Programme/Project Name, Project number	**Seeing is Believing: Combatting Blindness in Peru, P3035**
Project Location, Country	**Peru**
Partner organization	
Start and end date of the project. Project Phase	**July 2014 to June 2017**
Total project cost	**USD $1'206.723**
Purpose of the Evaluation	**- To use DAC criteria to assess the extent to which objectives and results of the project in the last year and a half have been met (July 2014-December 2015). - To identify challenges and lessons learned. - To outline training recommendations for the remaining period of the project.**
Evaluation Type (intermediate, end of phase)	**Intermediate**
Implementing Organization / Contact	
Names and organizations of the Evaluation Team members	**Marco Aspilcueta (Peru) Pedro Gómez (Mexico)**
Basic methodology	**Analysis of primary (field) and secondary information (reports)**
Start and end date of the Evaluation	**April 1 - May 11, 2016**
Recipient of the Final Evaluation Report	**CBM-Quito, Ecuador**
Date of submission of the report	**May 11, 2016**

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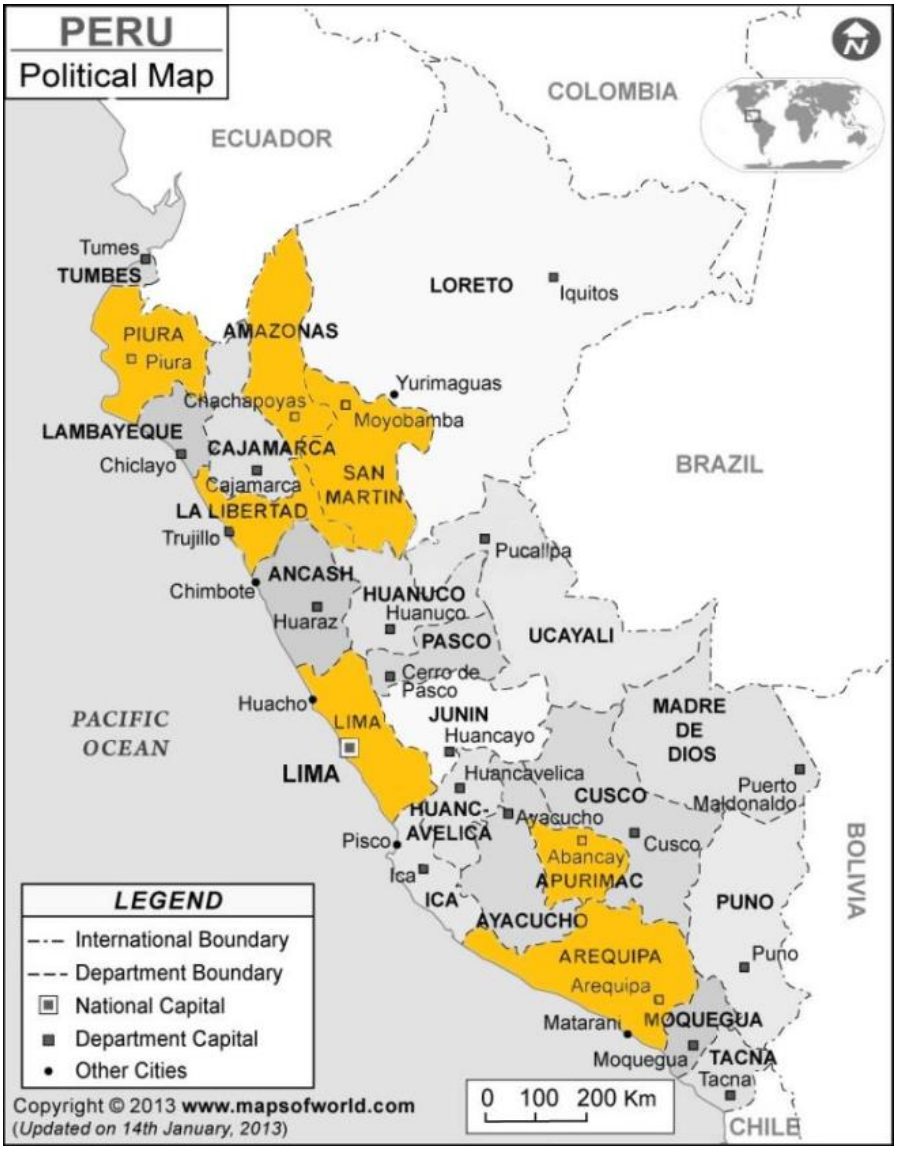
LIST OF ABBREVIATIONS AND ACRONYMS

CBM	Christian Blind Mission
CECOM	Centro Comunitario Oftalmológico Maranata (Maranata Eye Community Centre)
COMEP	Centro Oftalmológico Monseñor Enrique Pelach (Monseñor Enrique Pelach Eye Community Centre)
DIRESA	Dirección Regional de Salud (Regional Health Directorate)
DNJ	Clínica Divino Niño Jesús (Divino Niño Jesús Clinic)
FON	Fundación Oftalmológica del Norte (Eye Foundation of the North)
INO	Instituto Nacional de Oftalmología (National Eye Institute)
IPROS	Instituto de Prevención y Rehabilitación Oftalmológica de la Selva (Institute for Eye Prevention and Rehabilitation of the Forest)
IRO	Instituto Regional de Oftalmología (Regional Eye Institute)
MIDIS	Ministerio de Desarrollo e Inclusión Social (Ministry of Development and Social Inclusion)
MINDEF	Ministerio de Defensa (Ministry of Defense)
MININTER	Ministerio del Interior (Ministry of the Interior)
MINSA	Ministerio del Salud del Perú (Peruvian Ministry of Health)
NGO	Non-governmental organization
RAAB	Rapid Assessment of Avoidable Blindness
SiB	Seeing is Believing

PROJECT MAP / PROGRAMME AREA



EXECUTIVE SUMMARY

Programme partners are a group of experienced clinics with the medical quality needed to perform cataract surgeries. The revised results of Visual Acuity after Cataract Surgery are good, with an 85% with a better Visual Acuity.

The most important indicator of the Programme is the number of cataract surgeries performed. Regarding the goal for the July 2014-December 2015 period, there has been a progress of 66%, and 31% of the overall goal (3 years). Even rescheduling the goals, the Programme may not meet them, except the implementation term of the Programme is extended for six months.

Only IPROS Tarapoto has achieved the programmed goal; FUNDAR and DNJ have reached more than 70%, but failed to meet it. AMAZONAS (Bagua), FON (Piura) and CECOM (Trujillo) have only achieved a percentage between 45-59%. With the lowest performance is COMEP Abancay, with only 10% of the proposed goal.

The delay to start the Programme operations and the poor response of outreach at the outset of the Programme might impact on the results. The late delivery of supplies seems have also affected this achievement.

Also, in some cases as COMEP, the limitation is associated with its institutional weakness, not only due to the lack of financial resources to deal with any situation, but also to the lack of a sustainable management model.

In the case of IPROS, FUNDAR and DNJ- partners showing the best results, their success is related to the quality and stability of their health staff.

Strategic alliances with local stakeholders and institutions have been crucial for advocacy work and community care. Their support also allows to better focalising target population.

Training sessions of human resources improve project processes. The training sessions provided by the Programme through DNJ have allowed a significant improvement in the quality of counselling, administration,

outreach, and technical capacity of health staff of partners, such as FON, CECOM and IPROS.

The role and support of CBM is greatly appreciated by all partners of the Cluster. In all cases, it is recognized that its support has been critical to strengthen the operation of the clinics currently participating in the Programme.

Regarding the impact on the beneficiary population, patients interviewed expressed their satisfaction with the service received. Cataract surgeries have meant a major change in their family life and work.

Cluster partners are sustainable, especially those that have a model combining social work with private efficiency. Partners as FON, IPROS, FUNDAR or CECOM that have a private clinic as an ally, can ensure a quality service and document their income based on the sale of the service in the market.

DNJ has infrastructure, equipment and a medical capability of proven quality. However, we believe that some elements being implemented by other partners in the cluster should be adopted to consolidate its sustainability in the eye market, such as flexible prices, new surgical services (phaco, retina), tiered fees and treat patients with greater resources who can afford the service.

In the case of COMEP, promoting the service offer is required, entering in regional markets and improving human resources, especially enabling a greater permanence of the surgical team at the clinic.

In all cases it is recognized that the CBM Programme has been a factor contributing to the sustainability of their foundations and companies (clinics). However, the concept of total free service does not contribute to sustainability in the medium and long term. Consequently, the Programme strategy for gradually reduce the subsidy of 25% in the first year, 20% in the second, and 15% in the third has much sense.

FIRST PART

INTRODUCTION

1. PURPOSE AND SCOPE OF THE EVALUATION

1.1. PURPOSE

- To use DAC criteria to assess the extent to which objectives and results of the project in the last year and a half have been met (July 2014-December 2015).
- To identify challenges and lessons learned.
- To outline training recommendations for the remaining period of the project.

1.2. Scope

- 7 projects/clinics working in the Prevention of Blindness have been evaluated.
- The implementation period covered by this review is from July 2014 to December 2015 (one year and a half).
- Theoretical review and site visits to the following cities in Peru: Lima, Arequipa, Piura and San Martin.
- The target group consists of the executive teams of the respective partners (7) and selected users.
- Regulatory framework: The Programme plan and the health policy of the country.

