IMPACT ASSESSMENT REPORT

Titan Happy Eyes Initiative

Implemented by Sankara Eye Foundation

2024-2025

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Abbreviations

AAM	Ayushman Bharat Arogya Mandir
AWW	Anganwadi Worker
CBBF	Cataract Blindness Backlog Free
CSR	Corporate Social Responsibility
DAC	Development Assistance Committee
DBCS	District Blindness Control Society
FGD	Focus Group Discussion
FY	Financial Year
GOV	Gift of Vision
HDI	Human Development Index
IEC	Information, Education and Communication
IDI	In depth Interview
INR / ₹	Indian Rupee
IP	Implementing Partner
KIM	Key Informant Methodology
KII	Key Informant Interview
MoU	Memorandum of Understanding
MRVP	Mobile Rural Vision Programme
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
N	Number of respondents
NGO	Non-Governmental Organization
NPCBVI	National Programme for Control of Blindness and Visual Impairment
OECD-DAC	Organisation for Economic Co-operation and Development – Development Assistance Committee
SDG	Sustainable Development Goal
SEFI	Sankara Eye Foundation India
SERVIS	Sankara Electronic Remote Vision Information System

SN-SEES	Sankara Nethralaya School Children Eye Examination Study
STEM	Science, Technology, Engineering and Mathematics
UDISE+	Unified District Information System for Education Plus

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Titan Company Limited's Happy Eyes Program, implemented in partnership with Sankara Eye Foundation, addresses the persistent burden of preventable visual impairment among underserved populations. The initiative adopts a comprehensive service delivery model through four sub programme components: (i) Cataract Blindness Backlog Free (CBBF), (ii) *Nanna Kannu*, (iii) Mobile Rural Vision Programme (MRVP), and (iv) Gift of Vision (GOV), covering the full continuum of care from community outreach and screening to diagnosis, treatment, surgery, and post-operative follow-up.

The impact assessment for the four sub programmes under the Happy Eyes Program was guided by the Organisation for Economic Co-operation and Development- Development Assistance Criteria (OECD-DAC) evaluation framework and covered 5 districts across Tamil Nadu and Karnataka. It applied a mixed-methods approach comprising 112 respondents. Quantitative evidence was collected through surveys with 86 beneficiaries, whereas qualitative evidence was collected through In-depth interviews (IDIs), and Focus Group Discussions (FGDs) with 26 respondents, particularly beneficiaries, parents, teachers, headmaster, implementing partner, and Volunteers. Primary findings were triangulated with programme data and secondary literature wherever feasible.

CBBF addressed longstanding visual impairment among older adults, many of whom had normalised declining vision or delayed care due to limited awareness, affordability, and access. Quantitative findings indicate that 88% of the beneficiaries belonging to the age group ranging from 40-89 reported preexisting eyesight issues prior to programme engagement. Across the different programme components, the highest proportion of beneficiaries reporting pre-existing eyesight problems was observed in specific age groups. Under the GOV programme, 41% of beneficiaries in the 57–66 age group reported eyesight issues. Similarly, under MRVP, 34% of beneficiaries predominantly within the 66–75 age group reported visual impairment. Under CBBF, 29% of beneficiaries in the 70–79 age group reported pre-existing eyesight problems. Community embedded outreach, led largely by Volunteers (community health workers), supported awareness generation, screening, counselling, and mobilisation, with 63% of beneficiaries reporting Volunteers as their primary source of information. Beneficiaries received a comprehensive package of services, including free screening, spectacles, cataract surgery where required, transport, medicines, and postoperative care, contributing to high satisfaction levels (77% rated services 5/5). Reported outcomes included improved vision, mobility, independence, and ability to resume daily and livelihood activities, alongside emotional benefits such as relief and increased confidence following treatment.

Along similar lines, MRVP responded to unmet eye-care needs among rural populations facing geographic and financial barriers, with 90% of surveyed beneficiaries in the age group ranging from 16-80 reporting pre-existing eyesight challenges. The mobile outreach model facilitated access to screening and referral services closer to villages, supported by locally visible awareness channels, including banners, posters, and booths, cited by 34% of beneficiaries as their source of information . Rest of the responses were spread across family members, community awareness events, and Sankara field personnel as sources of information. Services delivered included screening, spectacle provision, referral for surgical treatment where necessary, and post-treatment advice, supported by Volunteers through counselling and follow-up. Beneficiaries reported improvements in vision clarity, daily functioning, and mobility, alongside reduced reliance on eye-care expenditure. While service delivery reduced travel burden and improved access, minor

operational issues (such as follow-up travel costs and data-synchronisation challenges) were noted in some locations.

GOV targeted underserved adult populations experiencing persistent visual impairment, with **86% of beneficiaries in the age group 37-75 reporting eyesight issues prior to programme participation**. Outreach relied on both Volunteers (**41% of beneficiaries**) and community events (**32%**) to generate awareness and encourage uptake. The programme delivered free screening, spectacles, cataract surgeries, transport, food, medicines, and post-operative follow-up, contributing to strong perceptions of reliability and trust in care. Beneficiaries reported improved vision, enhanced mobility, resumption of work activities, and reduced anxiety related to untreated visual impairment, with overall satisfaction remaining high (**68% rating services 5/5**). While short-term benefits were evident, strengthening follow-up communication and referral clarity was identified as important for sustaining outcomes over time.

Nanna Kannu addressed vision issues among school-going children through school-based screening and spectacle distribution, identifying problems that many households had not independently detected. The integration of services within school routines reduced financial and logistical barriers for families, particularly daily-wage households, by eliminating the need for hospital visits and associated costs. Parents and teachers reported improved visual comfort, classroom visibility, concentration, and learning engagement among children receiving spectacles. However, unlike other community-based programmes, structured follow-up beyond initial spectacle provision remained limited, with families reporting uncertainty regarding referral pathways, spectacle replacement, and post-treatment guidance. Strengthening communication mechanisms and instituting repeat screenings were identified as important steps to reinforce continuity and sustain educational gains.

Collectively, the Happy Eyes Program present a relevant and effective model for addressing avoidable vision impairment across age groups. By addressing gaps in awareness, affordability, and accessibility gaps, these programmes remove key financial and logistical barriers. Service delivery was generally organised and predictable - fostering trust, high satisfaction, and improvements in daily functioning, mobility, education, livelihoods, and quality of life for respective target groups. However, sustaining impact will require strengthening follow-up systems, improved communication, and greater support to frontline actors such as Volunteers, teachers, and outreach staff. Building on existing strengths through regular screening cycles, stronger follow-up pathways, and continued awareness efforts can support a more integrated and sustainable eye-care system.

INTRODUCTION

1. INTRODUCTION

1.1. Current Status of Eye health in India

Eye health is observed to remain a significant public health concern in India, with a substantial burden of visual impairment attributable to avoidable causes. India accounts for nearly **25% of the global visually impaired population**, indicating the scale of the challenge[1].

Recent estimates indicate that approximately **4.95 million individuals are blind and nearly 70 million are visually impaired** in India.[2]Among individuals aged 50 years and above, the prevalence of blindness has been reported at **around 1.99%**, with a significantly higher proportion experiencing some form of visual impairment[3].

Cataract has consistently been identified as the leading cause of blindness in India, accounting for **over 60% of total blindness cases**, followed by refractive errors and other conditions such as corneal opacity and glaucoma.[4]A large proportion of these conditions have been classified as avoidable, with estimates suggesting that **nearly 80% of blindness in India is preventable or treatable.[5]**

Despite improvements in surgical output and programme coverage over time, disparities in access to services have persisted. A higher burden of visual impairment has been observed among **rural populations (approximately 70%)**, as well as among economically disadvantaged and elderly groups.

Overall, while national-level improvements in eye care delivery have been observed, regional disparities and unmet needs have continued to persist.

1.2. Key Challenges affecting Eye health

Despite improvements in service availability and policy support, multiple structural, economic, and behavioural challenges were observed to affect eye health outcomes in India.[6]

- **Geographic and access-related barriers**: Access to eye care services was reported to remain uneven, particularly in rural and remote areas, where long travel distances and limited availability of providers constrained timely diagnosis and treatment.

[1] Institute for Health Metrics and Evaluation. Global Burden of Disease data visualizations. http://vizhub.healthdata.org/gbdcompare/

[2] Mannava S, Borah RR, Shamanna BR. Current estimates of the economic burden of blindness and visual impairment in India: A cost of illness study. Indian J Ophthalmol. 2022 Jun;70(6):2141-2145. doi: 10.4103/ijo.IJO_2804_21.

[3] Vashist P, Senjam SS, Gupta V, Gupta N, Shamanna BR, Wadhwani M, Shukla P, Manna S, Yadav S, Bharadwaj A. Blindness and visual impairment and their causes in India: Results of a nationally representative survey. PLoS One. 2022 Jul 21;17(7):e0271736. doi: 10.1371/journal.pone.0271736.

[4] Sarkar D, Sharma R, Singh P, Verma V, Karkhur S, Verma S, Soni D, Sharma B. Age-related cataract - Prevalence, epidemiological pattern and emerging risk factors in a cross-sectional study from Central India. Indian J Ophthalmol. 2023 May;71(5):1905-1912. doi: 10.4103/ijo.IJO_2020_22.

[5] Sharma B, Gupta R, Anand R, Rajput M. Demographic Profile of Blindness in Patients attending Tertiary Eye Care Centre in Central India. Int J Med Res Rev 2013;1(4). doi:10.17511/ijmrr.2013.i04.002.

[6] Cicinelli MV, Marmamula S, Khanna RC. Comprehensive eye care - Issues, challenges, and way forward. Indian J Ophthalmol. 2020 Feb;68(2):316-323. doi: 10.4103/ijo.IJO_17_19.

- **Financial constraints and indirect costs**: While several services were available free of cost, out-of-pocket expenditure related to transportation, accommodation, and wage loss continued to act as a barrier to utilisation, especially among low-income populations.
- **Low awareness and behavioural factors**: Limited awareness regarding eye conditions and treatment options, along with attitudinal barriers such as fear of surgery and misconceptions, were observed to delay care-seeking behaviour.
- **Low uptake of available services**: A gap between identification and treatment was reported, with a significant proportion of individuals not availing surgical care despite being diagnosed; for instance, over one-fourth of older adults with cataract were reported to remain untreated.
- **Social and support-related barriers**: Lack of family support, absence of an escort, and competing household responsibilities were identified as key factors limiting uptake of services, particularly among elderly populations.
- **Continuity of care and follow-up gaps**: Drop-offs were observed across the care pathway—from screening to referral to treatment—indicating gaps in follow-up mechanisms and patient tracking systems.
- **Health system capacity constraints**: Shortages of trained human resources and uneven distribution of infrastructure were reported to affect service delivery in certain regions, limiting the effectiveness of programme implementation.

Overall, these challenges indicate that, beyond availability of services, barriers related to awareness, accessibility, affordability, and continuity of care have continued to influence eye health outcomes in India.

1.3. Policy response and initiatives

The policy response to address visual impairment in India has been anchored primarily through the **National Programme for Control of Blindness and Visual Impairment (NPCBVI)**, supplemented by broader health system initiatives and state-level implementation mechanisms.

At the **national level**, the Government of India initiated the National Programme for Control of Blindness (NPCB) in **1976**, making India one of the first countries to adopt a dedicated programme for blindness prevention[7].
The programme was subsequently expanded and renamed as NPCBVI, with a focus on reducing the prevalence of blindness through a comprehensive approach encompassing prevention, treatment, and rehabilitation.

In parallel, broader health system initiatives such as **Ayushman Arogya Mandir**[8] were leveraged to strengthen primary eye care and integrate vision services within comprehensive primary healthcare delivery.

[7] https://npcbvi.mohfw.gov.in/Home
[8] https://aam.mohfw.gov.in/#about

At the **state level**, implementation of NPCBVI was operationalised through **District Blindness Control Societies (DBCS)**, which were responsible for planning and executing activities such as screening camps, surgical services, and follow-up care.

Table 1: State level policy responses

State	Institutional Mechanism	Key Interventions Undertaken	Implementation Characteristics / Observations
Tamil Nadu	Tamil Nadu State Blindness Control Society (TNSBCS) with District Blindness Control Societies (DBCS)	Free cataract surgeries through government and NGO hospitals; large-scale school eye screening; provision of free spectacles; training of ophthalmic personnel; tele-screening initiatives (e.g., diabetic retinopathy, ROP)	A decentralised implementation model was adopted, with strong NGO participation and district-level planning; high surgical output and extensive school screening coverage were reported (nhm.tn.gov.in)
Karnataka	NPCBVI implemented under National Health Mission through District Health Societies and DBCS	Cataract surgery programmes; school screening and spectacle distribution; outreach camps; integration with Ayushman Bharat and NGO-led service delivery	Programme delivery was supported through public–private partnerships and outreach-based approaches, with emphasis on expanding coverage in rural and underserved areas (nhinp.org)
Uttar Pradesh	District Blindness Control Societies (DBCS) under state health system	Cataract surgeries, screening camps, and Information, Education and Communication (IEC) activities implemented through district-level planning	Implementation gaps were reported in coverage, utilisation, and operational efficiency across districts, including issues related to service delivery and monitoring (Comptroller and Auditor General of India)

BACKGROUND OF THE HAPPY EYES PROGRAMME

2. BACKGROUND OF THE HAPPY EYES PROGRAMME

2.1. Overview

The Happy Eyes Programme is a multi-component eye health initiative supported by Titan Company Limited and implemented by Sankara Eye Foundation India. The programme has been designed to address avoidable blindness and visual impairment through a combination of preventive, diagnostic, curative, and rehabilitative interventions across selected geographies.

Sankara Eye Foundation India, established in 1977, operates as a social eye care enterprise with a network of 12 hospitals across multiple states. The organisation follows a cross-subsidy model wherein a significant proportion of beneficiaries are provided services free of cost, supported through revenues from paying patients. Its community outreach model, including the long-standing 'Gift of Vision' initiative, has been reported to focus on last-mile service delivery through structured outreach, referral, and hospital-based care[9].

Within this context, the Happy Eyes Programme has been operationalised through four sub-programmes, namely: (i) Cataract Blindness Backlog Free (CBBF) Taluk, (ii) Nanna kannu Project, (iii) Mobile Rural Vision-Screening Programme (MRVP), and (iv) Gift of Vision (GOV). Each component targets a specific beneficiary segment and delivery channel, while collectively contributing to improved access to eye care services.

2.2. Program Objectives

The objectives of the Happy Eyes Programme are centred on reducing avoidable blindness and improving access to eye care services across targeted geographies. These objectives are operationalised through component-specific interventions, while collectively contributing to broader visual health outcomes.

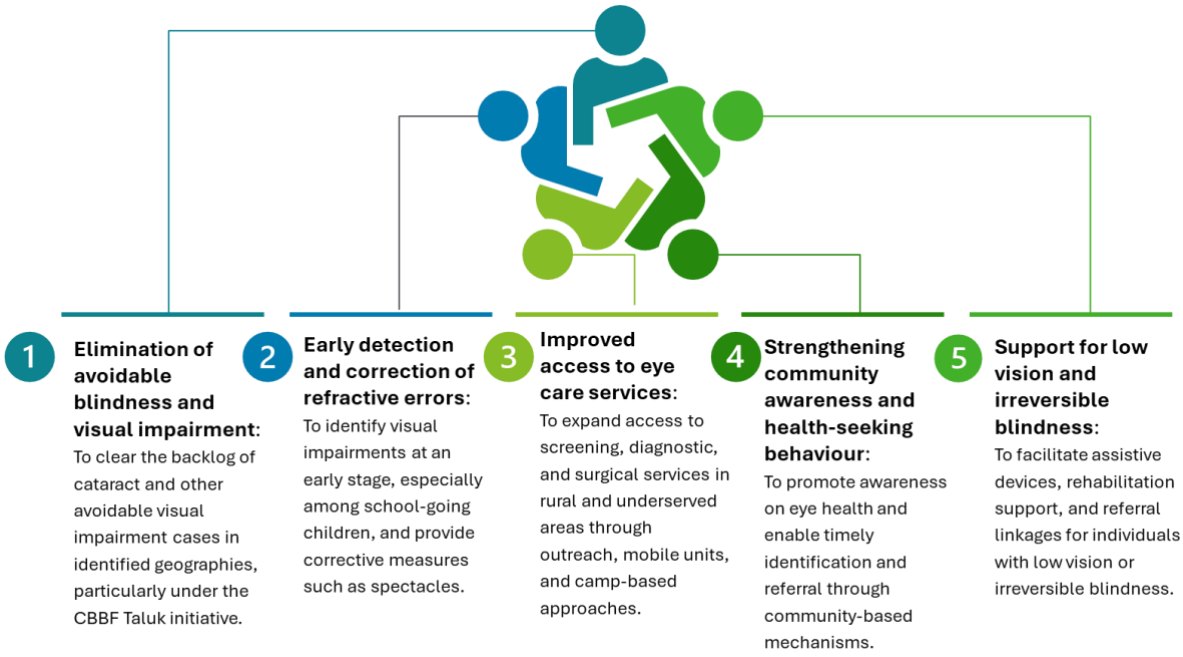


Figure 1: Key Objectives of Happy Eyes

[9] https://www.iapb.org/connect/members/members-directory/sankara-eye-foundation/

2.3. Geographical Coverage

The Happy Eyes Programme was implemented across multiple states, with each sub-programme targeting specific geographies based on need, feasibility, and programme design considerations.

- Tamil Nadu: The CBBF Taluk initiative was implemented in Rajapalayam (Virudhunagar district) and Mettuppalayam (Coimbatore district). In addition, the Gift of Vision component was implemented across districts such as Tiruvannamalai, Cuddalore, and Virudhunagar through outreach camps and surgical interventions.
- Karnataka: The Nannakannu Project and MRVP were implemented across multiple districts, including Bengaluru Urban, Bengaluru Rural, Tumkur, Ramanagara, Mysore, Chamarajanagar, Vijayapura, and Raichur. These components were focused on school-based screening and community-level outreach through mobile units.
- Uttar Pradesh: Under the GOV component, targeted interventions were undertaken in Varanasi, wherein a segment-based approach was adopted to reach specific occupational groups (e.g., weavers).

As per programme documentation, the selection of geographies was informed by factors such as prevalence of cataract and visual impairment, presence of underserved populations, and alignment with aspirational districts and low Human Development Index (HDI) regions. The geographic spread was characterised by a combination of cluster-based intensive interventions (e.g., CBBF Taluks) and broader outreach-based coverage (e.g., MRVP and Gift of Vision).

Table 2: Number of beneficiaries

SL. No.	Name of the Initiative under Happy Eyes	State	District/block	Number of Beneficiaries
1	CBBF	Tamil Nadu	Rajapalayam (Virudhunagar district)	128704
2	CBBF	Tamil Nadu	Mettupalayam (Coimbatore district)	117839
3	Nanna Kannu	Karnataka	Vijayapura	328358
4	Mobile Rural Vision-Screening Project	Karnataka	Bengaluru (Urban + Rural + tribal Locations)	32531
5	Gift of Vision Project	Tamil Nadu	Coimbatore, Krishnankoyil	12000
6	Gift of Vision Project	Karnataka	bengaluru	

SL. No.	Name of the Initiative under Happy Eyes	State	District/block	Number of Beneficiaries
7	Happy Eyes	Uttar Pradesh	Varanasi	1112

2.4. Timeline of Implementation

Titan Company Limited have maintained a sustained partnership with Sankara Eye Foundation India for over a decade. The current phase of the programme was initiated in May 2022, following the signing of the CSR agreement between Titan Company Limited and Sri Kanchi Kamakoti Medical Trust.

Within this broader partnership framework, the implementation of activities for the present assessment was undertaken during **FY 2024-25**, which constitutes the review period for this evaluation.

The timeline for implementation across sub-programmes during this period was as follows:

- **CBBF** : The programme was implemented from December 2023 to March 2025. While initial activities were undertaken during FY 2023-24, a substantial proportion of implementation was carried out during FY 2024-25.
- **Nanna kannu Project**: The project was implemented during FY 2024-25, with school-based screening, spectacle distribution, and referral services undertaken during this period.
- **MRVP**: The Mobile Rural Vision-Screening Programme was implemented during FY 2024-25, with camps and mobile screening services conducted across the identified districts.
- **GOV**: The programme was implemented from June 2024 to March 2025, with outreach camps, surgical interventions, and follow-up activities undertaken during this period.

2.5. Programme Activities and Milestones

As per programme design, activities were undertaken across sub-programmes to address different stages of the eye care continuum. The key activities and milestones are presented below, sub-programme-wise.

2.5.1.CBBF

Under the CBBF initiative, activities were focused on identification and elimination of backlog cases of avoidable blindness within selected taluks.

- **Door-to-door screening** was conducted using the Key Informant Methodology (KIM), wherein trained community members facilitated identification and referral of cases.
- **Cluster-based outreach camps** were organised at regular intervals for screening, clinical examination, and counselling.
- **Surgical interventions** were undertaken at base hospitals for patients diagnosed with cataract and other conditions, with priority given to severe cases.
- **Provision of spectacles** was ensured for individuals identified with refractive errors.

- **Post-operative follow-up** was conducted through village-level reviews in accordance with prescribed protocols.
- **Baseline and end-line assessments** were envisaged to assess prevalence and programme outcomes.

Key milestones included completion of household-level screening, conduct of outreach camps across clusters, and progress towards elimination of backlog cases in the identified taluks.

Table 3: Key activities performed under CBBF[10]

Activities	Mettupalayam	Rajapalayam
Total Panchayats Covered	19	22
No. of Door-Door screening	1,14,936	1,23,509
No. of Campsite screening	5,378	7,374
No. of School/Institutions screening	407	22,835
No. of Industrial screening	714	1,336
Total population screened in Panchayats	1,21,435	1,55,054
No. of camps conducted	95	235
No. of spectacles distributed	2,332	3,945
No. of surgeries advised	1,161	2,110
No. of surgeries performed	571	1,250

2.5.2.Nanna kannu Project

The Nanna kannu Project focused on school-based screening and early identification of visual impairment among children.

- **School-level screening** was conducted in government and aided schools through trained teachers and volunteers.
- **Secondary screening and clinical examination** were undertaken by the implementing partner's clinical team for identified cases.
- **Spectacles were provided** free of cost to children diagnosed with refractive errors.
- **Referral for surgical intervention** was facilitated for children requiring advanced treatment at base hospitals.
- **Low vision support**, including provision of assistive devices and referral to partner organisations, was undertaken for children with irreversible conditions.
- **Training of teachers and volunteers** was conducted to support primary screening and awareness generation.

[10] SEFI Titan FY25-26 Annual Report

Key milestones included coverage of targeted number of children through screening, provision of spectacles, and completion of identified surgical interventions.

Table 4: Key activities performed under the Nanna kannu Project[11]

Activities	Numbers
No. of school screened	2,130
Total children screened	3,19,756
No. of glasses distributed	8,448
No. of paediatric cataract surgeries / other surgeries conducted	154
Low vision devices / Rehabilitation references	20
Teachers / Volunteer screeners trained	1,989

2.5.3.MRVP

The MRVP component focused on expanding access to eye care services in rural and underserved areas through mobile units.

- **Mobile screening camps** were conducted across identified districts using a fully equipped vision-screening unit.
- **On-site diagnostic services**, including refraction and basic ophthalmic examination, were provided.
- **Spectacles were dispensed** to individuals identified with refractive errors.
- **Tele-consultation services** were utilised for cases requiring specialist inputs.
- **Referral to base hospitals** was facilitated for individuals requiring further treatment, including surgeries.
- **Counselling services** were provided to improve treatment adherence and awareness.

Key milestones included conduct of planned number of camps, screening of targeted beneficiaries, and provision of spectacles and referral services.

Table 5: Key activities performed under MRVP[12]

Activities	Numbers
No. of camps conducted	219
No. of people screened	24,597
Spectacles Distributed	7434
No. of GOV surgeries supported	500

[11] SEFI Titan FY25-26 Annual Report
[12] SEFI Titan FY25-26 Annual Report

2.5.4.GOV

The Gift of Vision component focused on large-scale outreach and surgical interventions for rural populations.

