Final Evaluation Report

Advancing Healthy Communities – Affordable, Accessible and Quality Eye Health Services in Mozambique, Malawi and Zimbabwe

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End of Term Evaluation

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Acronyms and abbreviations

AHC	Advancing Health Communities
BHSI	Beira Health Sciences Institute
CPD	Continuing Professional Development
CS	cataract surgeon
CSR	cataract surgical rate
DEC	District Executive Committee
DIP	District Implementation Plan
DPS	Provincial Department of Health (Nampula, Mozambique)
EC	eye care
EU	European Union
EFD	Eye For Development
FGD	focus group discussion
GoZ	Government of Zimbabwe
HR	human resources
HRD	human resources development
HReH	human resources for eye health
HSA	Health Surveillance Assistant
IAPB	International Agency For Prevention of Blindness
IEC	information, education and communication
INGO	International NGO
IOL	intra-ocular lens
IT	information technology
KRA	key results area
LftW	Light for the World
MCFTC	Malawi Council for the Blind
MCHS	Malawi College for Health Sciences
MDG	Millennium Development Goal
MECC	Mozambique Eye Care Coalition
MHEN	Malawi Health Equity Network
MoH	Ministry of Health (Malawi and Mozambique)
MoHCC	Ministry of Health and Child Care (Zimbabwe)
NCD	non-communicable diseases
NCH	Nampula Central Hospital
NECC	National Eye Care Coordinator (aka National Eye Health Coordinator)
NGO	non-governmental organisation
NHSI	Nampula Health Sciences Institute
NPH	Nampula Provincial Hospital
COESCA	College of Ophthalmology for Eastern, Southern and Central Africa
OCO	ophthalmic clinical officer
OPN	ophthalmic nurse
OT	ophthalmic technician
PEC	primary eye care
PHC	primary health care
RAAB	Rapid Assessment of Avoidable Blindness
RPC	Regional Programme Coordinator
ROM	Results Oriented Monitoring
SADC	Southern African Development Community
SW	South West
ToR	terms of reference
ToT	Training of Trainers
UBH	United Bulawayo Hospitals
VA	visual acuity
VHW	village health workers
WHO	World Health Organisation

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1. Executive Summary

1.1 Description of programme

The *Advancing Healthy Communities (AHC) programme* aimed to develop a mid-level eye care workforce to increase access to eye health services and to reduce the cataract surgical backlog in Malawi, Mozambique and Zimbabwe.

1.2 Evaluation objective and purpose

The end of programme evaluation addressed the following:

- Establishing to what extent the programme has contributed to improved eye health and prevention of avoidable blindness through the development of mid-level eye health professionals, and improved quality and quantity of cataract and other eye care services
- Measuring to what extent the programme has fully delivered outputs and attained outcomes
- Measuring cross-country learning and initiatives that have contributed to the programme and have provided added value to the regional structure.

1.3 Methodology

The evaluation approach was structured in line with the widely acknowledged evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability. The further criteria of scalability and coherence were also added, as well as an emphasis on eliciting the lessons learnt throughout the programme. Data collection for the evaluation targeted programme staff and key stakeholders for in-depth interviews, as well as programme beneficiaries for a combination of interviews and focus groups.

1.4 Main findings

The AHC programme generally performed successfully after evaluations mid-way highlighted weaknesses in project design and implementation. A stronger focus on targets adapted for each country context, deliberate capacity building of lead partner institutions to manage towards targets, and flexibility in the use and management of resources resulted in most goals being met by the project's end.

Malawi, initially selected to coordinate the project in the other two countries, began work on the AHC programme with the most experience and existing infrastructure in eye health. Having run a mid-level cadre training programme in the past, Malawi generally performed strongly on the AHC project, particularly with regards to PEC integration into PHC, development of a robust curriculum, and regular support and supervision of deployed mid-level cadres by ophthalmologists.

Mozambique started with a high cataract surgical backlog – especially in Nampula Province – and very low human resource capacity. In addition, role definition and clarification of responsibilities regarding project management during the first two years of the programme slowed implementation. However, performance on mid-level cadre training and deployment,

monitoring of surgical outcomes and understanding of eye health within government recovered once a management structure between the two provinces of operation was established. PEC worker training and integration into PHC proved less successful than in other country locations. One of the main factors affecting this was the lack of monitoring and support to recently-trained ophthalmic technicians by MoH Provincial Eye Health Coordinators, making the outcome of PEC worker training difficult to assess. Development of tools to effectively follow up on newly trained ophthalmic technicians would therefore be important in the future. As in Malawi, challenges with consumables and equipment supply frequently came up in the evaluation. However, the change in number of deployed eye care personnel and increasing government appreciation of eye health were key achievements of the programme.

Lastly, Zimbabwe had a challenging start to the programme because of the country's governance and economic environment and poor initial management arrangements for the country project. While there was limited success in the development of substantial additional capacity for cataract surgery, the training of ophthalmic nurses (OPNs) progressed well under the direction of the Parirenyatwa School of Nursing, growing this cadre significantly over the five years. Activities in Zimbabwe had a stronger focus than in other countries on integrating PEC into PHC. Zimbabwe was able to build capacity and a health care workforce at the primary level during the second half of the programme. Advocacy activities resulted in the production of a policy brief and position paper on PEC into PHC integration.

1.5 Implications of findings

The Advancing Healthy Communities Programme in Mozambique, Malawi and Zimbabwe began with very mixed results and slow performance, but over the course of its final two years achieved the majority of its goals. The project targeted the mid-level of the health system as the key to increasing the accessibility of eye health to rural communities and reducing the incidence of blindness in the region. Strengthened human resource capacity at this level, also enhanced the integration of PEC into PHC where the programme mobilised the village health worker cadre to support the role of mid-level eye health staff. Generally this was accomplished successfully, as shown by increased numbers of eye health staff deployed at the mid-level, and improved use and functionality of referral systems. The programme also had a positive effect on the technical capacity of training institutions, as all plan to continue to offer this training in future.

The project had some difficulty in establishing accurate baseline figures for cataract surgical rates (CSR). This matter was extensively addressed during the retrospective baseline and it was recommended that performance would be tracked against baseline figures. Recommended baseline figures as supplied by the retrospective baseline review were not used: instead the AHC Regional Programme Coordinator (RPC) reported that the project had calculated CSR for base years in each country – being 2010 for Malawi and Mozambique and 2011 for Zimbabwe and the regional programme – and then calculated its target based on this figure[1]. Using this method of calculation, targets were shown to have been achieved across all levels of the programme.

[1] GreaterCapital's discussion with the AHC RPC (18 – 19 May 2015) on the topic of baseline figures was concluded with agreement that results reported on the project indicator tracking tool for 2010 be used for Malawi and Mozambique; and that results for 2011 be used for Zimbabwe. GreaterCapital has decided to use 2011 as the base year for regional results because no CSR results are indicated for Zimbabwe on the project indicator tracking tool for 2010, thereby resulting in an incorrect cumulative baseline total in 2010 if considering all three target countries. GreaterCapital has not received or analysed source data used to calculate CSR totals reflected on the AHC project indicator tracking tool.

The work of the advocacy component made a difference to understanding of eye health within the national and district/provincial government, however this has not yet translated into adequate allocation of resources to eye health. Therefore while the project was successful in demonstrating how a multi-country and multi-stakeholder approach to building health systems can work, there are still outstanding areas – as indicated earlier in this paragraph – to be addressed.

The continued success of the project will highly depend on each Ministry of Health's (MoH's) ability to secure the resources needed to follow through on key elements of the programme, and on the process through which Sightsavers hands the project over. It will be key that a clear strategy for continuing activities at national and regional level is devised in order for the project to maintain the benefits delivered.