1.3. Determining the target group

CBM will use this Mid-Term Review to identify areas of strength and challenges of the SiB Programme (Seeing is Believing). Similarly, on the basis of the conclusions and recommendations of the Mid-Term Review, CBM, in coordination with partners, will determine the actions that should be implemented to achieve the objectives and results of the project.

In addition, partners of the SiB Programme (including Medical Directors) will use the review to determine the main areas requiring to be strengthened, as well as good practices of the Programme (from the medical and programmatic perspectives) in order to ensure learning. In addition, through the respective participatory approaches, it is expected the

ownership and inclusion of the results and recommendations of the Mid-Term Review. This will include a workshop at the end of the review where the methodology, approaches and preliminary results will be shared and discussed with partners.

In addition, CBM will use the results for its own learning and to determine the overall success of the Programme. Also, the donor Standard Chartered Bank will use the results to determine the overall success of the Programme.

As a result, an improvement in the quality of service provided by the various project partners under this Programme and the satisfaction of end users is expected.

2. BACKGROUND

Peru has a population of 29'733.800 and is ranked 77th from 187 countries in the Human Development Index. According to RAAB 2011 (Rapid Assessment of Avoidable Blindness), in Peru there is a prevalence of blindness of 2% (600.000 people) and 83.2% of all causes of blindness can be treated or prevented.

75% of the population lives in urban areas and 24.1% in rural areas, and 25.8% of Peruvians are poor, defining "poverty" as the inability to afford daily living expenses such as food, clothing and other essentials. 6% live in extreme poverty, which means they cannot afford food. The figures for poverty in urban and coastal areas are 16.5% and increases to 53-58% in rural areas.[1]

The main cause of blindness is due to cataracts (58%) equivalent to 348.000 people. Currently, surgical cataract rate is 1681 and needs to reach 3000 to satisfy population needs. This will include catch up on the backlog of cataract cases.

[1] Peruvian National Institute for Statistics and Information, 2012.

The project will focus on the leading cause of blindness, cataract, although any person identified with other eye condition will be referred to the respective services.

One of the main barriers to access eye care is related to costs. People cannot afford treatment and in some cases lack of money to move to facilities providing eye care services. This will be specifically addressed by subsidizing a significant proportion of all surgeries, according to the economic resources of each patient.

Another major barrier to people accessing eye care services is the lack of awareness that treatment is possible. Community eye health and awareness campaigns will help to address this barrier. Surgery fears based on myths or religious beliefs will also be addressed during awareness campaigns and through advisory services of our partners, which will provide detailed information about surgery techniques to each patient as well as advice on any other concern they might have.

The Programme will work with 7 partners/base hospitals in 13 of the 24 regions in Peru: Lima, Loreto, Ica, Arequipa, Cuzco, Puno, Apurimac, Piura, Lambayeque, Tumbes, La Libertad, San Martin and Amazonas.

CBM has been working on the Prevention of Blindness in Peru since 1990. It has been working and providing support to the 7 eye care providers for many years. In 2012, CBM grouped these partners under a national cluster for blindness prevention. This has allowed partners to work more holistically, and this has a more significant regional and national impact.

2.1. Programme scope summary

General purpose	Contribute to the prevention of avoidable blindness in Peru, mainly by increasing cataract surgeries.
Specific purposes	1. Provide high-quality cataract surgeries and aftercare for 250.000 patients in 13 regions of Peru. 2. Strengthen outreach, running 1494 community campaigns and improving access to services for cataract in 13 regions of

	Peru. 3. Improve the quality, efficiency and sustainability of seven partners providing eye care in Peru. 4. Strengthen networks between eye care providers and build alliances with key stakeholders in eye care to advocate for improving eye care services in Peru.
Budget	USD $1'206.723
Term	July 2014 to June 2017

3. EVALUATION METHODS AND LIMITATIONS

3.1. Information sources

Secondary information: We have reviewed available documents of the Programme (base documents, logical framework, semi-annual reports, monitoring indicators report, budget and expenditures, policy documents, reports from partners, etc.).

Primary information: The main field instrument of this evaluation was a semi-structured interview that was applied to partners' representatives, hospital staff involved in the Programme, users and community leaders, and government representatives.[2] Please note that all aspects included in this evaluation were also explored with the National Coordinator of the Programme[3].

3.2. Population to be interviewed

Key stakeholders were interviewed, such as: Partners (representatives), users, community leaders/hospital staff and government representatives (local and from the sector).

3.3. Limitations of the evaluation

1) Fieldwork limitations. As established by the TOR, field visits to 4 partners (from 7) were scheduled. The other 3 were interviewed in Lima. This limited us to meet other key stakeholders located in these three areas.

[2] The guidelines of the semi-structured interview are not surveys. It is a methodological resource to collect relevant field information, and adheres to the questions needed to be answered for this evaluation according to the TOR.

[3] None survey was applied to the National Coordinator, only open consultations (without a survey format) through coordinated meetings.

2) Given time limitations set out in the TOR, the impact evaluation of the Programme on the target population was limited. 4-7 field interviews were done in each area that was chosen by partners. With more time for fieldwork, it would have been possible to interview at least 10 people randomly and thus have information in a more diverse population.[4]

[4] This is a reference number and is limited to the duration of the evaluation. With two additional days of fieldwork, we could interview about 10 patients chosen randomly.

SECOND PART

ANALYSIS, RESULTS AND CONCLUSIONS

4. RELATION OF THE PROGRAMME WITH THE GOVERNMENT POLICY[5]

The government has a "National Strategic Plan for Eye Health and Prevention of Avoidable Blindness- 2014-2021" which aims to improve the health sector response, expanding the access to quality eye care services to Peruvians in the framework of a comprehensive and inclusive model of primary health care at national level[6].

It is important to note that the intervention strategy of the Plan includes: primary care, intersectoral alliances and intersectorality (other public sectors, civil society, private sector), communication and advocacy, organization of services in a network, territoriality, continuous training of human resources related to health, specialized education, evidence-based interventions, research and systematization, and alliances with international cooperation.

In this scenario, the actions of the CBM Programme are part of the government policy, because it not only carries out direct interventions through cataract surgeries and eye care, but also makes alliances with private organizations (clinics, grassroots organizations, among others) and public organizations (MINSA) to enhance the capabilities of health staff in the regions where the Programme is being implemented.

Likewise, we should also mention that DNJ is still a member of the "Comité de Prevención de Ceguera de Perú - CONAPRECE" (Committee for the Prevention of Blindness), although it does not have a managerial position currently.

[5] "National Strategic Plan for Eye Health and Prevention of Avoidable Blindness- 2014-2021", Lima, June 2011, Peruvian Ministry of Health.

[6] The National Coordination of the Strategy is responsible for its implementation, and to articulate it with the services provided by public sectors and social stakeholders involved with Eye Health such as MINSA, ESSALUD, MIDIS, MININTER, MINDEF, regional and local governments, NGOs, private sector associations, civil society organizations and international cooperation agencies.

The CBM Programme is relevant to the reality of the country where the rate of cataract surgery is 1.130 per million of inhabitants, which is lower than expected[7].

In Peru, there is a policy to face blindness caused by cataracts. The problem is to implement regulations because MINSA staff frequently must give priority to other activities, especially in regions outside Lima. For example, the DIRESA in Piura has a budget of S/60.000 per year and does not even have a goal. When a public health emergency arises as the Chikungunya or dengue, a Programme like this is stopped and priority is given to the emergency.

5. EFFICIENCY OF THE MEDICAL COMPONENT OF THE PROGRAMME

The Programme partners are a group of experienced clinics with the human and the medical quality needed to perform cataract surgeries. The revised results of Visual Acuity after Cataract Surgery are good, with an 85% with a better Visual Acuity.

Table # 01
Results of the achieved visual acuity
July 2014-December 2015

PARTNER	ZONE	Number of cataract surgeries	Number of people with post-surgical visual acuity better than 20/60	Quality %
IPROS	Tarapoto	1,222	1,156	95%
DNJ	Lima	2,493	2,174	87%
CECOM	Trujillo	566	486	86%
FUNDAR	Arequipa	1,103	899	82%
AMAZONAS	Bagua Grande	237	187	79%
COMEP	Abancay	73	56	77%
FON	Piura	706	488	69%
TOTAL		**6,400**	**5,446**	**85%**

Source: CBM report submitted by the National Coordinator[8]
Drafting: Own

[7] Source: VISION 2020, www.v2020la.org
[8] The data was provided by the National Coordinator of the Programme in Excel and was compared with the information of the clinics during the interviews in the regions.

The staff feels motivated working on this Programme. Some have attended training sessions, and others will in the coming months. This represents an extra incentive to do their work in the Programme.

Patients show their gratitude to the assistance received. We have verified that they have received free surgery and support in their homes, or were transported to the clinic to be operated. Visited centres (clinics cluster partners) enjoy a good reputation thus reducing patients fear requiring surgery.

Most partners have had the advice of International Eye Foundation (IEF), who is expert in processes to improve Programmes efficiency. It has implemented a care model by modules, providing a greater flow in patient care.

Data coverage of new patients versus subsequent patients varies widely in each centre, from 270% more new patients (FUNDAR) to 41% new patients (COMEP). We could not validate this information with the documents provided. The percentage mentioned belongs to the progress report for July-December 2015 period sent to the donor.