- **Outreach camps** were organised to identify individuals with visual impairment in rural areas.
- **Patient mobilisation and transportation** to base hospitals were facilitated for identified beneficiaries.
- **Surgical interventions**, including cataract surgeries, were performed at base hospitals free of cost.
- **Provision of accommodation, food, and medicines** was ensured during the treatment period.
- **Post-operative review camps** were conducted after one month to monitor outcomes and complications.

Key milestones included conduct of outreach camps, number of screenings completed, and surgical outputs achieved across target districts.

Table 6: Key activities performed under GOV[13]

Activities	Numbers
No. of camps conducted	120
No. of screenings conducted	17,675
No. of surgeries conducted	12,000

2.6. Implementation Process

As per programme design, the implementation process was structured to ensure a continuum of care from identification to treatment and follow-up. While specific modalities varied across sub-programmes, a broadly standardised process flow was followed.

- **Community mobilisation and identification**: Beneficiaries were identified through multiple channels, including door-to-door screening, school-based screening, outreach camps, and mobile screening units. Community-level actors such as Volunteers, teachers and community health workers ~~(including Vision Mitras)~~ were engaged to facilitate identification and referral.
- **Screening and primary assessment**: Screening was conducted at household, school, camp, and mobile unit levels using standardised protocols for visual acuity assessment. Trained personnel utilised screening kits, including vision charts and basic diagnostic tools, to assess distant vision and identify suspected cases of visual impairment.
- **Use of digital systems for data capture**: Screening and beneficiary-level data were recorded through digital platforms such as the SERVIS (Sankara Electronic Remote Vision Information System) application, enabling tracking of coverage, referrals, and service uptake.
- **Clinical examination and diagnosis**: Individuals identified during screening were examined by trained clinical teams, including optometrists and ophthalmic personnel, to confirm diagnosis and determine appropriate treatment pathways.

[13] SEFI Titan FY25-26 Annual Report

- **Referral and patient mobilisation**: Patients requiring advanced care were referred to Vision Centres or base hospitals. Referral mechanisms were supported through community-level follow-up, and logistical arrangements such as transportation, accommodation, and meals were facilitated to ensure access to services.
- **Treatment and service delivery**: Services including provision of spectacles, surgical interventions, and medical care were delivered at camp sites and base hospitals. In several instances, presbyopic spectacles were dispensed at the point of service, while prescription spectacles were distributed through follow-up mechanisms.
- **Counselling and patient support**: Identified beneficiaries were counselled on treatment options, particularly in cases requiring surgical intervention. Counselling also included information on procedures, timelines, and post-operative care, with follow-up undertaken for patients delaying treatment.
- **Post-treatment follow-up**: Follow-up was conducted through village visits, vision centres, and review camps to monitor outcomes, ensure compliance, and identify any post-operative complications.
- **Awareness generation and community engagement**: Awareness activities were conducted through interpersonal communication, distribution of IEC materials, and community events such as rallies and campaigns to improve health-seeking behaviour and participation in camps.
- **Sustainability and referral linkages**: Linkages with vision centres and community stakeholders were established to support continued identification and referral of cases beyond the programme period.

Overall, the implementation process was characterised by the integration of community-based identification mechanisms with institutional service delivery systems, supported by digital tracking and continuous follow-up.

2.7. Partnership

The Happy Eyes Programme was implemented through a partnership between **Titan Company Limited** and **Sankara Eye Foundation India (a unit of Sri Kanchi Kamakoti Medical Trust)**, with clearly defined roles in funding and implementation.

Titan Company Limited was responsible for providing financial support and strategic oversight for the programme, including approval of programme components and review of implementation progress. Sankara Eye Foundation India functioned as the implementing partner, responsible for programme design, field-level execution, service delivery, and reporting.

2.8. Stakeholder mapping

The Happy Eyes Programme involved multiple stakeholders across different levels of implementation, with distinct roles across the service delivery continuum. These stakeholders were mapped based on their functional roles in identification, service delivery, referral, and programme oversight.

- **Beneficiaries**: The primary beneficiaries included school-going children, rural adults, and individuals with visual impairment, including those with cataract, refractive errors, low vision, or irreversible blindness.
- **Community-level actors**: Community stakeholders such as Volunteers(community health workers), teachers, volunteers, and local leaders were engaged to support identification, awareness generation, and referral of beneficiaries.

- **Implementation teams**: Programme implementation was carried out by field workers, optometrists, ophthalmologists, and programme coordinators, who were responsible for screening, diagnosis, treatment, and programme management.
- **Institutional stakeholders**: Base hospitals and vision centres operated by the implementing partner provided clinical and surgical services, along with follow-up care. Partner organisations were engaged for rehabilitation support in cases of low vision and irreversible blindness.
- **Government and enabling stakeholders**: State and district-level authorities facilitated permissions and supported implementation, particularly for school-based and community-level activities.
- **Funding and oversight entity**: Titan Company Limited functioned as the funding partner, providing financial support and oversight for programme implementation.

2.9. Alignment with SDGs

The Happy Eyes Programme was aligned with select Sustainable Development Goals (SDGs), particularly in relation to health, education, and equity. The alignment was reflected through the programme's focus on reducing avoidable blindness and improving access to eye care services among underserved populations.

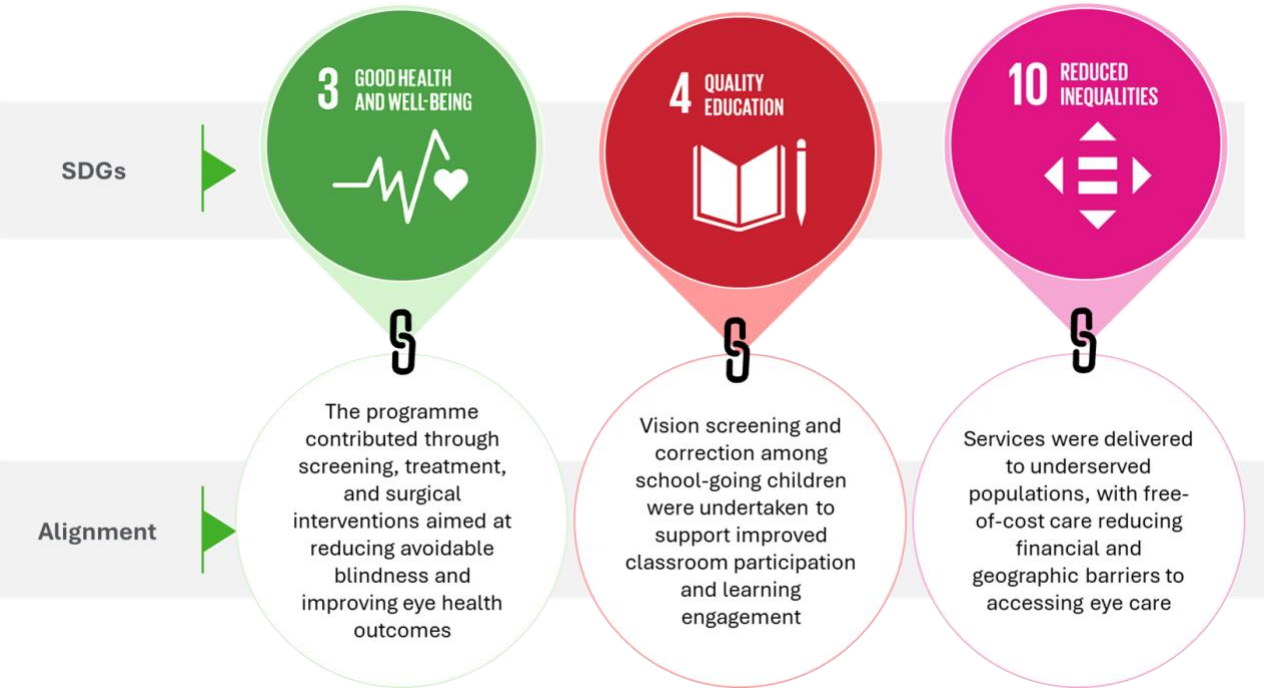


Figure 2: Alignment of the Happy Eyes Program with SDGs[14]

Overall, the programme's design was consistent with broader development priorities related to improving health outcomes, enhancing educational participation, and addressing disparities in access to essential services.

[14] https://sdgs.un.org/goals

2.10. Financial Utilisation

The financial utilisation of the Happy Eyes Programme was assessed against the proposed budget for FY 2024–25 across programme components and supporting investments.

Overall, funds amounting to **₹7,52,07,497** were reported to have been utilised against a proposed budget of **₹7,48,74,797**, indicating an overall utilisation of approximately **100%**, with a marginal positive variance of **₹3,32,700**. This variance was reported to have been met through interest accrued in the programme bank account and subsequently reallocated towards programme activities.

At the component level:

- **CBBF, Nanna kannu, and MRVP** reported **full utilisation (100%)** of allocated budgets, indicating adherence to planned financial allocations.
- **Gift of Vision (GOV)** reported a utilisation of **96%**, with a variance of **₹12,67,300**, suggesting minor under-utilisation against the proposed budget.
- **Varanasi Mobile Eye Clinic** reported **140% utilisation**, with an excess expenditure of **₹16,00,000**, indicating higher-than-planned resource deployment under this component.
- **Capital investments**, including procurement of a **55-seater bus (Coimbatore)** and **medical equipment (Shimoga)**, were reported to have achieved **100% utilisation**.

Table 7: Comparative analysis of Proposed V Actual fund utilisation[15][16]

Particulars	Proposed (INR)	Utilised (INR)	% Utilised vs Proposed	Variance (INR)
CBBF	1,30,00,000	1,30,00,000	100%	0
Nanna Kannu	89,15,000	89,15,000	100%	0
MRVP	66,61,000	66,61,000	100%	0
GOV	3,25,50,000	3,12,82,700	96%	-12,67,300
Varanasi Mobile Eye Clinic	40,00,000	56,00,000	140%	+16,00,000
Bus_55-Seater, Coimbatore	32,86,237	32,86,237	100%	0
Medical Equipment, Shimoga	64,62,560	64,62,560	100%	0
Total	7,48,74,797	7,52,07,497	100%	+3,32,700

[15] Titan Proposal 24-25

[16] Sankara-TITAN Utilisation Certificate

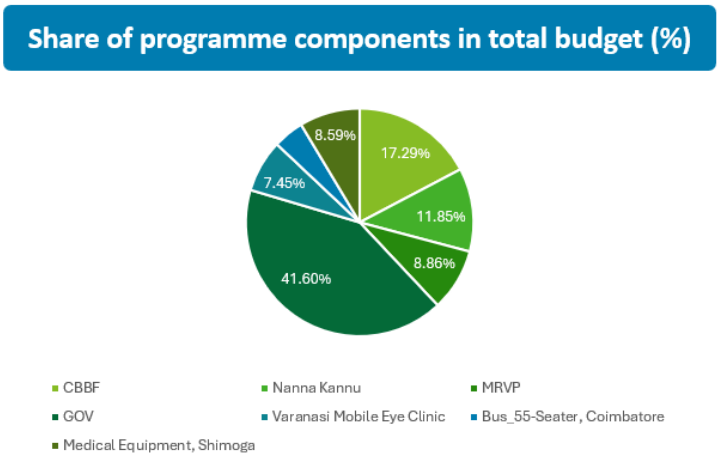


Figure 3 Share of Programme Components in Total Budget - Happy Eyes

The overall utilisation pattern suggests that programme funds were largely deployed as per plan, with limited variance observed across components. Instances of over- and under-utilisation were confined to specific components, while the marginal excess utilisation was managed through reallocation of accrued interest.

SCOPE & METHODOLOGY

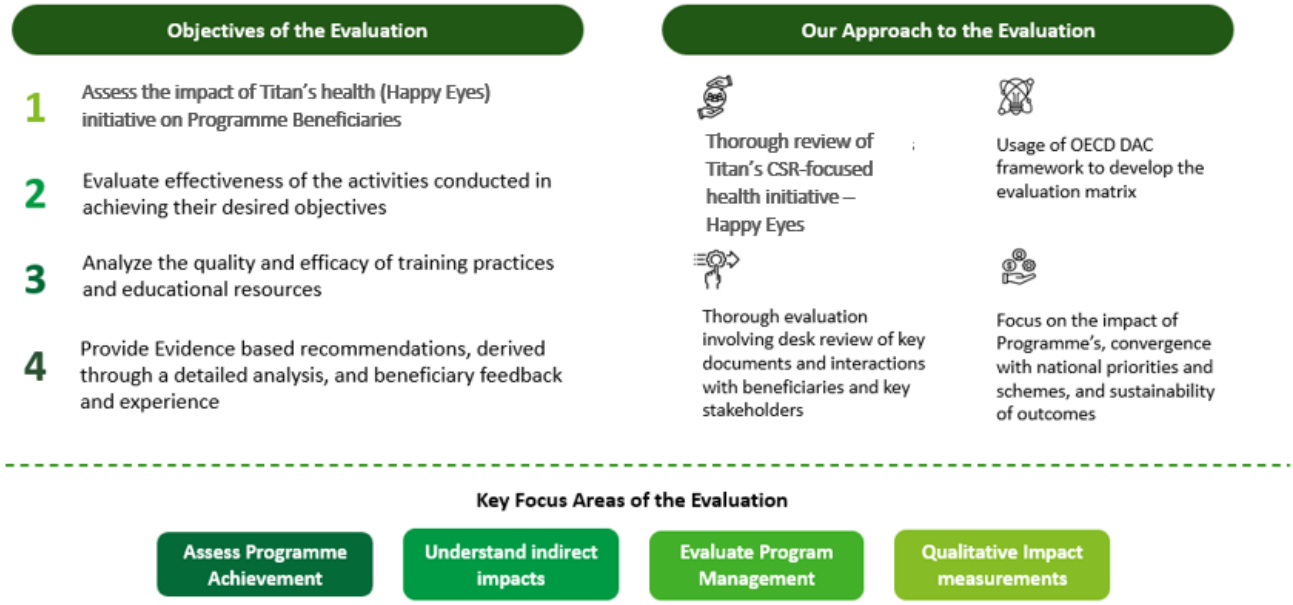
3. SCOPE AND METHODOLOGY

3.1. Scope of Work

The evaluation assessed the relevance, coherence, efficiency, effectiveness, impact and sustainability of Health (Happy Eyes Initiative) programmes for the year 2024-2025, focusing on how the interventions has influenced health outcomes. The study will review alignment with the programme objectives and the quality and applicability of support in community settings. The evaluation assessed programme performance using a set of measurable indicators derived from beneficiary surveys. These included service-level indicators such as the percentage of beneficiaries reporting pre-existing eyesight problems, percentage rating satisfaction with the programme services. Outcome indicators included the percentage of beneficiaries reporting improved ability to carry out daily and livelihood activities, and continuation of periodic eye check-ups. Additional indicators captured reduced out-of-pocket expenditure, early detection of eye ailments, ease of access to services, receipt of counselling or follow-up support, willingness to recommend the programme, and perceived improvement in community-level awareness of eye care.

Evidence from beneficiary feedback, stakeholder consultations, document review, and secondary data will inform recommendations for future planning and scale-up. Guided by OECD-DAC framework[17], the evaluation combined desk review and field insights to assess the impact of the programme.

Figure 4: Scope of work



[17] https://www.oecd.org/en/topics/sub-issues/development-co-operation-evaluation-and-effectiveness/evaluation-criteria.html

3.2. Approach & Methodology

The evaluation adopted a mixed-methods approach - quantitative methods to estimate outcome patterns among beneficiaries, while qualitative enquiry provides contextual understanding of programme delivery, enabling factors, and constraints. Evidence was drawn from primary data and secondary documentation and interpreted through triangulation across data sources.

The evaluation used a tailored approach to measure impact, analysing how specific activities led to observed changes. Since the Happy Eyes Initiative spans multiple states and various types of support, a single "one-size-fits-all" measurement model was not effective. Instead, the methodology was customised for each part of the programme, considering how long the intervention has been running, the local environment, and the specific ways the services are delivered. This ensured the results accurately reflected the unique successes and challenges of each component within the Happy Eyes initiative.

Table 8: Programme specific evaluation approach

Programme	Evaluation Focus	Key Data Sources and Tools
Happy Eyes (Eye Health)	Awareness, access to eye-care services, service utilisation, and perceived functional outcomes	Link-based awareness assessments with beneficiaries; IDIs with parents, school administrators, Volunteers (community health workers), and implementing partners.

3.2.1. Sampling Strategy

The evaluation adopted a mixed sampling approach, combining purposive and random sampling within a mixed methods design. Purposive sampling was used to select geographies, intervention models, and stakeholder categories to ensure balanced representation across programs, guided by programme scale and feasibility. Within the selected sites, quantitative respondents were randomly selected from available beneficiary records (e.g., programme databases) to support robust estimation of health outcomes.

Quantitative Sample Size Determination

The sampling approach was designed to meet the primary objective of estimating community-level health outcomes across diverse geographies. In the absence of prior variance data, Cochran's formula offers a transparent and conservative basis for determining sample requirements. This method supports descriptive analysis and learning, ensuring outcomes are estimated with a high degree of confidence while remaining operationally practical.[18]

Sample sizes were calculated using Cochran's formula for population proportions, assuming a 90% confidence level and a 10% margin of error. The calculation is based on the following parameters:

[18] Note: Alternative approaches, such as power-based sample size calculations, were considered but not adopted, as the evaluation is not designed to test statistically significant differences or estimate effect sizes between treatment and comparison groups. Simpler population-based formulas (e.g., Slovin's or Yamane) were also considered; however, Cochran's formula was preferred as it explicitly incorporates confidence levels and conservative assumptions in the absence of prior variance estimates.

Cochran's formula is expressed as:

$$n_0 = \frac{Z^2 \cdot p \cdot (1-p)}{e^2}$$

Where:

- n_0 (Initial Sample Size): The baseline requirement for an infinite population, which ensures the study has sufficient statistical power.
- z (Z-value of 1.645): Corresponds to the 90 % confidence level, providing a reliable balance between precision and the logistical realities of multi-state field data collection.
- p (Population Proportion of 0.5): Assumed at 50 % to maximise potential variability. This conservative approach ensures the sample size is large enough to remain valid regardless of how characteristics are distributed across the population.
- e (Margin of Error of 0.10): Sets a 10 % range of precision, ensuring that the findings reflect the true population values within a statistically acceptable window for social-impact programmes.

$$n = \frac{n_0}{1 + \frac{(n_0 - 1)}{N}}$$

Sample Calibration

As the beneficiary populations for Titan's programs are known, the initial sample size (n_0) was adjusted using the Finite Population Correction (FPC). This adjustment ensured the sample was representative of the specific population size without unnecessary over-sampling. The final sample sizes were further refined through an iterative calibration process to account for,

- Program design and intensity of the intervention.
- Beneficiary density across geographies covered during field visits.
- Expected homogeneity or variability of outcomes within specific cohorts.
- The feasibility of administering age-appropriate assessment tools.
- Availability of complementary qualitative evidence.

In several combinations, the final proposed sample exceeded the statistical minimum to enhance analytical robustness and enable more meaningful subgroup analysis.

Table 9: Study Coverage locations

State	District/ Block	Centres
Karnataka	Ramanagara	-
Tamil Nadu	Coimbatore	Mettupalayam
Tamil Nadu	Virudhunagar	Rajapalayam
Tamil Nadu	Virudhunagar	Krishnankoyil
Karnataka	Vijayapura	Aided Sei Rukmagad HPS
Karnataka	Vijayapura	Govt UBHPS No. 15 Indira Nagar
Karnataka	Mysore	Periyapatna
Karnataka	Kolar	Chikka Tirupathi

Table 10: Coverage across locations

Program Name	State	District/ Block	Centre/School Covered	Teachers IDI (govt)	Parents IDI	Beneficiaries	Vision Mitra FGD
Happy Eyes MRVP	Karnataka	Ramanagara	Ramanagara (survey)			9	
Happy Eyes MRVP	Karnataka	Ramanagara	Ramanagara (IDI)			3	
Happy Eyes (CBBF)	Tamil Nadu	Coimbatore	Mettupalayam (survey)			14	1
Happy Eyes (CBBF)	Tamil Nadu	Coimbatore	Mettupalayam (IDI)			3	
Happy Eyes (CBBF)	Tamil Nadu	Virudhunagar	Rajapalayam (survey)			21	1
Happy Eyes (CBBF)	Tamil Nadu	Virudhunagar	Rajapalayam (IDI)			3	
Happy Eyes (GOV)	Tamil Nadu	Virudhunagar	Krishnankoyil (survey)			12	
Happy Eyes (GOV)	Tamil Nadu	Virudhunagar	Krishnankoyil (IDI)			3	

Program Name	State	District/ Block	Centre/School Covered	Teachers IDI (govt)	Parents IDI	Beneficiaries	Vision Mitra FGD
Happy Eyes Nanna Kannu	Karnataka	Vijayapura	Aided Sei Rukmagad HPS	1	3		
Happy Eyes Nanna Kannu	Karnataka	Vijayapura	Govt UBHPS No. 15 Indira Nagar	2	2		
Happy Eyes GOV	Karnataka	Mysore	Periyapatna			10	
Happy Eyes GOV	Karnataka	Mysore	Periyapatna			3	
Happy Eyes MRVP	Karnataka	Kolar	Chikka Tirupathi			20	
				3	**5**	**101**	**2**

Qualitative Sampling

Purposive sampling was used for the qualitative component to support in-depth understanding of programme implementation, contextual factors, and perceived changes, rather than to estimate the prevalence of views. This approach enables engagement with stakeholders who have direct experience of programme delivery and participation. In-depth interviews were conducted with beneficiaries, parents, principals Volunteers, and implementing partners.

The qualitative sample was structured to ensure coverage across key stakeholder groups and programme geographies, allowing health-level outcomes to be interpreted alongside institutional, community, and implementation perspectives and strengthening triangulation with quantitative findings.

3.2.2.Study Approach

The evaluation is structured around a Define-Gather-Analyse-Report approach, with clear steps covering objective setting, data collection, analysis of findings, and structured reporting.

- Define:
  A detailed review of programme documentation, including Proposals, Annual reports, Quarterly reports, Utilisation Certificates, Memorandum of Understanding (MoUs) and partner submissions, was undertaken at the outset to establish an understanding of programme intent, delivery arrangements and expected outcomes. This review informed the framing of the evaluation parameters and the sampling design across geographies. The sampling strategy sought to reflect programme heterogeneity while retaining operational feasibility. Surveys were developed for the relevant respondent type. The in-depth interview guides for beneficiaries, parents, principals, and implementing agencies were structured around OECD DAC considerations. For CBBF, both Rajapalayam and Mettupalayam were visited, where the intervention was being implemented.

For Nanna Kannu, Vijayapura was selected as study location based on recommendations from the programme team, following which schools were selected where the concentration of beneficiaries was higher.

MRVP interventions were limited to Karnataka; therefore, locations were selected in consultation with the implementation partner, based on the availability of respondents. Similarly, for G.O.V, locations across Karnataka and Tamil Nadu were finalised based on respondent availability and feasibility in coordination with implementation partners.

