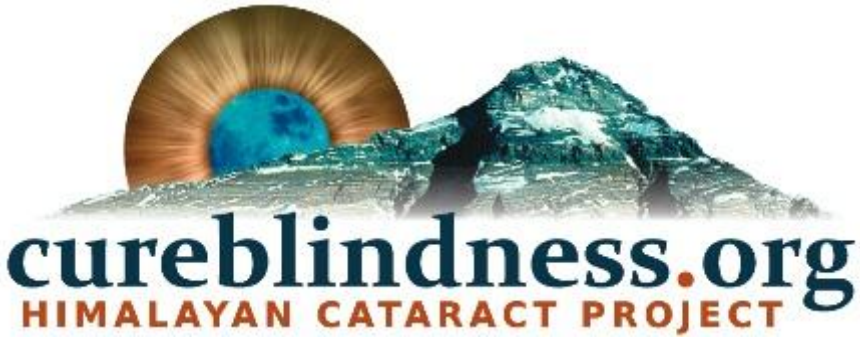

The Himalayan Cataract Project

Restoring Vision to the Developing World

A Case Study on Management Challenges in Ethiopia, by:

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with special thanks to Job Heintz and Pamela Clapp of HCP for providing essential information for this report.

HS518a: Management of Health Care Organizations
Professor David Rosenbloom, Ph.D.
Fall 2011

The Heller School for Social Policy and Management
Brandeis University

Introduction:

October 2011: Job Heintz looked out the window of his office in Waterbury, Vermont, sipping his morning coffee while rays of sunlight streamed in against the chilly autumn air. As he made his list of action items for the day, he reflected on yesterday's meeting with his Board of Directors for the Himalayan Cataract Project (HCP)[1], an organization dedicated to "eradicating preventable and curable blindness through high quality ophthalmologic care, education, and the establishment of a world-class eye care infrastructure."[2] Since its inception in 1994, HCP had distinguished itself as a leader in best practices for delivering health care services at low costs with favorable outcomes. Each year, the organization screened nearly 200,000 patients and performed between 20,000 to 25,000 cataract surgeries to disenfranchised patients who otherwise would never receive care. Since becoming Chief Executive Officer, Job had overseen many successful initiatives including the financing and completion of a $7 million expansion of HCP's flagship training partner, the Tilganga Eye Center in Kathmandu, Nepal. Job was especially proud of this achievement because it led to a ten-fold increase in HCP's budget as well as the development of a similar model in Kumasi, Ghana, and participation in the USAID Child Blindness Project in Nepal.[3]

With growth came challenges. Yesterday's board meeting had been scheduled to coincide with the annual meeting of the American Academy of Ophthalmology. Discussion centered around the execution of a new strategic plan and doubling the size of its workforce from four full-time staff members to eight by opening a new office in Washington, DC. In his team's effort to replicate best practices in Nepal to other countries, Job faced a key management challenge- how to get consumables and medical supplies through customs in certain countries in Africa, Ethiopia proving to be the most difficult. HCP had highly trained local ophthalmologists stationed in these countries ready to perform services, but their hands were idle without the instruments necessary to do their work. Job finished the last sip of his coffee and pondered how to address this problem.

History:

The Himalayan Cataract Project (HCP) was founded in 1994 by two ophthalmologists, Sanduk Ruit and Geoff Tabin, who shared a common vision of making eye care available to anyone who needed it regardless of ability to pay. In 1995, HCP was instituted as a charitable organization to support the work of these physicians. The organization is based in Vermont and also operates the Tilganga Eye Center in Nepal, the first outpatient cataract surgery facility in the Himilayan region. HCP has now expanded to include services in other parts of the world and is challenged with how best to reflect its global mission. This has raised a branding identity issue since many people do not realize it is a single organization. In 2011, HCP enlisted a consultant to advise the organization on branding identity and naming.