As for the counselling work, the conversion of patients who have programmed a surgery and those who have received surgery is 50% or more in all visited centres (70% in DNJ, 95% in IPROS; 50% in FON and 90% in FUNDAR).

Except FON, this is a good indicator that deserves to be highlighted. (The main barriers in FON were the distant location of patients and access problems due to weather).

We should also note that from the total surgeries performed in the evaluation period, 34% were fully subsidized and 66% partially subsidized. Members that show a higher percentage of fully subsidized operations are FON Piura and FUNDAR Arequipa. Others show a lower percentage.

Table # 02
Composition of allowances granted
July 2014-December 2015

PARTNER	ZONE	FULLY SUBSIDIZED	PARTIALLY SUBSIDIZED	TOTAL
FON	Piura	48%	52%	100%
FUNDAR	Arequipa	37%	63%	100%
IPROS	Tarapoto	31%	69%	100%
DNJ	Lima	31%	69%	100%
COMEP	Abancay	31%	69%	100%
CECOM	Trujillo	30%	70%	100%
AMAZONAS	Bagua Grande	30%	70%	100%
TOTAL		34%	66%	100%

Source: CBM Report submitted by the National Coordinator[9]
Drafting: Own

Regarding the efficiency of the screening campaigns carried out, the Programme shows a ratio of 127 people screened per campaign. IPROS Tarapoto and FUNDAR Arequipa show the highest ratios, while FON Piura, AMAZONAS Bagua Grande and DNJ Lima, show the lowest ratios.

Table # 03
Number of people screened per campaign
July 2014-December 2015

PARTNER	ZONE	Number of screened people	Number of screening campaigns	Screening/ Campaigns*
IPROS	Tarapoto	14,211	24	592
FUNDAR	Arequipa	4,961	15	331
COMEP	Abancay	1,525	12	127
CECOM	Trujillo	5,292	51	104
FON	Piura	9,685	106	91
AMAZONAS	Bagua Grande	1,569	23	68
DNJ	Lima	6,013	109	55
TOTAL		**43,256**	**340**	**127**

*The total screened people divided by the number of screening campaigns equals 127

Source: CBM Report submitted by the National Coordinator[10]
Drafting: Own

[9] The data was provided by the National Coordinator of the Programme in Excel and was compared with the information of the clinics during the interviews in the regions.

[10] The data was provided by the National Coordinator of the Programme in Excel and was compared with the information of the clinics during the interviews in the regions.

Cataract surgeries performed versus other surgeries

According to official information of the Programme, in the initial plan was expected to perform five cataract surgeries per each major or minor surgery performed, different from cataracts. The results to December 2015 show that this relationship is of 1.3, meaning that for each different surgery hardly one cataract surgery was carried out. The partner closest to the original plan is DNJ with about 3 cataract surgeries per each different surgery.

Table # 04
Cataract surgery versus other surgeries
Comparative: accomplished and planned
July 2014-December 2015

PARTNERS	Major Surgeries	Minor Surgeries	Total Surgeries without cataracts	Cataracts	Cataracts /other surgeries
COMEP	36	232	268	73	0.3
FUNDAR	1,298	151	1,449	1,103	0.8
CECOM	93	445	538	566	1.1
IPROS	333	811	1,144	1,222	1.1
FON	278	98	376	706	1.9
AMAZONAS	47	68	115	237	2.1
DNJ	714	141	855	2,493	2.9
TOTAL ACHIEVED	**2,799**	**1,946**	**4,745**	**6,400**	**1.3**
TOTAL PLANNED	**1,450**	**3,000**	**4,450**	**20,700**	**5**

Source: CBM Report submitted by the National Coordinator[11]
Drafting: Own

6. EFFECTIVENESS OF THE PROGRAMME

6.1. Fulfilment of the objectives, goals and factors affecting the compliance

The most important indicator of the Programme is the number of cataract surgeries performed. Regarding the goal for July 2014 - December 2015, there has been a progress of 66%, and 31% of the overall goal (3 years). Even rescheduling the goals, it is likely that the Programme will not meet the goals, except the duration of the Programme is extended by six months and corrective measures are adopted, such as doing more screening and detection as well as more surgeries, especially those showing the lowest results.

[11] The data was provided by the National Coordinator of the Programme in Excel and was compared with the information of the clinics during the interviews in the regions.

Only IPROS Tarapoto has achieved the programmed goal; FUNDAR and DNJ reached more than 70%, but failed to meet it. AMAZONAS (Bagua), FON (Piura) and CECOM (Trujillo) have only achieved a percentage between 45-59%. COMEP has only reached 10% of the proposed goal.

Table # 05
Achievements and goals of cataract surgeries to December 2015

Partner	Zone	Achievement	Goal July 2014- December 2015	Progress
IPROS	Tarapoto	1,222	1,150	106%
FUNDAR	Arequipa	1,103	1,400	79%
DNJ	Lima	2,493	3,500	71%
AMAZONAS	Bagua Grande	237	400	59%
FON	Piura	706	1,250	56%
CECOM	Trujillo	566	1,250	45%
COMEP	Abancay	73	700	10%
TOTAL		**6,400**	**9,650**	**66%**

Source: CBM Report submitted by the National Coordinator[12]
Drafting: Own

Table # 06
Achievements versus goals of cataract surgeries to December 2015
(3 years goals, July 2014-June 2017)

Partner	Zone	Achievement	Total Goal / 3 years	Progress
IPROS	Tarapoto	1,222	2,400	51%
FUNDAR	Arequipa	1,103	3,000	37%
DNJ	Lima	2,493	7,500	33%
AMAZONAS	Bagua Grande	237	900	26%
FON	Piura	706	2,700	26%
CECOM	Trujillo	566	2,700	21%
COMEP	Abancay	73	1,500	5%
TOTAL		**6,400**	**20,700**	**31%**

Source: CBM Report submitted by the National Coordinator[13]
Drafting: Own

[12] The data was provided by the National Coordinator of the Programme in Excel and was compared with the information of the clinics during the interviews in the regions.
[13] The data was provided by the National Coordinator of the Programme in Excel and was compared with the information of the clinics during the interviews in the regions.

The success of IPROS (Tarapoto) is associated with the quality, permanence and availability of the health staff, especially the surgeon, as well as its financial capacity to cover the necessary costs when CBM resources did not arrive on time. It is also important to note that IPROS has an incentive policy for the staff, who receives a bonus if the planned target is reached.

Another aspect that deserves to be highlighted is that IPROS has a mobile clinic, allowing it to carry out campaigns in remote rural communities. This increases health care effectiveness with the population that cannot easily move to the base clinic.

Why they did not meet the goals?

In the case of FUNDAR and according to their perception, the causes are associated with the increased competition in the region, as CLÍNICA ESPÍRITU SANTO, OFTALMOSALUD, among others. Also, the Tía María mining project halt of Southern Peru Copper Corporation would have also affected the demand. In the opinion of the evaluating team, the economic expansion of Arequipa in the past 10 years has led to increased investments in companies, including clinics, leading to an increased competition in this area.

On the other hand, FUNDAR decided to perform three campaigns in areas like Espinar and Cusco, but did not have the expected result[14].

In the case of the DNJ partner, the network established during the operations of the Clinton Foundation, was deactivated, so the recovery and reactivation process was slow to perform community work in 2014. Likewise, DNJ said that during the project formulation, goals a little higher than the expected had to be set, based on the previous experience with the Clinton Foundation goals.

In the case of AMAZONAS (Bagua Grande), limitations are related to the operational capacity of the clinic, as its director and head doctor have to share their time with MINSA and ESSALUD, where they also work (50%). Other factors affecting the achievement are: weather issues affecting

[14] Only four patients had surgery.

community campaigns, as the Chiriaco case occurred the first half of 2015. The delay in the delivery of supplies seems to have also affected the operational capacity of the clinic and the results.

In the case of FON (Piura), Programme partners as the Ministry of Health, were unable to respond adequately to the proposed campaigns, as they had to prioritize emergency response such as dengue or chikungunya in 2015. In this case, the reduction of community outreach affected their results. Also, the clinic capacity was reduced in this period because it did not have all the health staff.

In the case of CECOM (Trujillo), restrictions are associated with an increased offering of cataract surgery by the Instituto Regional de Oftalmología - IRO (Regional Institute of Ophthalmology) and other local clinics[15].

In the case of COMEP (Abancay), poor results are due to the lack of health and administrative leadership to implement the Programme. They also went through a long process of internal reorganization that reduced the dynamics of the clinic[16].

Nor they had full availability of health staff. It is expected that with the new ophthalmologist hired, the results will improve, although it is difficult for COMEP to achieve the goals. Moreover, the low financial capacity and delay of funds, which arrived in January 2015, also affected its performance.

Factors that explain the result

Several factors affected the achievement of the Programme as a whole. First, the gap arises in the initial setting of goals. According to partners, the goals were set considering the results achieved by the Clinton Foundation, a

[15] After the search, we could not have access to this information. However, the fact is relevant because Doctor Burga from CECOM has been the former Director of IRO and has an important knowledge of its dynamics.

[16] This process occurred in 2013-2104 and affected 2015, according to COMEP information.

similar Programme implemented earlier. However, the conditions of 2012, year when the Programme was formulated, changed in 2014[17].

Another factor that affected the results is the delay in the start of the Programme operations. The delivery of supplies had a considerable delay, and in some cases as COMEP Abancay, partners could not cover this deficit because they lacked of own resources. This situation could be solved by other partners, such as IPROS Tarapoto that did have the necessary funding to cover this initial deficit. The delay in the delivery of supplies has also been a factor affecting the results.