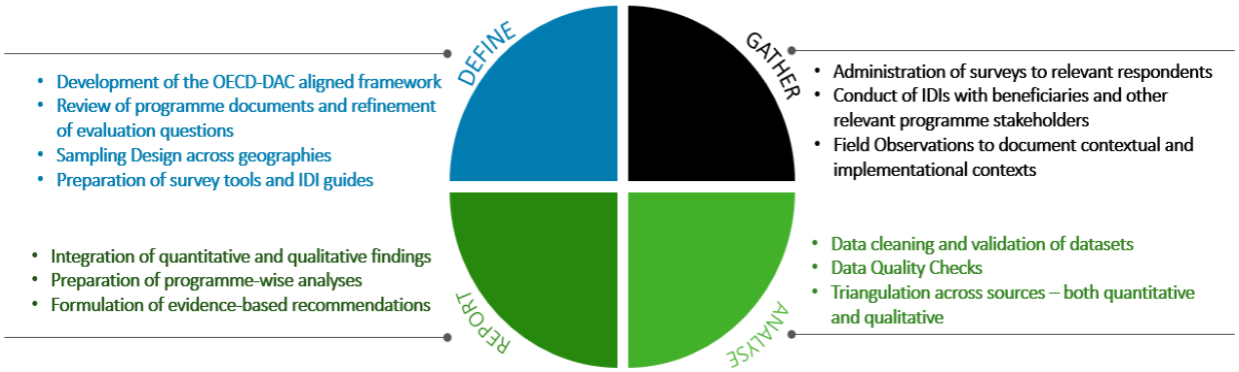
- Gather:
  Field activities included administering surveys (quantitative data collection) along with qualitative discussions and observational visits which took place from 30th January 2026 to 17th February 2026. These tools were designed to be appropriate, accessible, and suitable. The quantitative tool included structured questions on awareness, service utilisation, challenges faced, and satisfaction levels The qualitative tools included semi-structured open-ended questionnaires for conducting in-depth interviews with teachers, parents and beneficiaries of the vision programme, and key informant interviews (KIIs) were conducted with representatives from implementing agencies. The IDIs were conducted on a one-on-one basis during field visits to selected locations with the help of Sankara team members. The interviews were taken in the local language specific to programme geographies for the ease of communication. Responses were documented through notes and voice recordings, with prior verbal consent from respondents. Beneficiaries were reached with the support of the Sankara team. These discussions looked at changes in health outcomes, community engagement, and the sustainability of ongoing efforts. Observations took place at schools, and vision screening sites. These observations provided insights into the context of program delivery and how well it was carried out.[19]

- Analyse:
  The analytical process consisted of systematic cleaning, validation and examination of quantitative and qualitative data. Assessment datasets were subjected to descriptive and comparative analysis to identify patterns in performance, and sub-group analysis by gender, geography or grade wherever feasible using Microsoft excel. Qualitative data were transcribed using Generative AI and were subsequently manually reviewed and checked for accuracy. The qualitative data were then thematically analysed manually, without the use of qualitative analysis software, following the OECD DAC criteria. This approach enabled structured interpretation of stakeholder perspectives concerning programme relevance, operational effectiveness, resource deployment, emerging behavioural or learning changes, and sustainability prospects. Triangulation across tools, respondent categories and locations was undertaken to strengthen the credibility of findings and minimise interpretive bias.

- Report:
  The reporting stage involved synthesising quantitative and qualitative evidence into an integrated evaluative narrative aligned with the OECD DAC framework. The final report presents programme-

wise insights, supported by data findings and documentation derived from field interactions. Recommendations were framed to remain actionable, context-sensitive and oriented towards strengthening programme performance and sustainability

Figure 5: Study Approach



3.2.3. Evaluation Framework

The detailed evaluation framework is presented below, mapped against OECD-DAC criteria and corresponding probe areas.

Table 11: Evaluation Framework

#	OECD DAC Criteria	Evaluation Question	Data Sources	Methods	Probe Areas for Primary Data
1	Relevance	What gaps / problem statements / needs were identified, and how?	1. Needs assessment studies 2. Titan Programme Documents 3. Implementing Partners 4. Direct programme beneficiaries 5. Titan CSR team	1. Secondary review 2. IDIs / KIIs	1. Stakeholder consultations undertaken 2. Type of challenges faced in the community / amongst beneficiaries 3. Requirements of implementing partners
2		To what extent do Titan's CSR programmes align with the identified needs and gaps?	1. Titan CSR team 2. Programme documents (project-wise) 3. Implementing Partners 4. Direct programme beneficiaries	1. Secondary review 2. IDIs / KIIs	1. Awareness and understanding of Titan programmes amongst project beneficiaries 2. Perspectives of IPs on need alignment
3		What type of activities were conducted through Titan's CSR programmes, and to what extent were these responsive to the identified gaps? How were these activities developed?	1. Titan CSR team 2. Programme documents (project-wise) 3. Implementing Partners 4. Direct programme beneficiaries	1. Secondary review 2. IDIs / KIIs	1. Awareness and understanding of Titan programmes amongst project beneficiaries 2. Level of satisfaction with Titan support (project ben & IP) 3. Methods adopted by Titan to address needs
4	Coherence	Are the Titan CSR's focus areas and corresponding initiatives complementary to and compatible with other activities and interventions within the Titan ecosystem?	1. Titan CSR team 2. Programme documents (project-wise) 3. Implementing Partners	1. Secondary review 2. IDIs / KIIs	1. Other similar programmes / projects (within Titan system) 2. Type of funding available for these
5		What are the other initiatives in these geographies within the Titan programme areas? How aligned are they with Titan's CSR initiatives?	1. Implementing Partners 2. Titan CSR team	1. IDIs / KIIs	1. Other similar programmes / projects (other orgs) 2. Type of funding available for these - govt, private philanthropy, CSR, FCRA, etc. 3. Working models and experiences of IP with other donors / funding partners

#	OECD DAC Criteria	Evaluation Question	Data Sources	Methods	Probe Areas for Primary Data
6	Efficiency	To what extent are the Titan CSR programmes and its initiatives implemented in a cost-effective way and timely manner, and achieve significant impact?	1. Utilisation certificates and audited reports (project-wise) 2. Quarterly and annual reports (project-wise) 3. Titan CSR team	1. Secondary review 2. Discussions with Titan CSR team	1. Key challenges / bottlenecks in project implementation 2. Streamlining of key activities 3. Rationalisation of costs
7		What were the key inputs [finance, people, etc] allocated to the programme and how were they distributed across different components?	1. Titan CSR team 2. Quarterly and annual reports (project-wise)	1. Secondary review 2. Discussions with Titan CSR team	1. Key challenges / bottlenecks in project implementation 2. Streamlining of key activities 3. Rationalisation of costs
8		To what extent do the M&E systems utilised by the Titan CSR Programme ensure effective and efficient project management?	1. Titan CSR team 2. Quarterly and annual reports (project-wise)	1. Secondary review 2. Discussions with Titan CSR team	1. Methods utilised for M&E 2. Overall M&E framework 3. Mandatory submissions / compliance requirements
9	Effectiveness	In which areas does the Titan CSR programme have the greatest achievements? Why and what have been the supporting factors? How can Titan build on or expand these achievements?	1. Quarterly and annual reports (project-wise) 2. Implementing partners 3. Direct programme beneficiaries	1. Secondary review 2. IDIs / KIIs 3. Surveys / Quantitative assessments	1. Project-wise extent of achievements against key indicators of M&E framework (survey / IDIs) 2. Enabling factors 3. Linkages to other programmes / government systems
10		In which areas does the Titan CSR programme have the fewest achievements? What have been the constraining factors and why? How can or could they be overcome?	1. Quarterly and annual reports (project-wise) 2. Implementing partners 3. Direct programme beneficiaries	1. Secondary review 2. IDIs / KIIs 3. Surveys / Quantitative assessments	1. Project-wise shortfalls against key indicators of M&E framework (survey / IDIs), and reasons for same 2. Constraining factors 3. Areas where additional support is required
11		Were any course-correction strategies adopted by Titan? What were the outcomes?	1. Titan CSR team 2. Implementing partners	1. Secondary review 2. IDIs / KIIs	1. Challenges faced 2. Course correction strategies
12	Impact	Has the Titan CSR programme effected people's well-being, in line with contributing to the achievements of the SDGs?	1. Quarterly and annual reports (project-wise) 2. Implementing partners 3. Direct programme beneficiaries	1. Secondary review 2. IDIs / KIIs 3. Surveys / Quantitative assessments	1. Level of access to services 2. Persisting barriers to access 3. Overall improvement in well-being / socio-economic status / educational outcomes

#	OECD DAC Criteria	Evaluation Question	Data Sources	Methods	Probe Areas for Primary Data
13		Are Titan CSR initiatives being continued and scaled by the implementing partners, so they achieve longer-term outcomes and changes at an ecosystem level?	1. Implementing partners	1. IDIs / KIIs	1. Additional efforts, if any 2. Additional programmatic support by Titan
14		What were the unintended consequences of the Titan's CSR work?	1. Implementing Partners 2. Direct programme beneficiaries	1. IDIs / KIIs	1. Impact on other aspects of well-being / socio-economic indicators 2. Impact on non-beneficiaries / indirect beneficiaries
15	Sustainability	Do implementing partners have enough financial resources, and capacity, to sustain changes in the future, and create further impact?	1. Implementing Partners 2. Titan CSR team	1. IDIs / KIIs	1. Documentation of financial and non-financial support to IP from Titan and other organisations / govt 2. Key ecosystem challenges (current & upcoming) 3. Readiness to address challenges
16		How has Titan supported knowledge and capacity development of implementing partners?	1. Implementing Partners 2. Titan CSR team	1. IDIs / KIIs	1. Capacity building efforts 2. Outcomes of capacity building
17		To what extent are implementing partners continuing to rely on Titan? Is there a clear roadmap for phasing out these dependencies?	1. Implementing Partners 2. Titan CSR team	1. IDIs / KIIs	1. Documentation of financial and non-financial support to IP from Titan and other organisations / govt 2. Handover plans, if any 3. Community resilience

3.3. Limitations

The study has been subject to a set of practical constraints affecting data access, field scheduling, sampling coverage, and continuity of engagement. The key limitations were as follows:

- Changes in data collection arrangements
  Some modifications to the planned data collection arrangements were made in coordination with the implementing partner due to the unavailability of beneficiaries. These adjustments may have affected scheduling consistency and the planned coverage of respondents.
- Cultural influence:
  Local cultural norms may have shaped how respondents answered survey questions and engaged in KIIs and FGDs. This cultural context could have limited openness or influenced the way certain issues were discussed.
- Unintentional response bias:
  Responses may have been influenced by respondents' personal beliefs, perceptions, or external environmental factors. Such influences could have introduced unintentional bias, potentially affecting the objectivity of the findings.

KEY FINDINGS

4. KEY FINDINGS

4.1. Cataract Blindness Backlog Free

Respondent Profile

The survey was conducted with 35 beneficiaries from Rajapalayam and Mettupalayam blocks who had participated in the eye screening initiative. Out of the total respondents (N), 63% were female while 37% were male. The respondent profile was largely concentrated among older age groups. The 70-79 age group constituted the largest share (34%), followed by 50-59 years (26%) and 60-69 years (20%). A relatively smaller proportion of respondents were 40-49 years (11%) and 80-89 years (9%), indicating that most participants were aged 50 years and above.

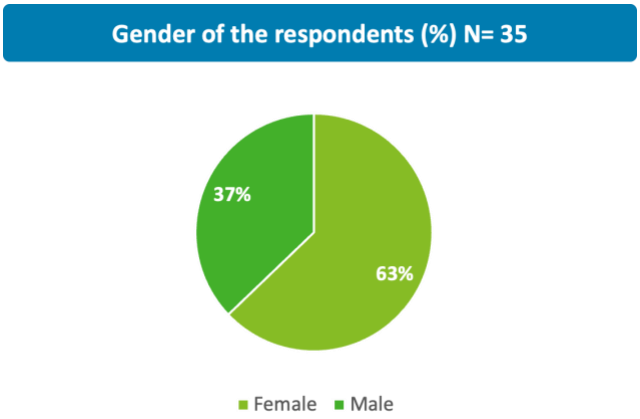


Figure 7: Gender of Respondents - CBBF

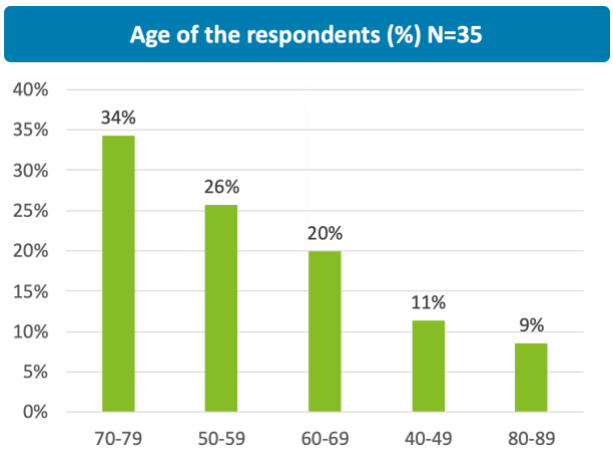


Figure 6: Age of Respondents - CBBF

Relevance

Pre-programme Eye Health Needs

> *"First, even we did not know what cataract is until we went inside and learned…People think it is due to age factor…They say flesh growth, but that is not correct."* – FGD, Rajapalayam, Tamil Nadu

Beneficiaries described longstanding visual impairments, including untreated cataract, blurred or foggy vision, double images, and difficulty recognising faces or reading. Many adapted their daily activities to reduced vision over extended periods.

Project Associates explained that before the programme, awareness of eye-health conditions was low. Cataract was not widely understood, and blurred vision was often assumed to be a normal part of ageing. Misconceptions such as attributing symptoms to "flesh growth" shaped how people interpreted their condition.

Only after we started going house to house and giving notices, they came to know that such a scheme even exists." – IDI, Project Associate, Mettupalayam, Tamil Nadu

They also indicated that there were no structured outreach efforts to identify individuals with visual impairment. Community members had limited information on where or when to seek care, and treatment was typically sought only when symptoms became severe.

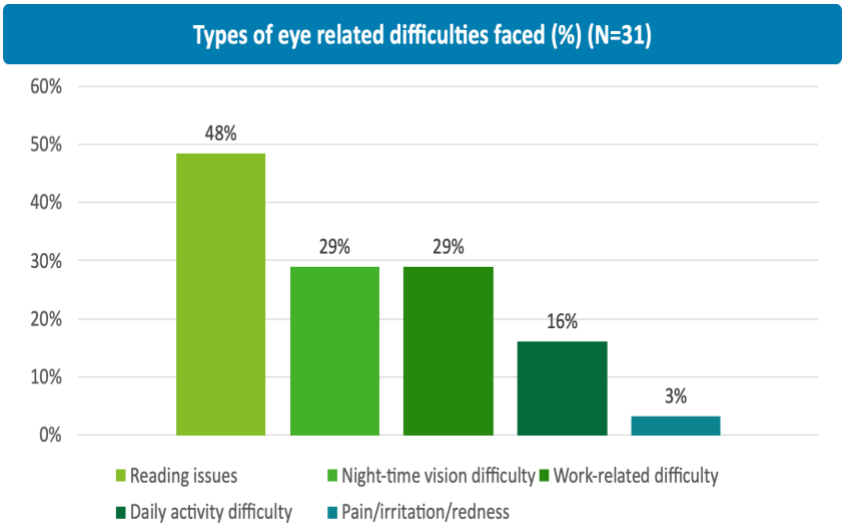


Figure 8: Types of eye-related difficulties - CBBF

Out of the 35 respondents, 31 respondents (88%) expressed that they were having issues with their eyesight. Further, respondents were asked about the types of difficulties they experienced in relation to their eye health prior to accessing the screening services. Reading-related difficulties were reported most frequently, affecting 48% of respondents. This was followed by night-time vision difficulty and work-related difficulty (29% each). A smaller proportion reported difficulty in carrying out daily activities (16%), while pain, irritation, or redness was reported by 3% of respondents.

Availability and Affordability of Eye-care Services Prior to the Programme

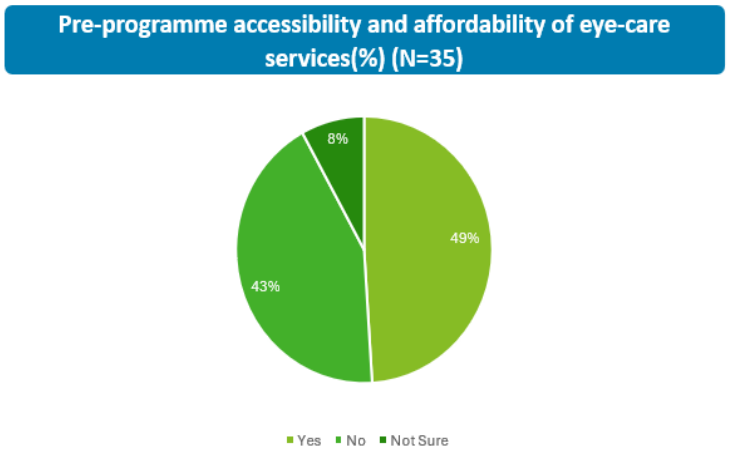


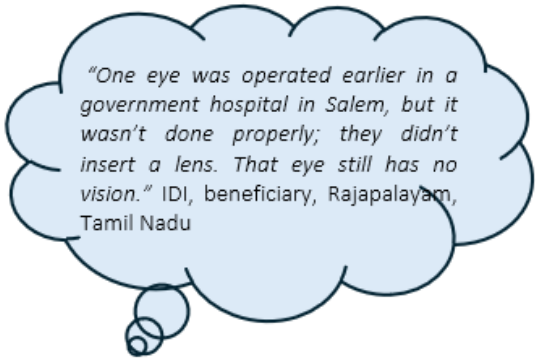
Figure 9: Pre-programme accessibility - CBBF

Before programme implementation, access to services was constrained by both financial and logistical barriers. Beneficiaries reported that the high cost of spectacles which is often between ₹2000 and ₹3000—discouraged timely care. Travel to healthcare facilities posed additional challenges, especially for those who required assistance or felt hesitant to travel alone. Quantitative evidence supports this claim.

Responses regarding the availability and affordability of eye-care services prior to the programme were relatively mixed. Approximately 49% of respondents reported that eye-care services were available and affordable in their area, while 43% indicated that such services were not easily accessible

or affordable. A smaller proportion of 8% of respondents were not sure about the availability of these services.

Concerns about the quality of previous treatments further deterred care-seeking. Some beneficiaries described undergoing procedures that did not resolve their condition.



Project Associates noted that in the absence of free or accessible services, individuals often postponed treatment because of cost, fear, or lack of awareness. Structured referral pathways were limited, and engagement with formal eye-care systems was typically reactive rather than preventive.

Acceptance of services improved once the programme introduced free screening, surgery, transport, and medicines. Beneficiaries highlighted that even small expenses had previously acted as barriers, and Associates observed that uptake increased as households became aware of the free provisions and saw positive outcomes among others in the community.

Awareness and Outreach of Screening Services

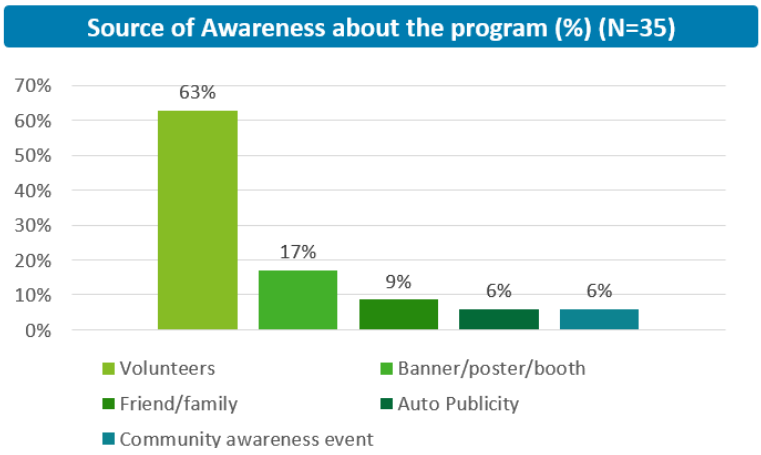


Figure 12: Source of Awareness about the program - CBBF
Figure 11: Programme Awareness - CBBF

Awareness of the screening camp or mobile clinic was primarily driven by Volunteers (community health workers), as reported by 63% of respondents. This was followed by banners, posters, or booths (17%), while 9% indicated that they learned about the camp through friends or family members. A smaller proportion reported becoming aware through auto publicity and community awareness events (6% each).

Coherence

Community-based Awareness and Entry into the Programme

Beneficiaries became aware of the programme through familiar, locally embedded communication channels such as printed notices, vehicle announcements, and direct contact from outreach workers or volunteers. These methods reflected existing information-sharing patterns in rural communities, where interpersonal communication plays a central role.

"A vehicle with loudspeaker announcements came… that is how I knew" – IDI, Beneficiary, Tamil Nadu

"Someone came and told me directly. They told me at home itself."- IDI, Beneficiary, Tamil Nadu

Door to door engagement was especially important for elderly individuals with limited mobility or literacy. Direct household interaction fostered trust, as programme information was delivered by individuals connected to or familiar with the community. This approach aligned with how villagers typically verified and responded to new information.

Project Associates described a set of awareness activities that were embedded in local systems. These included household visits to explain cataract and available services, distribution of notices, auto announcements prior to camps, and counselling for hesitant individuals. Demonstrative tools such as vision charts and torchlights supported practical explanation of eye conditions and helped overcome literacy barriers.

Behavioural Alignment and Trust-building Mechanisms

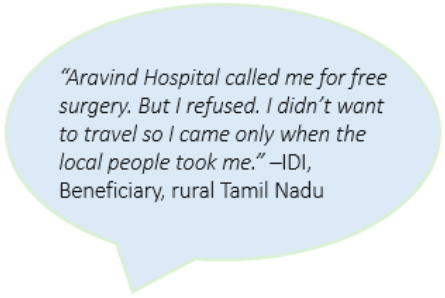
> *"Some people get scared immediately when they hear 'surgery.' We have to reassure them… only then they agree."* – Project Associate, Mettupalayam, Tamil Nadu

Project Associates emphasised that acceptance of programme messages was closely linked to trust-based dynamics within the community. Households were more likely to participate after seeing neighbours engage or after receiving information from familiar sources. Recognition of the hospital name reinforced confidence in the programme.

Influence of Awareness Activities on Misconceptions

Prior to the programme, both beneficiaries and Project Associates referred to common misconceptions-such as the belief that poor vision was a natural part of ageing or that cataract did not require treatment. Awareness activities helped address these misunderstandings through simple explanations and demonstrations. Project Associates noted that individuals initially lacked understanding of cataract, but repeated engagement increased receptiveness to screening and treatment. Visible improvements among peers further shifted perceptions of eye care and surgery.

Variations in Response to Awareness Efforts



Responses to awareness activities varied. Some beneficiaries with prior hospital experience already understood cataract and its treatment, meaning their participation depended more on accessibility than new information. In one case, a beneficiary declined earlier treatment due to lack of transport, illustrating that awareness alone did not guarantee participation without logistical support.

Project Associates also encountered households that questioned the purpose of data collection or hesitated to share personal information. Some required additional reassurance or joined only after observing others participate. A portion of higher-income households preferred seeking care directly at hospitals rather than through community-based outreach.

Alignment with Community Systems

> *"If one house refuses, and the next house accepts and checks, then the first house calls us back for check-up."* - Project Associate, Rajapalayam, Virudhunagar district

The programme's awareness and outreach strategies aligned well with existing community systems. Reliance on interpersonal communication, local networks, and demonstration tools matched how health information is typically shared and validated in villages. These approaches supported accessibility for individuals with limited mobility while leveraging peer influence to encourage participation.

At the same time, certain implementation aspects—such as requests for detailed personal information—created hesitation among some households. Variation across socioeconomic groups was also evident, with differences in readiness to engage with outreach efforts.

Effectiveness

Services Received and Coverage

Beneficiaries reported receiving a comprehensive range of services, including village-level vision screening, cataract surgeries, transport, food, accommodation, medicines, protective glasses, post-operative counselling, and scheduled follow-up visits. These services were delivered with no out-of-pocket expenditure and did not require beneficiaries to make additional arrangements.

