing a good working environment for the staff. The partner hospital will develop a growth plan for these individuals, post-training as part of the institutional HR retention strategy. To have a clear succession plan, required training and exposure will be given to facilitate leadership development and ensure their engagement to drive future growth and success of the organization. Exposure visits and vision building workshops will be conducted to facilitate Leadership Development of key team members of partner hospital and their engagement for success and growth of the organization

Close to the end of the project, the senior management at the partner hospital should conduct final review of the project from sustainability point of view and plan for exit.

Engagement with the partners post project period: Orbis and partner(s)' engagement does not end with the end of the project. Key activities undertaken post project to continue this engagement includes:

- **Annual Partners' Meet:** Orbis organizes a Partners' Meet every year to provide a common platform for discussion, sharing of knowledge and experiences as a means of continuous engagement among Orbis and its ICBI partners.

- **Quarterly Newsletter:** Orbis publishes a quarterly e-newsletter to disseminate news and information to its partners, well-wishers and the community at large. The newsletter spotlights Orbis activities and events, highlight the latest news at partner institutions, informs them about upcoming events and features inspiring stories from the field.

- **Research:** Orbis collaborates with its partners to conduct research to generate evidence

- **Thematic workshop:** From time to time, Orbis organizes thematic workshops, for example on new government guidelines for NGOs, to build the capacity of its partner organization

- **Donor visits and study tour:** Orbis organizes donor visits to showcase the work carried out under various projects. Occasionally delegates and groups of students visit the projects to learn best practices and models worthy of emulation.

- **Training program:** Orbis continues to support human resource development in partner organizations by encouraging them to participate in training program organized by Orbis in the likes of Hospital Based Programs, Skill transfer workshop and training through Flying Eye Hospital.

- **Cybersight:** Orbis continues to support them with advanced online tools, techniques and training through Cybersight which offers them an opportunity to remotely access education and guidance.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AKHANDJYOTI
Sight. Life. Hope.
Children's Eye Center
at
Akhand Jyoti Eye Hospital
has been established
with the support of
Orbis International
Inaugurated by
Bob Ranck
President & CEO
Orbis International
April 03, 2019
अखंड ज्योति आई हॉस्पीटल
के
बाल नेत्र चिकित्सा केन्द्र
को
ऑर्बिस इन्टरनेशनल
के सहयोग से
स्थापित किया गया है।
बॉब रैन्क
अध्यक्ष और मुख्य कार्यपालक पदाधिकारी
ऑर्बिस इन्टरनेशनल
द्वारा उद्घाटन
अप्रैल 03, 2019

Annexures

Annexure 1

Initial Assessment Form for Potential Orbis Partner

1. **Organization Contact Information**

Name of Organization			
Street Address			
Postal Address			
City/Town/District			
Province/State/Region			
Postal Code			
Telephone 1			
Fax			
Website			

2. **(DIRECTOR)**

Last Name	
First Name	
Year when attained position	
Email Address	
Telephone Number	

3. **Board Chair**

Last Name	
First Name	
Year when attained position	
Email Address	
Telephone Number	

4. **Head of Ophthalmology Department**

Last Name	
First Name	
Year when attained position	
Email Address	
Telephone Number	

5. **Sector Affiliation** (Please √ one)

Private, For-Profit	
Private, Not-for-Profit (provide registration number if applicable)	
Public	

6. **Establishment Date**

Year of establishment	

7. **Institution Type** (Please √ one and indicate how many beds in column to the right)

General Hospital		Number of beds
Children's Hospital	-	number of beds
Eye hospital with child eye care unit		number of beds
Eye Hospital without child eye care unit	-	number of beds
Other (please specify)	-	number of beds

8. **Level of Care** (Please √ one)

Primary full eye screening, prescription and supply of low-cost spectacles, referral to the next level for treatment, link to other community services	

Secondary diagnostic evaluation, cataract surgical services, other minor surgical procedures, low vision services	
Tertiary basic, secondary & tertiary care; training of residents and other ophthalmic staff; low vision & rehabilitation services; clinical and operational research	
Center of Excellence basic & super-specialty tertiary care; sets standards; develops training materials for national/regional health eye care systems; clinical & operational research	