Likewise, the level of goals achieved can also be associated with the capacity for expenditure execution. Partners like IPROS, FUNDAR and DNJ, that have better results in the operations performed, show a better efficiency of the spent budget. At the other end, partners as COMEP and CECOM, show a lower spending efficiency.

On the cost-benefit ratio (expenditure of the Programme- number of surgeries done), the Programme shows a ratio of $74 per surgery. The FUNDAR, DNJ, IPROS and CECOM partners have the best efficiency ratio, no more than $69 per surgery. At the other end, AMAZONAS and COMEP show the highest ratios, less efficient.

These two efficiency ratios have a correlation with the results, i.e., partners that better implement the budget and are more cost-effective also show a better performance in achieving proposed goals.

[17] The workshop for preparing the plan was in April 2012.

Table # 07
Cost-Benefit by Partner
July 2014-December 2015
(in dollars)

Partner	Spent by Partner	Spending of Coordination Office (prorated)(1)	Total Expenditure	Number of cataract surgeries	Surgeries Cost/Benefit (without Central Office)	Surgeries Cost/Benefit (with Central Office)
FUNDAR-AREQUIPA	26,396	23,503	49,899	1,103	24	45
DNJ-LIMA	103,290	23,503	126,793	2,493	41	51
IPROS-TARAPOTO	59,575	23,503	83,078	1,222	49	68
CECOM-TRUJILLO	15,596	23,503	39,099	566	28	69
FON-PIURA	36,597	23,503	60,100	706	52	85
AMAZONAS-BAGUA GRANDE	27,433	23,503	50,936	237	116	215
COMEP-ABANCAY	40,687	23,503	64,190	73	557	879
CENTRAL OFFICE + SUPPORT COSTS FOR IMPLEMENTATION OF THE PARTNERS (2)	164,523					
TOTAL	474,097			6,400		74

(1) The cost of the Coordination Office is assumed as a prorated cost equally in each region under the premise that its technical and administrative commitment are similar in each case.

(2)The expenses related to support the implementation of partners are managed by DNJ.

Source: CBM Report submitted by the National Coordinator[18]
Drafting: Own

Table # 08
Spending efficiency
July 2014-December 2015
(in dollars)

Partner	Total Budgeted US $	Total Transferred CBM US $	Total Spent by Partner US $	Spent/ Transferred US $	Spent/ Budgeted US $
AMAZONAS-BAGUA GRANDE	42,343	26,730	27,433	103%	65%
FUNDAR-AREQUIPA	42,146	25,924	26,396	102%	63%
IPROS-TARAPOTO	86,124	62,990	59,575	95%	69%
DNJ-LIMA	262,116	198,427	173,677	88%	66%
FON-PIURA	64,052	57,145	36,597	64%	57%
COMEP-ABANCAY	72,762	65,286	40,687	62%	56%
CECOM-TRUJILLO	42,291	32,347	15,596	48%	37%
OFICINA CENTRAL	78,322				
TOTAL U$	690,156	468,849	379,961		

Source: CBM Report, Lima
Drafting: Own

In short, the delay to start the Programme operations and the poor response of outreach at the outset of the Programme might impact on the results. However, this may explain only part of the situation.

We believe that in some cases as COMEP, the limitation is associated with its institutional weakness not only due to the lack of financial resources to

[18] These data was provided by the National Programme Coordinator in Excel.

deal with any situation, but also to the lack of a sustainable management model (see sustainability analysis below).

Factors that explain the success

With regard to the positive results, a crucial success factor is related to the quality and stability of the health team. In the case of IPROS, FUNDAR and DNJ- partners that show the best results-, they have a good health staff and were able to carry out timely consultations and surgeries[19].

We cannot fail to mention the importance of strategic alliances with local stakeholders and institutions, especially for advocacy and community care. In most cases, campaigns are coordinated with institutions such as the Church, mothers' clubs, government entities such as MINSA and municipalities, among others, which have an important presence in communities.

For the remainder of the Programme, it is important that partners having greatest difficulties, manage to overcome three fundamental aspects: 1) Increase outreach coverage because potential patients come from it; 2) strengthen counselling, which is a key element in the decision-making of patients; 3) consolidate health staff, particularly to ensure a greater dedication of the surgeon, as in COMEP. Additionally, it is important to strengthen the management model of some partners based on a social approach with a strategy allowing them to combine outreach with greater efficiency.

Rescheduling goals

It is worth mentioning that the goals have already been adjusted and rescheduled. We have talked with partners about it. Still, they believe they will achieve goals about 6 months after the expected completion date.

[19] According to a field evaluation done by Doctor Pedro Gómez, member of the evaluation team.

Table # 09
Rescheduled goals of cataract surgeries
June 2017

Partners	New Goals
DNJ	7,093
FON	2,100
AMAZ.	237
CECOM	2,100
IPROS	3,072
COMEP	223
FUNDAR	2,303
TOTAL	**17,128**

Source: CBM Report, Lima
Drafting: Own

6.2. Attention to the target group (focalization)

Partner clinics of the Programme are supported by a network of institutions and grassroots organizations, enabling them to carry out campaigns and better focalise the target population of the Programme. This network is made up of private and public organizations, which have presence in the communities, and also serves a population potentially consistent with the Programme.

For example, in the case of DNJ, outreach is done with organizations like "Vaso de Leche", soup kitchens, church organizations, and the Lions Club. In the case of IPROS, FON, FUNDAR, AMAZONAS and CECOM, the Ministry of Health, municipalities and grassroots organizations are key allies.

One strategy that has been implemented and can further improve is the use of public networks such as those from the Ministry of Health and the municipalities. These institutions carry out prevention and health care Programmes with elderly people, who are a potential population for the Cluster. For example, patients' recruitment in Piura and Arequipa had MINSA as main ally, as well as municipalities and other civil organizations. However, partners having MINSA as ally must have a contingency plan allowing them to maintain a convening power in community campaigns. You cannot rely on a single ally.

On the other hand, these partner institutions help to increase the coverage of potential beneficiaries (patients) and to better focus their target population, since often these institutions as the Ministry of Health or government Programmes as "Pension 65", already have a prior evaluation to identify poor population.

On the other hand, partners identify the people who really need the subsidy to receive care and cataract surgery through the evaluation done by counsellors. While counselling staff of all partners who conduct the evaluation has experience in identifying the needy population, this decision is made on a discretionary basis, using heterogeneous criteria.

In this sense, it is required that identification can be made more objectively through more standardized criteria, such as the analysis of the characteristics of dwellings (number of household members, number of income earners, materials of floors and walls, number of bedrooms, location, etc.). This would help to reduce the discretional nature when evaluating the population we want to help.

6.3. Good practices

1) The Programmes that combine the offer of a private service, whose incentive is clearly aligned with market efficiency (clinics), with a foundation that carries out social work, have more opportunity to be sustainable, as they can access to a credit in the financial system as well as to receive donations, among other sources.

Tiered pricing helps to increase the income of clinics and can serve to target the people who really need a subsidy, partial or total. This is the case for IPROS, FUNDAR or FON[20].

Free consultation and surgery should be offered to patients in extreme poverty, but even they should contribute to their health. The all free system is a double-edged sword. When projects end, people do not want to contribute waiting for a new similar project appears. We should raise

[20] As a example, a cataract surgery can cost 0 if subsidized to 2.500 soles. There are various surgery prices according to the patient's ability to pay.

awareness that the disease and its treatment must be a shared responsibility with the patient, even with some minimum contribution. This is a model that should be integrated into clinics, as DNJ and COMEP.

On the other hand, offer a free service may cause doubts and generate distrust. COMEP said that some patients may feel distrustful against a free service, and prefer to travel to Cusco and pay for cataract surgery, including higher costs.

Local partners and the support of institutions like MINSA, which often have a prior evaluation of the poor, can help to identify patients who can pay and who cannot.

2) Having strategic alliances for advocacy and community care with municipalities, public hospitals, churches, service clubs, are important to attract patients and create awareness on the services offered by the members of the Programme. In this regard, the participation of community leaders is essential for the confidence-building in the population.

Also, the use of local radio, loudspeakers and handing out flyers is a useful method to advice population.

3) A mobile operating room, as IPROS in Tarapoto, has shown to be very effective to perform cataract surgeries in small and scattered rural areas without an operating room.

4) Training sessions of human resources improve project processes. As explained below, training sessions provided by the Programme through DNJ has allowed a significant improvement in the quality of counselling, administration, outreach, and technical capacity of the health team of partners, such as FON, CECOM and IPROS (see training sessions chart below).

Staff quality and permanence (low turnover) from partner clinics, has also been an important factor in their performance and goals compliance.

5) An incentive system reinforces the commitment of community promoters with the objectives of the clinic. The experience of clinics as FON in Piura,

which pays S/100/day per goal achieved, generates a greater commitment of professionals who perform this community work.

6) The use of models, Power Point presentations and other visual tools helps a lot in counselling. The information and persuasion process can be diminished when not working didactically with patients. This is a practice that has been successfully applied by FUNDAR, IPROS, DNJ and FON.

Likewise, communicating with the population in their mother tongue is essential, as has happened with FUNDAR and COMEP that are working in high Andean areas where there is an important Quechua-speaking population.

7) The quality of medical-surgical services of visited clinics is a strength of the Cluster.