Doctors Ruit and Tabin encountered three major challenges as they laid the foundation for HCP during the 1990s. These challenges included: convincing the medical community that the care at outreach eye camps in rural settings was equivalent to hospital-based care; implementing a cost recovery system where paying patients subsidized cataract care for the poor; and making high-quality intraocular lenses affordable. In 1993, roughly 10,000 cataract

[1] The Himalayan Cataract Project is also known as CureBlindness.org.
[2] Cure Blindness homepage: www.cureblindness.org.
[3] Ibid.

surgeries were performed in Nepal using intraocular lenses. These lenses cost approximately $100, making them out of reach for the poor. Dr. Ruit discovered that the same lenses could be produced for only $6 (USD) and the manufacturing companies were making huge profits. By 1995, he had established a lens factory in Nepal with the Fred Hollows Foundation, a NGO working to eradicate blindness in Australia, New Zealand, and the United Kingdom. This new factory was capable of manufacturing high quality lenses at a fraction of the cost. Today, the factory produces over 300,000 units of high quality intraocular lenses annually which are then exported to over 60 countries.[4] As a tribute to his ingenuity and exceptional achievements, Dr. Ruit has received some of the highest awards in international health possible.[5]

Organizational Structure:

HCP is a nonprofit corporation headquartered in Waterbury, Vermont, USA. The organization is managed and run by Job Heintz, J.D., M.S.L., Chief Executive Officer and Emily Newick, M.P.H., Chief Operating Officer. Other staff in the Vermont office include Pamela Clapp, Project Manager and Marie A. Gakuba, Program Coordinator. The programmatic work and vision of HCP is determined by its Board of Directors. The Board consists of six members and is chaired by co-founder Geoffrey Tabin, M.D. HCP is guided by recommendations from a separate Advisory Board made up of long-time supporters and leaders in the field of international ophthalmology and development. The organization is indebted to local volunteers who work tirelessly to deliver eye care where it is needed most.

HCP's Eye Care Model – A Best Practice and Formula for Success:

Reaching the greatest number of un-served blind people, with the highest quality care at the lowest cost possible, is HCP's top priority. In order to carry out this objective, HCP utilizes a four-component formula to ensure desirable service.[6] The organization's eye care model is a perfect example of what authors W. Chan Kim and Renee Mauborgne refer to as a "Blue Ocean Strategy,"[7] a new wave or tool for solving problems that stand in stark contrast to the "red ocean" of what other organizations have attempted. Through its eye care model, HCP has rendered the competition irrelevant by designing an effective, low cost, and highly innovative way to treat cataracts unlike what any other organization has been able to achieve. Each component of HCPs' eye care model is discussed below:

Component #1 (Cost-Effectiveness):

HCP is committed to developing high quality surgeries and medical procedures that are comparable to Western standards. These procedures reduce the cost, complexity and operating time of procedures without compromising ocular safety and vision outcome. Dr. Ruit's technique of using small incision cataract surgery only takes five minutes or less with

[4] Cure Blindness homepage. "History": http://www.cureblindness.org/who/history.
[5] Cure Blindness homepage. "Dr. Sanduk Ruit- Co-Director Himalayan Cataract Project": http://www.cureblindness.org/who/dr-sanduk-ruit.
[6] Cure Blindness homepage. "HCP's Eye Care Model: Creating Long Term, World Class Eye Care for the Poor": http://www.cureblindness.org/what/hcp-eye-care-model.
[7] Blue Ocean Strategy website: http://www.blueoceanstrategy.com/abo/about_bos.html.

mature cataracts and does not require costly instrumentation or expensive consumables. His technique is safe and stable with rapid effective rapid visual rehabilitation.[8]

Cost-Recovery Program: The majority of facilities that the Project has helped establish are financially self-sustaining through a cost-recovery program which is designed to ensure that all poor patients receive cataract surgery for a minimal cost of $20. The 45% of patients who can afford to pay the full price of care are charged $120; 20% of patients pay a smaller amount based on what they can afford; 35% receive full care for free.[9]

Sources and Uses of Funding: HCP maintains a lean administration. Only 10% of the organization's budget is dedicated to staff salaries and other overhead expenses. The remainder is directed toward programs. HCP receives funding from individuals, private foundations, corporations and the United States Agency for International Development (USAID). HCP also receives donated equipment and consumables from ophthalmic corporations and individual physicians, as well as donated service time from ophthalmologists.

Component #2 (Infrastructure):

HCP is committed to building infrastructure from community eye centers to full specialty eye hospitals that ensure long-term, world class eye care. Although Tilganga and the Himalayan Cataract Project support ophthalmic practices in numerous hospitals throughout different countries, the Tilganga Eye Center remains the home-base and most important part of the HCP. Since 1994, due to a dramatic increase in demand for eye services, the Tilganga Center has expanded and transformed from an outpatient cataract surgery center to a full-scale, comprehensive tertiary center of excellence in eye care.