Two repeated themes that fell outside the immediate scope of the AHC project's delivery but were consistently raised during the end of term evaluation by mid-level eye health professionals as critical, ongoing challenges were:

- Difficulties with procurement and maintenance of consumables and equipment for work at mid-level; and
- Mid-level cadres – while motivated by the impact of their work on beneficiaries – being unclear on their career paths.

These have been noted in this report as key areas for lessons learned that are likely to reoccur on future projects of a similar nature, and are detailed in Appendix F.

1.6 Recommendations[2]

Programme Conceptualisation and Planning

1. Conduct detailed in-country situational analyses as part of proposal development and collect quality baseline data in the first year of new programmes.
2. Consult expertise at regional and country offices on feasibility and existing needs, and to develop any specific programme elements, such as monitoring and evaluation, and programme management approach. Planning for each country should include all members of relevant teams from the start, including both programme and finance staff, and ensure that highly skilled project staff are recruited for implementation.
3. Develop tools, systems (including meeting cycles) within the first six months of project and ensure targets are tailored to country specific contexts and are realistic given circumstances at project start-up, including a resource guide that provides definitions of the 'common and shared language' embedded within the project and associated with specific activities and targets.

Overall Programme Management

4. For any multi-location programmes involving multiple partners, embed management approach and activities within project design to actively cultivate successful elements of and relationships supporting partnership approach. Regional Programme Coordinators should embody this approach.
5. The complementary programming approach taken by Sightsavers Nampula – which allows for support for other eye conditions when screening and treating for trachoma (new TT+ programme) – should be adopted wherever possible by other projects addressing trachoma.

[2] This summary presents recommendations at regional level. Country-specific recommendations are included in Sections 5.2-5.4 of this report.

Programme Learning

6. Learning arising through use of project tools (e.g. quality of life tool; situational analyses of readiness for integration of eye health into district health plans) should be shared internally and with key regional eye health forums (such as IAPB Africa).
7. Provide for IT-based Continuing Professional Development (CPD) for mid-level eye health professionals in each of the three countries through structured programmes housed at training institutes that facilitate online discussion groups, case discussions/case studies, advice/problem solving, and regularly updated links to resources and best practices involving available ophthalmologists/cataract surgeons and other mid-level eye health professionals.

Programme Evaluation

For future project reviews employing FGDs:

8. Ensure that evaluation team is advised well before the time on the indigenous language requirements of groups so that appropriate arrangements can be made for interpreting of indigenous languages.
9. Request the evaluation team to develop a checklist outlining criteria for composition of groups to ensure that clinic staff involving in recruiting groups can use the checklist in their selection of a representative sample in line with evaluation requirements. Obtain collective verbal consent at the start of FGDs rather than formal written consent.

Advocacy

Key opportunities that have emerged through this programme and can be implemented at a regional level:

10. Document and share evidence and approaches to key advocacy activities such as the development of policy and position papers, introduction of policy change and training curricula, lobbying for equipment and consumables at regional level; and understanding of community attitudes and traditional practices to cure blindness, and how to address these.
11. Support push for increased cataract surgery capacity through development of cadres that are recognised within the national health system and have a clear career path. Ensure that the cadres developed are aligned with possibilities within each country (e.g. Malawi to introduce training on OPNs for cataract surgery) and that this support is available and career paths mapped before training mid-level eye health professionals.
12. The Sightsavers Regional office should continue to engage with Southern African Development Community's (SADC's) Health and Pharmacy Division around the integration of eye health into primary health in order to ensure that the gains made thus far are not lost. Given efforts needed to achieve this commitment, it would be in Sightsavers' interest to develop a clear strategy on how this will be pursued.
13. At programme inception, develop sustainability strategy for advocacy group member organisations performing advocacy work on a voluntary basis.

1.7 Evaluation ratings

GreaterCapital has understood the evaluation ratings system provided by Sightsavers to refer both to end of term performance and achievements, as well as the project's performance across the entire five-year period of the project.

With regards actual ratings, it is acknowledged that performance across the project was overall very strong during the period mid-2012 to end-2014. If this period alone had been the focus of the review, ratings per country and at regional level would have been higher. However, poor performance at a number of levels across the programme during its first half cannot be discounted during a full term review such as this. As a result, we have adjusted our ratings to take stock of weaker performance during the first half of the project period, as well as strong recovery during the second half.

In addition, we have recorded some ratings as satisfactory but have noted in the narrative component of the report that there may still be some areas that require attention going forward in such cases. We thus request that the ratings are not simply interpreted in isolation from our narrative content detailing specific findings and recommendations.

Relevance

Regional	***Rating:* Highly satisfactory**	G
Malawi	***Rating:* Highly satisfactory**	G
Mozambique	***Rating:* Highly satisfactory**	G
Zimbabwe	***Rating:* Highly satisfactory**	G

Effectiveness

Regional	***Rating*: Satisfactory**	GA
Malawi	***Rating:* Satisfactory**	GA
Mozambique	***Rating:* Satisfactory**	GA
Zimbabwe	***Rating:* Satisfactory**	GA

Efficiency

Regional	***Rating*: Satisfactory**	GA
Malawi	***Rating:* Satisfactory**	GA
Mozambique	***Rating:* Satisfactory**	GA
Zimbabwe	***Rating:* Satisfactory**	GA

Impact

Regional	***Rating*: Satisfactory**	GA
Malawi	***Rating:* Highly satisfactory**	G
Mozambique	***Rating:* Highly satisfactory**	G
Zimbabwe	***Rating*: Satisfactory**	GA

Sustainability

Regional	***Rating*: Satisfactory**	
Malawi	***Rating*: Satisfactory**	
Mozambique	***Rating:* Highly satisfactory**	
Zimbabwe	***Rating*: Caution**	

Coherence/Coordination

Regional	***Rating:* Highly satisfactory**	
Malawi	***Rating:* Satisfactory**	
Mozambique	***Rating:* Satisfactory**	
Zimbabwe	***Rating:* Highly satisfactory**	

Replicability/Scalability

Regional	***Rating:* Satisfactory**	
Malawi	***Rating:* Satisfactory**	
Mozambique	***Rating:* Satisfactory**	
Zimbabwe	***Rating:* Satisfactory**	

2. Introduction and Background

2.1 Purpose of Evaluation

An end of programme evaluation for the Sightsavers programme *Advancing Healthy Communities (AHC) – Affordable, Accessible and Quality Eye Health Services in Mozambique, Malawi and Zimbabwe* was intended to measure to what extent the programme has fully delivered outputs and attained outcomes; and to measure cross-country learning and initiatives that have contributed to the programme and have added value to the regional structure.

The terms of reference for the consultancy is attached in Appendix A.

2.2 Description of Programme Being Evaluated

The Sightsavers programme *Advancing Healthy Communities (AHC) – Affordable, Accessible and Quality Eye Health Services in Mozambique, Malawi and Zimbabwe* was funded by the European Community. This five-year regional programme ran over 01.2010–12.2014, and aimed to improve the quality and quantity of eye care services for a total population of 8 million people. A key focus has been the development of a mid-level eye care workforce to increase access to eye health services and to reduce the cataract surgical backlog in Malawi, Mozambique and Zimbabwe.

2.3 Identification of Target Population and Relevant Audiences and Stakeholders

The evaluation sought to elicit an assessment of the AHC programme through the collection and analysis of data from direct project beneficiaries, being eye health service users and training beneficiaries. It also included interviews with project partners directly involved in the conceptualisation, management and implementation of the programme. Prior to field data collection in each of the three countries of focus and at regional level, GreaterCapital conducted a desk review of project documents, which then informed key targets for primary data collection which were agreed and finalised in consultation with Sightsavers.