9. **Organization** Framework for its Work

9.1 What is the mission and/or vision of your organization?

Vision MISSION:

9.2 Does your organization have a strategic or business plan? When the plan was last updated?

10. **Catchment Area Details**

Child Population (0-6) of the state is (All data as per provisional data of population census 2011)	
Male Child Population is (All data as per provisional data of population census 2011)	
Female Child Population is (All data as per provisional data of population census 2011)	
Total percent of state population is in age group of 0-6. (All data as per provisional data of population census 2011)	
Percent of male population of state in age group of 0-6. (All data as per provisional data of population census 2011)	
Percent of female population of state in age group of 0-6. (All data as per provisional data of population census 2011)	

Child sex ratio of state is (All data as per provisional data of population census 2011)	
Actual Population of state as per census 2011.	
Male Population of state is (All data as per provisional data of population census 2011)	
Female Population of state is (All data as per provisional data of population census 2011)	
State population percent of total population of India. (All data as per provisional data of population census 2011)	
Regions constituting catchment area	
Total catchment area population	
% of males vs. % females	
% of adults vs. % children under 14 years of age	
Blindness prevalence in the catchment area (please specify year and source of data)	

Major causes of blindness in the catchment area (please specify year and source of data)	
Cataract Surgical Rate in the catchment area (please specify year and source of data)	
Within the catchment area:	
- Does your institution have satellite/vision centers? If so, how many?	

- Are there other organizations that provide eye care services? If so, please name them and their areas of focus.	

11. **Type of services offered** (Please √ where applicable and provide details)

Treatment in different ophthalmic subspecialties (specify subspecialties)		
Training courses in ophthalmology (specify subspecialty areas and durations)		
Other (e.g., laboratory, pharmacy, optical shop) (please specify)		

12. **Systems**

12.1 Does your organization monitor the quantity and quality of clinical services? If so, please explain how clinical services are monitored.

12.2 Does your organization collect data that has patient gender and age disaggregated? If so, how is this data analysed?

12.3 Does your organization have a Management Information System (MIS)? If yes, please describe it, its function, and purpose.

12.4 How does your organization maintain and manage patient medical records and how long are they kept?

12.5 Does your organization have reliable internet connections?

13. **Community Relations and External Collaborations**

13.1 Does your organization provide outreach eye care services to poor populations?

13.2 Does your organization currently collaborate with the government?
If yes, provide details including who, why, what, brief results, and current status. (Maximum 150 words) ***If your institution is a government agency, please skip this question.***

13.3 Does your organization work with local or international non-governmental agencies?
If yes, provide details: who, why, what, brief results, and current status. (Maximum 150 words)

14. **Working with ORBIS**

14.1 If your institution has previously worked with ORBIS, please provide details, including when it has worked with ORBIS, in what capacity, and with what results.
(Maximum 250 words)

14.2 Brieflyexplain your institution's current interest in partnering with ORBIS and what it hopes to gain from this partnership**.**
(Maximum 250 words)

Detailed Information: Service Outputs, Human Resources, Financial Resources

* Please include data from your last three fiscal years. Insert year where indicated.

Client Services

1. **Patient Data for last 3 years (This data is of only paid services at Base Hospital)**

Patients	(Year 1)	(Year 2)	(Year 3)	Reference Document/ Information Source
Number of Outpatients (Adults)				
Number of Outpatients (Children)				
Number of Inpatients (Adults)				
Number of Inpatients (Children)				

2. **Surgeries in the last 3 years (This data is of only paid services at Base Hospital)**

Adult Eye Surgeries	(Year 1)	(Year 2)	(Year 3)	Reference Document/ Information Source
Cataract – *ECCE*				
Cataract - *Manual Small Incision*				
Cataract – *Phaco*				
Cornea				
Glaucoma				
Oculoplasty				
Retina (including Diabetic Retinopathy)				
Other				

Pediatric Eye Surgeries	(Year 1)	(Year 2)	(Year 3)	Reference Document/ Information Source
Cataract – *ECCE (this includes LMA+PAV+PCCC)*				-
Cataract - *Manual Small Incision*				-