6.4. Perception of the CBM work

6.4.1. Roles of CBM and the National Coordination Office

CBM support is greatly appreciated by all partners in the Cluster. In all cases, it is recognized that its support has been essential, even long before. It has allowed consolidating the operation of many of the clinics currently participating in the Programme. For example, foundations- as IPROS (Tarapoto)- are created as a result of the presence and support of CBM (we should mention that CBS has about 40 years of presence in Peru). With its support, partners have also been able to expand their networks and institutional contacts.

Partners state that CBS was essential in the design of the Programme, especially because it was a guarantor against Standard Chartered Bank for the project formulation.

What aspects do not work well?

The delay on the onset of Programme operations also affected, at least in the first year, goals achievement, especially because CBM did not deliver supplies on time. In the case of COMEP, funds arrived in January 2015. This is a critical aspect that should not be repeated.

On the other hand, some partners perceive that administrative requirements are excessive, especially those concerning to reporting expenses. They argue that this administrative complaint was not foreseen initially. In any case, it is recommended to CBM a review of those administrative requirements that can be simplified without losing the quality of information needed.

Regarding the role of the National Coordinator, in general, partners consider that the National Coordinator develops well the administrative and technical monitoring in the seven areas of the Programme, in addition to coordinating specific activities with partners.

Partners suggest that the National Coordinator could support some issues that are important to their performance. One of them is to facilitate agreements and strategic alliances with institutions that are located in Lima, as the Ministry of Health, where joint work nationwide can be proposed. Another topic suggested is the support in the dissemination of the Programme results.

Partners also propose that the National Coordinator of CBM can centralize the stock of medicines at a single point in the cluster and then distribute them to each member according to their needs. The expiration of drugs stock causes losses.

While these are needs and proposals that can help partners, the work of the National Coordinator should prioritize the monitoring and coordination task entrusted to him, and support those that are feasible. Some of the proposals may exceed the role and operational capacity of the Coordinator.

6.4.2. DNJ role as Programme Coordinator and Training Provider

DNJ is the institution supporting the Cluster management and works closely with CBM implementing the Programme. Partners perceive that this task is performed with order and efficiency. However, DNJ states that this

responsibility generates an important workload that was not foreseen initially[21].

Regarding its work as a training provider to cluster members, partners state that the assistance received has helped them a lot to improve aspects of clinical management related to counselling and outreach. Later we will see in more detail this result.

6.5. Highlights of the Programme Management

Some good practices of the partners are also highlights of the Programme management.

The first refers to the management model with some partners that have a foundation and a private clinic at the same time; the incentive is clearly aligned to the efficiency of the market (clinics), and on the other hand, the existence of a foundation that meets social work. This model makes them more sustainable.

Under this model, cataract surgery prices are variable and tiered, where the patient can choose the option that best suits its budget, while increasing the income of the clinics being used.

Secondly, strategic alliances for the promotion and community care with municipalities, public hospitals, churches, service clubs, are an important source to attract patients.

Thirdly, the quality and permanence (low turnover) of human resources of partner clinics, has also been an important factor in the management of the Programme.

In some cases, an incentive system based on goals achieved allows a greater commitment of community promoters with the Programme.

6.6. Aspects that need to be improved

6.6.1. At the level of Partners in the regions

[21] Information provided by the DNJ Medical and Administrative Management.

- To strengthen outreach and counselling, especially with partners like COMEP, CECOM, FON and AMAZON having a low level of progress on the goals. To expand coverage and improve the counselling persuasion power can have a direct effect on more patients receiving care.

  This task also involves consolidating alliances with institutions such as the Ministry of Health and municipalities, especially where the Programme has not made contact.

- Incorporate a clinical management approach that combines social work with a private market model and efficiency. This will make the activity more sustainable. Likewise, having more flexible prices may allow increasing the income of the clinic, while better focus the subsidy to the population that really needs it. This perspective could be well used by partners as DNJ and COMEP.
- Improve the evaluation criteria of patients requiring subsidy. Partners currently use some criteria to select patients requiring a partial or total subsidy from the Programme. However, often these are subjective and are not standardized. For example, in the case of IPROS, Managers (promoters) verify if the person does not have any support and his/her living conditions. In the case of FON, patients often are already classified because they come from MINSA, which has criteria to focalise the poor. In the case of FUNDAR, the evaluation includes to investigate the type of work of the patient, income earners, people paying the surgery, among other similar topics.

  In order to improve this selection, we recommend using objective practical criteria, such as the material of ceilings and floors for housing, family size, access to drinking water, access to electricity, education level of household head, among others. Many of these indicators are often used in anti-poverty Programmes.

6.6.2. At the level of the CBM National Coordination Office

- To reduce the delay on the transfer of funds and supplies to partners. This directly affects their performance, especially those with limited resources.

  One way to optimize the distribution of supplies is buying them at the local market. Thus, the distribution would be made more quickly and expiration of supplies would be reduced.

- To simplifying administrative requirements without affecting CBM requirements.

- We believe that the number of performance indicators of the Programme may be lower. Not all indicators are equally important. A higher number does not necessarily mean that the Programme will be better monitored. By contrast, a larger number of indicators can affect the quality of the data and incur in higher costs of collection and supervision.

  Indicators related to surgeries are the most important because they directly reflect the nature of the Programme and the expected result. The health education and beneficiaries indicator, and the training indicator, although are part of the logical framework should be reduced to a smaller list if possible, leaving only the best proxy.

7. IMPACT

7.1. Impact on the target population (key impacts, evidence that there is a better quality of life)

Patients interviewed expressed their satisfaction with the service received. Cataract surgeries have meant a major change in their family life and work[22].

[22] Due to time limitation of the evaluation, it was only possible to interview patients proposed by the clinics (partners), and we could not choose beneficiaries randomly allowing us to interview patients with different results.

Some partners like IPROS showed documented case stories of patients whom have improved their life quality after surgeries. We believe that this practice, although it is mandatory for all partners, would be valuable for the Programme if tries to document a higher number of cases[23]. This task can be carried out and systematized by a professional hired by CBM, when there is no option to do it in each region.

A few life stories of the Programme in Tarapoto are included in the appendixes section.

7.2. Impact on improving partners capabilities (training sessions)

In general, partners expressed their satisfaction with the training provided by DNJ. It is recognized that training in counselling and administrative aspects has had a positive impact on partners' management. It would make sense to continue strengthening these areas, especially with partners having this weakness.

Table # 10
People trained by the Programme
June 2014-December 2015

TYPE	Indicator	DNJ (Lima)	FON (Piura)	AMAZONAS (B.Grande)	CECOM (Trujillo)	IPROS (Tarapoto)	COMEP (Abancay)	FUNDAR (Arequipa)	TOTAL
Eye Care Specialists	Number of trained community care promoters	0	20	0	5	45	0	14	84
	Number of trained counselors	0	0	1	1	2	1	0	5
	Number of ophthalmologists trained in SICS	2	0	0	0	1	1	0	4
	Other training (administration, management, etc.)	0	0	0	2	1	1	0	4
Community Level	Number of outreach workers trained	0	0	1	1	0	0	0	2
	Number of ophthalmic assistants and nurses trained in different areas	0	0	0	0	1	0	0	1
SUBTOTAL		2	20	2	9	50	3	14	100
Primary Vision Care	Number of persons of MINSA trained in community eye health	133	182	22	50	55	36	0	478
	Number of primary health care workers trained and competent in community eye health	0	30	73	0	35	1	0	139
SUBTOTAL		133	212	95	50	90	37	0	617
GRAND TOTAL		135	232	97	59	140	40	14	717

[23] According to the National Coordinator, all partners must document at least 2 stories per semester to be selected for the report to be sent to the donor. Finally one of the 14 received is chosen to be sent to donors. In the field visit, only IPROS of Tarapoto said it had life stories.

Source: CBM report submitted by the National Coordinator[24]
Drafting: Own

In the case of IPROS, FON, COMEP, AMAZONAS, CECOM, training on counselling is much appreciated as it has a direct impact on patient decisions. Training sessions in outreach and in administrative aspects are also highly valued. In the case of COMEP, the training sessions to ophthalmologists have also been highly valued.

Moreover, partners have also provided training sessions to MINSA staff, mainly in screening. In this period, 478 professionals have been trained, 66% of which were trained by DNJ and FON.

While it is true that DNJ carries out a final evaluation of the training provided, there is no monitoring to verify that the knowledge acquired improves the technical and administrative capacity of the clinics. It is recommended to do this exercise at least once a year.

It is necessary to continue improving the capacities of the technical teams of partner clinics. The staff interviewed said they would like to continue improving their skills in eye diseases and their prevention. Another aspect that should be further strengthened is counselling, because preparation or updating is a continuous process of any organization. The more trained are the counsellors in the knowledge of eye diseases, methods to deal with patients, use of technology, reports and others, the Cluster will be better strengthened.

FON and COMEP have raised the need to train the surgeon of the clinic. In the case of FUNDAR, training sessions should be focused on improving information systems, a key element to improve the administrative efficiency of the clinic.

8. PARTNERS SUSTAINABILITY

Partners' sustainability is essentially based on their capacity to sustain in the ophthalmologic market. For the analysis, we will take into account two

[24] The data was provided by the National Coordinator of the Programme in Excel and was compared with the information of the clinics during the interviews in the regions.

aspects: the profitability of the activity and the management model in a scenario of competition in the market.