This report has relevance for Sightsavers at country and regional level, as well as for project partners participating at all of these levels.

2.4 Overview and Description of Report Structure

This report describes the methodology and approach of the end of programme evaluation, including tools, data collection activities and limitations experienced. Results are presented in accordance with the four levels of operation of the programme, being regional, Malawi, Mozambique and Zimbabwe. Recommendations follow the same structure as for results.

3. Methodology

3.1 Evaluation Approach and Design

The evaluation approach was structured in line with the widely acknowledged evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability. The further criteria of scalability and coherence were also added, as well as an emphasis on eliciting the lessons learnt throughout the programme. These criteria were used to guide the development of the evaluation questions, as well as provide a framework for analysis. As a key focus, importance was placed on gathering data from all primary sources on the areas of impact, effectiveness and sustainability.

A list of all evaluation questions is provided in Appendix B.

3.2 Sample Development

The sample for data collection for the evaluation included programme staff and key stakeholders for in-depth interviews, as well as programme beneficiaries for a combination of interviews and focus groups.

Key stakeholders and programme staff selected for interviews were selected purposively in accordance with their involvement on the AHC programme. Training beneficiaries were selected for interviews, while service users were selected for focus groups. An outline of the number of interviews and focus groups held in each country is available in Appendix D.

Sampling strategy for training beneficiaries (mid-level eye health professionals)

The target sample of training beneficiaries was 25% of those who had undergone mid-level eye health training, as outlined on Table 1 below:

	OCOs/OPNs/OTs: Total number trained	**OCOs/OPNs/OTs: Target for interview during data collection (25%, rounded off)**	**Cataract surgeons: Total number trained**	**Cataract surgeons: Target for interview during data collection (25%, rounded off)**
Malawi	30	8	18	5
Mozambique	30	8	0	0
Zimbabwe	30	8	4	1
Overall total	**90**	**24**	**22**	**6**

Table 1: Targets for training beneficiary data collection

The following approach was used to identify ophthalmic staff at mid-level who had been beneficiaries of mid-level training activities:

- A weighting in favour of staff working in previously under-resourced, rural settings
- Where there had been two intakes of students, graduates from both intakes to illustrate differing levels of effectiveness and impact
- Proportional representation of male and female students.

Sampling of service users for focus group discussions (FGDs)
GreaterCapital developed specific criteria for FGDs, which were shared with country offices involved in the programme through the AHC Programme Coordinator prior to the field visit. District health offices linked to the programme were then informed by relevant AHC country staff of the evaluation and requested to identify FGD participants using the criteria, being:

- Gender: As far as possible, a 50/50 representation of males and females in order to capture the experience of both men and women accessing eye health services.
- Type of eye surgery done: Staff were instructed not to focus solely on cataract patients as the project's impact tackled all eye conditions. Approximately 50% cataract patients and 50% other eye health patients were to be selected.
- Two different geographical locations within each country: The intention was to demonstrate the differing conditions under which the project was implemented.
- Group size: Each FGD was to consist of between eight and fifteen people.

Rather than selecting districts for FGDs based on random sampling, country teams selected locations that were accessible during the data collection period. Results from these groups may have a positive bias as approximately half of the beneficiaries selected were those who were already attending the hospital for a follow-up procedure on the same day as the discussion, or those who were easily available to health institutions who assisted in organising the FGDs.

3.3 Timing of Data Collection

The timing of data collection was informed by the availability of project partners in each country. The collection of primary data took place over the month of March 2015.

3.4 Data Sources

Desk Review
A desk review was conducted at the outset of the evaluation, consisting of a review of relevant project documents. Reviewed documents included AHC programme reports, interim evaluations and financial reports; as well as position papers and policy briefs for each country and regional level policy briefs. The review of these documents provided a foundational understanding of the structure and overall progress of the programme to date, as well as relevant contextual information to situate the programme in the regional and national environments in which it has been operating.

Documents identified during the kick-off meeting were supplied to the evaluation team in a timely manner by the AHC Regional Programme Coordinator (RPC). A full list of documents reviewed is included in Section 5 of this report.

Primary Data
All data collection tools were reviewed by Sightsavers and revised in accordance with feedback received. The collection of primary data in field was undertaken via both semi-structured interviews with various stakeholders, as well as FGDs with beneficiaries. Semi-structured interviews were conducted with each stakeholder following a pre-determined interview schedule. For FGDs, a tool for a patient satisfaction survey (as proposed during the kick-off meeting) was not developed since the data collection method that emerged as most suitable was FGDs. A focus group guideline document was also used to guide the facilitation of these groups. Sightsavers' feedback on the FGD tool was that it should prioritise aspects

of beneficiary experience other than service delivery components so these were excluded from the finalised FGD tool that was used.

Data collection tools are attached in Appendix C.

Additional Sources of Data
Additional documents informing the review process were requested and provided by the AHC RC and other project partners during and following field visits. Additional secondary data sources were also reviewed to give depth to the analysis. These are also reflected in Section 5 of this report.

3.5 Data Analysis

All primary data collected via interviews with programme staff, stakeholders and training beneficiaries was analysed using a thematic qualitative analysis method. Data collected from FGDs was also analysed thematically, identifying the salient themes that emerged from the discussions.

3.6 Limitations of the Evaluation

Focus Group Discussions
While generally the FGDs went well, there were a number of limitations encountered across the three countries.

The consent form for FGD participants (agreed for use during finalisation of the inception report) presented a number of practical challenges when used (two groups in Mozambique and one in Zimbabwe). GreaterCapital did not have time to translate the form into indigenous language of the groups it met with, thereby resulting in beneficiaries having to sign a form written in English after it had been explained to them in their indigenous language. Efforts to obtain written consent for the first FGD proved time-consuming and confusing for participants who interpreted the form as an official record and were inhibited by the requirement that they provide their names on the consent forms, despite a repeated assurance of confidentiality regarding their participation in the group. In all, the consent forms took almost 30 minutes to complete, using valuable time that could otherwise have been spent on discussion in the FGD and somewhat eroding a trusting environment within the FGD. In discussions between the Zimbabwe Ministry of Health and Child Care (MoHCC) and the Sightsavers Regional AHC Coordinator, it was agreed that verbal consent be obtained at the start of future FGDs. This proved a good solution and allowed for progress without delay during the second FGD in Zimbabwe. This practice was then adopted for the FGDs held in Malawi as well.

Strict criteria were not applied to the selection of beneficiary locations because logistical limitations influenced which areas were selected for FGDs. Primary health care staff involved in recruiting eye health beneficiaries did not always apply requested criteria for selected beneficiaries as set out in the inception report. As such, FGDs did not always contain the requested mix of cataract and other eye conditions, or a 50/50 gender split. The evaluators proceeded with groups as long as they met the required minimum number (being eight) and did not contain any children (under the age of 18).

Data sources not covered by tools
In Zimbabwe and Malawi, the finalised schedules made provision for a number of interviews and meetings for which tools had not explicitly been developed:

Zimbabwe

- 2 groups of village health workers (community health workers) trained in PEC
- One primary health care nurse who had been trained in PEC
- One district based community nurse
- Two district medical officers.

Malawi

- Group presentation of Thyolo Radio Listening Club
- 1 group of paediatric case finders
- 1 group of theatre nurses
- 1 group of Health Surveillance Assistants, medical assistants and nurses

Open-ended interviews were held with such participants. The focus on interviews was on the key areas of effectiveness, impact and sustainability. Data collected from these sources was organised under the key themes of enquiry as supplementary to core data, and was used to inform broader statements about the functioning of the eye health system at district and community levels in Zimbabwe and Malawi.