Cataract – *Phaco*				-
Cornea				-
Glaucoma				-
Strabismus				-
Oculoplasty				-
Retina (including ROP laser)				-
Other (SQUINT)				-

3. **Patients Receiving Free and Subsidized Surgeries (Activity Report attach)**

% Patients	**(Year 1)**	**(Year 2)**	**(Year 3)**	**Reference Document/ Information Source**
% of adults receiving *free* surgeries				
% of adults receiving subsidized surgeries				
% of children receiving *free* surgeries				
% of children receiving subsidized surgeries				

3.a Please explain how patient services are subsidized. For example, if it is through public insurance, what percentage of the cost of services are covered by the government? Are patients reimbursed?

Human Resources in the Ophthalmology Department

Number of Staff	**(Year 16-17) April - March**	**(Year 17-18) April - March**	**(Year 18-19) April - March**	**Reference Document/ Information Source**
Ophthalmologists				-
Pediatric ophthalmologists				

Ophthalmic residents			
Ophthalmic nurses			
Anesthesiologists			
Biomedical engineers / technicians			
Optometrists / Orthoptics			
Neonatologists (if applicable)	-	-	-
Other			

Financial Capacity (Use USD)

1. **Revenue in US Dollars ($ 1=Rs. 71.58) Enclosure (INR)**

Funding Sources	(Year 17-18) April -March	(Year 18-19) April -March	(Year 19-20) April -March
(A) Revenue at Year's Start			
(A) SubTotal:			

(B) External Revenue			
Government funds (local and national)			
NGOs (local, national, international)			
Bilateral/multilateral agencies			
Corporate sponsorships			
Endowments			
Loans			
Other (please specify)			
Other (please specify)			
(B) SubTotal:			

(C) Internal Revenue			
Patient fees			
Optical shop			

Pharmacy			
Laboratory services			
Camp Reimbursement			
Project Income			
Other Income			
(C) SubTotal:			

(D) Total Revenue = (A)+(B)+ (C)			

2. **Operating Expenses in US Dollars ($ 1=Rs. 71.58) enclosure**

Operating Expenses	(Year 17-18) April -March	(Year 18-19) April -March	(Year 19-20) April -March
Consultancy Charges			
Employee Cost			
Medical Expenses			
Rent/Repairs & Maintenance			
Power & Fuel			
Project Expenses			
Administrative Cost			
(E) Total Operating Expenses:			

(F) Net Income/Loss = (D) - (E)			

Capital Expenditures (list separately)			
1: Addition to Fixed Assets in Enclosure (1)			
2: Land			
3: Building			
4: Furniture & Equipment			
(G) Total Capital Expenditures:			

3. **Financial Position ATTACHED**

In the table below, please provide details on your institution's assets and total liabilities (USD) for each of the past three years: ($ 1=Rs. 71.58)

Expenses	(Year 17-18) April -March	(Year 18-19) April -March	(Year 19-20) April -March
Assets			
FIXED ASSETS - Enclosure (2)			
DEFERRED REVENUE EXPENSES			
F.C.R. FUND			
(A)			
CURRENT ASSETS			
CASH & BANK			
FIXED DEPOSIT WITH SCHDULE BANKS			
SUNDRY DEBTORS			
LOANS & ADVANCES			
SECURITY DEPOSIT			
TDS RECEIVABLE			
(B)			
Total (A) + (B)			
Liabilities			
CORPUS FUND			
GENERAL FUND			
PROJECT FUND			
SECURITY DEPOSIT			

(A)			
CURRENT LIABILITIES			
SUNDRY CREDITORS			
CAUTION MONEY REFUNDABLE			
TAX PAYABLE			
(B)			
Total (A) + (B)			
Total Net Assets (Current Assets Less Current Liabilities)			

4. Are your institution's finances externally audited every year and who does the audit?

5. Does your institution have a multi-tier pricing system for eye care services?
If yes, please provide details about various categories in the pricing system.