> *"They picked us up, did the operation, gave food, medicines, and dropped us back. We didn't face any issues."* – Beneficiary, Moothurai Village, Tamil Nadu

Project Associates described supporting service delivery across multiple stages: awareness generation, screening, referral, and follow-up. Their responsibilities included coordinating patient movement, assisting at camp sites, and ensuring that beneficiaries received appropriate care throughout the process. Survey data below demonstrates the types of services and their proportion of the total services received by the beneficiaries

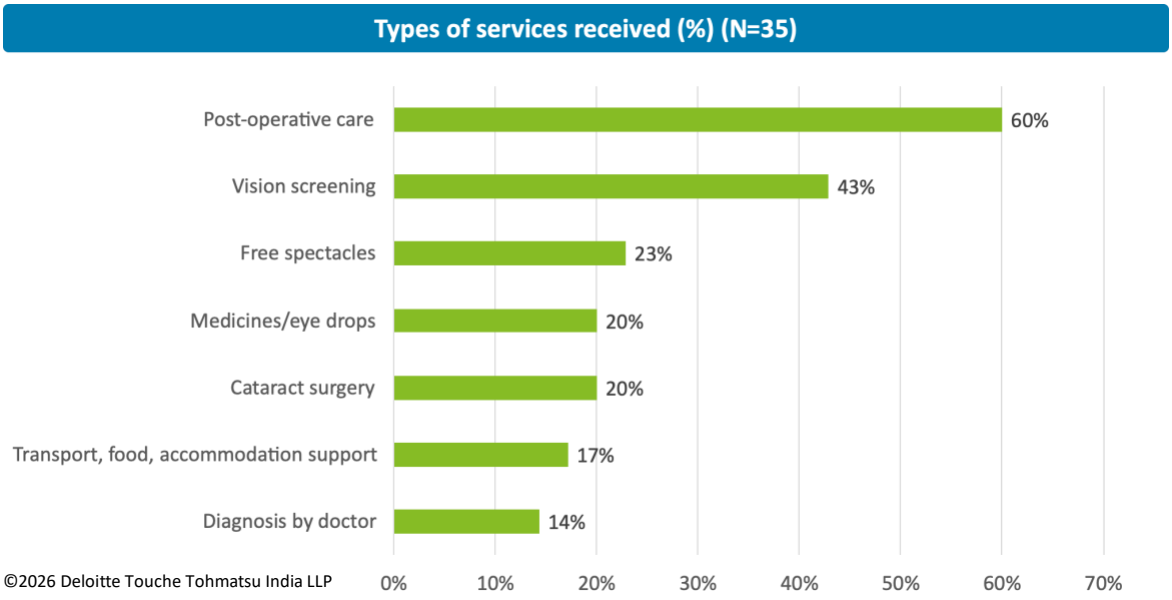


Figure 13: Types of Services Received

Post operative care was reported by 60% of respondents, followed by diagnosis by a vision screening (43%). In addition, 23% reported receiving free spectacles, while cataract surgery and medicines or eye drops were each reported by 20% of respondents. A smaller proportion indicated receiving transport, food, or accommodation support (17%) and diagnosis by doctor (14%).

Post-operative Care and Follow-up

Postoperative care was structured and easily accessible. Beneficiaries received clear instructions on precautions-avoiding dust, bending, lifting weights, and direct sunlight along with medication schedules and village level follow up visits. Reminder calls were also part of the process.

Project Associates conducted follow up visits, reinforced medication adherence, and encouraged attendance at checkups, contributing to continuity of care. While most beneficiaries adhered to guidance, one did not attend follow up visits because she "felt fine,".

Surgical Outcomes and Functional Improvements

> *"Now I can even see the small symbols on coins."* - IDI, Beneficiary, Tamil Nadu

Beneficiaries described clear improvements in vision following surgery, such as the ability to recognise faces, read small print or symbols, and resume daily activities with greater ease. Visual disturbances like fogginess, cloudiness, and double vision were resolved.

These improvements supported a return to routine functioning and increased confidence.

Beneficiary Experience and Quality of Care

Among the beneficiaries who underwent cataract surgery (n = 22), respondents were asked to rate their experience of post-operative care on a scale of 1-5 (1 being very poor and 5 being excellent). The findings indicate that 68% of respondents rated their experience of post-operative care at the highest level (5), while 27% provided a rating of 4. A smaller proportion (5%) rated their experience at 3, indicating that most beneficiaries reported a positive experience with the post-operative care received.

Table 12: Experience of post-operative care (%)

Ratings	Responses (%) (n=22)
5 (Excellent)	68%
4 (Good)	27%
3 (Fair)	5%

Regarding receipt of counselling or advice on eye care and follow-up, 89% of respondents reported receiving counselling or guidance on eye care and follow-up, while 11% indicated that they did not receive such support. Most respondents reported that they did not face challenges in accessing the services, as indicated by 94% of respondents. In comparison, 6% reported experiencing challenges while accessing the services. Among the respondents who reported facing challenges in accessing services, travel or transport-related issues were identified as the primary challenge.

Table 13: Challenges while accessing services - CBBF

Challenges faced while accessing services	Responses (%) (N=35)
No	94%
Yes	6%

Nearly half of the respondents (49%) reported continuing periodic eye check-ups after treatment, indicating that follow-up eye care practices are being maintained among a substantial proportion of beneficiaries. A similar share (46%) reported that check-ups did not continue, suggesting scope to further encourage regular follow-up to strengthen sustained eye health monitoring.

Table 14: Post-treatment eye check-up - CBBF

Continuation of Periodic eye check-up after treatment	Responses (%) (N=35)
Yes	49%
No	46%
Did not answer	6%

Beneficiary Satisfaction

Beneficiaries expressed high satisfaction with the services provided, frequently noting the convenience of transport, food, and the overall care experience. Their positive experiences during screening, surgery, and recovery contributed to trust in the programme. Many reported recommending the programme to others within their communities.

Role and Effectiveness of Volunteers (community health workers)

Project Associates described receiving practical training in vision chart testing, torchlight examinations, cataract identification, counselling, and patient handling. Some also received training related to organisational values and workplace conduct. The screening kit—vision charts, torchlights, ropes, and a mobile application—enabled them to conduct assessments and document beneficiary details effectively.

Their role extended beyond screening to include counselling, addressing misconceptions, referring beneficiaries to camps, and supporting them throughout treatment and follow up. Beneficiaries noted that Associates provided guidance on procedures, documentation, and precautions, and some sought them by name at camps, reflecting familiarity and trust.

Operational challenges included mobile application issues such as data synchronisation problems and network disruptions.

"If I screen 100 people, due to server issues only 80 will upload."- IDI, Project Associate, Tamil Nadu

Some households also required repeated engagement due to initial hesitation, and training exposure varied across different batches.

Efficiency

Accessibility of Services and Logistical Support

Beneficiaries described programme services as highly accessible due to strong logistical support. Free transport for pickup and drop, timely provision of food at hospital facilities, and organised processes for documentation and check in reduced practical barriers. Surgery and medicines were provided without cost, with only minimal expenses (₹20–₹70) reported for additional items.

> *"They picked me up from home and dropped me back. No issues."- IDI, Beneficiary, Tamil Nadu*

Transport arrangements were especially significant for elderly beneficiaries who had difficulty travelling independently or navigating long distances. Organised transport enabled them to participate in screening and surgical services. Project Associates similarly highlighted the importance of free transport, food, accommodation, and surgical care in reducing concerns about travel and expenses, contributing to greater willingness among households to attend camps and proceed with surgery.

Financial Accessibility and Cost Reduction

Beneficiaries contrasted the programme's free services with the high costs associated with treatment elsewhere. The absence of charges for surgery and related services addressed major financial barriers and enabled individuals to access care they had previously deferred.

> *"People spend ₹20,000 -30,000 elsewhere. Here everything is free, it's a blessing."- IDI, Beneficiary, Tamil Nadu*

Project Associates noted that communicating the lack of costs helped encourage households to consider and accept treatment.

Operational Processes and Service Flow

Beneficiaries described service delivery as smooth and well organised, with no major issues related to staff interaction, delays, or documentation. The sequence of activities, from screening to surgery and follow up was generally experienced as efficient and manageable.

A few variations were reported. One beneficiary described an unpleasant interaction with a nurse during surgery, differing from the predominantly positive accounts of staff behaviour. Another mentioned delaying earlier participation due to fear of travelling alone. A single instance of delayed spectacle availability was also noted. These experiences were isolated and did not affect the overall service flow for most beneficiaries.

Impact

Improvements in Daily Functioning and Independence

> *"Earlier during evenings, it was difficult… headlights from opposite vehicles blinded me. Now that problem is mostly solved."* – IDI, Beneficiary, Tamil Nadu

Beneficiaries reported clear improvements in their ability to perform daily activities following surgery. They described being able to recognise faces, identify objects and symbols, and see distant figures with clarity. Visual disturbances such as fogginess and double vision were resolved, allowing greater ease in moving outdoors and travelling independently.

These changes contributed to increased confidence in navigating everyday environments. Survey findings support these experiences, with 80% of respondents reporting that they were able to carry out daily activities more easily after treatment, while a smaller proportion reported no change or were unsure.

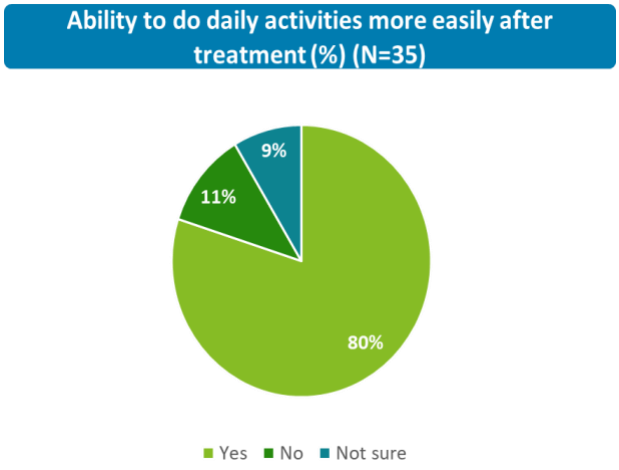


Figure 14: Daily activity post-treatment - CBBF

Work Participation and Productivity

Improved vision enabled beneficiaries to resume or continue income generating- activities, including cattle grazing, agricultural labour, household work, and driving. Visual recovery supported sustained participation in these tasks. One exception was noted where a beneficiary, despite medical clearance, avoided work for several months due to concern about affecting recovery, reflecting a perceived rather than clinical limitation.

Quantitative responses indicate that 69% of respondents reported improvement in their ability to work, suggesting that visual recovery translated into functional benefits for livelihood-related activities for most beneficiaries. However, there is a sizeable proportion of beneficiaries (31%) that are either unsure or report no improvement in the ability to work.

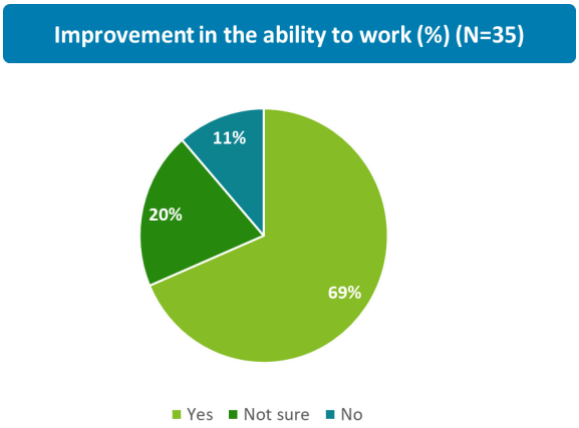


Figure 15: Work Improvements - CBBF

Financial Implications of Eye Care

Beneficiaries described a substantial reduction in eye-care expenditure. Surgery, transport, food, and medicines were provided without cost, and only minimal additional expenses were reported in a few cases. This contrasted with earlier costs for treatment and spectacles, which had limited access to timely care. The removal of major expenses reduced financial burden and enabled beneficiaries to receive services they might otherwise have postponed. Consistent with these accounts, 63% of respondents reported a reduction in spending on eye-care or related medical expenses following programme participation.

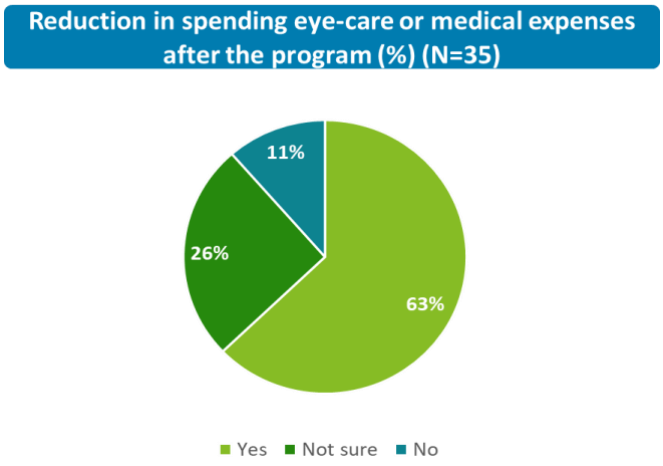


Figure 16: Financial Implications - CBBF

Early Identification and Access to Care

Although beneficiaries did not explicitly refer to early detection, their responses indicated that engagement with the programme was facilitated through household visits, notices, and encouragement from outreach workers. These mechanisms prompted individuals to seek care who might not have done so independently, indicating a shift from delayed to earlier engagement with eye care services.

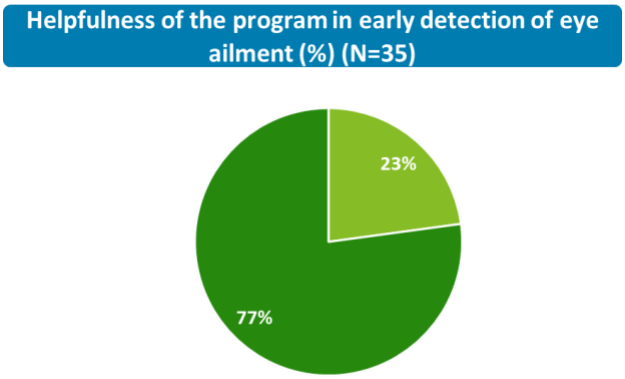


Figure 17: Identification and Access to Care - CBBF

Survey data further indicate that 77% of respondents felt the programme helped in the early detection of their eye ailment, supporting the role of outreach and screening in facilitating timely access to care.

Community Influence and Recommendations

Beneficiaries described recommending services to neighbours and relatives, noting that groups from the same villages attended screening and surgery together. These patterns demonstrated the influence of peer experience in shaping participation.

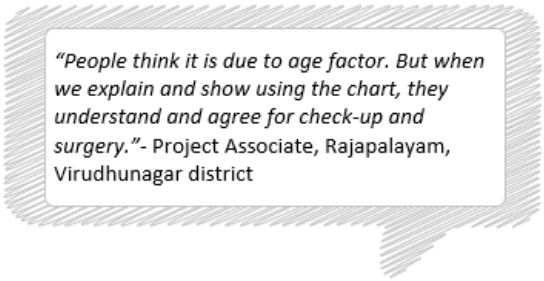
"Some elderly people are afraid of surgery… we counsel them and bring them to camp." - Project Associate, young adult, Rajapalayam, Virudhunagar district

Changes in Health-seeking Behaviour and Awareness

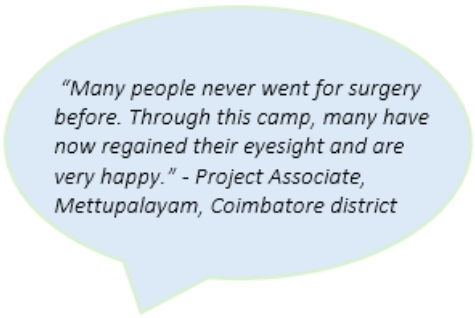
Project Associates described a noticeable shift in community behaviour. Initial hesitation, often linked to fear of surgery, misconceptions about cataract, or concerns about income loss-reduced over time with counselling and repeated engagement.

They reported that community members increasingly approached them for vision testing, requested spectacles, and sought referrals, reflecting greater willingness to engage with eye-care services earlier.

Shifts in Understanding of Cataract and Eye Health



Project Associates indicated that awareness regarding cataract and its treatment improved within communities. Misconceptions, including viewing cataract as an inevitable part of ageing or perceiving surgery as unsafe, were addressed through programme activities. Individuals developed an understanding that cataract could be treated and that surgery was a viable option. These changes contributed to a broader acceptance of screening and treatment within villages.



Trust in Services and Community-level Effects

Trust grew through repeated outreach, successful surgical outcomes, and positive experiences shared by beneficiaries. Family influence also played a role, with encouragement facilitating participation, while hesitation within households sometimes delayed engagement.

Some variations remained: a subset of households continued to hesitate about screening or sharing information, and some individuals delayed surgery despite counselling. A few households preferred to seek care directly at hospitals rather than through camp-based services.

Overall Satisfaction

Respondents were asked to rate their overall satisfaction with the services received through the programme on a scale of 1–5. The findings indicate that 77% of respondents rated their satisfaction at the highest level (5), while 17% provided a rating of 4. A smaller proportion of respondents rated their experience as 3 (3%) and 2 (3%), indicating that most beneficiaries reported a high level of satisfaction with the overall services received through the programme.

Table 15: Overall Programme Satisfaction - CBBF

Level of Satisfaction with the program	Responses (%) (N=35)
5	77%
4	17%
3	3%
2	3%

Sustainability

Follow-up and Periodic Check-ups

> *"They asked us to come by car for the second check-up. We went. They came again after a month also."* – IDI, Beneficiary, Palanisami

Beneficiaries described varied patterns in attending follow-up visits after surgery. Some continued to attend scheduled check-ups, particularly when transport was arranged. For instance, one beneficiary referred to attending multiple follow-ups over time when such support was available. In contrast, others did not return for follow-up visits if they did not experience any discomfort. These indicate that continuation of periodic check-ups was influenced by both perceived need and availability of logistical support.

Adoption of Eye Care Practices

> *They said don't go in dust, don't lift weight, avoid sunlight. For one month I didn't go out at all."* - Beneficiary, middle-aged woman, Mooththurai village, Tamil Nadu

Beneficiaries described adhering to post-operative care instructions, including avoiding sunlight and dust, refraining from heavy physical labour, using prescribed medicines, and wearing protective glasses. This reflected an initial shift toward recommended practices. In one case, a beneficiary continued restricting activities for several months beyond medical guidance due to concerns about recovery, illustrating variation in interpretation of advice

Community Awareness and Peer Influence

Beneficiaries continued sharing their experiences with neighbours and relatives, encouraging others to seek treatment. Multiple individuals from the same locality accessed services after hearing these accounts, demonstrating the role of peer communication in sustaining awareness after programme activities ended.

> *"After I told them, two people from my area went and did the operation."* - Beneficiary, middle-aged man (46 years), Rajapalayam area, Virudhunagar district

Sustained Changes in Awareness and Health-seeking Behaviour

Project Associates described ongoing improvements in community understanding of cataract and eye health. Community members increasingly recognised symptoms, considered treatment, and approached workers for screening or spectacles. These patterns reflected continuation of awareness generated during the programme. At the same time, Associates noted that sustained behavioural change required continued presence in the field to reinforce practices and address emerging concerns.

Challenges Affecting Continuity

> *"If we have a jacket or t-shirt with Sankara's logo and a proper ID card, then people will automatically trust us." – Project Associate,* Tamil Nadu

Project Associates identified several factors influencing the continuation of benefits. Convincing hesitant individuals- particularly elderly persons or those worried about income loss remained challenging. Some households were reluctant to share personal information or declined entry during screening. Operational challenges, such as delays and network issues with the screening application, also affected workflow. While the programme provisioned identifiers such as ID cards, jackets, and t-shirts with logos, etc. for Project Associates, field realities indicated that these were not always consistently available or used during household visits. This suggested a gap not in provision, but in follow-through. In this instance, mechanisms to confirm receipt, ensure consistent use, and monitor visibility of identification in the field could be strengthened.

Certain groups continued to engage less consistently, including households concerned about family reactions or those who preferred accessing care directly at hospitals rather than through camp-based services. Project Associates also highlighted the need for ongoing support to maintain their role, with one stating:

> *"This project may end soon… if the hospital can provide some long-term job opportunities for us, it would help a lot."* – FGD, Mettupalayam

Community Perceptions. Awareness, and Willingness to Recommend

Respondents were asked whether they would recommend the programme to others in their family or village and whether the initiative contributed to improved awareness about eye care in their locality. The findings indicate high levels of perceived programme value within the community. Approximately 97% of respondents reported that they would recommend the programme to others, while a similar proportion (97%) indicated that the initiative improved awareness about eye care in their village or locality.

Table 16: Willingness to Recommend - CBBF

Recommendation of the program to others	Responses (%) (N=35)
Yes	97%
No	3%

Table 17: Community-level eye care improvements - CBBF

Improvement about eye care in village/locality due to the program	Responses (%)(N=35)
Yes	97%
No	3%

4.2. Mobile Rural Vision Screening Project

Respondent Profile

The survey was conducted with 29 beneficiaries from Kolar and Ramanagra blocks who had participated in the eye screening initiative. Out of the total respondents (N), 41.37% were female while 58.62% were male. The respondent profile was largely concentrated among older age groups. Most respondents are older adults, with the largest proportion in the 66–75 age group (38%), followed by those aged 56–65 (28%). Smaller but equal shares are observed in the 36–45 and 46–55 age groups (14% each). Very few respondents fall into the youngest (16–25) and oldest (76–85) age categories, each accounting for only 3% of the sample.

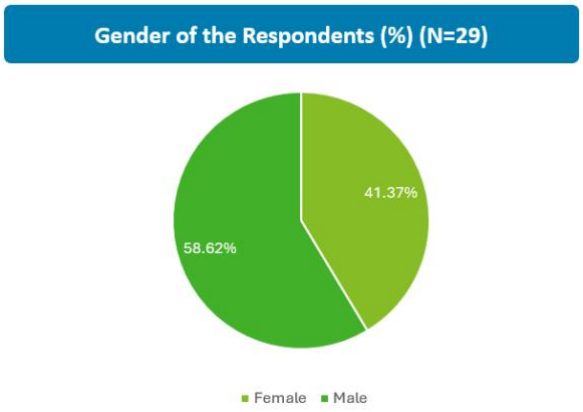


Figure 19: Gender of the Respondents

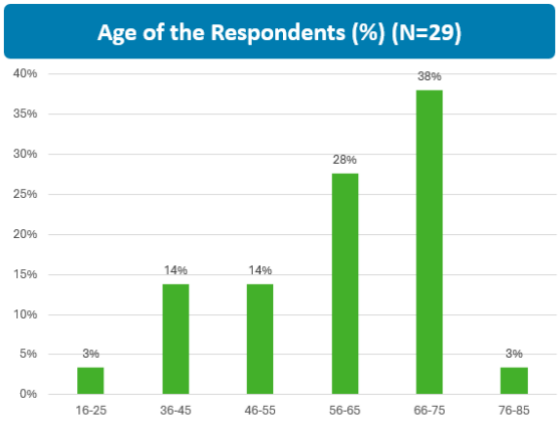


Figure 18: Age of the Respondents MRVP

Relevance

Alignment with Personal Health Needs

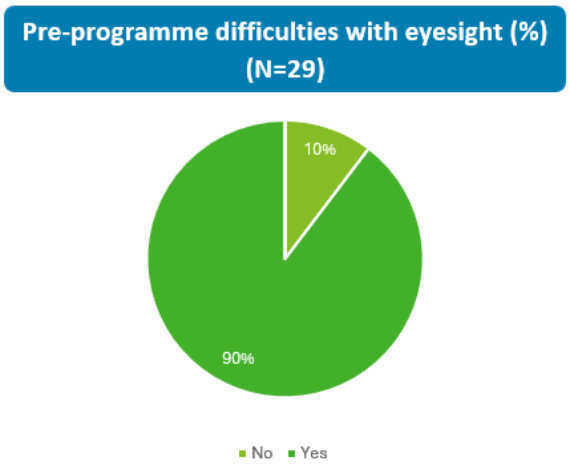


Figure 20: Pre-programme difficulties with eyesight - MRVP

Adult community beneficiaries described programme services as closely aligned with their immediate vision related needs. The high prevalence of reported pre-programme eyesight difficulties (90%) suggests that most beneficiaries entered the programme with significant yet unmet eyesight needs (Figure 20)

Beneficiaries entered the programme with issues such as difficulty reading, blurred vision, or persistent eye watering that affected everyday functioning. Figure 21 indicates that difficulties experienced by beneficiaries were varied, with daily activity-related challenges being the most reported (66%). Reading-related difficulties

and work-related challenges were each reported by 38% of respondents, indicating that eyesight issues also had implications for both literacy-related tasks and livelihood activities. Fewer respondents reported night-time vision difficulties (21%) and pain, irritation, or redness (14%), suggesting that while discomfort was present, functional limitations were more prominent than acute symptoms for most beneficiaries.

Overall, the distribution shows that vision impairment affected both everyday functioning and productivity, rather than being limited to clinical discomfort alone.