Numbers of eye health professionals interviewed
Recent movement of some OPNs in Zimbabwe resulted in a number of those targeted for interview not being available at time of interview and in line with schedule. Alternative arrangements were made in all cases except for one, resulting in one less OPN being interviewed than planned. A compensatory factor here is the very high number of interviews that took place with varying other levels of the health system involved with eye health (6 additional interviews).

Scheduling
The fieldwork schedule was generally adhered to, although adjustments were made during inception meetings in each country. Some interviews were conducted in the evenings, and at times the evaluator and data collection assistant conducted interviews in parallel so as to reach target numbers within available time.

Access to advocacy partners
In Sofala, Mozambique, the lead partners explained that the most relevant advocacy representatives were based in Nampula Province and Maputo, and therefore there weren't any additional advocacy partners to interview in Beira. Since the lead partners in Sofala Province had done advocacy work during the project, these questions were included in their interview.

Language
While Malawi and Zimbabwe are English-speaking countries, Mozambicans conduct their business through the medium of Portuguese. GreaterCapital made arrangements for data collectors in both locations to carry out the additional task of interpretation services to ensure that data in Mozambique was captured as effectively as possible. The challenge around language in Mozambique was further exacerbated by the need to double translate the focus group discussions.

4. Results

4.1 Introduction

4.1.1 Regional level

Overall, the AHC programme generally performed successfully after evaluations midway highlighted weaknesses in project design and implementation. A stronger focus on targets adapted for each country context, deliberate capacity building of lead partner institutions to manage towards targets, and flexibility in the use and management of resources resulted in the majority of goals being met by the time of the project's completion.

The coordination of the regional programme was initially done through the Malawi office, an arrangement which changed during the third year of the programme's functioning. Of the three countries under the programme, Malawi started with the most experience and existing infrastructure in eye health. Having run a mid-level cadre training programme in the past, Malawi generally performed strongly on the AHC project particularly with regards to PEC integration into PHC, development of a robust curriculum, and regular support and supervision of deployed mid-level cadres by ophthalmologists. Inconsistent supply and maintenance of drugs and equipment, and resourcing of primary level activities came up as challenges, but overall the programme performed well.

Mozambique started with a high cataract surgical backlog – especially in Nampula Province – and very low human resource capacity. In addition, project management roles were unclear for the first two years of the programme. However, once a management structure between the two provinces of operation was established, performance on mid-level cadre training and deployment, monitoring of surgical outcomes and understanding of eye health within government, recovered. PEC worker training and integration into PHC proved more expensive in Mozambique than the other two countries, so this area of the project did not fully develop in the five years. Like Malawi, challenges with consumables and equipment supply frequently came up in the evaluation. However, the change in number of deployed eye care personnel and increasing government appreciation of eye health were key achievements of the programme.

Lastly, Zimbabwe had a challenging start to the programme, largely due to the country's governance and economic environment, which limited the roles that HelpAge Zimbabwe and Sightsavers Zimbabwe were able to play over the first half of the project period[3]. While there was limited success in the development of substantial additional capacity for cataract surgery, the training of OPNs progressed well under the direction of the Parirenyatwa School of Nursing, growing this cadre significantly over the five years. Activities in Zimbabwe strongly focused on integrating PEC into PHC. Zimbabwe was able to build capacity and a health care workforce at the primary level during the second half of the programme. Advocacy activities resulted in the production of a policy brief and position paper on PEC into PHC integration.

[3] As was commonly experienced by civil society in Zimbabwe at this time, both NGOs were unable to obtain registration to operate in country during the period 2010 – 2012. The project successfully resolved this by locating itself within the MoHCC office, thereby facilitating a strong leadership role from within the MoH and ensuring that the role of NGOs during the second half of the project was fully supportive of the broader MoHCC strategy regarding eye health.

4.1.2 Malawi

Malawi's overall performance under the AHC programme was generally been very good and, as with the programme as a whole, improved significantly over the duration of the second half of the programme. It has succeeded in achieving most of its targets and has excelled in a few key areas, such as target numbers for patients referred, the amount of cataract operations performed and the number of primary eye care workers trained.

There have been a number of notable successes in Malawi. Firstly, there has been a great improvement in the integration of primary eye care services into primary health care. This has resulted from effective strengthening at the community level, together with the training of primary eye care workers such as health surveillance assistants (HSAs), medical assistants and nurses on the importance of primary eye care. Regular outreach activities such as eye clinics are also being conducted, contributing to the improvement in the level of primary eye care services. In terms of further coordination, the extent and appropriateness of referrals between differing levels of the health system have also improved.

The scheduling of surgeries performed by ophthalmologists at district level has also been a positive outcome, easing the pressure on other tiers of the health system. It has further assisted in the professional development of ophthalmic clinical officers (OCOs), allowing them to receive regular supervision from ophthalmologists. The deployment of OCOs in the districts of the South West Zone has also been largely successful. A significant factor contributing to these successes in Malawi has been the extent of the nation's pre-existing health infrastructure. A primary-level structure and workforce was already established, facilitating the integration of PEC as well as supporting referrals and further coordinated working between other levels of the health system.

4.1.3 Mozambique

With 54.7% of Mozambique's population living below the poverty line[4] and 1% of the population estimated to be blind, there was a great need to address the prevalence of avoidable blindness and high cataract surgical backlog in the country.

Over the five years of the project, Mozambique has successfully grown the cadre of ophthalmic technicians trained and deployed in the two provinces of operation. This has had a significant impact on access to healthcare for rural communities and has also contributed to strengthened capacity at the primary level of each province's health care system. The training of the mid-level cadre also had the effect of introducing a new curriculum into the Health Science Institutes of both provinces, as well as building their understanding of this sector and skills in management and monitoring of the course offering. These capabilities strengthened the institutions as a whole. Finally, the work of the project's advocacy component in creating national advocacy groups, pushing for the integration of PEC into PHC as well as of eye health into key government strategy documents and plans, was a major achievement of the programme.

Key documents currently governing the country's approach to eye health include the Vision2020 National Strategic Plan, the Ministry of Health Strategic Plan 2013–2017 and the Human Resources for Health Development Plan 2008–2015. The project inputted into the Vision2020 National Strategic Plan through the Mozambique Eye Care Coalition (MECC) to

[4] World Development Indicators, poverty headcount ratio at national poverty line (100% population) Mozambique. http://data.worldbank.org/indicator/SI.POV.NAHC/countries/MZ?display=graph

ensure that human resource development for eye health forms a key part of national eye health strategy. Additionally, the Ministry of Health's Strategic Plan 2013–2017 already demonstrates some commitment to eye care as it promotes increased access to ophthalmological services through community mobilisation and the activities of community health workers. The Strategic Plan also contains an Eye Care Programme Plan that emphasises the need for improved cataract surgery, glaucoma and refractive error diagnosis. The development of these documents, and the AHC project's input into the Vision2020 Plan are evidence of some of the impact the programme it has brought about since its inception in 2010.

4.1.4 Zimbabwe

Considering the fact that there were few project results that were on track at mid-term in Zimbabwe, end-of-project achievements have been remarkable. Overall, the Zimbabwe element of the AHC has shown significantly accelerated progress in delivery and reach over the second half of the programme. A key factor contributing to this success was the introduction of focused and well-coordinated support activities that were closely aligned with both the AHC and the strategic vision of the MoHCC. The AHC project also successfully developed partnerships of trust and transparency, making it a role model for other projects which seek to work in partnerships to achieve goals over time.