Global Expansion: Together with Tilganga and The Fred Hollows Foundation, the HCP supports eight Community Eye Centers (CECs) and a Community Eye Hospital in Hetauda, in Nepal. In addition, the HCP has helped establish and supports two community eye hospitals in northern India, and Tibet. The HCP is in the process of developing a stand-alone eye clinic that is part of a specialty eye center in Ghana. Finally, the HCP supports Quiha Zonal Hospital in Mekelle, Ethiopia.

Component #3 (Education, Training, and Skill Transfer):

Working closely with a variety of partners, the HCP provides education to local medical professionals at all levels with proven medical techniques to improve surgery and surgical outcomes. The Project supports a full range of ophthalmic education – from the traditional rigorous training of surgeons to the intensive training of field workers that includes nurses, field staff and community leaders.

Component #4 (Outreach):

HCP sponsors outreach through Outreach Surgical Mobile Camps that reach un-served people in remote areas. HCP adapts modern techniques for remote settings while still

[8] Ruit S, Paudyal G, Gurung R, Tabin G, moran D, Brian G; An innovation in developing world cataract surgery: sutureless extracapsular cataract extraction with intraocular lens implantation; Clinical and Experimental Ophtalmology; 2000.
[9] Cure Blindness homepage: www.cureblindness.org

maintaining high quality and low cost. This evolution in medical care for the poor became the basis for the Eye Care Model that is now replicated in other countries in the developing world. Tilganga outreach teams often reach inaccessible areas by foot and more often than not arrive to communities with no electricity and minimal sanitation and potable water. Within a matter of hours, the team can turn a dusty schoolhouse, or whatever building is available, into an equivalent medical ward where sight-restoring surgery is carried out.[10]

Challenges in Ethiopia:

Sub-Saharan Africa is the region with the highest burden of avoidable blindness and visual impairment in the world. The magnitude of eye problems in Ethiopia is very high with blindness alone affecting 1.6% of the population or just under 2 in every 100 people.[11]

Quiha Zonal Hospital in Mekelle, Ethiopia is where HCP provides support to Ethiopians who need cataract surgery (See Appendix 1). HCP provides critical support to Quiha Zonal Hospital with a focus on high-volume, high-quality cataract delivery and training for ophthalmologists and mid-level eye care personnel. HCP is supporting the expansion of Quiha, in collaboration with Proyecto Vision (a Spanish NGO). Although Nepal produces 3 million lenses per year and supplies them to 75 countries, long hours of power outage in Kathmandu during the winter season make it difficult to manufacture lenses fast enough to fulfill the growing demand of cataract surgery[12].

The most pressing problem that physicians face in Ethiopia is a recurring need for surgical supplies to serve their patients. These include items such as foldable intraocular lenses, viscoelastics, and equipment such as a visual field analyzer and different instruments (i.e. reusable surgical knives). As Dr. Kefyalew, leading resident ophthalmologist explains, "Of course we have the basics, but we don't have everything. We cannot find any consumables locally. For example, we cannot get different viscoelastic materials in Ethiopia. There is no organization that is importing these goods. We have to depend on [NGOs for] support."[13] From a management perspective, these factors make it challenging for HCP to maintain its standards of delivering high quality health care in Ethiopia.

While supply shortage is a universal problem, the shortage is especially high in Ethiopia due to specific problems with immigration customs in that country. HCP began facing problems with delivery of consumables from Nepal to Ethiopia when the organization first began expanding services there in 2006. According to Pamela Clapp, HCP Project Manager, most medical supplies and consumables are hand carried by doctors who carry a certificate of donation indicating the items and the recipient. When a large shipment is sent to Ethiopia, the recipient is responsible for obtaining the duty exemptions since all goods for the purpose of humanitarian work are exempted. Duties can be as high as 20% if exemptions are not obtained. If not exempted in advance, the cost increases substantially. Due to extensive government bureaucracy in Ethiopia, goods are held at customs for an excessively long time, preventing HCP from being able to send shipments of supplies and consumables to ophthalmologists on the ground in a timely fashion.