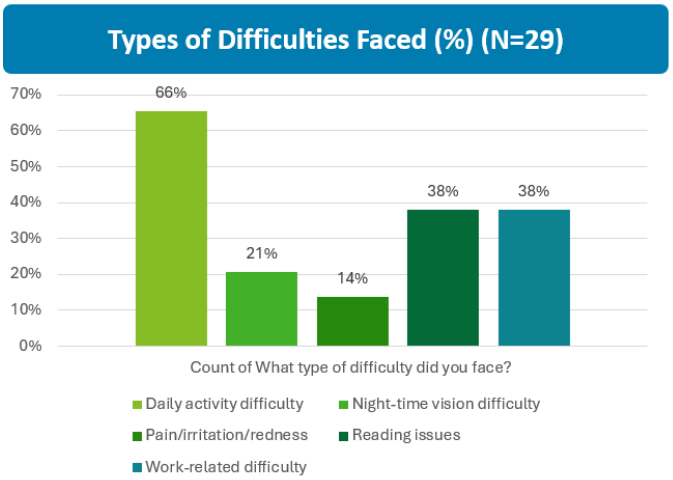


Figure 21: Types of Difficulties Faced - MRVP

Community level screening helped identify these problems and facilitated appropriate interventions such as the provision of spectacles or referral for surgical treatment.

As shown in Figure 22, beneficiaries accessed a range of services through the programme, reflecting the varied nature of their eyesight-related needs. Vision screening was the most reported service (97%) – this establishes its role as an entry point to care. Diagnostic consultations (79%) and post-operative care (79%) were also widely accessed, while a substantial proportion of beneficiaries received free spectacles (76%) and medicines or eye drops (72%). Support services such as transport and food were provided to 76% of respondents, suggesting efforts to reduce access-related barriers. Cataract surgery was reported by 72% of beneficiaries, indicating that surgical intervention was available where clinically required.

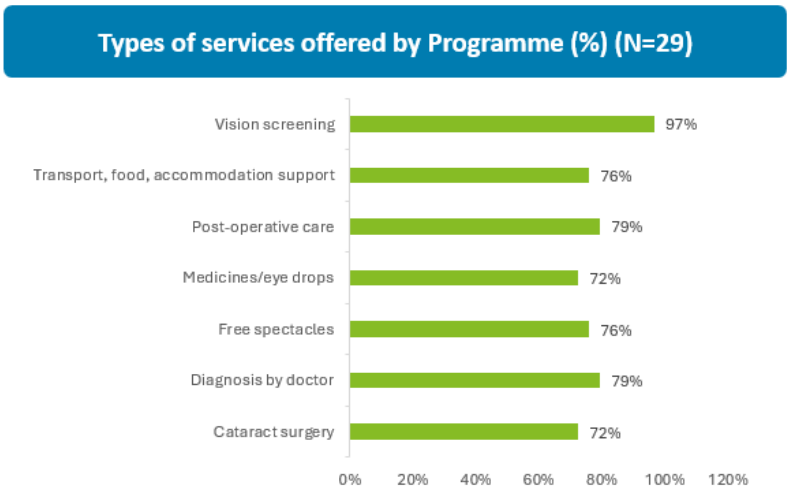


Figure 22: Types of Services Offered by Programme - MRVP

Beneficiaries who received spectacles reported improvements in their ability to read and write, which had previously been difficult due to declining near vision. In other cases, individuals experiencing blurred vision and continuous eye watering were referred for surgical procedures, after which symptoms reduced, and visual clarity improved. These outcomes indicate that the services responded effectively to the different levels of vision related needs present among beneficiaries.

Improvements in vision also translated into better performance of daily activities, including the ability to move outdoors with greater

clarity and awareness of surroundings. Overall, beneficiaries described the interventions as useful and well suited to the vision related challenges they were experiencing.

However, a small gap in service completion was noted in relation to post operative care, where spectacles expected after surgery were not delivered in one instance. Although the beneficiary reported overall improvement in vision following the procedure, the absence of the expected spectacles indicated a limitation in addressing post operative refractive correction in that case.

Accessibility and Contextual Fit

> *"They have given me all the food and snacks. I did not have to spend on the bus fare too."*
> – IDI, Beneficiary, Annalli village, Ramanagara taluk, Karnataka

Programme features such as free screening, surgery, and spectacles supported accessibility for beneficiaries, particularly those from rural and low-income contexts. The absence of service fees reduced financial barriers and enabled individuals to seek treatment without incurring significant expenses. Beneficiaries also referred to the provision of logistical support, including food and refreshments during hospital visits and assistance with transport during certain stages of treatment.

The organisation of screening camps within villages or through mobile units further improved accessibility. Local service delivery reduced the need for long distance travel and allowed beneficiaries to attend screenings without significant disruption to daily responsibilities. Information about screening camps was typically communicated through pamphlets, newspapers, and word of mouth within the community.

At the same time, a few gaps in accessibility were observed. In one instance, a beneficiary reported that no formal announcement had been made in the village regarding the screening camp, suggesting that communication about programme activities did not always reach all communities consistently. Additionally, although most services were provided free of cost, a small transport expense was incurred for a follow up visit in one case, indicating that minor residual costs could still arise at certain stages of the care pathway.

Service Experience and Communication

Beneficiaries generally described positive interactions with programme staff and healthcare providers. Information about eye conditions and treatment procedures was explained in a clear and understandable manner, which contributed to a high level of satisfaction with the service experience. Beneficiaries reported that the guidance provided helped them understand the nature of their eye problems and the steps required for treatment.

Following surgical procedures, patients received instructions related to recovery practices such as the use of prescribed eye drops, temporary restrictions on certain activities, and the need to attend follow up check-ups. These instructions reflected efforts by service providers to ensure that beneficiaries were informed about post operative care and recovery requirements.

Overall satisfaction with the services was high, with beneficiaries describing the programme as helpful in addressing their vision related difficulties. While most beneficiaries reported following the medical guidance provided, there were instances where not all instructions were fully adhered to during the recovery period.

Such cases reflected individual behavioural variation rather than a lack of communication from programme staff.

Coherence

Awareness Pathways and Initial Access to the Programme

> *"Pamphlets were given, and people in the locality generally check newspapers for information. A known acquaintance also mentioned the programme."*
> – IDI, Beneficiary, Biddy village,

Adult community beneficiaries described multiple channels through which information about the screening camps reached them. These channels reflected common information sharing practices within rural communities and indicated alignment between programme outreach approaches and local communication patterns. Information about the camps circulated through pamphlets, newspapers, acquaintances, and relatives. Community members also learned about the camps through informal village level communication, where information was shared through local discussions and personal networks.

Findings also indicated that informal communication within the village enabled awareness to spread beyond those who directly encountered programme announcements.

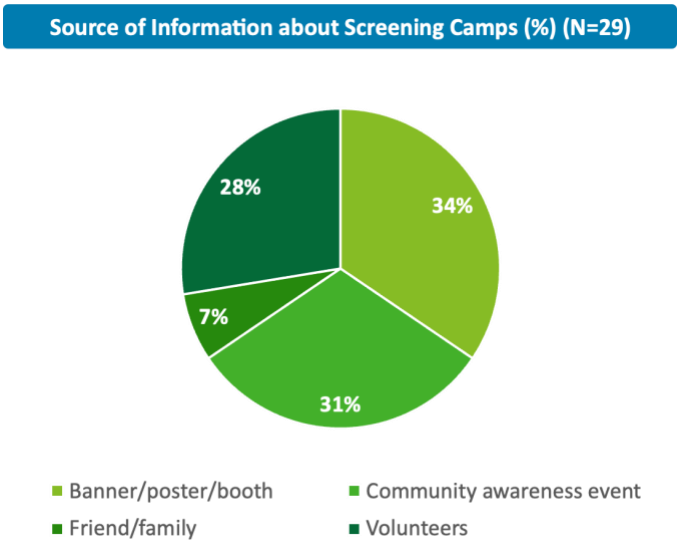


Figure 23: Programme Awareness - MRVP

Figure 23 illustrates the primary sources through which beneficiaries learned about the screening camps. Information was most disseminated through banners, posters, or booths (34%) and community awareness events (31%), followed by outreach through Volunteers (community health workers) (28%). A smaller proportion of respondents (7%) reported receiving information via friends or family, indicating that formal community-based communication channels played a greater role than informal networks

Coherence Across Service Delivery Pathways

Experiences described by adult community beneficiaries indicated a structured sequence of service delivery beginning with screening at the village level and extending to treatment and follow up care. The steps undertaken during the care process corresponded with the expectations communicated during screening. Service pathways included screening followed by provision of spectacles, as well as referral to hospitals for further treatment when required. In cases requiring advanced care, the pathway involved referral, treatment procedures such as injections or surgery, and subsequent follow up visits.

Beneficiaries also described alignment between the services communicated during screening and the services delivered during treatment. Screening, spectacles, and treatment procedures were provided without payment. Surgical patients also referred to logistical support, including transport and food, during the treatment process.

Community Awareness of Eye Health

> *"I have recommended the programme to my family and neighbours… I believe the programme brought awareness in my village about early identification and timely treatment of eye issues."*
> – IDI, Beneficiary, Baichauli village, Ramanagara taluk, Karnataka

Participation in the programme contributed to the spread of information about eye health within households and the wider community. Beneficiaries described recommending the programme to family members, neighbours, and other village residents. Such interactions encouraged additional individuals to attend screening camps and seek eye care services. These examples illustrated how awareness generated through individual programme participation extended to the broader village context.

Communication with Beneficiaries and Guidance Provided

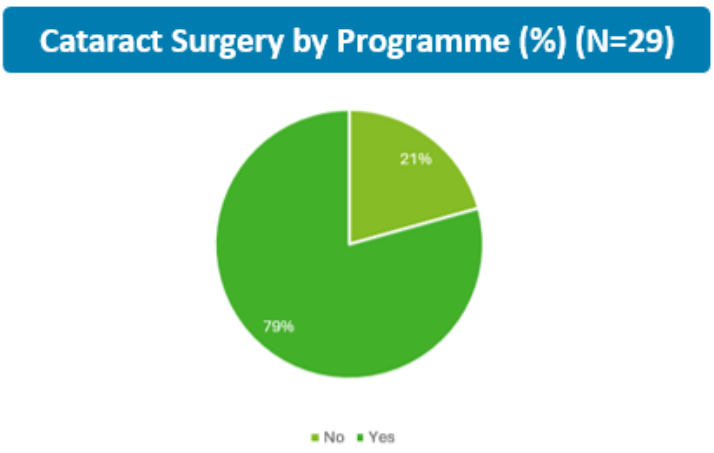
Interactions with programme staff included explanations of eye conditions and the treatment process. Beneficiaries described receiving guidance on the steps required for treatment and on post treatment care. In cases involving surgical intervention, instructions were provided regarding recovery practices such as avoiding bathing for a specified period, using prescribed eye drops, and attending follow up visits.

Responses also indicated that while instructions were communicated, adherence to all recommendations varied in isolated cases, reflecting variation in beneficiary compliance rather than a gap in programme communication.

Effectiveness

Services Received through the Programme

Adult community beneficiaries described receiving a range of services through the programme, beginning with community level screening and extending to treatment and post treatment care. Screening functioned as the initial entry point for all beneficiaries and led to different forms of intervention depending on the identified condition. These included the provision of spectacles for refractive issues and referral to hospitals for advanced treatment when required.



Spectacles were provided free of cost to beneficiaries experiencing difficulties with reading and near vision. The provision of spectacles contributed to improvements in everyday activities that required clear vision.

Surgical intervention was provided in cases where screening identified more severe eye conditions. The treatment pathway included referral to a hospital, medical procedures such as injections and surgery, and the provision of medicines during recovery. The findings in Figure 24 indicates that 79% of respondents (23 out of 29) underwent cataract surgery under the programme, while 21% did not receive surgical intervention. This suggests that a substantial proportion of beneficiaries identified with cataract-related needs were able to access surgery through the programme, though a smaller segment either did not require surgery or may have faced other clinical or personal constraints.

Beneficiaries described improvement in symptoms following treatment. Logistical support formed part of the service experience and contributed to the completion of treatment. Beneficiaries described receiving food, snacks, and assistance with transport during the treatment process. These measures reduced the need for personal expenditure during visits for care.

Alignment between Expected and Delivered Services

Figure 24: Cataract Surgeries - MRVP

Experiences described by beneficiaries indicated alignment between the services they expected to receive and those delivered through the programme. Screening, diagnosis, and treatment options corresponded with the concerns expressed during the initial consultation. Beneficiaries seeking support for reading difficulties or watery eyes received spectacles and follow up support, while those requiring medical treatment were referred for further procedures.

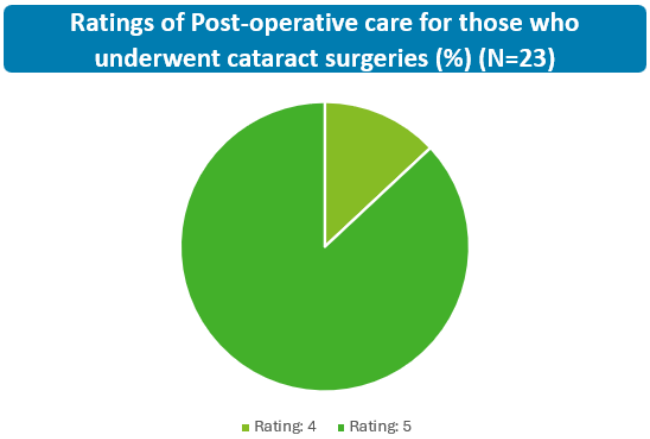


Figure 25: Perception of Post-Operative Care - MRVP

Among respondents who underwent cataract surgery (N=23), post-operative care was rated positively, with the majority assigning the highest rating. Most beneficiaries provided a rating of 5, while a smaller proportion rated the care as 4, indicating generally high satisfaction with post-surgical follow-up and support, without evidence of significant dissatisfaction.

Qualitative interactions reflected that the programme delivered screening, treatment, and follow up care in accordance with the information communicated during the initial stages of the process. Free services were emphasised during the screening stage and beneficiaries confirmed that spectacles, treatment, and related services were provided without payment.

Follow up Care and Continuity of Treatment

Post treatment care formed part of the service pathway for beneficiaries who underwent surgery. Guidance on recovery practices and follow up visits was provided during the treatment process. Instructions included avoiding bathing for a specified period, using prescribed eye drops, and returning for follow up consultations at the hospital.

Beneficiaries described attending follow up appointments and receiving medicines during the recovery period. In some instances, follow up care was accessed through government hospital facilities, and travel for these visits involved minor transport expenses. Figure 26 illustrates the extent of eye-care follow-up received by beneficiaries after treatment. All respondents (100%) reported receiving follow-up care. This suggests that beneficiaries were provided with guidance on recovery and follow-up consultations, and that continuity of care was maintained

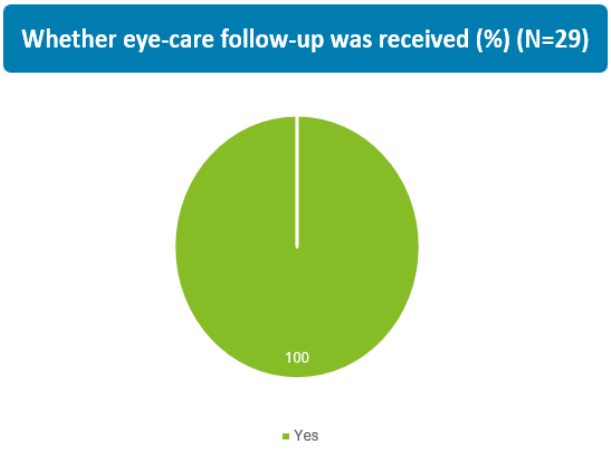


Figure 26: Eye care follow-up - MRVP

Satisfaction with Services

Figure 27 presents beneficiaries' overall satisfaction with the programme. Most respondents (86%) reported being satisfied with the services received, while 14% indicated they were not satisfied. This suggests generally positive perceptions of the programme among participants, while also indicating some variation in experience that may be influenced by individual expectations or service-related factors.

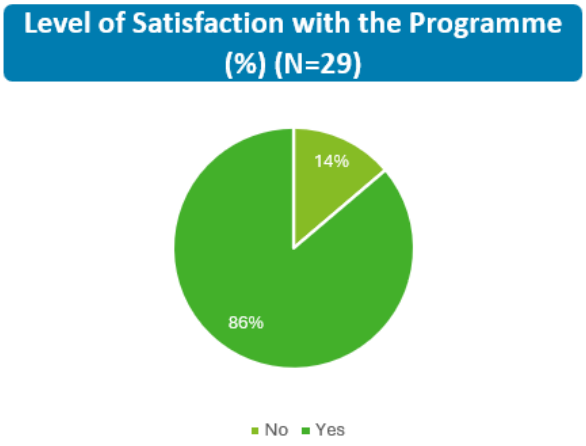


Figure 27: Programme Satisfaction - MRVP

Satisfaction was linked to improvements in vision, the ability to resume everyday activities, and the absence of treatment costs. The restoration of functional abilities such as reading, writing, and seeing clearly outdoors contributed to positive assessments of the programme.

Expressions of satisfaction also referred to the treatment process and the support received during care. Beneficiaries described feeling pleased with the outcome of treatment and with the assistance provided during hospital visits.

Efficiency

Accessibility of Services

Community beneficiaries described service access as largely straightforward. Screening camps were organised within or close to villages, which reduced the need for long distance travel and enabled beneficiaries to attend without major disruption to daily routines. The proximity of services supported participation, particularly for older individuals and those with limited mobility.

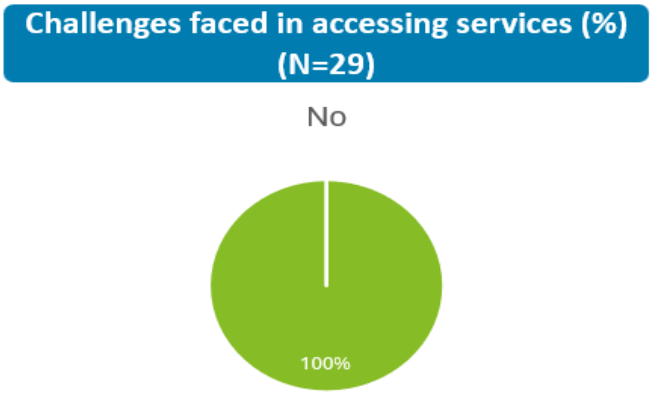


Figure 28: Accessibility of Services - MRVP

Following screening, beneficiaries progressed through service pathways that included the provision of spectacles or referral to hospitals for further treatment when required. The transition from screening to treatment and follow up care occurred through a structured sequence, with beneficiaries attending hospital appointments or receiving follow up communication when necessary. Beneficiaries indicated that these steps were manageable and aligned with the instructions provided during screening or treatment.

Logistical arrangements supported accessibility during the treatment process. Beneficiaries who underwent hospital-based treatment referred to arrangements such as transport support and provision of food during hospital visits. These measures reduced the effort required to access care and enabled completion of treatment procedures.

However, a communication gap was noted in one village where a beneficiary indicated that there had been no formal announcement regarding the screening camp. Although access was still achieved through informal communication within the community, the absence of structured announcements suggested uneven dissemination of information prior to the camps.

Operational Challenges Faced by Beneficiaries

Most beneficiaries described the process of accessing services and receiving treatment as smooth, with no major operational difficulties encountered during screening, treatment, or follow up stages. The sequence of services from initial screening to treatment and post treatment follow up was described as manageable and predictable. This is supported by quantitative evidence (Figure 28) where none of the respondents reported facing any challenges in accessing services.

In qualitative interactions, a small operational challenge was identified in relation to travel for a follow up visit. In one case, a beneficiary incurred a bus fare when travelling to attend a follow up consultation. While

transport arrangements had been provided during other stages of treatment, this instance reflected a minor logistical burden associated with a specific stage of the care pathway.

Apart from these isolated experiences, the process of accessing services and completing treatment was described as functioning without major operational barriers.

Cost of Services

Beneficiaries described the programme as largely free of financial cost. Screening, spectacles, surgical procedures, medicines, and related services were provided without payment. The absence of treatment costs reduced financial barriers and enabled beneficiaries to seek care without concerns about affordability.

In addition to the free provision of clinical services, logistical support also reduced expenditure associated with treatment. Beneficiaries referred to receiving food and refreshments during hospital visits, and transport support was arranged for some stages of treatment, particularly for those undergoing surgical procedures.

Impact

Improvements in Vision and Health Outcomes

Adult community beneficiaries described clear improvements in visual health following treatment through the programme. Individuals who experienced blurred vision, tearing, or difficulty seeing prior to treatment indicated that these symptoms reduced after receiving appropriate interventions such as spectacles or surgical care. The resolution or reduction of these symptoms contributed to improved visual clarity and greater comfort in everyday life.

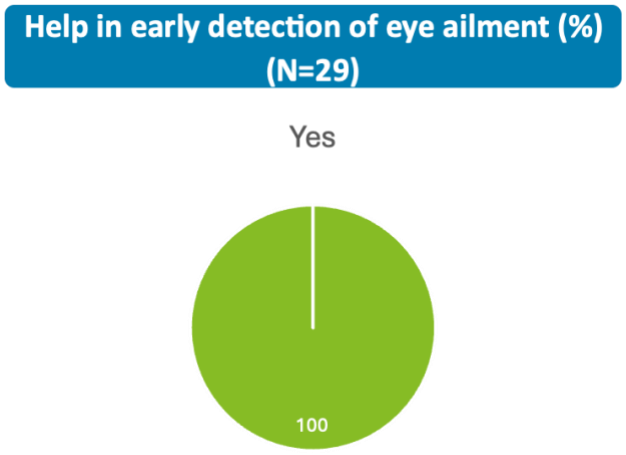


Figure 29: Early Detection of Eye ailments - MRVP

Surgical treatment resulted in relief from severe visual disturbances, including blurred and watery vision. Beneficiaries described noticeable changes in their ability to see clearly after undergoing medical procedures. In cases where spectacles were provided following screening, beneficiaries described improvements in near vision that enabled them to see more clearly during routine tasks. Figure 29 shows that all respondents (100%) reported that the initiative helped in the early detection of their eye ailment, indicating effective screening and identification at the community level.

Changes in Daily Activities and Functional Ability

Restoration of vision led to improvements in the ability of beneficiaries to perform routine activities that required clear eyesight. Beneficiaries described regaining the ability to read and write after receiving

spectacles. This improvement supported engagement in everyday tasks that had previously been difficult due to reduced vision.

Improved eyesight also enhanced visibility in outdoor environments, allowing beneficiaries to move more confidently within their surroundings and observe details in the environment that were previously difficult to see. These changes reflected improvements in mobility and environmental awareness.

All beneficiaries (100%) reported being able to carry out daily activities more easily after treatment, suggesting functional improvement following the interventions. For beneficiaries who underwent surgical procedures, the reduction of persistent symptoms such as blurred or watery vision contributed to improved comfort and functionality in daily life. The ability to carry out everyday activities without visual discomfort represented an important outcome of treatment.

Emotional and Psychological Effects

Beneficiaries described positive emotional responses associated with improvements in vision. The experience of regaining the ability to see clearly contributed to feelings of relief and satisfaction. Surgical treatment was associated with expressions of excitement and appreciation for the restoration of sight. These emotional responses reflected the broader personal impact of treatment beyond clinical outcomes, as improved vision reduced frustration associated with visual limitations and increased confidence in daily activities.

Community Influence and Programme Diffusion

Experiences of treatment also influenced awareness and participation within the wider community. Beneficiaries described recommending the programme to family members, neighbours, and other residents within the village. These interactions contributed to the spread of information about the availability of screening camps and treatment services.

Some beneficiaries reported encouraging other individuals to attend screening camps or directly bringing additional participants to the programme. In certain cases, family members sought treatment after hearing about the services through these recommendations. This pattern illustrated how the programme's impact extended beyond individual beneficiaries to influence service uptake within households and the broader community.

Sustainability

Continued Engagement with Follow-up Care

Adult community beneficiaries demonstrated continued engagement with follow up care after receiving treatment. Beneficiaries reported responding to follow up communication from service providers and attending check-ups when advised.

For individuals who underwent surgical procedures, follow up visits were completed according to the instructions provided by medical staff. Beneficiaries attended scheduled post-operative check-ups and remained in contact with programme personnel when additional consultations were required. These follow

up interactions supported monitoring of recovery and helped ensure that treatment outcomes were maintained.

Adherence to Post-treatment Medical Advice

Beneficiaries generally reported following the medical guidance provided after treatment. Individuals who underwent surgical procedures described adhering to instructions related to medication use, activity restrictions, and post operative care during the recovery period. These practices contributed to the continuation of treatment benefits and supported positive long-term outcomes.