It is noted that Zimbabwe's AHC project management structure has been effective in ensuring a sustained focus on eye health over the period 2012–2014, against a backdrop of a Zimbabwean context undergoing rebuilding of the health system overall. Over the life of the project, the country has stabilised somewhat, with international donor funding providing the backbone of resourcing to rebuild the health system, including within the eye health sector. The overall environment for the implementation of focused health care activities remains extremely challenging, with levels of need being very high.

The decision by Sightsavers to provide specific support to the MoHCC for eye health coordination activities (through Sightsavers Zimbabwe) going forward is a wise one, taking stock of the severe shortfall in funding at GoZ level. However, such dependence by the MoHCC on external funding does mean that Sightsavers should consider its input carefully, with a strong continuation of its approach of health systems strengthening rather than direct service delivery.

4.2 Relevance

Regional	***Rating:* Highly satisfactory** G
Malawi	***Rating:* Highly satisfactory** G
Mozambique	***Rating:* Highly satisfactory** G
Zimbabwe	***Rating:* Highly satisfactory** G

4.2.1 Regional level

The fundamental design of this project is solid and could certainly be used as a foundation for projects involving other countries in sub-Saharan Africa, and perhaps elsewhere as well. Each of the four focus areas is highly relevant and pertinent as at least 1% of the population in each country is blind. In addition, there was a backlog of cataract surgery and lack of skills to manage the need for eye care in rural communities. Implementation of the project involved the most relevant actors in each of the countries, and aligned with the relevant strategy and governance documents on health and eye care.

The project was conceptualised without sufficient attention to the in-country variances in terms of existing eye health infrastructure and resources, as well as contextual and political factors that fundamentally influenced the environment and placed restrictions on the degree to which certain activities could be carried out. A full situational analysis of eye health in each of the countries and intended provinces of focus was not carried out prior to start-up or during the first two years of the project. Of the three countries, Malawi was best understood at the start of the project: it had been the subject of a number of eye health studies, and already had fairly well developed human resource capacity at different levels of the health system (including, for instance, a National Eye Care Coordinator (NECC) and paediatric cataract case finders, both features which were not in place in either of the other two countries of focus).

At a regional level, while the project contributed a critique to the African Union Africa Health Strategy of 2007–2015, and liaised with the WHO Afro on the possibility of developing a Southern Africa eye health strategy, efforts to develop an eye health strategy for SADC were less effective. Leaders of the project's advocacy component also served as members of the International Agency for the Prevention of Blindness actively lobbied relevant sub-regional and continental bodies for the increased prioritisation of eye health in overall health strategy. Sightsavers has also been able to contribute to regional best practice in eye care, conducting regional workshops and improving regional-level influence via their advocacy activities. Though the programme actively advocated for eye health and specifically human resource development in the above regional bodies, and succeeded in including narrative on eye health in the draft SADC Non-Communicable Disease (NCD) Strategy, the project was more strongly aligned to national health priorities than regional strategy.

Not enough research was done on SADC and it was a very difficult organisation to penetrate. (Partner, Regional level)

4.2.2 Malawi

The AHC programme was well aligned to Malawi's on-the-ground needs around eye care. It was also a fitting addition within the broader range of national and regional initiatives to enhance eye health. Among all mid-level cadre trainees, both cataract surgeons (CSs) and

OCOs, there was consensus that the training they received was adequate and relevant preparation for the eye health services they are expected to provide. All are currently employed in the field, the majority in posts made available upon the completion of their training.

There is a strong sense among stakeholders that the objectives and activities of the AHC programme are deeply aligned with national and regional strategies. It was noted that the programme's focus areas parallel the primary areas addressed by the National Prevention of Blindness Commission as well as the Malawi Country Strategy Paper 2012–2016; namely human resource development, the building of health institutions and disease prevention.

Stakeholders also believed that the programme contributed toward the goals of increased quality of health services, reduced risk to health and equity of access to health services, as outlined in the Malawi Health Strategic Plan. It was further noted that the programme aligns with a number of MDGs, such as poverty reduction, gender equality and universal primary education. The Ministry of Health's National Eye Care Coordinator stated that due to Malawi's progress in this field, it was selected as a pilot country for the implementation of a health management information system.

At a national level, the programme aligns to objectives contained within the Malawi Vision 2020 Eye Care Plan. Sightsavers is a member of Vision 2020, a global initiative between the WHO and IAPB which outlines an action plan for eye health; the Malawi Vision 2020 document has been based on this formative plan. It advocates for improved policies, institutions, infrastructure, technology and management, with the end goal of strengthening human resources and systems for eye care. These match the focal areas of the AHC programme, specifically strengthening HR capacity at mid-level, improving effective collaboration around eye health and mobilising resources at community level.

The programme is further aligned with Malawi's Health Sector Strategic Plan 2011–2016. The Strategic Plan promotes increased availability of high quality health services, and a strengthening of the health system to improve efficiency and equitable access. The AHC programme addresses these goals through activities like the training of mid-level cadres to improve the quality and availability of eye care services, working to increase access via mobilising communities at ground level and integrating primary eye care into primary health care. Similarly, Malawi's National Prevention of Blindness Commission identifies HR development as a significant area for strengthening the eye care sector; an area which is a focal point of the AHC programme.

In line with these objectives, the programme is making a significant contribution to mid-level HR needs in Malawi. This is evidenced by the fact that currently 20 of Malawi's 28 districts have at least one OCO working at mid-level, with five districts having two or more. This is an improvement of an additional seven districts over the initial 13 that were noted at mid-term. Over the five-year AHC programme period, 30 OCOs and 18 cataract surgeons have been trained. Surgeons that completed the training have generally taken up positions in district hospitals, with a few being deployed to central hospitals, as a direct outcome of the training.

The project has also engaged well with relevant national structures, having been developed with input from key policy actors. From inception, there has been involvement from the Ministry of Health, including the Director and Deputy Director, and the principal of the Malawi College for Health Sciences (MCHS): from Sightsavers there has also been considerable engagement by the Sightsavers Regional Director and AHC Regional Programme Coordinator.

4.2.3 Mozambique

Generally the AHC project was very relevant to the two provinces of operation given the existing need for eye care services and lack of ophthalmic personnel to meet this demand. Nampula, a province which has only had support from Sightsavers since 2008, covers a vast geographical area and, as demonstrated in the 2011/2012 RAAB, has a high cataract surgery backlog. Sofala Province reported a comparatively low prevalence of blindness at 3.2% compared to Nampula's 7.1%, and found that 73% of blindness cases were avoidable and primarily caused by cataract.

Conceptualisation of the project in Nampula was shaped by Sightsavers in collaboration with the Head Ophthalmologist and UniLurio, who served as key 'champions' in shaping and supporting strategic vision throughout the life of the project. In Sofala, Light for the World and the Sofala Provincial Department of Health had been working in partnership on a project to prevent avoidable blindness since 2003.

The project took an incremental approach to building human resources, allowing it to make a contribution at both provincial and national levels, where it was echoed through advocacy efforts by the MECC (in which Sightsavers was also an active participant). Implementation of the project was thus underpinned by a shared agenda regarding priorities for delivery on eye health and projected needs. Strengthened by the efforts of HelpAge Mozambique in the MECC and in training national advocacy groups, the project ultimately influenced the drafting of the Ministry of Health's Vision2020 Action Plan in Health Care. Over time, the project also saw the increased participation of the Ministry of Health in AHC Programme regional meetings in Malawi and Zimbabwe.

4.2.4 Zimbabwe

Partners and stakeholders alike applauded the project design, agreeing that its fundamental focus on human resources for eye health filled a critical gap in Zimbabwe. Through the training and support of ophthalmic nurses, the project has also contributed significantly to putting in place a cadre of mid-level eye health workers at district level within provinces of focus.