SWOT Analysis: (kindly priorities the five key SWOT and list below**)**

1. List five good things (Strength) about your centre

2. List five things that needs improvement (Weakness) in your centre

3. List five things that prevents the development of the centre

4. List five areas that the centre should focus in the next five years

Additional Comments (add if any)

Persons Who Compiled this Report

	Name	**Designation**	**Section of Proforma Completed**
1.			

2.			
3.			

Date: ……

Annexure 2
Detailed Partner Assessment Forms (PAF)

Annexure 3
Partner Assessment Tool (PAT)

Annexure 4
Summarization Tool

Annexure 5

ORBIS CONCEPT NOTE TEMPLATE

Title:
Location:
Timeframe:
TotalCost: $ USD
Potential Partner(s):
Potential Donor (s):
Disease Focus: *Please select from categories on page 3.*
Stakeholder/partner consultation done? ☐ **Yes** ☐ **No** **Not Applicable**
Pitch: *1-2 concise sentences that describe the project. Pitch should include the previous work if any and issues related to gender, inclusion etc.*

Problems	Opportunity	Orbis Solution	Sample Activities	Impact Statements
List problems that directly relate to this project and thus helps makes the case why this project is necessary. No need to include global or national statistics that are generally application to any Orbis country eye health project.	*Opportunity refers to a situation that favors us to implement project activities as we want to. It is the state in which it is possible for something to be done. Opportunity may include partner reputation, prior project experience and performance, good relationship with government and other stakeholders etc.*	*Describe solutions that address the problems you outlined. Solutions should be organized by the following categories:* 1. Child Eye Health 2. Human Resources for Eye Health (HReH) 3. Primary Eye Care 4. Trachoma elimination and the SAFE strategy 5. Advocacy 6. Creation of Eye Health Referral Networks 7. Demand Generation 8. Developing Sustainable Eye Care Services and Systems *For more information on how each category is defined, please see next pages 3-4. It is recommended that you take 2-3 Orbis solutions based on your priorities.*	*List some major and/or innovative activities organized by the solution categories you used. Please make sure to include HBTs and Cybersight, if application.*	*This should be a powerful statement that clearly states the expected impact of the project. Different than a result or outcome statement, the impact should inspire and demonstrate the influence this project may have in behavior and/or institutional change related to our Orbis mission and vision.* *Impact is the long-term effects or changes in people's lives that is caused by or attributable to a development intervention. These changes can be socio-economic, environmental, technological, institutional, health and wellbeing.*

