A conversation with Victoria Sheffield and John Barrows, June 5, 2017

Participants

- Victoria Sheffield – President and Chief Executive Officer, International Eye Foundation
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Note: These notes were compiled by GiveWell and give an overview of the major points made by Ms. Sheffield and Mr. Barrows.

Summary

GiveWell and IDinsight spoke with Ms. Sheffield and Mr. Barrows of the International Eye Foundation (IEF). Conversation topics included the program's history, intervention model, monitoring and evaluation efforts, and potential for scaling up.

The International Eye Foundation

Background

IEF prevents and treats blindness by improving access to high quality eye care services in developing countries, primarily through increasing the efficiency and sustainability of existing providers.

IEF was founded in 1961 in Washington, DC, USA. Initially, it sent volunteers to developing countries for short- and long-term assignments, then in the 1980s it ran programs combating vitamin A deficiency, river blindness (onchocerciasis), and trachoma. However, by 1999 it realized that many eye care providers had adequate but under-utilized staff, skills, and equipment, so the focus shifted to systems reform, especially management practices in order to strengthen hospital sustainability.

The most recent approach began in 2000 with a grant from the United States Agency for International Development (USAID), starting with seven hospitals in six countries. To date, the organization has assisted 55 hospitals in 22 countries.

Global eye care resources

There is considerable interest in global eye care, with many blindness prevention organizations working on cataracts and other diseases. There is also some research on the impact of blindness and its association with poverty and productivity as well as its impact on comorbidities. However, the issue is not nearly as well financed as other areas of global health, such as neglected tropical diseases (NTDs).

Funding

IEF has a budget of $5-6 million per year. The majority of that consists of donated medical supplies. Most of IEF's funding is oriented toward its sustainability initiatives where the disease focus is on treating cataracts.

Program model

Aims

In developing countries, the number of surgeries per ophthalmologist is generally low – sometimes ~20 per month when ~200 are feasible. IEF's focus is on improving utilization of existing resources with the resulting aim to enable the providers to become financially self-sustaining social enterprises. Revenue earned from user fees using multi-tiered pricing is reinvested back into the services while foreign donations are invested for capital expenditure to enable growth.

The initial focus of a partnership is usually on cataract surgery and refractive error, as these services can earn revenue that grows services and cross-subsidizes care for the poor. It is necessary for the provider to be profitable in order to cover costs and discourage ophthalmologists from moving abroad or into private practice. As it grows, the revenue can be used to cross-subsidize other services, such as retinal surgery and pediatric care.

Types of support

Three broad levels of support are given to partners.

1. **Technical assistance.** Some providers just need training, retraining, and support to manage changes in clinical and management protocols and processes, which may cost IEF as little as $25,000.
2. **Sub-grants.** Some providers receive a grant, usually between $50,000 and $400,000, which is given in tranches as various benchmarks are met. Funding is provided for whatever key investment is required to overcome barriers to becoming an effective social enterprise: extensive training for the staff, renovation of the building to improve patient flow or make improvements to the operating theatre, hiring staff (~18 people are needed for a clinic with one or two ophthalmologists to run efficiently), equipment, supplies, developing outreach and referral services, developing management information systems, etc.
3. **Construction.** Occasionally, hospitals are built from scratch in places where there is a lack of available services, as in Haiti and Nicaragua. These hospitals serve as a model for other hospitals in the country.

Provider types

IEF looks at the eye care market as a whole, and works with a range of service providers: government, private and non-profit. The public sector is the largest but also the least productive, and has more constraints on change. Private practitioners tend to be small, family-run businesses that serve relatively few, mostly better-off clients at high prices. IEF encourages governments to become more business-like in

order to improve their efficiency, and private providers to become more socially-oriented, arguing that targeting the high volume of poorer patients would also make sense from a profit-making perspective.

Partner selection

IEF first carries out a written assessment of a potential partner, looking at elements such as the number of ophthalmologists, infrastructure, type of organization, and leadership. If it seems promising, a site visit is made, including interviews with staff at all levels and verification of the hospital's statistics and data. Once IEF feels there is a real commitment to change, funds are raised and the provider is connected with a mentoring team, either from IEF or an IEF partner in the same region. This team brings all relevant people – a doctor, anesthetist, nurse, administrator, and financial manager – to help the provider become a social enterprise.

Mentor development

A strategic decision was made to build capacity in the regions in which IEF works rather than at its U.S. headquarters. Consequently, mentors are often organizations that have received IEF assistance in the past, such as Visualiza in Guatemala, the Divino Niño Jesus (DNJ) Eye Hospital in Peru, and a Rotary Hospital in north India. Some of these mentors are also given funding to work with providers that do not have a direct partnership with IEF.