The project has made a strong contribution to informing the outlook and specific content of the first-ever National Eye Health Strategy which was launched in 2014. The project's intention and key objectives are also embedded within this strategy. This was noted as a success by the Chief Ophthalmologist, who also drew attention to the strong alignment of the AHC project with in-country eye health priorities.

In line with the regional approach of mainstreaming eye health into broader health care and Sightsavers' commitment to health systems strengthening, the project successfully contributed at the national level to building the eye health infrastructure in Zimbabwe by supporting the development of a structure and systems for delivery of eye health services across all levels of the health system in provinces of focus. This included clear designation of roles, a standardised referral system, and the monitoring and reporting of eye health activities on a monthly and quarterly basis. This is a considerable success in light of the many competing health programmes running concurrent to the project (for instance, maternal and child health, communicable diseases – particularly HIV/AIDS – and nutrition).

Provincial management of eye health services in country falls to Provincial Ophthalmologists where such staff exist. In two of the three provinces of focus under the AHC, there has not been an ophthalmologist in place for the duration of the project; and in the third (Midlands Province) the position of ophthalmologist has been vacant for the past two years. A new system put in place with support from the AHC project during the second half of the project to address this gap was the coordination of provincial eye health activities by the Provincial NCD 'Focal Point', who reported to the MoHCC NCD Deputy Director through the Provincial Medical Directorate. This has been a good interim measure compared with the situation which existed at the start of the project, where no focal point for eye health activities was in place in any of the provinces. Stakeholders working within MoH structures at national and provincial levels noted that this arrangement does not replace that of Provincial Ophthalmologists, which are still sorely required. In addition, the creation of positions for dedicated senior ophthalmic nurses at provincial level (under discussion within MoHCC) would greatly assist with ensuring regular support supervision and CPD for OPNs at district level.

The Sightsavers Programme Manager was instrumental during 2013 in providing active support and assistance on eye health issues to the MoHCC's NCDs Unit. This approach both facilitated functional partnership development on the AHC project and allowed for pooled planning and use of available resources for eye health priorities. Capacity in the MoHCC NCD's office increased over the life of the programme, with two programme managers being appointed within the past three years, thereby allowing for increased internal capacity to focus on national eye health coordination.

4.3 Effectiveness

Regional	***Rating*: Satisfactory**	
Malawi	***Rating:* Satisfactory**	
Mozambique	***Rating:* Satisfactory**	
Zimbabwe	***Rating:* Satisfactory**	

4.3.1 Overview

Regional
Performance was uneven across the project during the first half but significant progress was made in the second half, resulting in good performance overall by end of project. The poor understanding of regional interests and priorities in eye health coupled with the lack of a monitoring system that was relevant and well understood in each context meant that targets were not reached, and early challenges not detected until midway.

Before 2012, if monitoring tools had been available, it would not have taken the ROM to realise that there were problems. (Project partner, Regional level)

Following mid-term assessments, the role of the Regional Programme Coordinator was strengthened and targets were adjusted to take into account each country context.

Malawi
Echoing primary data collected from stakeholders, data from the Programme Framework and Indicator Tracking Tool indicates that project performance in Malawi was excellent. Programme targets were generally met for both training and clinical outputs, with some exceptional examples of targets being exceeded. This is an excellent result, considering the obstacles that were encountered in the first half of the project and reported through the ROM and mid-term review that was conducted in 2012.

There was broad acknowledgement that the first two years of the programme were not used efficiently, and that focused activities and strong management only began in earnest around the midpoint. Weaknesses highlighted in the 2012 ROM and mid-term evaluation were addressed and largely transformed for the duration of the project.

In terms of programme design, the consortium approach as well as regional coordination were seen as overall very helpful for learning and for ensuring sustainability. As reported in other countries, there were challenges at the outset in working collaboratively between NGOs and other partners, particularly around clarifying the goals and expectations of each and defining performance objectives and metrics, but this eventually resulted in agreement and effective coordinated working.

Mozambique
Discrepancies in performance between Nampula and Sofala Province – evident at mid-term – reduced during the second half of the project's life, resulting in a more even performance overall across the two provinces. This was largely facilitated by improved management arrangements within country along with support from the Regional AHC Coordinator in focusing attention towards the achievement of the specific activities embedded within the project's KRAs.

According to the draft final report on the AHC project, the project achieved almost all of its targets and demonstrated notable over-performance in some areas, including the number of health facilities operating with the minimum supply of consumables and equipment, the percent of facilities in the project area offering eye health services, and the number of patients referred between different levels of care in the health system.

The only two areas where it underperformed were on percentage of patients seen who were classified as having positive cataract surgery outcomes (86% against a target of 95%) and on the integration of primary eye care into the national primary health care system (only 70% of target number of PEC workers reached through training).[5]

Zimbabwe
The project made strong progress during its second half: the end-of-project Programme Framework and Tracking Tool results indicate that overall performance on outputs against targets has been good, with exceptional performance in some instances. As stated by one of the project partners:

The way the AHC project started was not good, but a lot of progress came once this was corrected. (Project partner, Zimbabwe)

Performance on the level of outcomes (as reflected in log frame under purpose of project) was strong in many respects but did not meet targets for cataract surgical coverage (80.3% achieved) and percentage of patients seen that were classified as having positive cataract surgical outcomes (83% achieved). Effectiveness of the AHC project in Zimbabwe was

[5] As estimated in Nampula Province RAAB 2011 & Sofala Province RAAB 2013

significantly hampered during the first half of the project's life due to little involvement of the MoHCC during this period. This was reported on extensively in the ROM 2012 and GreaterCapital external mid-term review of early 2013.

Apart from management arrangements, a second major challenge faced by the project at onset was that contextual factors in Zimbabwe – particularly in the period 2006–2009 – had not been accommodated in project design. A full situational analysis of the Zimbabwean context – including extremely low capacity of eye health services and minimal resourcing thereof – at the time of conceptualisation of the project would have resulted in activities for the country being better tailored at project start-up. Equal treatment of all three countries addressed under the AHC was carried through the first half of the project (through, for instance, the splitting of all targets by three to arrive at equal targets for each country under the project).

The project successfully addressed difficult targets and made provision for the tailoring of activities during its second half, for instance with regards the unrealistic number of cataract surgeons to be trained under the project. This strategy, coordinated by the AHC Regional Programme Coordinator, allowed for more honed and relevant targets than originally embedded within the proposal.

4.3.2 Outcome Area: To contribute to poverty eradication through the prevention of avoidable blindness by 2020

Of the three impact indicators that were identified to measure impact at this level, only CSR produced results that could be measured across all levels of the programme. These results are discussed below.

A second tool identified for impact measurement at this level was the quality of life index tool. This was not developed until mid-year 2013 and could thus not be used on the programme until its last year. This was used with small samples (under 40 beneficiaries) in each of the countries of focus. Results of the survey generally showed some improvement in pre- and post-surgery quality of life although this was sometimes marginal[6]. The weighting of the tool was on functionality, everyday tasks and work-related activity. It was found through using the tool that it was biased towards patients who were in their adult years but not advanced in age. Older patients were shown to have a smaller improvement in quality of life as a result. In order to conduct a more substantial analysis, the tool would also have needed to be implemented earlier in the life of the programme and with a larger sample of clients.

For the third impact indicator – number of children now attending school – targets and results tracking the measurement of progress were not provided in the final draft report prepared by the AHC programme. It was reported that it had proven too onerous for the programme to undertake detailed tracking of children who were not attending school in order to assist family members who required assistance with mobility. The AHC RPC reported that the programme had instead adopted a case-study approach because quantitative measurement thereof had been assessed as expensive.