According to the financial information provided, the Programme partners that have achieved the best ratio of income/expenditure are FUNDAR Arequipa and CECOM Trujillo, with ratios of 1.60 and 1.20, respectively. COMEP and IPROS show ratios of 1.03 and 1, respectively. Finally, the lowest ratios come from DNJ Lima and FON Piura with ratios of 0.97 and 0.94. In the latter two cases we can say that revenues were lower than expenses. The AMAZONAS clinic did not provide data about it.

Table # 11

income and Expenditure of Program Partners - Year 2015

Partner	Income	Expenditure	Profit	Income/Expenditure
FUNDAR (1)	Not available	Not available	Not available	1.60
CECOM-Centro Comunitario Oftalmológico Maranata	206,702	172,797	33,905	1.20
COMEP-Centro Oftalmológico Monseñor Enrique Pelach	592,873	577,820	15,053	1.03
IPROS- Instituto de Prevención y Rehabilitación Oftalmológica de la Selva (2)	175,151	175,151	0	1.00
DNJ-Diviño Niño Jesús	4,502,952	4,632,697	-129,746	0.97
FON-Fundación Oftalmológica del Norte	211,784	224,602	-12,818	0.94
AMAZONAS	Not available	Not available	Not available	Not available

(1) FUNDAR only provided as information the ratio income/expense

(2) According to IPROS, the income only comes from the Project and its spending has been 100%. July 2014-December 2015 Period

Source: Financial reporting of partners
Drafting: Own

It is important considering that some partners as CECOM, IPROS and FON, work closely with private clinics, whose owners are both partners and/or promoters of the associations that make up the Cluster[25].

In the case of Arequipa, the ORGANIZACIÓN DE LUCHA CONTRA LA CEGUERA (Organization to Combat Blindness), is the non-profit allied organization performing social Programmes, while FUNDAR is the private enterprise.

According to the information provided by partners, the private clinics allied to IPROS, FON and CECOM show good profitability ratios, as shown in the following table.

[25] In the case of CECOM, the allied clinic is CENTRO DE CIRUGIA DE CATARATA LUZ Y VIDA (CATARACT SURGERY CENTER); in the case of IPROS is CLINICA OFTALMOLOGICA DE LA SELVA (EYE CLINIC OF THE JUNGLE); and in the case of FON is CLINICA OFTALMOLOGICA DE PONGO (EYE CLINIC OF PONGO).

Table # 12

Profit and Loss Statement of the companies (clinics) related to the partners - Year 2015				
Clinics related to the partners	Income	Expenditure	Profit (1)	Income/Expenditure
CLINICA OFTALMOLOGICA DE LA SELVA (2)	571,029	391,807	179,222	1.46
CLINICA OFTALMOLOGICA DE PONGO (3)	1,115,245	905,660	209,584	1.23
CENTRO DE CIRUGIA DE CATARATA LUZ Y VIDA (4)	177,838	151,688	26,150	1.17
(1) Before taxes and profit sharing				
(2) Working with IPROS				
(3) Working with FON				
(4) Working with CECOM				

Source: Financial reporting of partners
Drafting: Own

Sustainability based on the efficiency and the market

While non-profit associations have a predominantly social mission, private clinics are dedicated to provide their ophthalmologic services for profit, like any other company.

In this way, CECOM, IPROS, FUNDAR, FON and their allied clinics underpin their strategy of sustainability in two components: 1) Associations comply primarily with social work, channel financial support (donations), develop advocacy and provide attention to a well identified target population, and 2) Companies (clinics) are dedicated to provide ophthalmologic services competitively in an open market. It is important to emphasize that the "quality mark" of the health service derives from the prestige of the private clinic which has been built for many years.

In these cases, patients care is channelled through the allied private clinics. Cataract patients of the cluster are treated in these clinics, since they have the infrastructure, operating room, human resources, logistics, equipment and medical supplies necessary to perform their jobs. In this way, the strategy consists of a model that combines two components: the offer of a private service, whose incentive is clearly aligned to the efficiency of the market (the clinics), and on the other hand, the existence of a foundation that complies with a social work.

On the other hand, we have DNJ and COMEP who meet a social mission and also offer their services on the open market, but under the legal and organizational form of a non-profit association.

Even when these associations have many strengths (as in the case of DNJ that account with infrastructure, equipment and a medical capacity of proven quality), we believe that some elements being applied by other members of the cluster should be adopted to consolidate its sustainability in the ophthalmologic market, such as flexible rates and considering the possibility of charging fees to patients who have the capacity to pay, even if the payment is only partial.

In the context of the Programme, there is a need for a comprehensive approach to pricing flexibility, i.e., assuming that population can afford partly or fully the cost of the service[26].

It is understood then that revenues are based on the partial or full payment of customers, and the subsidy arises from an evaluation of the patient who really cannot afford the payment. This strategy may allow the foundation to fulfil its social mission through a service of good quality, as occurred with other partners in the Cluster. In this way, incomes may increase and make the activity more sustainable. With the exception of DNJ, partners currently have tiered rates, where the payment depends on the real capacity of patients.

For example, if a patient can pay in full, a third or a fifth of the price, his proposal is accepted. The partial or total subsidy derives from the evaluation that is usually performed in the counselling area. In this way, the social work alleged is accomplished without leaving aside the sustainability of the clinic, which is based on the private management, competition and market.

In short, we believe that cluster partners are sustainable, especially those that have a model combining social work with private efficiency. Rather, in cases like DNJ, more elements of this model should be adopted: make prices more flexible, provide new surgical services (phaco, retina[27]), apply

[26] The Programme subsidizes 25%/20%/15% in a comprehensive manner and the rest partially.
[27] Currently the DNJ clinic treats these cases, but the retina surgical service is outsourced through the ophthalmic clinic CONTRERAS, which has the necessary equipment.

tiered fees and be able to attend patients with greater resources who can pay for the service.

In the case of COMEP, promoting the service offer is required, scaling up treatment coverage, entering in regional markets and improving human resources, especially enabling a greater permanence of the surgical team at the clinic.

Did the Programme contribute to the cluster sustainability?

In all cases it is recognized that the CBM Programme has been a factor contributing to the sustainability of their foundations and companies (clinics). However, the concept of total free service does not contribute to sustainability in the medium and long term. Therefore, the partial and tiered subsidy established by the Programme is a success.

8.1. Sustainability with contributions from the Government

Although MINSA established the "National Strategic Plan for Eye Health and Prevention of Avoidable Blindness 2014-2021", a real possibility that the government contributes to partners' sustainability is not shown. In any case, the interesting thing is to consolidate strategic alliances with MINSA to strengthen outreach and training of health personnel. This would expand the cluster coverage with a population that has been identified and focalized by MINSA (with cataracts and as poor), and which can be derived to partner clinics for their respective attention.

8.2. Involvement and support of central and local government[28]

There has been a joint effort between the Programme and the MINSA, although the result is differentiated in each region. The most important actions are:

- **Training of MINSA personnel** with CBM support**.** Until December 2015, CBM has trained 478 health professionals in screening and eye

[28] One direct interview with the person responsible for the "Regional Strategy for Eye Health of the DIRESA Piura (Regional Health Directorate)" was only made.

diseases. The regions with a greater number of trained were Lima (DNJ) and Piura (FON).

- **MINSA work agreement, through the "Regional Strategy for Eye Health of DIRESA"** with FON Piura. The agreement establishes that the MINSA helps to organize screening community campaigns and patients requiring a cataract surgery are identified. Additionally, FON trains MINSA staff in screening and other aspects related to eye diseases, thereby strengthening the care policy the government has in the region.

  In this case, CBM contribution is essential, since the MINSA only has a budget of S/60.000/year for eye health strategy in this region, amount that is extremely limited to combat blindness. This limitation is expressed in the fact that this Programme does not have an indicator of results, nor incentives for their staff.

  This situation is aggravated with the low capacity of cataract surgery that the MINSA has in Piura, despite having 8 ophthalmologists.

  Under these conditions, the strategic alliance between FON and MINSA improves MINSA capabilities, while FON can identify more patients. However, in 2015, the support from MINSA was reduced because health staff had to prioritize the dengue and chikungunya emergencies. This fact affected the results.

- **Agreement between MINSA and CBM in Amazonas.** Through this agreement, it has been possible treating identified patients with cataract in the MINSA, and assist them through the clinic in AMAZONAS.

9. CROSS-CUTTING ISSUES RELEVANT TO THE PROGRAMME

9.1. Inclusion of persons with disabilities

Partners are assisting people with disabilities. In the case of DNJ, it has treated cases of deaf-mute people. In the case of FUNDAR, it has treated cases of people with rheumatism and deafness.

However, there is a restriction in providing cataract surgery to persons with disabilities, since most of the centres visited do not have equipment or anaesthesiologist in order to perform these surgeries safely. Only FUNDAR has an anaesthesiologist for these cases.

On the other hand, all the visited centres have operating rooms located on the first floor and ramps for wheelchair users.

Except DNJ, clinics with second floor does not have elevator or ramps, are not accessible, but in most of the clinics patients receive attention in the first floor.

9.2. Strategies for awareness-building

The most commonly used methods have been: community campaigns with allies, mainly municipalities, parishes and social Programmes of the Government as "Pension 65". In the case of DNJ, the awareness work is performed with grassroots organizations, such as "Vaso de Leche", soup kitchens, the Church, among others. A key element of this task is to have local leaders who know the reality and generate confidence in the locality. In the case of IPROS, the practice is quite similar. In the case of FON and AMAZONAS, the MINSA helps a lot with this purpose.