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[10] Cure Blindness homepage: www.cureblindness.org
[11] Cure Blindness homepage: www.cureblindness.org
[12] Cure Blindness homepage: www.cureblindness.org, Video interview with Dr. Ruit.
[13] Faith A; "Sitting down with Dr. Kefyalew". American Society of Cataract and Refractive Surgery 2011: http://www.eyeworld.org/printarticle.php?id=5986.

Recommendations for HCP:

1. **Lobby government authorities in Ethiopia:** A report by the U.S. Agency for International Development, outlining barriers to moving contraceptives through customs in Ethiopia may shed light on similar issues with medical supplies. As with supplies for eye care, the paperwork associated with the clearance procedures for contraceptives is lengthy and time consuming. This holds true even for NGOs and importers that have an agreement with the Ministry of Health (MOH) to cover the duty for imported contraceptives. The report recommends that barriers should be addressed by advocacy and public policy dialogue activities at both federal and regional levels. For HCP's purposes, the public institutions that need to be lobbied at the federal level for medical supplies and consumables include Parliament (the highest decision making body in Ethiopia), the Customs Authority (which is responsible for facilitating the clearance of imports), and the MOH (which is responsible for facilitating the paperwork). The report states that these are the target organizations for addressing the customs barrier.[14]

2. **Work through NGOs that have experience importing goods duty-free:** The Ethiopian law provides that capital goods imported by NGOs shall enter into the country free of duty on the basis that the project is approved by the Federal Government or Regional Government organs. NGOs are exempted from customs duties on imported capital goods, upon ascertainment by the Investment Authority that: the goods are related to projects; and qualify for customs duties exemption under the investment law after examination of project documents submitted to it by the appropriate Federal Agency or Regional Government.[15] Examples of NGOs that HCP could work with include Europe Aid, African Development Bank, and World Bank. A more comprehensive list can be found through the Consortium of Christian Relief and Development Fund (www.crdaethiopia.org), an umbrella organization of NGOs operating in Ethiopia. By cooperating with local NGOs in Nepal, HCP could move consumables out of customs faster so that they can reach people in need.

3. **Resolve problem with electricity outages in Nepal:** Successful resolution of this problem is key to enabling efficient development of lenses in Nepal so that HCP can better meet the global demand for cataract surgery. However, issues with customs in Ethiopia need to be addressed first so that consumables can be imported properly.

Case Questions:

1. HCP has been very successful in replicating its eye care model in different countries. What aspects of this best practice might be difficult to implement in Ethiopia once supplies have managed to get through customs?

2. Should Job form alliances with local NGOs in Ethiopia before lobbying government authorities there, or should HCP proceed independently?

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[14] Getahun, Haileyesus and Eshete, Hailegnaw. "Macro-level Operational Barriers to Family Planning Services in Ethiopia: Taxation and Importation of Contraceptives and the Role of NGOs." Policy Project, Oct. 2003. Accessed from the United States Agency for International Development, p. 17: http://pdf.usaid.gov/pdf_docs/pnacw057.pdf.

[15] Consortium of Christian Relief and Development Association: www.crdaethiopia.org.

3. What questions should Job ask the Ethiopian Parliament, MOH, and Customs Authority respectively when lobbying for changes to customs procedures? What specific requests should he make of each of these entities?

4. What should be of higher priority for Job as a manager: Solving the problem with customs in Ethiopia or addressing the electricity outage in Nepal so that more lenses can be produced?

5. HCP intends to expand business in other countries too. What laws, regulations, economic conditions, and socio-cultural considerations should HCP evaluate when deciding whether to offer eye care in a given country?

Appendix 1: Demand for Cataract Surgery in Ethiopia (2008, 2009 and 2010)

Source: Cure Blindness annual reports for 2008, 2009, and 2010. (Not all numbers are available).

ETHIOPIA **Quiha Zonal Hospital, Mekelle**			
SCREENING	**2010**	**2009**	**2008**
Hospital Based Screenings	28,006		
Outreach Screenings	10,320		
Total Screenings	**38,326**	**15,907**	3,650
SURGERY			
Hospital Based Surgeries			
Minor	4,004	273	
Major	3,185	2,185	
Total Hospital	7,189	2,458	
Outreach Surgeries			
Minor	3,469	3,380	
Major	3,505	2,719	
Total Outreach	6,974	6,099	
Total Surgeries	**14,163**	**8,557**	**630**