Regional

The programme aimed to reduce the cataract surgical backlog in all three target countries by achieving a cataract surgical rate of 20% over baseline. Using 2011 regional CSR as the

[6] For example, twenty-five patients from Midlands Province in Zimbabwe who had cataract surgery took part in pre- and post-surgery quality-of-life questionnaires in 2013. Overall, results showed a minor improvement in quality of life (from 53% to 58%, with both ratings falling within the 'coping' range), which is lower than would generally be expected.

base rate[7], the project's regional-level target was 515. This target was reached in all remaining years of the project. CSR performance on the programme dropped from a high of 761 in 2013 to 632 in 2014. Figure 1 shows CSR at regional level per annum over 2011-2014.

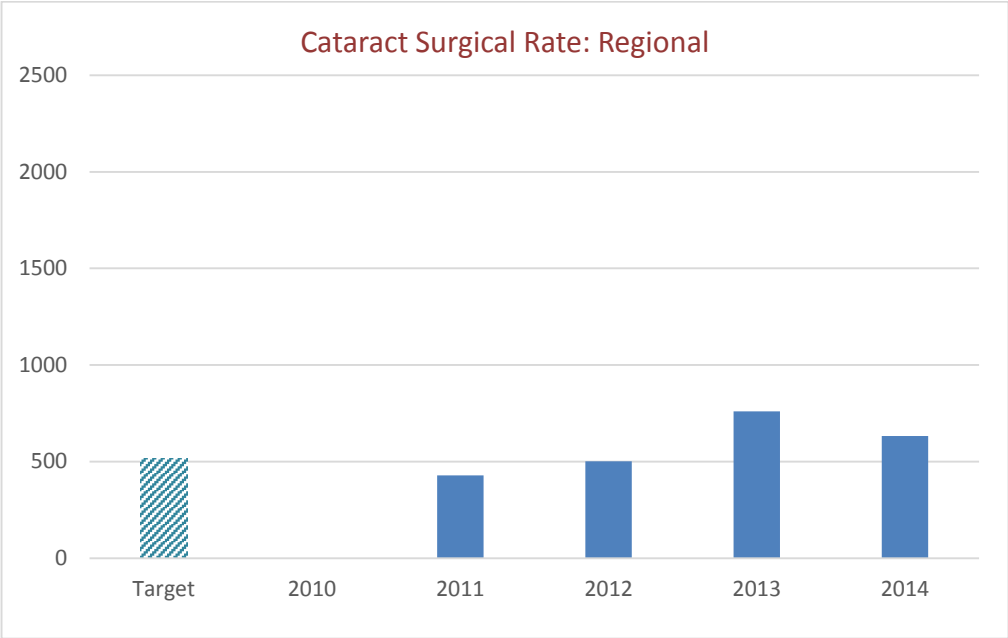

Figure 1: Cataract Surgical Rate at Regional Level per annum (non-cumulative)

Malawi

The cataract surgical rate in Malawi displayed dramatic improvement each year to 2013 and then stabilised at the same level in 2014. Between 2010 and 2011, there was a 335% increase, with steady increases each year until 2013, whereafter the rate stabilised. This is illustrated on Figure 2 below:

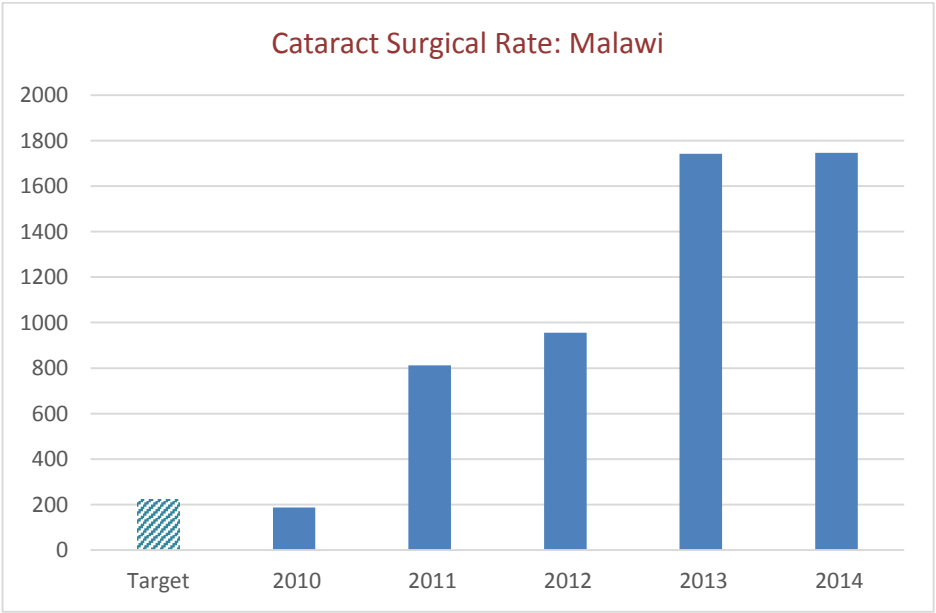

Figure 2: Cataract Surgical Rate in Malawi per annum (non-cumulative)

Malawi thus made excellent progress in increasing its CSR with a final rate of 1747.2 in 2014, up from 186.4 in 2010. Of the three countries on the programme, Malawi had the longest

[7] GreaterCapital has excluded data on 2010 from the figure because no data was available for Zimbabwe in 2010.

track record, experience and pre-existing infrastructure because of its history of hosting the SADC Ophthalmic Training Centre housed at the Malawi College of Health Sciences (MCHS). The initial output of training centre programmes in the past was low – only five cataract surgeons were trained over a 20-year period – but the experience of human resource development in eye health targeting the mid-level facilitated the country's relatively strong CSR.

Mozambique

It was estimated that Nampula Province had a cataract surgical backlog of around 33,000 in 2009, and Sofala Province a backlog of 28,629 in 2013.

The target set for total number of cataract surgeries over the life of the project was 9,300, with a total of 10,095 being achieved. The project thus overachieved against target by 8.55%.

As shown in Figure 3, there was a steady increase in CSR over each year of the project:

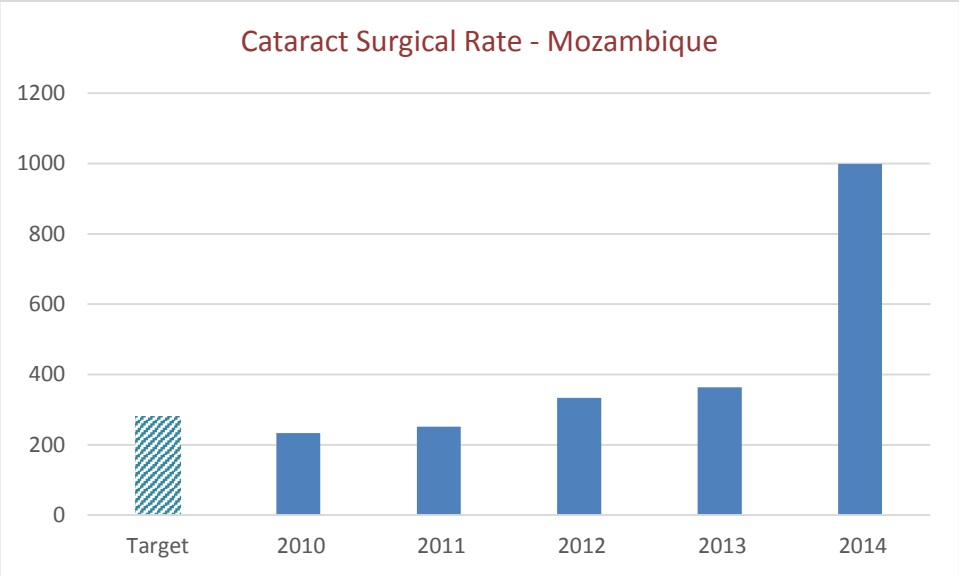

Figure 3: Cataract Surgical Rate in Mozambique (non-cumulative)

By the end of 2014, Mozambique had achieved a CSR of 999 per million people which represented a 174% increase over the previous year and performance of more than three times its target.