Follow up consultations and the use of prescribed medicines were reported as part of the recovery process. Beneficiaries described complying with most of the recommendations given by medical professionals, including attending repeated check-ups during the recovery period.

Beneficiary Suggestions for Sustaining Programme Benefits

Beneficiaries generally expressed satisfaction with the services received and did not identify major changes required to sustain the programme. However, one suggestion highlighted the importance of improving communication about screening camps across villages. Ensuring that announcements are made consistently in all communities was identified to improve awareness and encourage wider participation. Improved dissemination of information about screening camps could help ensure that eligible individuals are informed about upcoming services and are able to access them in a timely manner.

Service Continuity and Long-term Sustainability

The continued provision of services without financial cost was identified as an important factor supporting sustainability. Free screening, treatment, medicines, and logistical support such as food and transport reduce financial barriers and enable individuals from lower income households to continue accessing eye care services when needed.

Overall, beneficiary experiences suggest that the programme has established conditions that support sustained benefits through continued follow up engagement, adherence to medical advice, and the spread of awareness within communities. Minor logistical and service delivery gaps highlight areas where improvements could further strengthen long term sustainability.

4.3. Gift of Vision

Respondent Profile

Out of the 22 respondents (N=22) surveyed for Gif of Vision, the respondent distribution was reported to be 55% from Tamil Nadu and 45% from Karnataka. 55% were reported to be male, while 45% were female, indicating participation from both gender categories in the study. In terms of age-wise distribution, most respondents belonged to the higher age brackets. Specifically, 55% were reported to fall within the 57-66 years age group, followed by 32% in the 67-76 years category. A smaller proportion of respondents were reported in the 47-56 years age group (9%) and the 37-46 years category (5%). The distribution indicates that the respondent profile was concentrated in the 57 years and above age groups.

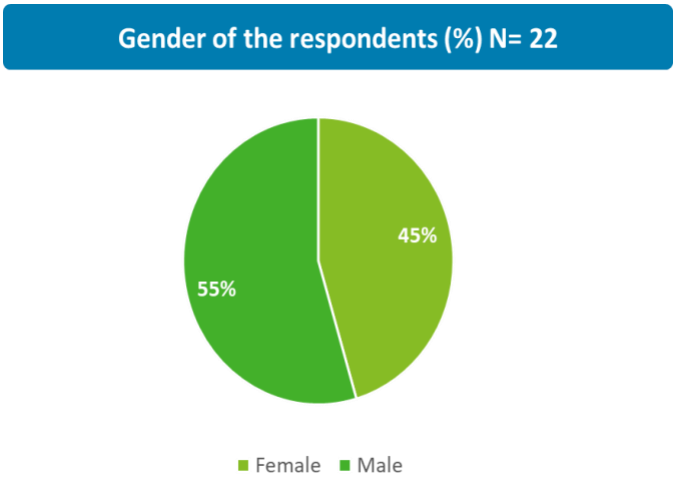


Figure 30: Gender of Respondents - GOV

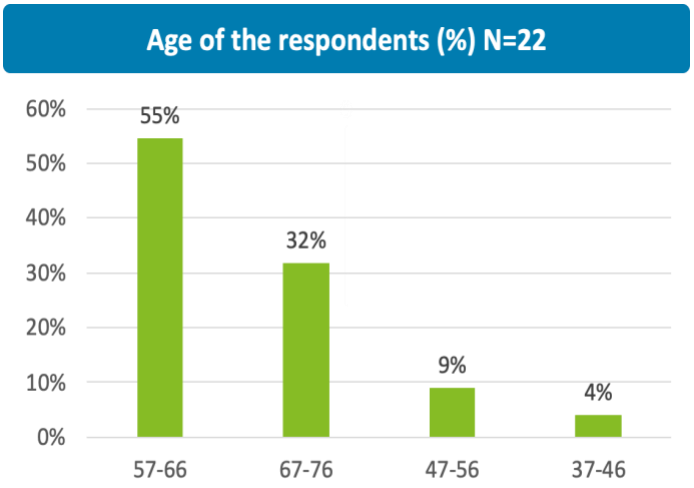


Figure 31: Age of Respondents - GOV

Relevance

Alignment with Personal Health Needs

Adult community beneficiaries described programme services as closely aligned with their vision related needs. Individuals entered the programme with concerns such as difficulty reading, blurred vision, and persistent eye watering, which affected daily functioning. Community-level screening helped identify these issues and led to appropriate interventions, including spectacles for refractive errors and referrals for surgical treatment when necessary.

Beneficiaries who underwent surgical procedures described reductions in symptoms after treatment and improved visual clarity. These outcomes indicate that services effectively addressed a range of vision related problems.

Improved vision supported better performance of daily activities, including outdoor mobility and overall awareness of surroundings. Beneficiaries generally considered the interventions useful and appropriate to their needs.

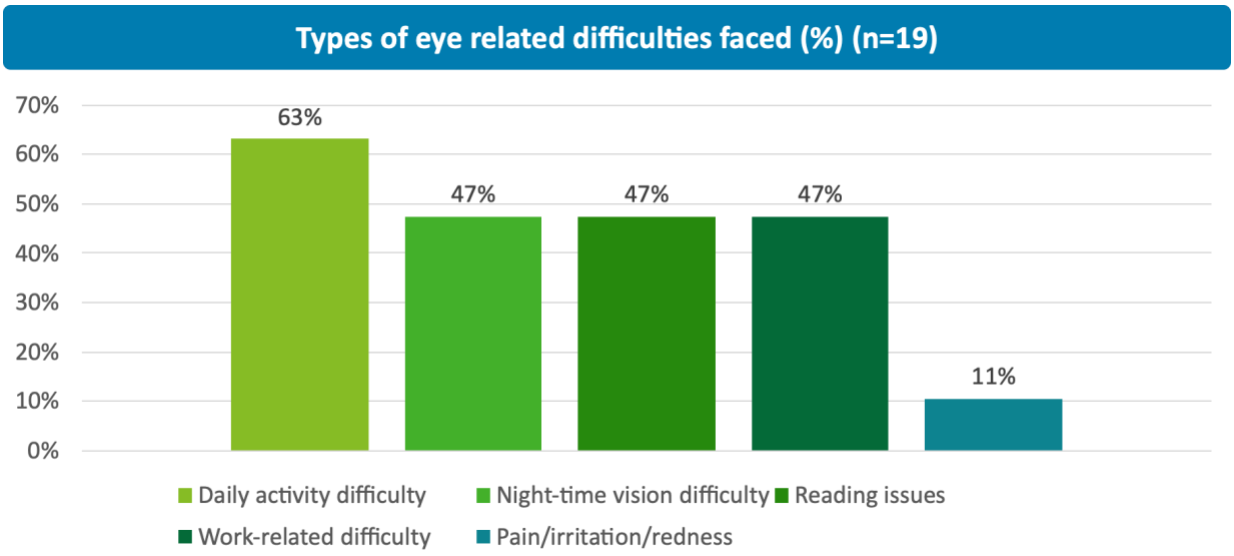


Figure 32:Types of eye-related difficulties - GOV

Responses regarding the availability and affordability of eye-care services prior to the programme indicate limited access in the surveyed areas (N=22). The respondent distribution shows that 82% reported that eye-care services were not easily available or affordable in their area before the programme, while 18% indicated that such services were available and accessible.

Respondents were first asked whether they had experienced difficulty with their eyesight prior to receiving the services (N=22). The respondent distribution indicates that 86% reported experiencing difficulty with their eyesight, while 14% indicated that they had not faced such issues before receiving the services.

Among those who reported experiencing eyesight-related difficulties (n=19), respondents were further asked to indicate the types of challenges faced. The respondent distribution shows that 63% reported difficulty in performing daily activities. Additionally, 47% reported challenges related to night-time vision, reading, and work-related activities. A smaller proportion (11%) indicated experiencing pain, irritation, or redness in the eyes.

Accessibility and Contextual Fit

Accessibility was strengthened through free screening, surgery, and reducing financial barriers for beneficiaries from rural and low-income contexts. Logistical support such as food, refreshments, and transport assistance at certain stages further eased access to treatment.

Screening camps were organised within villages or nearby locations, minimising travel requirements and allowing beneficiaries to participate without major disruption to daily routines. Information was shared through pamphlets, newspapers, and community networks.

However, there were instances where programme communication did not reach all communities equally. In one case, no formal announcement about the camp had been made. Additionally, although services were largely free, a minor transport cost was incurred during a follow up visit by one beneficiary.

Service Experience and Communication

Beneficiaries generally reported positive interactions with staff and clear communication regarding health conditions and treatment procedures. Explanations helped individuals understand their eye issues and the steps required for care.

Post surgery instructions included guidance on eye drops, activity restrictions, and follow up visits. Beneficiaries acknowledged the clarity of these instructions, though adherence varied in a few cases due to individual behaviour rather than communication gaps. Overall, satisfaction with the service experience was high.

Coherence

Awareness Pathways and Initial Access to the Programme

Beneficiaries became aware of screening camps through multiple channels, including pamphlets, newspapers, acquaintances, relatives, and village-level discussions. These channels aligned well with common communication practices in rural communities. Informal sharing within villages also helped spread awareness to individuals who may not have seen programme announcements directly.

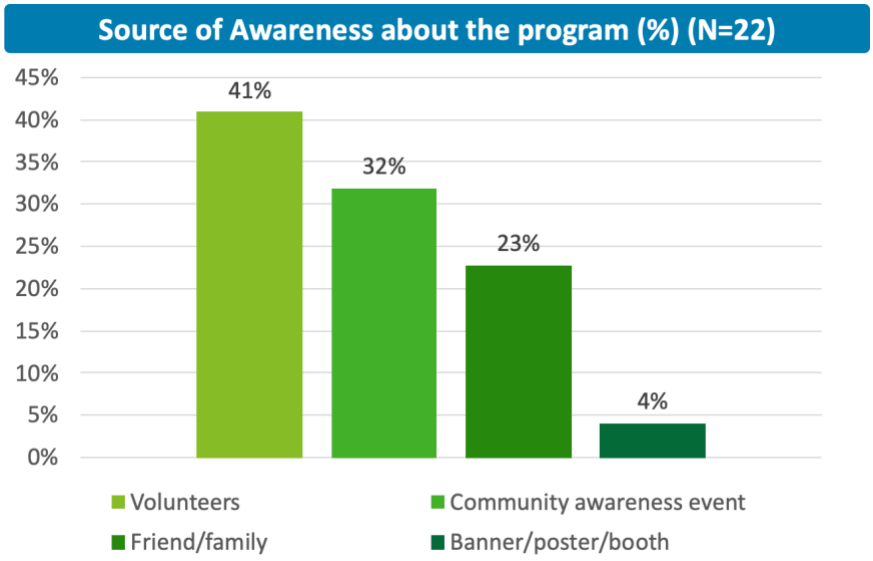


Figure 33: Programme Awareness - GOV

Awareness regarding the screening camp or mobile clinic was reported to have been generated through multiple outreach channels among the surveyed respondents (N=22). The respondent distribution indicates that 41% first heard about the services through Volunteers (community health workers), followed by 32% who reported becoming aware through community awareness events. Additionally, 23% indicated that they received the information through friends or family members, while 5% reported learning about the initiative through banners, posters, or booths. The distribution indicates that community-level outreach and interpersonal communication channels played a key role in disseminating information about the screening services among beneficiaries

Coherence Across Service Delivery Pathways

Beneficiary experiences indicated a coherent and structured service pathway beginning with community level screening and extending to spectacles, referrals, treatment, and follow up care. Individuals requiring spectacles received them after screening, while those needing specialised care were referred for procedures such as injections or surgery. Beneficiaries described consistency between what was communicated during screening and the services delivered later.

Free services, including screening, spectacles, and treatment were provided as expected. Surgical patients also mentioned receiving logistical support, including food and transport, during the treatment process.

Community Awareness of Eye Health

Participation in the programme contributed to broader awareness of eye health within households and villages. Beneficiaries recommended the programme to family members and neighbours, encouraging them to attend screening camps and seek timely treatment. These interactions helped extend awareness beyond initial participants.

Communication with Beneficiaries and Guidance Provided

Programme staff provided clear explanations regarding conditions, treatment processes, and post-treatment care. Surgical patients received instructions related to recovery, including eye-drop usage and temporary activity restrictions. While most beneficiaries adhered to these instructions, a few did not fully follow all recommendations, reflecting individual compliance rather than communication lapses.

Effectiveness

Services Received through the Programme

Beneficiaries received screening, or referrals depending on their diagnosed condition. For severe conditions, surgical interventions such as injections or cataract procedures were offered, along with medicines for recovery. Logistical support during treatment, such as food and transport, helped beneficiaries complete necessary care.

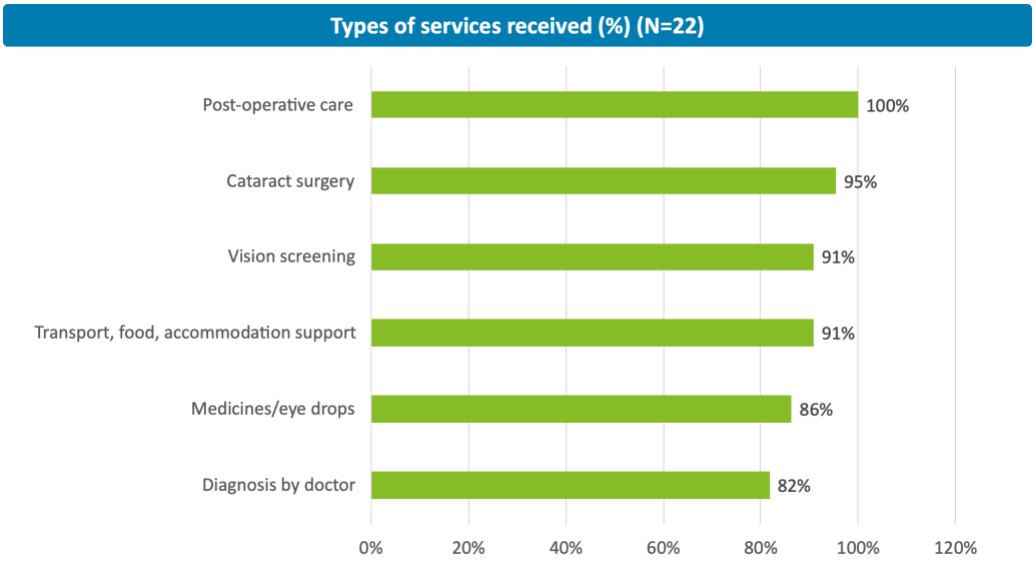


Figure 34: Types of Services Received - GOV

Respondents were asked to indicate the types of services received through the programme (N=22). The respondent distribution indicates that 100% reported receiving post-operative care, while 95% reported undergoing cataract surgery. In addition, 91% reported receiving vision screening and transport, food, and accommodation support during the treatment process. Further, 86% reported receiving medicines or eye drops, 82% indicated that they received diagnosis by a doctor. The responses indicate that beneficiaries reported receiving a range of services covering screening, treatment, and post-operative support through the programme.

Follow up Care and Continuity of Treatment

Beneficiaries were asked to indicate whether they had undergone cataract surgery through the programme, to which 21 respondents reported having undergone the procedure. The respondent distribution indicates that 95% reported undergoing cataract surgery, while 5% indicated that they did not undergo the procedure under the programme. Respondents who received post-operative care after surgery were further asked to rate their experience with the services provided. The respondent distribution indicates that 52% rated the post-operative care as excellent, while 48% rated it as good, reflecting positive feedback on the post-operative support services reported by beneficiaries.

Table 18: Post-operative care Ratings - GOV

Ratings regarding post operative care	Responses (%) (n=21)
5 (Excellent)	52%
4 (Good)	48%

Post treatment care included clear recovery instructions and scheduled follow up visits. Surgical beneficiaries attended these appointments and received additional medicines during recovery. Some followup care was accessed through government hospitals, occasionally requiring minor transport expenditure.

Satisfaction with Services

Beneficiaries expressed high satisfaction with the services, citing improvements in vision, restored ability to perform daily activities, and the absence of treatment costs. Satisfaction also stemmed from the support and guidance received throughout the treatment process. Overall satisfaction with the programme was reported to be high among the surveyed respondents. The respondent distribution indicates that 68% provided a rating of 5, while 32% provided a rating of 4 for their level of satisfaction with the programme.

Table 19: Programme Satisfaction - GOV

Level of Satisfaction with the program	Responses (%) (N=22)
5	68%
4	32%

Efficiency

Accessibility of Services

Service access was described as straightforward. Screening camps held within or near villages reduced travel burdens and supported participation, especially among older adults. Beneficiaries progressed through service pathways: ~~spectacles~~, referrals, treatment, and follow up according to clear instructions. Logistical support such as transport and food increased convenience during treatment stages.

A single communication gap was noted where no formal announcement was made in a village, although community members still learned of the camp informally.

Operational Challenges Faced by Beneficiaries

As part of the survey, respondents were asked to indicate whether any challenges were faced while accessing the services provided through the programme. The respondent distribution shows that 91% reported that they did not face any challenges, while 9% indicated that certain difficulties were experienced.

Among the respondents who reported facing challenges, the issues mentioned included travel or transport constraints, documentation requirements, delays in service provision, communication or awareness gaps, and difficulty in scheduling follow-up appointments. Qualitative conversations corroborated this finding - beneficiaries described the service process as smooth, with no major operational difficulties during screening, treatment, or follow up. A minor challenge involved a bus fare incurred for a single followup visit. Otherwise, service pathways functioned without significant barriers.

Table 20: Challenges in accessing services - GOV

Challenges faced while accessing services	Responses (%) (N=22)
No	91%
Yes	9%

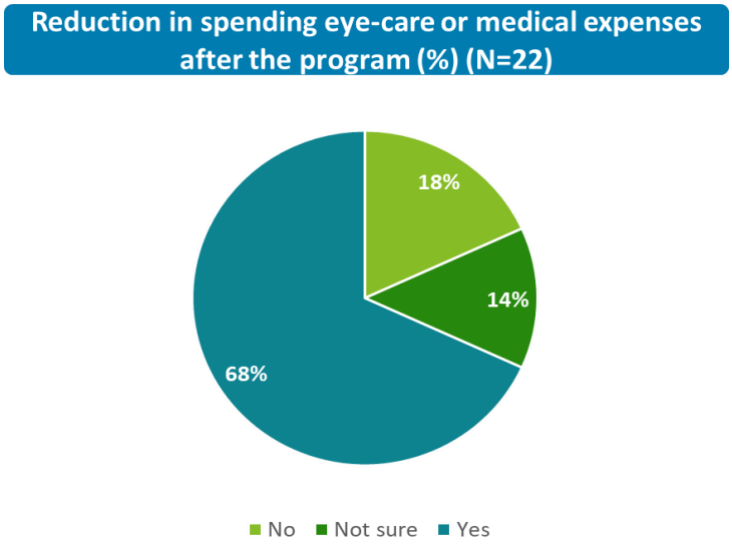


Figure 35: Post-programme reduction in eye-care expenses - GOV

Cost of Services

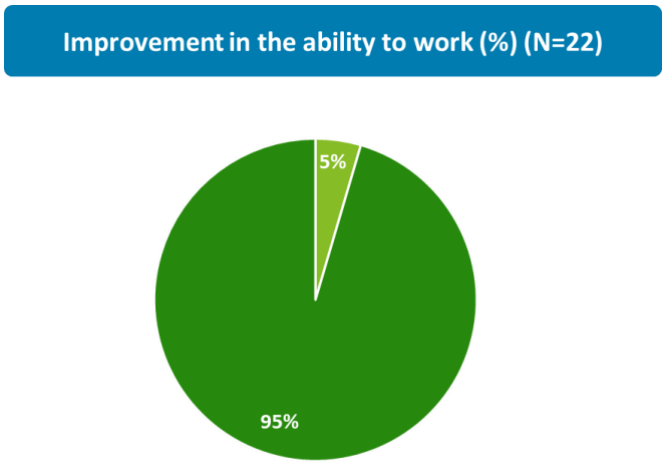
Programme services including screening, surgery, and medicines were largely free, reducing financial barriers. Food and transport support further minimised out-of-pocket- expenses.

Impact

Improvements in Vision and Health Outcomes

Beneficiaries reported notable improvements in vision following spectacles provision or surgery. Symptoms such as blurred vision, tearing, and discomfort reduced after receiving appropriate care, contributing to greater visual clarity and comfort.

Changes in Daily Activities and Functional Ability



Improved vision enabled beneficiaries to resume daily tasks such as reading, writing, and navigating outdoor environments with greater ease. Surgical patients also described relief from persistent symptoms, enhancing comfort and efficiency in routine life. A pattern was observed with respect to work-related functioning, where 95% of respondents reported that their ability to work had improved after receiving treatment, while 5% indicated that no improvement was experienced.

Figure 36: Work Improvements -GOV

Improvement in the ability to carry out daily activities after treatment was also reported by most respondents, with 95% indicating that they were able to perform daily tasks more easily following the intervention, while 5% reported no change

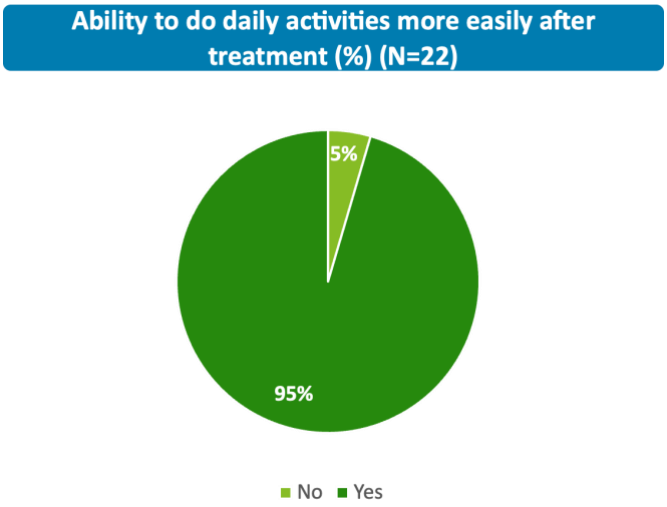


Figure 37: Daily Activities Improvement - GOV

Emotional and Psychological Effects

Improvements in vision contributed to feelings of relief, satisfaction, and renewed confidence. Beneficiaries expressed positive emotional responses, particularly after surgery, where restored sight had a significant personal impact.

Community Influence and Programme Diffusion

Beneficiaries often encouraged family and neighbours to attend screening camps, contributing to increased programme reach. Some community members sought treatment after learning about positive outcomes from beneficiaries, indicating a ripple effect within villages.

Sustainability

Continuation of periodic eye check-ups

Beneficiary narratives indicated that several individuals continued engaging with eye care services after surgery through follow-up visits and consultations. Participants described attending check-ups either through visits by medical teams to their villages or by accessing nearby Vision Centers when required. These follow-up interactions enabled beneficiaries to monitor their recovery and seek medical advice if they experienced discomfort or required medicines.

In certain cases, beneficiaries visited Vision Centers for prescriptions or consultation when minor issues arose. Access to these centres allowed individuals to obtain guidance and medicines without travelling long distances. Other participants explained that doctors conducted follow-up checks for patients who had undergone surgery, either collectively during visits or through scheduled reviews.

Adoption of healthy eye-care practices

Beneficiaries described following the medical advice provided after surgery, including guidance related to medicines, hygiene, and precautions during recovery. Participants recalled receiving instructions regarding the correct use of eye drops and tablets, along with recommendations to protect the eyes from dust and avoid certain activities during the recovery period.

Some beneficiaries explained that they followed instructions regarding diet, bathing restrictions, and protecting the operated eye from exposure to dust or water. These precautions were described as part of the recovery process and were generally adhered to by participants.

Such practices indicate that beneficiaries applied the guidance provided by doctors and health workers after surgery, which supported recovery and the maintenance of improved vision.

Community awareness on eye health

Beneficiaries also described sharing their experiences of treatment with neighbours and relatives after surgery. Participants indicated that they informed others in their communities about the availability of eye camps and the services provided through the programme. Some beneficiaries expressed the view that the programme should continue operating in the future so that others could benefit from the services provided. Participants also emphasised that informing others about the quality of care could encourage more people to seek treatment.