Other activities

Aside from building the capacity of providers and mentors, IEF has two additional projects.

- **River Blindness.** IEF has an ongoing onchocerciasis (river blindness) control program in Cameroon since 1992. This is a more traditional public health program involving the annual distribution of drugs by community health workers.
- **SightReach Surgical (SRS).** Donated equipment is often broken or spare parts are no longer available, and most eye care providers lack the opportunity to attend meetings where new equipment is exhibited. Since 1999, SRS has helped providers purchase (with their own money from earnings, governments, or non-governmental organizations [NGOs]) new eye care products at a lower profit margin.

Monitoring and evaluation

Indicators

IEF is currently carrying out a review of the last 15 years of the program. Most providers will only be able to report on a few core indicators, such as:

- **Number of examinations.** These include attendance at first and subsequent visits, and number of new and previous patients.
- **Number of cataract surgeries.**

- **Number of other surgeries.** Often these are lumped together into "other."
- **Number of surgeries per ophthalmologist.**

Where possible, IEF gathers additional information, such as:

- **Outcomes.** When possible, service quality is assessed by comparing visual acuity pre- and post-surgery and other quality of life measures.
- **Financial indicators.** Ideally, these include the main sources of revenue, including sales, as well as expenditures.
- **Numbers counseled for and accepting cataract surgery.** This is difficult to get accurate information on.
- **Numbers of prescriptions and the number of eye glasses sold.**

If the provider has both private and "social" services, separate statistics are sought.

IEF is also exploring equity issues, such as how many patients access private versus social clinics, how many services are free, and customers' socioeconomic status. Demographic information is often not routinely recorded, though IEF is working on systems to validate a patient's choice of service and their ability and willingness to pay for the service.

Reporting

Data collection and reporting practices vary among partners. Most partners record patient statistics using manual reporting systems. Some have sophisticated, computerized systems that can rapidly generate detailed information. However, these systems require investment, training, and maintenance. Data collection is one issue that is often addressed during the provider's transition period.

The type of provider and funding arrangement can affect data availability. For programs with clearly defined donors and goals there is very intensive monitoring. In contrast, public sector providers are often reluctant to give detailed information, especially about finances and manpower. However, it is usually possible to obtain a list of staff, allowing a basic analysis of productivity. For instance, IEF may discover that a hospital has 23 ophthalmologists but only carries out 2,000 surgeries a year because it operates like a group practice, with each doctor only working a few hours a week. IEF may then help it streamline, so that just 4-5 specialists are doing most of the surgeries. Often decisions on public institutions are made not only by the Ministry of Health but the Ministries of Finance, Social Security, and others, which complicates efforts.

Most reporting is currently done manually using patient records and Microsoft Excel. There are programs under development where clinics may upload their data from Excel sheets to a database.

Scaling up

Scaling

Because of the clinical expertise required, cataract surgery cannot be scaled up in the same way as some other interventions, such as NTD treatment, vitamin A supplementation, or provision of anti-malarial bed nets. Previously, large numbers of operations were carried out in a short period of time in "eye camps," but they generally are not sustainable. These days, there is more focus on capacity building of existing eye hospitals and developing outreach to communities from those hospitals in order to establish more sustainable services.

Use of additional funds

Possible uses of additional unrestricted funding include the following:

- **Staff.** Just a couple of people currently manage most of IEF's work with hospitals. Sustainability planning and mentoring is quite a time-intensive intervention, so to increase its reach, more staff would be needed.
- **Monitoring and evaluation.** If IEF expands the number of hospital partners, additional improvements to technical tools and staff are needed to improve reporting and analysis.
- **Partnerships.** The number of groups IEF works with could be increased, and perhaps a whole-country approach could be adopted, allowing large numbers of staff from different providers to be trained and mentored together. IEF is confident there are plenty of groups that would benefit from its assistance.
- **Training and mentorship.** Mentoring provided by IEF's field partners is time-intensive and impacts the mentors' own businesses. Likewise, using hospital staff for training affects its service delivery. It would therefore be better to have dedicated resources for this, including more suitable facilities; in particular, there are currently few places to train eye care managers in Latin America.
- **Loans.** It is currently difficult for most eye care providers to obtain capital. If IEF could provide loans at ~6% interest (compared to ~20% through banks), many providers would be able to make the required investments. Conditions would still be attached to ensure money was being used to benefit the poorest patients.

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