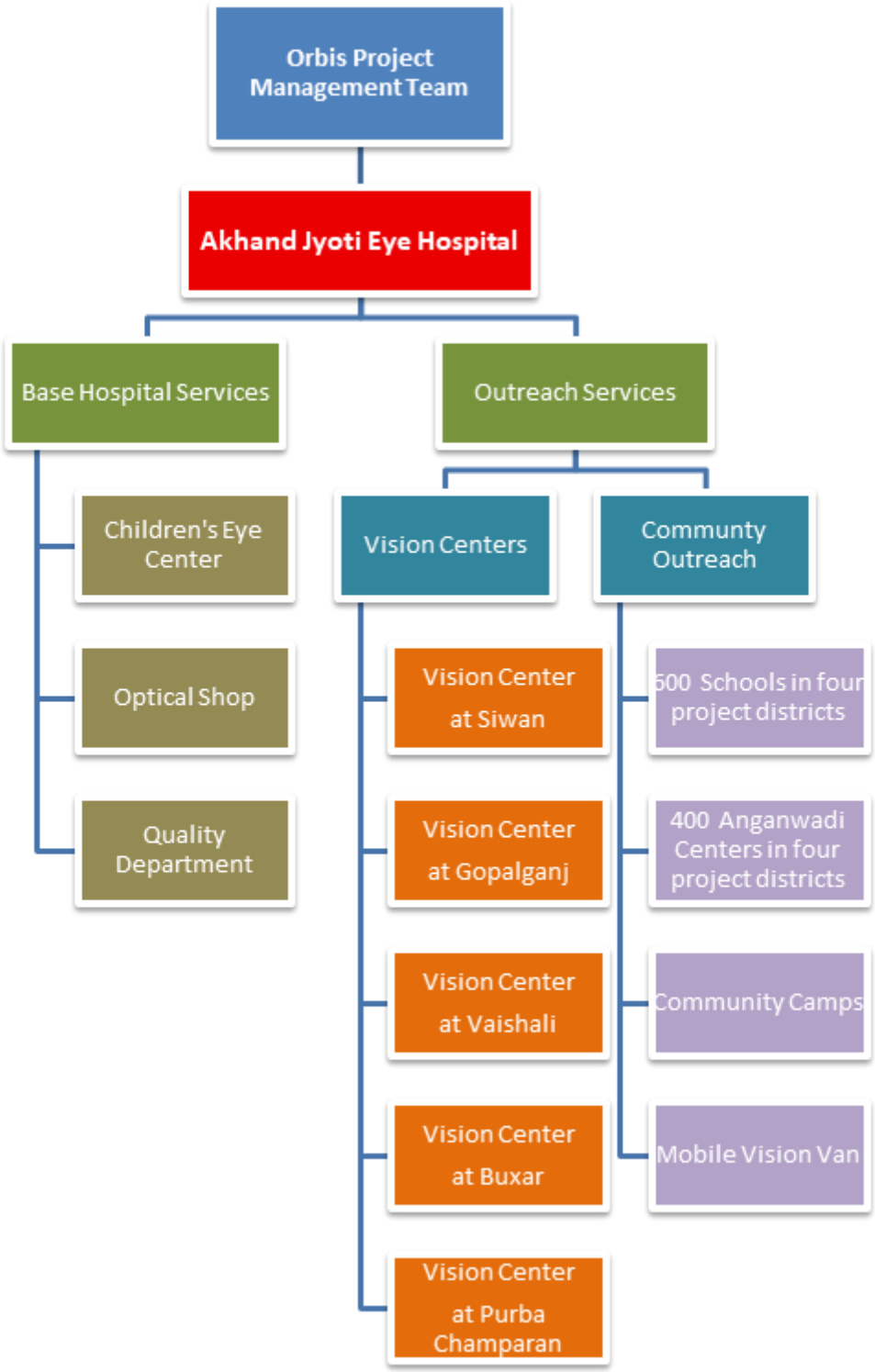
Annexure 6

Performance Monitoring Plan

Annexure 7

Project Name: Akhand Jyoti-Orbis Comprehensive Childhood Blindness Project

Project Organogram *(based on template sample)*



Annexure 8

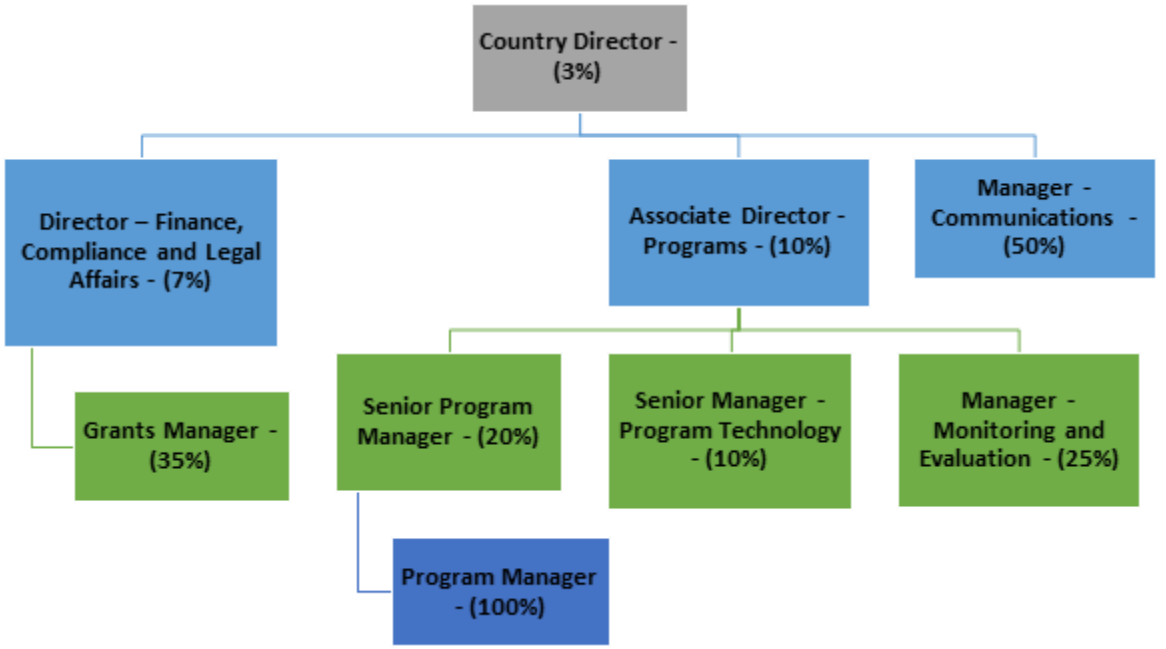
Budget Spreadsheet

Annexure 9

Project Work Plan

Annexure 10

Sample Project Management Structure



Annexure 11

Orbis standard Logframe Template*(Add as many rows as needed. Select a small but readable font size)*

Goal*:*			
Objective 1	**Outcomes (Results)** • 1.	**Outputs** . •	**Activities**
	Indicators #	**Indicators** #	
Objective 2	**Outcomes (Results)** •	**Outputs**. •	**Activities**
	Indicators #	**Indicators** #	

Annexure 12

Budget template

Annexure 13

Attendance sheet of School Teachers

Attendance List for Teachers Training						
Date : **Training Location:**						
SL.no.	**Name of the Block**	**Name of the Teacher**	**Gender**	**School Name**	**Contact Number**	**Signature**

Annexure 14

Attendance sheet for orientation of Anganwadi workers

Attendance List for Orientation of Anganwadi workers						
Date: **Training Location:**						
SL.no.	**Name of the Block**	**Anganwadi Center Code**	**Anganwadi Center Location**	**Name of the Anganwadi Worker**	**Contact Number**	**Signature**

Annexure 15

Infrastructure Requirements for Pediatric Ophthalmology Unts

1.Waiting area:

- Registration room (new/follow-up patients)
- Waiting area along with feeding room and play area: only toys, books and safe play items should be kept in the play area

2. Examination rooms:

- Examination rooms for optometrists/ophthalmic technicians and pediatric ophthalmologists. Each of these rooms should be 3.5 meters by 2.5 meters. All windows should be fitted with blinds. Each examination room should have two visual acuity charts -- LEA symbols and LEA letters. LEA symbols illuminated stand, which is kept at the eye level of the child/patient.

3. Orthoptic Room:

- Patient counselling section
- There could be a second waiting area for the patients/attendants who will consult doctors

4. Play area for kids:

- The furniture should be child-friendly in nature. For example, more rounded edges are preferable over sharp corners.
- Toilets should be adjacent to the playing area, waiting room and child friendly. For example, low toilet seats, low wash basins and showers.
- Enhance a child -friendly ambience through pictures/wallpapers of cartoons on the walls of the counselling rooms, wards and OPD. The examination room can be plain.
- Child-friendly wall paintings in the pediatric OPD

5. Pediatric beds (minimum five).

- Patient recovery room adjacent to operation theatre
- Patient ward dedicated for pediatrics with a small child-friendly area and nursing station.

Annexure 16
Outreach activities

Reference Document No.	16
File Name	Sample_SOP_Outreach Camps.docx
Document Title	SOP-Outreach Camps
Document core area	Project implementation
Document Format	Word
Document used by	Partner Hospitals
Process	Sample SOP for partner hospitals to develop a SOP for outreach camps at their hospital
Is it part of the Orbis Global Project Plan Format	No
Last Updated Year	