Community Perceptions, and Willingness to Recommend

The findings indicate that beneficiaries reported positive perceptions regarding the programme's community outreach. With 100% of respondents indicating willingness to recommend the initiative and reporting improved awareness about eye care in their locality, the responses reflect the potential role of the programme in disseminating information on eye health within the community.

Table 21: Programme Recommendation - GOV

Recommendation of the program to others	Responses (%) (N=22)
Yes	100%

Table 22: Improved Awareness about eye-care - GOV

Improved Awareness about eye-care	Responses (%) (N=22)
Yes	100%

4.4 Nanna Kanu

Respondent Profile

For the Nanna Kannu programme, only qualitative interviews were conducted with 8 respondents, comprising 5 parents, 2 teachers, and 1 school principal across Vijayapura district in Karnataka.

Relevance

Limited Household-level Awareness and Delayed Recognition

> *"Before the hospital camp, I did not know that my child had any eye problem."*
> – IDI, Parent, Rukmanga Primary School, Vijayapura

The identification of student eye health needs occurred primarily through school-based screening, which served as the first point of formal diagnosis for most households. Parents indicated that they became aware of their child's condition only after the screening camps, with information communicated by teachers or children.

In some cases, parents had noticed early symptoms such as difficulty seeing distant objects, squinting, headaches, or watering eyes. These observations did not lead to timely action due to misattribution to mobile phone use, competing work priorities, or uncertainty regarding available services. A smaller group of parents reported prior awareness of the condition, where the programme supported updated prescriptions rather than initial diagnosis.

Role of Teachers in Identification

Teachers played a central role in identifying vision problems through classroom observation. Difficulties such as inability to read the board, leaning forward, squinting, and complaints of headaches or dizziness prompted further attention. Teachers also indicated that some students did not communicate these issues at home, increasing reliance on school-based detection.

> *"Shankara Eye Hospital properly checked the children and around 20–30 children we found were suffering from eye diseases."*
> – IDI, Teacher, Rukmanga Primary School, Vijayapura

The use of chart-based screening and symptom recognition formalised this role, enabling identification of approximately 20 to 30 students per cycle with potential vision issues.

Institutional Facilitation through School Leadership

> *"What you said inside the camp that day… many of our children have followed it."*
> – IDI, Headmaster, Sri Rukmanga Kannada Higher Primary School, Vijayapura

Headmasters described programme entry as structured through formal communication channels involving cluster-level coordination. They facilitated mobilisation by informing students, communicating with parents, and preparing school infrastructure. Screening was conducted for all students present, ensuring coverage beyond those with visible symptoms. Some headmasters also referred to behavioural changes following programme guidance.

Student-reported Symptoms and Behavioural Indicators

Students described symptoms including difficulty seeing the board, inability to view/ distant objects, headaches, eye strain, and the need to hold books closer. These expressions often prompted action from teachers or parents. One student from Vijayapura stated, "*Because of the glasses, I am concentrating better in my studies."*

Coherence

Structured Coordination through School Systems

> *"No one has taken anything. All completely free. Freely delivered to the children."*
> – IDI, Headmaster, Rukmanga Primary School, Vijayapura

Programme implementation was integrated within existing school systems through structured coordination mechanisms. Headmasters described a flow of information from Cluster Resource Persons to schools, followed by dissemination to teachers, students, and parents. Preparatory activities included class-wise organisation and communication through established channels such as WhatsApp groups.

Screening was conducted for all students present, indicating alignment with school schedules and administrative processes. Operational aspects such as timely arrival, systematic screening, and spectacle distribution were described as aligned with school routines.

Role of Teachers in Coordination and Continuity

Teachers functioned as the primary coordinators between programme implementation, school administration, and families. Their responsibilities included conducting initial screening, managing student flow during camps, communicating with parents, and reinforcing programme guidance. They also acted as the first point of contact for issues related to spectacle use and recurrence of symptoms.

Follow-up arrangements were communicated to beneficiaries; however, feedback indicated that these channels were not always clearly signalled or easily actionable. While screening and service delivery were described as smooth, post-treatment concerns were often addressed independently by families rather than through programme pathways. Teachers similarly noted the absence of clearly defined escalation routes with the medical team, limiting support for referrals, replacements, and symptom management. Strengthening the visibility and usability of follow-up mechanisms would support more consistent continuity of care.

Teachers highlighted their extended role in supporting students, particularly in contexts where parents were engaged in labour-intensive work. This responsibility was described as going beyond academic functions to include caregiving and follow-up. Some respondents emphasised the need to strengthen communication through additional support mechanisms. The suggestion to deploy volunteers across clusters was presented to reduce communication gaps.

> *"We had already instructed all the students of our school. I sent a message to my parents on WhatsApp asking them to get ready. Accordingly, they came and checked the eyes of the students."*– IDI, Headmaster, Sri Rukmanga Kannada Higher Primary School, Vijayapura

Parental Dependence on School-mediated Communication

Parents relied on schools for information regarding screening, diagnosis, and treatment, including notification of camps, communication of results, and receipt of spectacles.

> *"The programme did not provide any direct contact number for follow-up or emergencies."*
> – IDI, Parent, Government Upper Primary School catchment, Vijayapura

Beyond the school setting, coordination remained limited. Parents indicated the absence of direct contact with service providers, lack of clarity on follow-up procedures, and limited awareness of programme ownership.

A minority of parents independently sought follow-up care at hospitals without programme facilitation.

System-level Structures and Gaps in Follow-up

The programme utilised an existing cluster structure, with each Cluster Resource Person overseeing multiple schools, which facilitated communication with school leadership and enabled wide coverage. Teachers suggested that this structure could be strengthened through designated volunteers to improve communication and follow-up processes.

While implementation aligned with school systems through defined roles and structured communication, coordination beyond the school environment remained limited due to the absence of follow-up mechanisms and direct communication channels.

Effectiveness

Delivery and Quality of Eye Care Services

Parents described a sequential process involving school-based screening, communication of diagnosis, and provision of spectacles within a short timeframe. Spectacles were typically delivered within 4 to 15 days.

Teachers indicated satisfaction with training and service delivery. They highlighted thorough testing by medical teams and support for surgical cases. A minority of teachers requested more advanced diagnostic training, indicating perceived limitations in current training methods.

Post-Treatment Care and Compliance

Parents indicated that children generally adhered to spectacle use, supported by improved visibility. However, guidance on post-treatment care was limited to basic instructions such as wearing spectacles and reducing screen time. One parent noted, “No additional medications or eye drops were provided.”

Teachers reinforced compliance through reminders and school routines. However, the absence of follow-up mechanisms limited sustained adherence. Teachers also indicated that parental work constraints affected monitoring at home. A minority of teachers reported introducing informal eye exercises, which were not part of programme design.

Implementation Challenges

Parents described the screening and distribution process as smooth, with challenges emerging primarily after treatment. These included lack of follow-up information and absence of contact channels. In case of eye-related issues post-treatment, students typically informed their parents, who then sought care independently from nearby hospitals rather than reaching out to the Sankara team (even when contact details had been shared). Teachers highlighted the absence of clear and functional communication pathways with the medical team. This limited support for referrals, replacements, and symptom management.

This revealed a critical need to establish more accessible and trusted follow-up mechanisms; such mechanisms could either be a common helpline or a designated local point of contact (e.g., a teacher), who could liaise with the medical team and facilitate timely support. As suggested by a teacher from Rukmanga Primary School, Vijaypura - establishing local centres or partnerships with nearby hospitals could further strengthen continuity of care.

Efficiency

Accessibility and Ease of Service Delivery for Parents

Parents described the programme as accessible primarily due to its school-based delivery. Screening and spectacle distribution took place within the school premises, removing the need for hospital visits. This arrangement reduced both financial and logistical constraints, particularly for daily-wage households. Parents indicated that, in the absence of the school camp, they would not have sought eye care for their children due to limited awareness, time constraints, and perceived costs.

Treatment at home involved only the use of spectacles, which parents managed without difficulty. The absence of medicines or complex care routines simplified adherence. However, parents indicated that guidance on post-treatment care was limited. As a result, regulation of screen time varied across households, dietary or preventive advice was not available, and some parents were uncertain about when to seek follow-up care.

A minority of parents independently approached private hospitals for replacement spectacles in cases of loss or damage. This was not facilitated through the programme.

Accessibility and Ease of Coordination for Teachers

Teachers described the screening and distribution processes as organised and aligned with school routines. Class-wise arrangements enabled smooth movement of students, and communication with parents was managed effectively. Teachers undertook responsibilities including identification of students, coordination with programme staff, and support during spectacle fitting and follow-up reminders.

The school-based model reduced the need for families to access external services. Teachers emphasised that many parents belonged to daily-wage households, could not afford private care, and were unable to travel to distant hospitals. By delivering services within schools, these barriers were addressed, enabling access to care.

Despite smooth initial coordination, teachers highlighted the absence of direct communication channels with hospital teams. They indicated that no contact numbers or helplines were available for follow-up queries. This limited their ability to address issues such as spectacle replacement, symptoms including itching or redness, changes in vision, and referral for further treatment.

Reduced Burden on Schools and Families

Across stakeholder accounts, school-based delivery reduced the need for hospital visits and associated costs. Parents avoided travel expenses, loss of wages, consultation fees, and medication costs. This was particularly relevant for low-income households.

Headmasters described administrative processes as aligned with school functioning. Programme staff adhered to scheduled visits, screening covered all students present, and spectacles were distributed within expected timelines. These processes did not create additional administrative burden for schools.

Impact

Improvements in Student Functioning and Learning

Parents described improvements in children's ability to read books and the blackboard, increased comfort in academic activities, and reduced physical discomfort such as headaches, eye strain, and watering. Children were able to sit at the back of the classroom and complete homework with less difficulty, indicating improved visual clarity and independence in studies.

> *"Now, she wears glasses to read and write, and she's so good at it."*
> – IDI, Parent, Government Upper Primary School, Vijayapura

Parents also referred to improvements in daily functioning. Children experienced reduced strain while reading or using mobile devices, no longer squinted, and were able to identify objects more clearly. Teachers described improvements in classroom visibility and participation. Students showed fewer distractions linked to blurred vision, and demonstrated greater confidence and engagement in class. Improvements in reading and writing accuracy and speed were also noted.

Household and Educational Benefits

Parents highlighted financial relief due to free eye care services. Costs associated with private treatment, including consultation fees, spectacles, and travel, were avoided.

> *"The service is especially valuable for poor families… otherwise treatment would cost ₹20,000–₹50,000."*
> – IDI, Parent, Vijayapura

Improvements in educational outcomes were also described. Parents referred to better academic performance, increased ease in completing homework, reduced dependence on parental support, and avoidance of academic decline. Emotional and behavioural changes included increased confidence, reduced frustration associated with visual strain, and a sense of relief within families following improvement. Teachers indicated that early detection addressed previously unrecognised vision issues, thereby preventing potential learning loss. They also noted increased engagement among parents following diagnosis and some adherence to behavioural recommendations such as reduced screen time.

In some schools, teachers themselves received spectacles, contributing to improvements in their own functioning.

Community Awareness and Behaviour Change

Parents indicated increased awareness of eye health within households. They became more attentive to children's screen time, complaints of headaches, blurred vision, and the need for periodic eye testing. The programme influenced how parents monitored children's visual health.

However, changes at the wider community level were limited. Parents noted that neighbours showed interest and appreciated the provision of free spectacles but did not necessarily seek eye care services themselves.

Teachers described increased knowledge of eye health, including identification of symptoms, use of screening charts, and recognition of refractive errors. They extended this knowledge through school platforms such as assemblies, parent-teacher meetings, and classroom interactions.

Some teachers suggested the need for additional awareness tools, including digital content and broader communication strategies, to strengthen behavioural change beyond the school.

Sustainability

Parental Suggestions for Programme Strengthening

Parents emphasised the need for regular and repeated eye camps, suggesting annual or biannual screenings. This was considered necessary because children's vision changes over time, families are unable to afford regular check-ups independently, and similar vision issues are prevalent among children in the community. Parents indicated that without periodic screening, changes in vision would remain undetected.

One parent stated, "Regular follow-up is essential, ideally at least once a year." Parents also highlighted the absence of follow-up mechanisms and requested direct contact points. They expressed the need for phone

numbers, clarity on where to seek re-checks, defined follow-up schedules, and support in case of emergencies. The lack of contact information created uncertainty regarding continuity of care.

There was also a demand for greater information on eye-care practices. Parents indicated that while treatment was provided, guidance on diet, prevention, management of eye strain, and frequency of spectacle rechecks was limited.

Some parents expressed comfort with the existing system and indicated that they trusted programme staff to make decisions regarding future improvements.

Teacher Suggestions for Strengthening and Sustaining the Programme

Teachers emphasised the importance of establishing local access points for eye care. They suggested setting up district-level branches or developing partnerships with nearby hospitals to provide accessible and affordable follow-up services. This was considered critical given the challenges families face in travelling long distances for care. They also strongly highlighted the need for a dedicated communication system. They recommended the introduction of a helpline, referral mechanisms, and clearly defined escalation pathways to manage follow-up needs, complications, and changes in vision. Since the referral hospitals were located far away, establishment of hospitals close-by would improve accessibility.

There was a clear recommendation for increasing the frequency of eye camps. Teachers suggested annual and biannual camps, with some proposing more frequent intervals to ensure early detection, given that children may not report vision problems and that vision can change rapidly. Additionally, teachers proposed expanding awareness and behaviour change efforts. Suggested approaches included the use of

digital content, demonstrations, and large-scale communication strategies to reinforce preventive practices within families and communities.

Teachers also recommended strengthening their own capacity through advanced training. This included exposure to machine-based testing, improved identification of complex conditions, and periodic refresher sessions to sustain skills beyond programme visits. Some teachers suggested introducing a volunteer system at the cluster level to improve communication and coordination.

Headmaster Suggestions for Sustaining Programme Impact

Headmasters emphasised the importance of conducting annual eye camps as a long-term measure, noting that new students enrol each year, children's vision changes over time, and access to private care may be limited for some families. Annual screenings were therefore considered necessary to ensure continued coverage.

They also highlighted the need for sustained continuation of the programme to maintain consistent service delivery across school communities. Some headmasters indicated that implementation had been smooth and did not present operational challenges, suggesting feasibility for continuation.

OBSERVATIONS AND RECOMMENDATIONS

5. OBSERVATIONS AND RECOMMENDATIONS

The following observations synthesise cross-cutting patterns that emerged across the four programmes. They highlight broader insights regarding access to eye-care, programme delivery, user experiences, and systemic factors influencing effectiveness and sustainability.

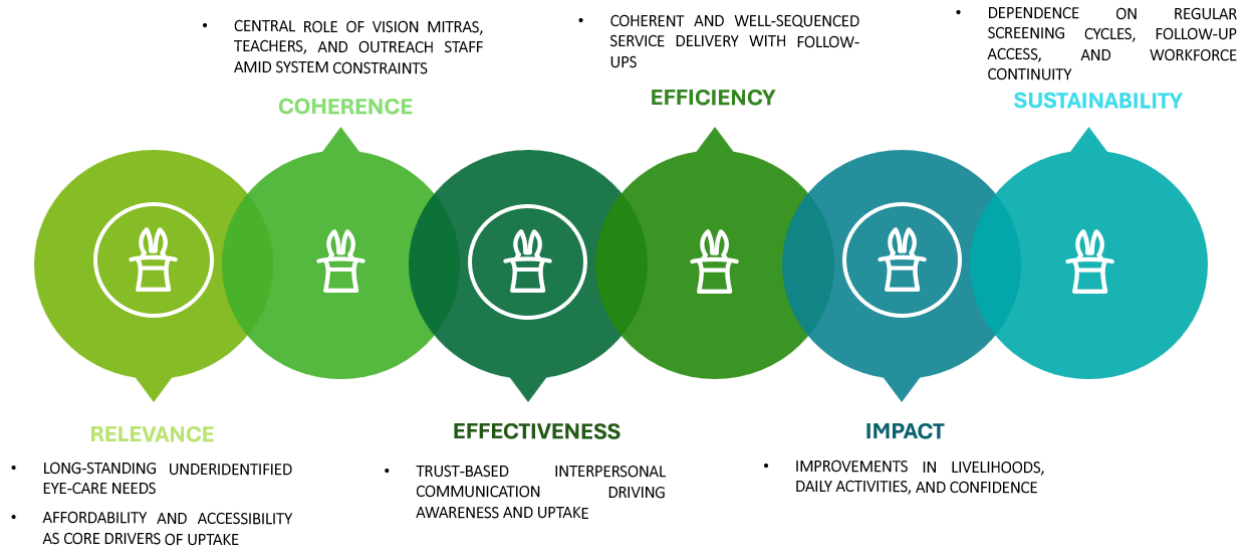


Figure 38: Observations - Happy Eyes Initiative

Observation 1: Relevance - Eyecare needs across all cohorts were longstanding, under identified, and often normalised until screening enabled formal detection.

Across community and school programmes, most beneficiaries entered the initiative with persistent visual impairments: blurred vision, difficulty reading, fogginess, watering, and headaches that had been unmanaged for extended periods. Adults often normalised cataract symptoms as a natural part of ageing, while parents of children frequently misattributed symptoms (e.g., squinting, headaches) to mobile phone use or considered them minor issues.

Teachers played a central role in surfacing children's undiagnosed conditions by observing behavioural cues such as leaning forward or inability to see the board. In community settings, Volunteers (community health workers) became the first point of identification due to limited awareness, absence of structured screening, and misconceptions about cataract. Quantitative findings underscore this: **86% (GOV)**, **88% (CBBF)**, and **90% (MRVP)** respondents reported pre-existing eyesight issues.

Recommendation

While the program consists of awareness, checklist poster and training of volunteers, the strengthening of periodic screening models across schools and communities would be helpful. This would enable a shift from reactive to preventive eye-care.

- Introduce annual or biannual screenings for adults and children to reduce delays in detection.

- Conduct awareness sessions clarifying that cataract and refractive errors are treatable and not an inevitable part of ageing.

Observation 2: Relevance - Programme relevance was strongly rooted in affordability and accessibility, addressing major financial and logistical barriers to eye-care.

Before programme implementation, treatment costs (₹2,000-3,000 for spectacles; ₹20,000-30,000 for surgeries) and travel challenges deterred timely care for both adults and children. Free screening, spectacles, surgery, transport, food, and medicines created a pathway to care that would otherwise have been inaccessible.

. School based delivery under Nanna Kanu nearly eliminated logistical burdens for families, especially daily wage workers who could not afford time off.
Quantitatively, 68-77% across programmes reported reduced medical expenditure post intervention.

Recommendation

Sustain zero cost and locally delivered service models to ensure continued reach among economically vulnerable groups.

- Maintain transport and food support for elderly beneficiaries.
- Strengthen school based care as a primary channel for children.
- Ensure spectacle replacement support for low income families to avoid recurrence of untreated impairment.

Observation 3: Coherence - Awareness and uptake were driven by interpersonal communication and trust based engagement rather than mass outreach.

Across programmes, beneficiaries learned about screening primarily through Volunteers (community health workers), teachers, neighbours, door to door contact, and familiar local channels (vehicle announcements, pamphlets). Trust in known individuals and hospital reputation shaped acceptance.

Fear of surgery was a consistent barrier, requiring repeated reassurance. Peer influence-seeing neighbours undergo surgery successfully was a powerful motivator.
Quant data supports this: **63% (CBBF)** and **41% (GOV)** heard about services from Volunteers (community health workers); **32% (GOV)** through community events, and 34% (MRVP) through banners, posters, or booths

Recommendation

Strengthen community embedded communication strategies that leverage local actors and visible success stories.

- Formalise neighbourhood evel peer ambassador groups (post surgery beneficiaries).
- Expand demonstration based outreach (vision charts, torch screening).
- Use teacher led assemblies and village WhatsApp groups to reinforce awareness.

Observation 4: Effectiveness - Service delivery was coherent, well sequenced, and largely aligned with beneficiary expectations, though followup communication systems remain limited.

Across all programmes, beneficiaries described a clear pathway from screening → diagnosis → spectacles or surgery → follow-up. Services matched what was communicated in the initial stages; logistical support was consistent. Beneficiary satisfaction was uniformly high (e.g., 77% rated CBBF services 5/5; 68% GOV rated 5/5).

However, gaps emerged in follow-up communication. Parents and teachers lacked contact numbers for referrals, spectacle replacements, or post-operative queries. Teachers especially noted an absence of escalation pathways, and outreach personnel faced data synchronisation issues that impacted workflow.

Recommendation

Establish structured follow-up and communication mechanisms across all programmes.

- Provide helplines/WhatsApp numbers for schools, parents, and community members.
- Strengthen referral pathways with district hospitals for complications.
- Enable outreach workers with ID cards, uniforms, and stable digital tools to enhance credibility and operational efficiency.

Observation 5: Impact - Programmes generated clear improvements in functional ability, academic performance (for children), livelihood capacity (for adults), and confidence.

Adults reported improved mobility, reduced fogginess, restored ability to work in fields, drive, or manage cattle. 69-95% across programmes noted improved work ability.

Children experienced enhanced classroom visibility, improved reading speed, reduced headaches, and increased concentration leading to better academic performance and independence in studies. Teachers observed increased confidence and reduced frustration.

Emotional benefits were strong; restored sight generated relief, pride, and greater willingness to seek care early.

Recommendation

Integrate functional ability tracking and followup counselling to consolidate behavioural change and longterm impact.

- Introduce simple follow-up cards for adults recording daily activity progress.
- In schools, track learning indicators (reading accuracy, homework completion) post-spectacle use.
- Provide families with guidance on behavioural practices (screen time, hygiene, dosage routines).

Observation 6: Efficiency - Volunteers (community health workers), teachers, and outreach staff form the backbone of delivery, yet face capacity constraints and require stronger system integration.

Volunteers (community health workers) handled screening, counselling, mobilisation, patient movement, and follow-ups-often managing workload variation and technical issues (data upload delays). Teachers bore informal caregiving roles-identifying symptoms, coordinating camps, supporting spectacle use despite lacking structured training or follow-up support.

Cluster-level staff ensured broad coverage but needed strengthened communication pathways.

Recommendation

Strengthen and formalise human-resource support structures for frontline delivery.

- Strengthen refresher trainings for Volunteers and teachers, including advanced diagnostic skills.
- Provide standard operating procedures for symptom escalation and spectacle replacement.
- Deploy cluster-level volunteers to reduce load on teachers and outreach workers.
- Review technology systems to address upload issues and integrate offline data-capture functionality.

Observation 7: Sustainability – Design intent is strong, but implementation consistency varies

Sustainability is an explicit component of the project design and is supported through teacher capacity-building, trained volunteers, and the establishment of Vision Centres under the CBBF project. These elements are intended to enable continued awareness generation, screening, referral, and access to follow-up eye care services.

However, evidence from field interactions indicates that implementation of these sustainability mechanisms is uneven across contexts. Follow-up behaviours varied considerably: 49% (CBBF) beneficiaries reported continuing periodic check-ups, compared to 91% (GOV) and 100% (MRVP). Parents expressed the need for clearer guidance on follow-up timelines, locations, and contact points, particularly after school-based camps concluded. Teachers and headmasters consistently emphasised the importance of annual or biannual screenings, noting that children's vision needs change over time and cannot be addressed through one-time interventions alone.

Additionally, outreach workers highlighted that short-term or uncertain employment arrangements affect continuity of community engagement, which is critical for sustaining awareness, follow-up, and trust at the local level.

Recommendation

Strengthen implementation of existing sustainability mechanisms

To reinforce sustainability already embedded in the project:

- Operationalise annual school screenings and biennial community screenings as standard practice, building on existing teacher and volunteer capacity.
- Improve visibility and utilisation of Vision Centres and partner facilities by clearly communicating follow-up pathways to families.

- Provide printed follow-up schedules and service contact details to parents at the time of screening or spectacle distribution.
- Support workforce continuity for outreach and volunteer staff, exploring longer-term or repeat engagement models to sustain community presence and trust.
- MRVP can be extended to cover MGNREGA (Mahatma Gandhi National Rural Employment Guarantee Act) and Bengaluru metro construction workers, enhancing access to eye care for a wider workforce.