However, this task is often limited by the lack of knowledge of elderly people, whom many times is influenced by the comments of people with lack of grounds who claim to have had "bad experiences" with cataract surgeries in their family environment. Added to this is the unfounded idea that surgery may make them blind. To mitigate this false perception, it is important that partners maintain the quality of the service and inform the population in campaigns about the benefits of surgery.

Also, the word-of-mouth recommendation remains the most effective for patients to come to the service and have the confidence to surgery.

If the Programme can move to the communities to operate and there are the necessary means (operating room), it is a good way to identify and operate patients effectively.

9.3 Gender

No cases were identified where women participation has been limited. Partners said they are attending without distinction both sexes.

However, a noteworthy element is that the greater part of persons dedicated to outreach in the regions, especially leaders, are women. This situation may lead to a greater participation of women, and therefore to a greater likelihood that they will be benefited by the Programme.

9.3. Child protection

Care is mainly for elderly people. Care policies of partners agree with the CBM policies in this aspect.

In all consulted cases, the cases of children are referred to other institutions. For example, when DNJ had some cases, they were referred to INO.

Only FUNDAR did surgeries on children occasionally. Most centres do not operate children due to the lack of general anaesthesia services.

9.4. Partner participation in the Programme intervention

As it has been mentioned throughout the document, partners are the main implementers of the Programme. They identify the potential target population, perform campaigns with support from ally institutions and carry out medical attention, mainly cataract surgery.

With regard to Planning, Cluster members participated in the initial planning board of the Programme and have keep participating in the meetings convened by the National Coordinator, like the one that was recently held in April 2016 in Lima, in the framework of the mid-term evaluation, with the purpose of reviewing the programmatic aspects of the cluster and to draw up measures to improve their performance.

CONCLUSIONS

1) Programme partners are a group of experienced clinics with the medical quality needed to perform cataract surgeries. The revised results of Visual Acuity after Cataract Surgery are good, with an 85% with a better Visual Acuity.

2) The most important indicator of the Programme is the number of cataract surgeries performed. Regarding the goal for July 2014-December 2015 period, there has been a progress of 66%, and 31% of the overall goal (3 years). Even rescheduling the goals, the Programme may not meet them, except the implementation time of the Programme is extended for six months.

Only IPROS Tarapoto has achieved the programmed goal; FUNDAR and DNJ reached more than 70%, but failed to meet it. AMAZONAS (Bagua), FON (Piura) and CECOM (Trujillo) only achieved a percentage between 45-59%. With the lowest performance is COMEP Abancay, with only 10% of the proposed goal.

The delay to start the Programme operations and the poor response of outreach at the outset of the Programme might impact on the results. The late delivery of supplies seems have also affected this achievement.

Also, in some cases as COMEP, the limitation is associated with its little use of financial resources and its institutional weakness, not only due to the lack of financial resources to deal with any situation, but also to the lack of a sustainable management model. During 2013-2014, COMEP went through a reorganization process to improve efficiency, which affected even 2015.

3) In the case of IPROS, FUNDAR and DNJ- partners showing the best results-, their success is related to the quality and stability of their health staff. Despite CECOM and FON also have equipment of good quality and medical experience; its results were affected by the lower coverage of patients as a result of the limitations of the outreach.

4) Strategic alliances with local stakeholders and institutions have been crucial for advocacy work and community care. Their support also allows a better focalisation of the target population.

5) Training sessions of human resources improve project processes. The training sessions provided by the Programme through DNJ has allowed a significant improvement in the quality of counselling, administration, outreach, and technical capacity of the health team of partners, such as FON, CECOM and IPROS.

6) The role and support of CBM is greatly appreciated by all the partners of the Cluster. In all cases, it is recognized that its support has been critical to strengthen the clinics operation currently participating in the Programme.

7) Regarding the impact on the beneficiary population, the patients interviewed expressed their satisfaction with the service received. Cataract surgery has meant a major change in their family life and work.

8) Cluster partners are sustainable, especially those that have a model combining social work with private efficiency. Partners as FON, IPROS, FUNDAR or CECOM that have a private clinic as an ally, can ensure a quality service and document their income based on the sale of the service in the market.

DNJ has infrastructure, equipment and a medical capability of proven quality. However, we believe that some elements being implemented by other partners in the cluster should be adopted to consolidate its sustainability in the eye market, such as have flexible prices, provide new surgical services (phaco, retina), apply tiered fees and treat patients with greater resources who can afford the service.

In the case of COMEP, expanding the coverage and fostering the service offer is required, entering in regional markets and improving human resources, especially enabling a greater permanence of the surgical team at the clinic.

9) In all cases it is recognized that the CBM Programme has been a factor contributing to the sustainability of their foundations and companies (clinics). However, the concept of total free service does not contribute to sustainability in the medium and long term. Consequently, the Programme strategy for gradually reduce the subsidy of 25% in the first year, 20% in the second, and 15% in the third has much sense.

RECOMMENDATIONS

1) It is recommended to extend its execution for at least six months to reach the proposed goals, since the Programme has been doing a good job in the seven regions.

It is important that partners showing the lowest results implement the following strategies: 1) increase the outreach coverage because potential patients come from it. Expanding partnerships with institutions is essential. 2) strengthen counselling, which is a key element in the decision-making of patients; 3) consolidate the health staff, particularly to ensure a greater dedication of the surgeon, as in COMEP. Additionally, it is important to strengthen the management model that combines social support with market efficiency.

2) Regarding the focalisation of the target group, it is recommended that, although members do a good job in this regard, is required to be done more objectively, using variables such as number of household members, number of income earners, material of floors and walls, number of bedrooms, housing location, among others. This would help to reduce the discretional nature when giving a subsidy.

3) On reporting burden, it is recommended to CBM a review of those administrative requirements that can be simplified, without losing the quality of the information needed. This can be done with an administrative review plan, which involves identifying the variables which are necessary and cannot be omitted, especially when there is a commitment to the donor of the Programme.

4) CBM is recommended to seek ways to reduce the delay of the transfer of funds and supplies to partners. This directly affects their performance, especially those with limited resources. To do this, bottlenecks that cause this delay should be identified, and specific corrective measures with the administrative units involved in the management, approval and disbursement of funds should be adopted.

5) It is recommended to continue showing the impact on the beneficiary population through life stories. It would be worthwhile to assess the possibility of hiring a consultant familiar with the matter who can

systematize and extend these findings, at least six months before the Programme ends.

6) It is recommended a smaller number of Programme indicators. Not all indicators are equally important. A higher number does not necessarily mean that the Programme will be better monitored.

Priority should be given to those indicators that are directly related to the performance of the cluster, such as: number of cataracts, number of people with post-surgical visual acuity, number of screenings and number of people trained.

7) It is recommended the sale of eyeglasses as an important source of income helping the sustainability of the project. It is important to strengthen the optical services in all centres. Partners that do not have boosted this option should make an investment plan to organize the store and manage funding to have the necessary stock.

8) It is recommended the opening of services such as Retina (photo-coagulation, injection of anti-angiogenic) due to the increase in the prevalence of diabetes in the country in order to strengthen the sustainability of the Programme.

9) It is recommended that all centres keep a digital system for managing statistics. Only FUNDAR and DNJ have a digital system. A short-term plan should be formulated, setting the necessary budget and dates for implementation. In this task, DNJ can be an important support.

10) It is recommended to implement a detection and cataract surgery system in a single visit to the clinic. Most of the centres requires several visits to patients before the surgery (varies from 3 to 5 visits before the surgery). This can cause loss of patients in the meantime. This implies that partners who have not yet meet this condition, can readjust their administrative flows and correct those bottlenecks that extend the number of patient visits. DNJ training can assist in this process. Patient should be operated in not more than two days.

11) It is recommended the local purchase of supplies and not bring them from India. This can serve to make more efficient the attention and to avoid losses caused by the expiration of the product. It should be found a way to implement a Collection Centre for all partners.

LESSONS LEARNED

1) A good practice for members is to generate management based on a model that combines two components: the offer of a private service, whose incentive is clearly aligned to market efficiency (clinics), and on the other side the existence of a foundation that meets social work. This practice has shown good results, as the case of IPROS or FUNDAR, for instance.

2) A good practice of this experience is associated with the search for a sustainable operating model of the clinics. Free consultation and surgery should be offered to patients in extreme poverty, but even they should pay some is possible. The all free system is a double-edged sword. When projects end, people do not want to contribute waiting for a new similar project appears. The concept of total gratuity does not contribute to the sustainability of the partners in the medium and long term. It requires a mixed scheme that combines help with efficiency.

3) The strategic alliances with institutions are important, but you cannot rely only on one of them. You must always have options to achieve results.

4) A system of incentives for achieved goals can allow a greater commitment of community promoters and a better outcome for the Programme, as FON or IPROS have done.