Updated by	
No. of pages	
Remarks	

Annexure 17
HBT Planner for Orbis India

HBT Planner for Orbis India					
S.No	**Activity**	**Required Documents**	**Timeline**	**Responsible Person/s**	**Remarks**
1	Share the HBT forms based on discipline (from intranet) with partner	**HBT Training Form(s)** Partner Hospital Checklist Hands-on Surgeon Self-Assessment Form(s)	9 -10 months before HBT	PO/PM	Provide 3-4 week's time to partner to fill the HBT forms. The documents must be reviewed by PO/PM along with Senior Program Manager and Associate Director – Programs and to be shared further with to share with Global Faculty Relations team (OI) for the VF recruitment.
2	lobal Faculty Relations team to share the credentials of VF for temporary registration in India	Two sets of updated temporary registration forms Selfattested/notarized degrees (if degree is in other than English) Self-attested passport copies Duly signed consent form by VF Updated CV and two passport photographs	6 months before HBT		Once the filled-in forms are received, PO/PM must share the documents with the partner for signature of Clinical Head. Obtain letter of invitation and demand draft from partner for VF's temporary registration.
3	Apply for VF's temporary registration	Two sets of complete documents	4 months prior to HBT	PO/PM	Expected approval for registration 3 - 4 weeks prior to HBT
4	Teleconference calls with VFs	NA	Initial call: 8 weeks prior to HBT Final call: 3 weeks prior to HBT	Initial Call- PO/PM Final Call- VP Clinical Services	**Participants for the tele conference calls** - PO/PM, Senior Program Manager and Associate Director Programs to attend the initial call along with trainees from partner, VFs, Global Faculty Relations team, and VP Clinical Services.
5	Cybersight	NA	Two months prior to HBT	PO/PM, Cybersight Administrator	Registration of all the trainees on Cybersight is required. Upload cases on Cybersight for VFs to review. Review of cases and share information with PM.

6	Logistics	NA	4 - 6 weeks prior to HBT	Office Manager along with PM	Coordinate with Orbis travel team for VFs flights and share letter of letters from partner and Country office for Visa. Arrange local travel, accommodation, visas, and hotel transfer

Annexure18

Objective of the teleconference calls

	Initial Teleconference Call (TO BE SCHEDULED 8 WEEKS BEFORE THE HBT)
Objective	• Introduction of Orbis India team involved in HBT, trainees of the partner hospital, VFs, Global Faculty Relations Team and VP Clinical Services • Review training objectives and make sure that this aligns with the focus of cases submitted to Cybersight. • Review and Finalize lecture topics, equipment/instruments at hospital and any needed supplies for the HBT. Daily Schedule with review of daily OR plans (covering approximate number of cases/days, General Anesthesia requirements (if needed), etc.) • HBT Patient Records - reviewing how to complete, • Logistics Updates • Questions / Concerns
	Check-In/Final Teleconference Call (TO BE SCHEDULED 3 WEEKS BEFORE THE HBT)
Objective	• Review Cybersight pre-screening cases • Logistics Update (Flights, Visa, Accommodation, Ground Transfers • Concerns related to any equipment/ supplies • Questions/Concerns related to logistics and HBT

Annexure 19

Susrut – Orbis Childhood Blindness Project

Communication Matrix

Objective of the communication	What to communicate *Message*	With whom *Target Audience*	When to communicate *Frequency*	How to communicate *Medium*
Awareness on the importance of eye examination for children	Get an annual eye check-up for your child ***<to be filled by implementing team>***	Parents, Teachers, AWW ***<to be filled by implementing team>***	Send 1 chart every year at the beginning of the academic year Disseminate during PTM Disseminate in Mothers meet ***<to be filled by implementing team>***	Charts at schools and anganwadi Flyers for dissemination ***<to be filled by implementing team>***
Awareness on symptoms, treatment and prevention				
Improve treatment seeking behaviour for Squint				
Objective of the communication				
Eliminate fear of surgery				
Awareness on nutritious food				
Awareness about service points				
Awareness about Susrut				
Myths & Misconceptions				
Rinsing eye with cold water				

Awareness about pediatric cataract				
Awareness about usage of spectacles				
Awareness that surgery is possible at a very young age (73% ignorant/not aware)				
Medical treatment via local sources instead of consulting doctor for eye related issues				

Annexure 20

Pre-test of IEC

Annexure 21

Dissemination of IEC

Annexure 22

Monitoring the progress, usage and impact of IEC

Annexure 23

Measurable outcomes