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CONCLUSION AND WAY FORWARD

6. CONCLUSION AND WAY FORWARD

The four programmes, Cataract Blindness Backlog Free (CBBF), Mobile Rural Vision Screening Project (MRVP), Gift of Vision (GOV), and Nanna Kanu, together demonstrate a highly relevant and impactful model for improving eye health across diverse age groups and contexts. Each initiative successfully addressed long-standing vision problems that had often gone undiagnosed due to low awareness, normalisation of symptoms, and limited access to care. School-based screening under Nanna Kanu enabled early detection for children who would otherwise have remained unidentified, while community-based outreach under CBBF, MRVP, and GOV reached older adults who had struggled with cataract, refractive errors, and other visual difficulties for years. The strong alignment with user needs was reinforced by the elimination of major financial and logistical barriers through free screening, spectacles, surgeries, transport, medicines, food, and accommodation. Beneficiaries consistently highlighted that, without these programmes, they would not have sought or been able to afford treatment.

Across all four programmes, service delivery processes were perceived as organised, predictable, and well sequenced. Screening, diagnosis, treatment, and follow-up generally aligned with what had been communicated, which contributed to high trust and satisfaction. Beneficiaries described significant improvements in daily functioning, mobility, work participation, educational engagement, and confidence. For children, better classroom visibility reduced eye strain and improved academic participation, while adults regained independence and the ability to carry out livelihood activities. These improvements also generated positive emotional effects, including relief, reduced worry, and renewed motivation to participate in daily routines.

However, the programmes also revealed important gaps that impact long-term sustainability. Follow-up arrangements were often unclear to beneficiaries, and families lacked direct contact points for re-checks or concerns. Teachers and Volunteers (community health workers) played central roles in coordination and counselling but required stronger system support, including clearer escalation pathways and consistent communication channels. Community behaviour change, while strengthened, continued to rely heavily on interpersonal communication and would benefit from more structured and continuous awareness-building. Digital and operational challenges, such as data upload issues and the lack of visible identification for outreach staff, affected service efficiency in some areas. These gaps present opportunities to reinforce sustainability and continuity as the programmes evolve.

Looking ahead, the way forward involves consolidating strengths while systematically addressing the barriers. Regular screening cycles are essential to ensure that changing vision needs are identified early. Annual screenings in schools and periodic community screenings can transform the current model into a sustained preventive care system. Strengthening follow-up care will require establishing clear referral pathways, providing helplines or WhatsApp contact numbers, and ensuring that families know where to go for re-checks or spectacle replacements. Improved communication mechanisms will help address the current fragmentation between screening events and subsequent care. Human-resource capacity must also be enhanced. Volunteers (community health workers), teachers, headmasters, and outreach workers would benefit from refresher training, advanced diagnostic exposure, and operational support that includes visible

identification, standardised tools, and structured escalation systems. Deploying volunteers at the cluster or community level can further ease the coordination burden.

Sustained awareness-building is another critical priority. Continued engagement through school assemblies, parent meetings, demonstration tools, and community ambassadors will strengthen behaviour change and reinforce early health-seeking practices. Families also need clearer guidance on spectacle care, screen time regulation, symptom monitoring, hygiene, and when to seek medical attention. At the operational level, investment in reliable digital systems, offline data capture options, and timely availability of spectacles will reinforce service efficiency. Maintaining the free or low-cost nature of services will remain central to equity and access.

By advancing these measures, CBBF, MRVP, GOV, and Nanna Kanu can build on their strong foundation and evolve into a sustained, integrated eye-health system that continues to reduce avoidable vision impairment, supports educational and livelihood outcomes, and strengthens community well-being in the long term.

Annexures

6.1. Annexure I - Data Collection Tools for the Happy Eyes Programme

6.1.1. In-Depth Interview – Parents- Happy Eyes

Interviewer Prompt:

Hello! My name is _____.
I am representing Deloitte, which has been engaged by Titan to carry out a research study to understand the impact of Titan's CSR initiatives, including the *Happy Eyes* Programme.

This discussion is part of a larger study that looks at how Titan's projects have helped communities: particularly in areas like health, education, and well-being. Through this conversation, we hope to understand your experiences as a caregiver of someone who has benefited from the eye-care services provided under this programme.

Your responses will help us learn how the programme has supported families, what challenges people may have faced, and how it can be made even more effective in the future.

I want to assure you that:

- The information you share will be kept strictly confidential and used only for research purposes.
- Your participation is completely voluntary. You may choose not to answer any question or to stop the interview at any time.
- This discussion will take about 30 to 40 minutes. We also seek your permission to record this conversation.

There are no right or wrong answers, we are interested in your honest views and experiences.

Before we begin, do you have any questions or concerns about this discussion? I'll be happy to clarify anything that is unclear.

SECTION 1: General Information

Question	Response Type
1. Name of the respondent	Open text
2. Name of the beneficiary	Open text
3. Gender of the beneficiary	
4. Age of the beneficiary	____ years
5. Relationship with the beneficiary	
6. Location (village/taluk/district)	_____
7. Association with project	Nanna Kannu

SECTION 2: Role, need and context

1. How did you first learn about the eye care program or screening camp?
2. What type of support and/or treatment was received through the Happy Eyes Program?

Probe: Were the services provided (screening, spectacles, surgery, counselling) suited to the specific needs of the person?

SECTION 3: Quality of the services received

3. Please describe the overall process from screening to diagnosis to treatment/ surgery.
4. How easy or difficult was it for you to follow treatment and care instructions at home, such as using eye drops, managing spectacles, or post-surgery care?
5. Was any support or follow-up guidance provided to help you manage patient care after the treatment?
6. What challenges did you face, if any, during or after the intervention?
7. How satisfied were you with the services received?

SECTION 4: Changes in Functioning, Confidence, and Household Well-being

9. What specific benefits do you feel your family received from the programme?

Probes: Better school performance, Saving on medical expenses due to free services, Reduced travel or hospital visits, Emotional relief or improved confidence of the patient.

10. Since receiving treatment, have you noticed any changes in your child's ability to perform daily activities such as reading, mobility or self-care?
11. How has this programme changed your family's awareness or behaviour regarding eye health?
12. Has the improvement in their vision brought any changes in your own responsibilities as a parent?
13. Have others in your community been encouraged to get their vision checked or attend camps after seeing your experience?
14. Do you have any suggestions for making the programme better?

6.1.2. In Depth Interview – Beneficiary- Happy Eyes

Interviewer Prompt:

Hello! My name is _____.
I am representing Deloitte, which has been engaged by Titan to carry out a research study to understand the impact of Titan's CSR initiatives, including the *Happy Eyes* Programme.

This discussion is part of a larger study that looks at how Titan's projects have helped communities: particularly in areas like health, education, and well-being. Through this conversation, we hope to understand your experiences as a beneficiary of the eye-care services provided under this programme.

Your responses will help us learn how the programme has supported families, what challenges people may have faced, and how it can be made even more effective in the future.

I want to assure you that:

- The information you share will be kept strictly confidential and used only for research purposes.
- Your participation is completely voluntary. You may choose not to answer any question or to stop the interview at any time.
- This discussion will take about 30 to 40 minutes. We also seek your permission to record this conversation.

There are no right or wrong answers, we are interested in your honest views and experiences.

Before we begin, do you have any questions or concerns about this discussion? I'll be happy to clarify anything that is unclear.

SECTION 1: General Information

Question	Response Type
1. Name (optional)	Open text
2. Gender	
3. Age	____ years
4. Location (village/taluk/district)	_____
5. Association with project	Gift of Vision/ Mobile Rural Vision-Screening Program/ Cataract & Visual Impairment Free Talukas
6. Who accompanied you during treatment?	• Family member • Volunteer • Health worker

SECTION 2: Need and context

1. How did you first come to know about the eye screening camp or mobile eye clinic in your area?
2. What kind of problems were you facing with your eyes before you joined the programme?
3. What kind of services/treatment did you receive from this programme?
4. Were eye care services like screening, cataract surgeries, or free spectacles were previously available or affordable in your area?

SECTION 3: Quality of the services received

5. Did you receive all the services you expected (e.g., screening, diagnosis, treatment, follow-up)?

Probes: Surgery, Spectacles, Eye screening kits, eye drops or other medication, etc.

6. Did you receive any surgical support through the program? Did you receive adequate post-operative care and follow up support (E.g. Hospital Admission, follow-up appointments with paramedics/camp/vision centre, medication, etc.)?
7. What challenges did you face while accessing or using the services provided through the programme?

(Probe: Documentation, travel, follow up, communication gaps, delays etc.)

8. Were you required to pay anything for surgery/treatment/spectacles?
9. Have you continued periodic eye screenings after your treatment? Are you following the medical advice given after your eye treatment?
10. Did the team provide any counselling or awareness on maintaining healthy eyesight?
11. Did the program help in the early detection of any eye condition you had?
12. How satisfied were you with the services received?

SECTION 4: Changes in Functioning and Overall Well-being

13. What changes, if any, have you noticed in your life after receiving the treatment?

(Probe: changes in ability to perform daily activities, work routine, interaction with others)

14. Have you recommended the program to your family or neighbours?
15. Do you think this program has improved the overall health awareness in your village/area?
16. Have you noticed any change in your or your family's spending on eye care or treatment since participating in this program? Please describe.

17. Do you have any suggestions for making the programme better?

6.1.3.In Depth Interview – School Administration/Teacher- Happy Eyes

Interviewer Prompt:

Hello! My name is _____.
I am representing Deloitte, which has been engaged by Titan to carry out a research study to understand the impact of Titan's CSR initiatives, including the *Happy Eyes* Programme.

This discussion is part of a larger study that looks at how Titan's projects have helped communities: particularly in areas like health, education, and well-being. Through this conversation, we hope to understand your experiences as a facilitator of the eye-care services provided under this programme.

Your responses will help us learn how the programme has supported families, what challenges people may have faced, and how it can be made even more effective in the future.

I want to assure you that:

- The information you share will be kept strictly confidential and used only for research purposes.
- Your participation is completely voluntary. You may choose not to answer any question or to stop the interview at any time.
- This discussion will take about 30 to 40 minutes. We also seek your permission to record this conversation.

There are no right or wrong answers, we are interested in your honest views and experiences.

Before we begin, do you have any questions or concerns about this discussion? I'll be happy to clarify anything that is unclear.

SECTION 1: General Information

Question	Response Type
1. Name (optional)	Open text
2. Gender	
3. Age	_____ years
4. Designation	_____
5. Location (village/taluk/district)	_____

SECTION 2: Need and context

1. How did your school first become part of the Happy Eyes-
   Nanna Kannu Project? (Probes: education department, health officials, or the project team)
2. Did the program help identify specific issues with students' vision? What kind of support was provided?
3. What other health programmes/health check-ups does your school offer?

4. Prior to this programme, did you have any tie-up with any other foundation or hospital for conducting camps? If yes, how does your experience compare between the current programme and the previous one? If no, how were eye issues identified and diagnosed?

SECTION 3: Quality of the services received

5. Were you satisfied with the training and guidance provided for screening?
6. Did the students and parents understand and follow the instructions given after screening (for spectacles use, follow-ups, or surgery)?
7. Did you face any challenges during the entire process (screening to treatment- e.g., availability of spectacles, documentation, delays in approval, referrals, issues with coordination with hospital team)?
8. Are you satisfied with the support provided by the programme to the beneficiaries (screening, spectacles, surgery referrals, etc.)?

SECTION 4: Changes in Functioning and Overall Well-being

9. What noticeable changes have you seen among students who received treatment or spectacles?
10. Did being part of the Nanna Kannu programme help you improve your knowledge or understanding eye health?
11. Have you noticed any broader benefits as a result of Nanna Kannu programme?

(Probes: Awareness among teachers, parents, and other students, early detection of eye issues, learning outcomes of students)

12. How did your school and teachers coordinate with parents for children's follow-up treatment, and were there any discussions or concerns related to payment or medical expenses?
13. Do you have any suggestions for making the programme better?

6.1.4. Beneficiary Survey tool- Happy Eyes

Namaste! We are reaching out to beneficiaries to carry out a research study to understand the impact of Titan's CSR initiatives, including the Happy Eyes Programme. We would like to understand your experiences and feedback on services received.

Your participation is completely voluntary. There are no right or wrong answers. We are interested only in your honest views and personal experiences. The information you share will be kept confidential and will be used only for study and learning purposes.

This questionnaire will take about 15 to 20 minutes to complete.

Before starting, please read the statement below and select your response.

Consent:
"I have understood why this assessment is being conducted. I know that my participation is voluntary, that my responses will be kept confidential. I agree to take part in this questionnaire."

☐ Yes, I agree to participate
☐ No, I do not agree to participate

Question	Response Type
1. Name (optional)	Open text
2. Gender	
3. Age	____ years
4. Location (village/taluk/district)	_____
5. Association with project (please tick from the options given)	□ Gift of Vision □ Mobile Rural Vision-Screening Program/ □ Cataract Visual Impairment Free Talukas
6. Who accompanied you during treatment?	• Family member • Volunteer • Health worker

1. How did you first hear about the screening camp / mobile clinic?
    - Vision Mitras (referred as Volunteers in the report)
    - Community awareness event
    - Banner/poster/booth
    - Friend/family
    - Other source (please mention)
2. Before receiving services, were you experiencing difficulty with your eyesight?
    - Yes
    - No
3. *(If yes)* What type of difficulty did you face? (Multiple select)
    - Reading issues
    - Night-time vision difficulty
    - Daily activity difficulty
    - Work-related difficulty
    - Pain/irritation/redness
    - Other (please mention)
4. Before this programme, were eye-care services easily available/affordable in your area?
    - Yes
    - No
    - Not sure

5. Which services did you receive through this programme? (Multiple select)
    - Vision screening
    - Diagnosis by doctor
    - Cataract surgery
    - Free spectacles
    - Medicines/eye drops
    - Post-operative care
    - Transport, food, accommodation support
    - Other (please mention)
6. Did you receive all services you expected?
    - Yes
    - No
    - Not sure
7. Did you undergo cataract surgery under this programme?
    - Yes
    - No
8. If yes, Rate your post-operative care (after surgery) experience on a scale of 1 to 5:
   1 = Very poor | 2 = Poor | 3 = Fair | 4 = Good | 5 = Excellent
   Please mention your input_____
9. Did you receive counselling or advice on eye care and follow-up?
    - Yes
    - No
10. Were you required to pay anything for surgery, spectacles, medicine or services?
    - Yes
    - No
11. If yes, how much did you pay? Please mention INR_____
12. Did you face any challenges in accessing services?
    - Yes
    - No
13. If yes, what challenges did you face? (Multiple select)
    - Travel/transport
    - Documentation
    - Delays
    - Communication/awareness
    - Follow-up appointment difficulty
    - Other (please mention)
14. Do you continue periodic eye check-ups after treatment?
    - Yes
    - No
15. Please tell us whether the following statements are true for you after receiving treatment through the programme. (Please tick the options in the bracket)
    - This initiative helped in early detection of my eye ailment. (Yes/No)
    - I am able to carry out daily activities more easily after the treatment. (Yes/No/Not Sure)

- My ability to work has improved after the treatment. (Yes/No/Not Sure)
- My spending on eye-care or medical expenses has reduced after the programme. (Yes/No/Not Sure)

16. How satisfied were you with the overall services from the programme? Please rate on a scale of 1-5
    1 = Very dissatisfied | 2 = Dissatisfied | 3 = Neutral | 4 = Satisfied | 5 = Very satisfied
    Please mention your input_____
17. Would you recommend this programme to others in your family or village?
    - Yes
    - No
18. Did the programme improve awareness about eye care in your village/locality?
    - Yes
    - No
    - Not Sure

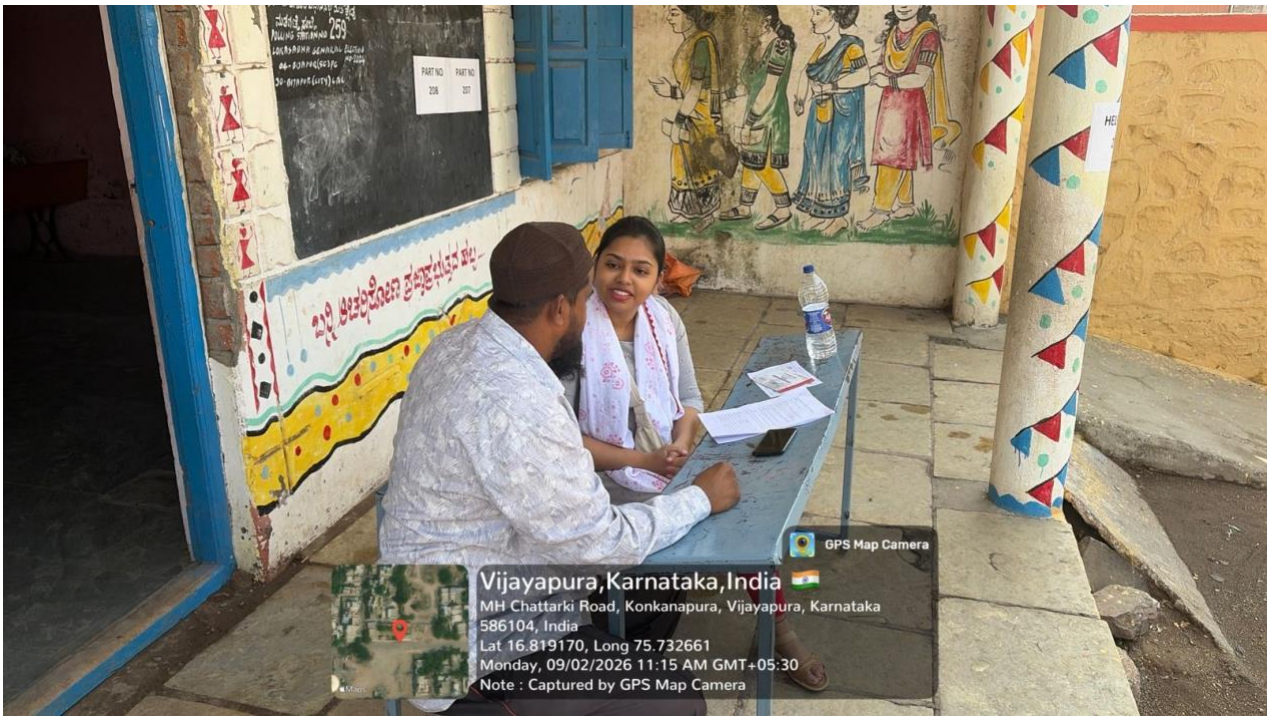
6.1.5.FGD Guide for Vision Mitras (Referred to as Volunteers in the report)

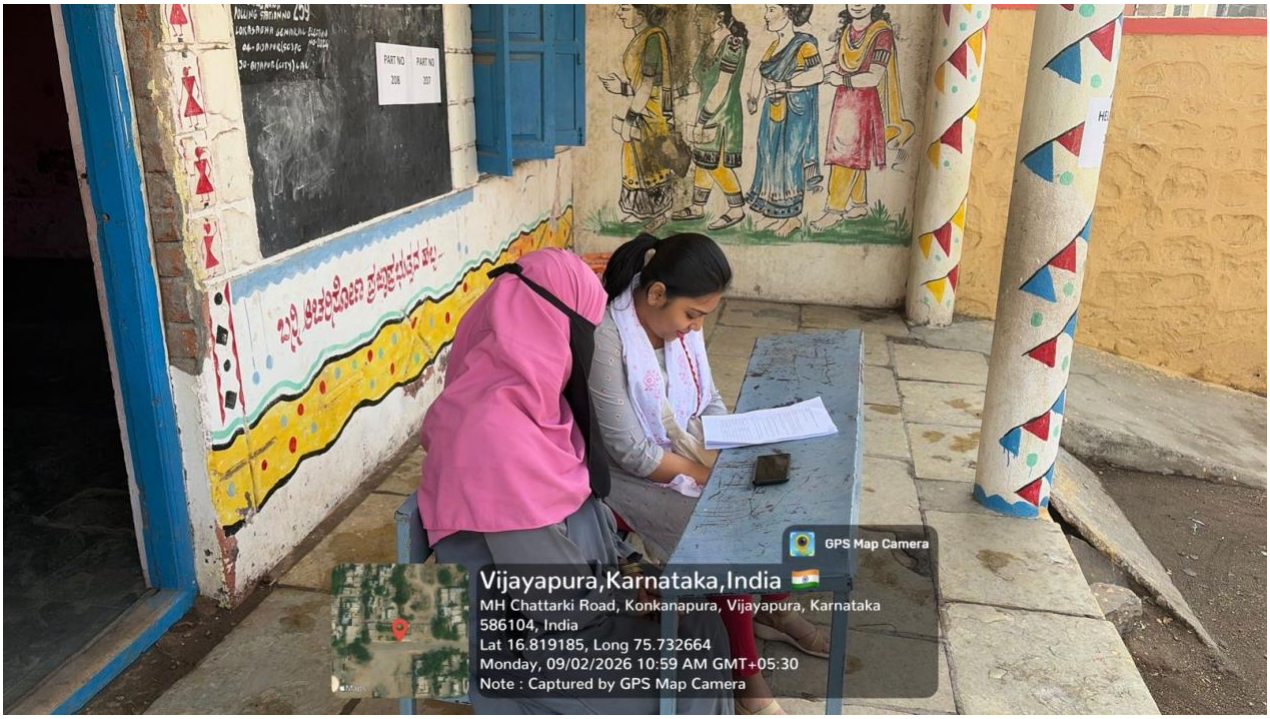
I am representing Deloitte, which has been engaged by Titan to conduct a research study to understand the impact of Titan's CSR initiatives, including the Happy Eyes Programme. This discussion is part of a larger study to understand how Titan's projects have supported communities, especially in areas such as health, education, and overall well-being. Through this discussion, we would like to understand your experiences and perspectives as Vision Mitras involved in delivering eye-care services under this programme. Your responses will be used only for research purposes, and there are no right or wrong answers. We will require around 40 mins of your time.

1. Before this project started, what usually happened to people in your villages who had cataract or poor vision?
   (severity of cataract cases, whether they sought treatment, delays, coping without care)
2. In what ways did the project help meet eye-care needs in your villages, and how well was the household screening accepted by families, especially elderly people and women?
   (coverage of needy groups, community acceptance)
3. How helpful was the training provided in preparing you to work as a Vision Mitra?
   (eye disease knowledge, near and distance vision testing, identifying cataract, counselling patients, SEVA values, POSH awareness)
4. How easy or difficult was it to conduct household screening with the screening kit received?
   (training adequacy, challenges with elderly or illiterate persons)
5. *(Note: screening kits consists of 3-meter vision charts, common eye disease cards, torch lights, referral cards, household stickers, pamphlets, and even umbrellas and water bottles)*
6. Can you describe your role as a Vision Mitra in this project and the main responsibilities you handle in your villages?
   (household screening, counselling, referral, camp support, follow-up)
7. As part of your role, what awareness activities did you carry out in the community, and how did people respond to them?
8. What kinds of support do you provide to beneficiaries beyond screening and referral?
   (counselling, escorting, explaining procedures)

9. How useful was the SERVIS application for recording screening and tracking beneficiaries?
   (ease of use, network or data issues)
10. What were the main reasons beneficiaries accepted or delayed attending camps or Vision Centres?
    (fear, livelihood loss, family influence)
11. How well did the outreach screening camps work in giving people all the services they needed in one place?
    (vision test, doctor consultation, counselling)
12. How helpful were free transportation, food, accommodation, and surgery in converting patients for surgery?
    (reduction of financial and access barriers)
13. How did you help beneficiaries get their spectacles and follow up after surgery, and did follow up support encourage more people to go to the hospital or take better care of their eye health?
    (spectacle distribution, reminders, follow-up visits, increased hospital visits, health awareness)
14. Did you receive any incentive? If yes, how did it influence your motivation and performance?
    (referrals, follow-up pressure)
15. How has people's behaviour toward eye care changed during the project period in your village/area?
    (early reporting, willingness for surgery)
16. What changes did you notice in awareness levels after rallies, street plays, and campaigns?
    (understanding cataract is treatable, myth reduction)
17. What are the main challenges you face while doing your work as a Vision Mitra in the field?
    (household screening, convincing patients for surgery, coordination with camps/vision centres/hospitals, using the SERVIS app, training or tool gaps, unreached groups)
18. What changes or additional support would make you more effective as a Vision Mitra?
    (resources, coordination, incentives, Vision Centres, community awareness)

6.2. Annexure II – Photographs





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