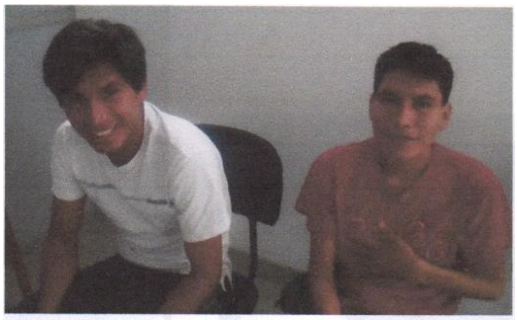
APPENDIXES

APPENDIX 1

EXAMPLE OF AN IMPACT STORY OF THE PROGRAMME

IPROS-TARAPOTO

Watson



Watson (Right), accompanied by his brother Frank (left)

Watson Guevara Sanchez is 28 years old. He is the oldest of three brothers and uncle of several young boys and girls. It is not yet father, but is looking for a girlfriend. In the year 2014, while driving -he is a cab driver- he felt that something entered in his eye. When he got home, one of his brothers told him that his right eye was red. However, he didn't paid attention to that. After the third night of the incident at the road, his left eye also bothered him. After a few days, he went to a doctor who prescribed him some drops to be applied in both eyes. The results were not positive, quite the opposite. "I went to a doctor in another place, they gave me a few drops of forty soles that I placed into the eyes, but it got worse. I couldn't see anything".

Nine months passed before he received the correct diagnosis. Today he is at his first control, after the cataract surgery in the right eye. Watson explained: "My view is quiet. I am calm. It's quite a change. Yesterday I couldn't see anything. I couldn't walk by myself. No I can walk on my own. My brother and sister helped me; they dressed me up and put my shoes on. Now I can do it alone".

Today, I hope to return to work as quickly as possible. "I feel that the operation has changed my life," he ends.

APPENDIX 2

LIST OF INTERVIEWED PEOPLE

N°	NAME	INSTITUTION	POSITION
01	CESAR GONZALES	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	DIRECTOR
02	ALBERTO LAZO	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	MANAGING DIRECTOR
03	CINTIA MONTORO	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	NURSING TECHNICIAN
04	CRISTINA FLORES	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	NURSING TECHNICIAN
05	SUMIKO BURGA	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	OPHTHALMOLOGIST
06	CECILIA MEDINA	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	OPHTHALMOLOGIST
07	GLORIA DURAN	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	MUNICIPAL PROMOTER - SJM
08	GLORIA CHAVEZ	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	MUNICIPAL PROMOTER - SJM
09	DORCAS GUILLERMO	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	COMMUNITY LEADER
10	ELIZABETH PEREZ	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	COORD. COMMUNITY AREA
11	CRISTINA ALFARO	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	COMMUNITY AREA
12	JOSELIN QUISPE	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	COUNSELLOR
13	PATRICIA LONDOÑE	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	COUNSELLOR
14	LAURA MOTA	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	PATIENT
15	JULIO LOPEZ	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	PATIENT
16	LUCIA TORRE	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	PATIENT
17	FILOMENA LOPEZ	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	PATIENT
18	EUFEMIA MARCA	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	PATIENT
19	GUILLEROMO OCHOA	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	PATIENT
20	ALBERTO VIERA	CLÍNICA DIVINO NIÑO JESÚS (DIVINO NIÑO JESÚS CLINIC)	PATIENT

21	LUIS FELIPE AREVALO	IPROS	DIRECTOR
22	CESAR CORONEL	IPROS	ADMINISTRATOR
23	BETSY INUMA	IPROS	NURSING TECHNICIAN
24	MARY GOMEZ	IPROS	NURSING TECHNICIAN
25	BILMER RENGIFO	IPROS	PROMOTER
26	CARLOS VEGA	IPROS	PROMOTER
27	TERESA GUERRA	IPROS	COMMUNITY LEADER
28	LIZ SORIA	IPROS	COMMUNITY LEADER
29	KELLY ROSAS	IPROS	COUNSELLOR
30	CARLOS INGA	IPROS	PATIENT
31	LUIS PONGO	FON	DIRECTOR
32	ANIE GIRON	FON	ADMINISTRATIVE ASSISTANT
33	ADI GRANADINO	FON	COUNSELLOR
34	ELOISA CRUZ	FON	COUNSELLOR
35	MARIELA CHUYES	FON	NURSING TECHNICIAN
36	FLOR SUAREZ	MINSA (Ministry of Health)	COORDINATOR OF THE BAJO PIURA NETWORK
37	PANTA AREVALO	FON	PATIENT
38	JOSEFA ALDANA	FON	PATIENT
39	BEATRIZ PANTA	FON	PATIENT
40	JOSE GIRO	FON	PATIENT
41	FANY CHOQUE	MINSA	REGIONAL COORDINATOR (EYE HEALTH STRATEGY)
42	LUIS SALAZAR	COMEP	ADMINISTRATOR
43	DONALD MEJIA	AMAZONAS	DIRECTOR
44	ARTEMIO BURGA	CECOM	DIRECTOR
45	GIOVANNI SALAS	FUNDAR	DIRECTOR
46	NANCY OPORTO	FUNDAR	ADMINISTRATOR
47	ELIADA YANA	FUNDAR	COMMUNITY WORKER
48	PATRICIA TAPIA	FUNDAR	COUNSELLOR
49	EVELIN ROJAS	FUNDAR	STATISTICIAN
50	CARMEN VEGA	FUNDAR	OPHTHALMOLOGIST
51	FELIX ORTEGA	FUNDAR	OPHTHALMOLOGIST
52	EFRAIN LEON	FUNDAR	PATIENT
53	PASCUAL CONCHA	FUNDAR	PATIENT

APPENDIX 3

CBM EVALUATION
COMBATTING BLINDNESS IN PERU
SEMI-STRUCTURED INTERVIEW

TYPE:……

DATE:……

PLACE:……

CLINIC (RELATED TO):……

PERSON: ……..

POSITION:……..

Type of semi-structured interview	Scope
Partners representatives	Relation of the Programme with the government policy. Scope and results of the Programme to the government. Fulfilment of the objectives and goals (Total cataract surgeries performed versus total other major or minor surgeries performed, regarding the initial plan). Outreach level to the target group of the Programme according to the profile sought and coverage. Factors that have contributed to the achievements of the Programme (internal and external). Factors that have limited the Programme's objectives, if any (internal and external). External factors to consider when redesigning the Programme. Good practices implemented by partners that deserve to be replicated. - In the increase of patients. - To overcome barriers and achieve surgical goals. CBM management results: Perception (satisfaction) of the National Coordinator role. CBM management results: Perception (satisfaction) of the CBM central office role. CBM management results: Perception (satisfaction) of the role of other relevant

	stakeholders of the Programme. Main management aspects or factors that are positive and deserve to be highlighted. Main management aspects or factors that need to be improved. Programme contribution to the quality of life of users and their families. Impact of the training Programme on the surgery. Impact of advice, management and outreach. Other relevant impacts not foreseen in the initial plan. Feasibility that the government assumes subsidy after completion of the Programme. Level of involvement of Local and Regional Governments. Sustainability of organizational and technical capacity of the partners after the end of the Programme. Financial sustainability of partners at the end of the Programme. Level of accessibility of the target population to the Programme services. Barriers that have been overcome to improve the inclusion of disabled people. Strategies implemented by partners to achieve better awareness. Most effective means to encourage access to services. Level of involvement of partners in implementing the Programme in the planning. Level of involvement of partners in implementing the Programme in the execution. Women level of participation in the Programme. Identified barriers that limited access to the Programme. Child protection policies formulated and implemented by partners.
Hospital staff	Factors that have contributed to the achievements of the Programme (internal and external). Factors that have limited the Programme's objectives, if any (internal and external). External factors to consider when redesigning the Programme.

	Good practices implemented by partners that deserve to be replicated. - In the increase of patients. - To overcome barriers and achieve surgical goals. CBM management results: Perception (satisfaction) of the implementing partners. CBM management results: Perception (satisfaction) of the role of other relevant stakeholders of the Programme. Programme contribution to the quality of life of users and their families. Impact of the training Programme on the surgery. Impact of advice, management and community work. Other relevant impacts not foreseen in the initial plan. Barriers that have been overcome to improve the inclusion of disabled people. Strategies implemented by partners to achieve better awareness. Most effective means to encourage access to services. Women level of participation in the Programme. Identified barriers that limited access to the Programme.
Users and community leaders	Outreach level to the target group of the Programme according to the profile sought and coverage. Factors that have contributed to the achievements of the Programme (internal and external). Factors that have limited the Programme's objectives, if any (internal and external). External factors to consider when redesigning the Programme. Good practices implemented by partners that deserve to be replicated. - In the increase of patients - To overcome barriers and achieve surgical goals. CBM management results: Perception (satisfaction) of implementing partners. CBM management results: Perception (satisfaction) of the role of other relevant stakeholders of the Programme. Main management aspects or factors that are positive and deserve to be highlighted.

	Main management aspects or factors that need to be improved. Programme contribution to the quality of life of users and their families. Impact of the training Programme on the surgery. Impact of advice, management and outreach. Other relevant impacts not foreseen in the initial plan. Level of accessibility of the target population to the Programme services. Barriers that have been overcome to improve the inclusion of disabled people. Strategies implemented by partners to achieve better awareness. Most effective means to encourage access to services. Level of participation of women in the Programme. Identified barriers that limited access to the Programme.
Government representatives	Relation of the Programme with the government policy. Scope and results of the Programme to the government. Programme contribution to the quality of life of users and their families. Feasibility that the government assumes subsidy after completion of the Programme. Level of involvement of Local and Regional Governments. Barriers that have been overcome to improve the inclusion of disabled people.