Zimbabwe

It is estimated that Zimbabwe has a current cataract surgical backlog of around 60,000[8]. However, no RAAB has been carried out in the country, and so accurate data on prevalence of cataract is not currently available.

While Zimbabwe saw the slowest change of all three countries in terms of CSR over the project period, this was a considerable achievement given the current state of the country's health infrastructure. CSR results per year are shown on Figure 4:

[8] As reported in interviews with Chief Ophthalmologist and MoHCC NCD Deputy Director.

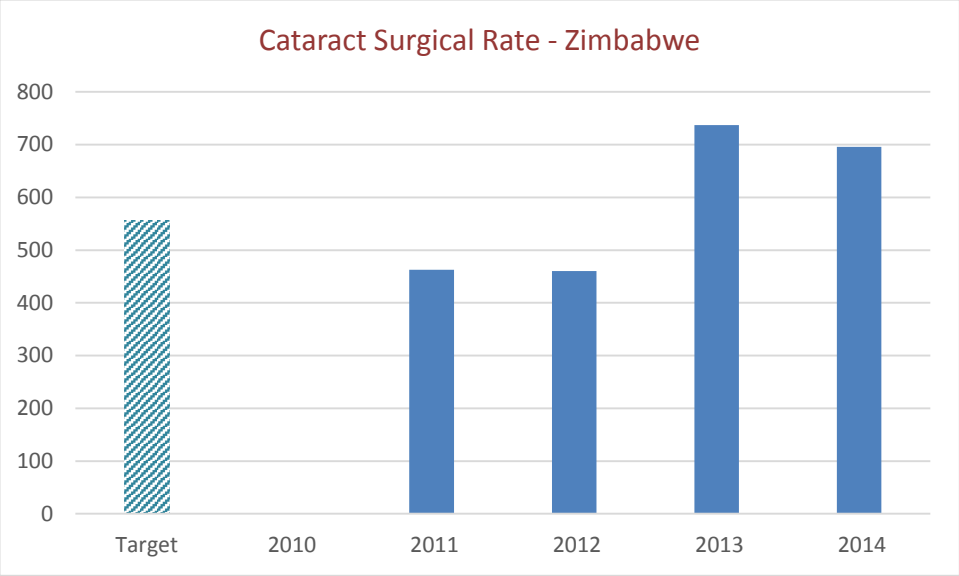

Figure 4: Cataract Surgical Rate in Zimbabwe (non-cumulative)

4.3.3 Outcome Area: To improve the quality and quantity of cataract surgeries and other eye care services for approximately 2.5 million people in Malawi and Zimbabwe, and 3 million people in Mozambique by the end of 2014

Looking at outcome indicators at this level, almost all targets were achieved, including the percentage of patients classified as having a positive surgical outcome and the number of facilities operating with the required supply of consumables and equipment. Other clinical targets such as the percentage of facilities offering eye care services and the number of eye conditions treated were fully met, while the target number of patients receiving eye care services was exceeded by 15 % and cataract surgical coverage by 14%.

The project surpassed expectations of the number of eye health conditions treated by 40%, and saw 28% more patients arriving at and receiving eye health care at project facilities than had been originally targeted. All three countries saw this increased health-seeking behaviour at primary and district levels, which was largely attributed to increased demand driven by community level mobilisation.

In Mozambique, the change we saw in addressing CSR was through the collaboration between the MECC and the government. The new National Eye Health Coordinator was struck by the advocacy concept and she wanted to see it in more districts. She saw the impact this could have at the district level in terms of planning, budgeting and mobilisation. (Project partner, Regional level)

There was also a reported improvement in the proportion of patients seen who were subsequently classified as having positive surgical outcomes, pointing to an improvement in the number as well as quality of surgeries performed. Nonetheless, it appears that further work is still required on the comprehensive integration of the surgical outcome monitoring tool at mid-level cadre level. The programme implemented a monitoring tool consistent with WHO reporting standards; however, at district level in the three countries, interviews with mid-level eye health professionals indicated that usage of the surgical outcomes monitoring tool was producing poor quality results in a number of instances. Mid-level cadres in all three countries reported difficulties with deriving accurate results for the measurement of surgical outcomes: some reported they did not have access to the tool and had not yet been trained in its use; some shared that they were collecting results but that these were not forming part of their

standard monthly reporting; and others indicated that they were unable to finalise surgical outcome results because of poor patient attendance at required follow-up assessments.

Conversely, the programme fell short of fully equipping health facilities with the recommended staff profile, as shown in Figure 5:

Figure 5: AHC Regional Percentage of facilities with recommended staff profile

The programme reached targets set for the recommended profile of eye health staff in Mozambique and Zimbabwe. However, in Malawi,[9] only one of a target of eight facilities was able to fulfil this requirement[10], as shown on Figure 6:

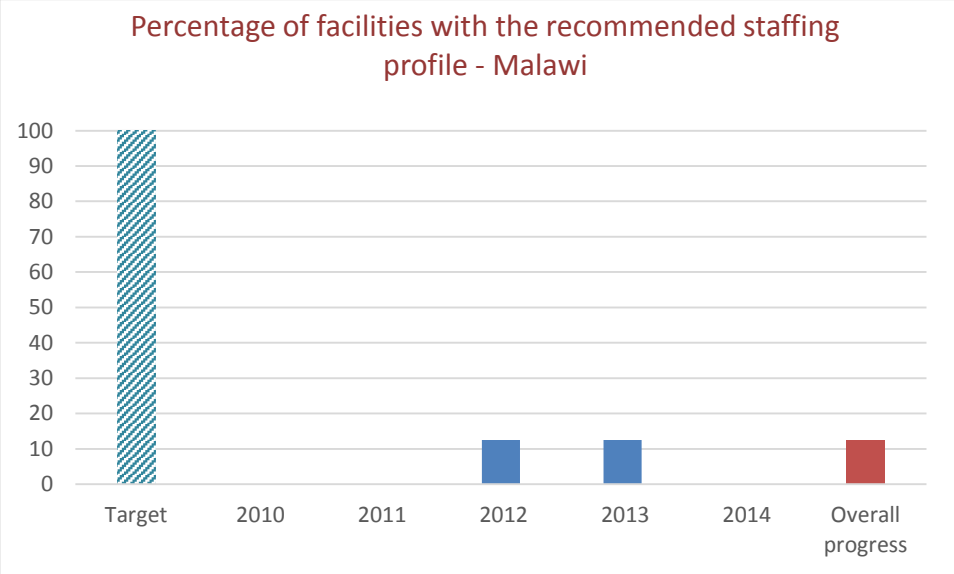

Figure 6: Percentage of facilities with the recommended staffing profile in Malawi

[9] As per outcome indictor 4.1 for AHC project. Findings presented here are drawn from the AHC Project Indicator Tracking Tool supplied for desk review.

[10] The facility that achieved its target is a tertiary hospital, while the seven other health facilities target are district hospitals. Although they did not reach the full target, all these district hospitals generally made progress towards achieving the WHO recommended profile because they deployed additional mid-level cadres.

In Zimbabwe, no baseline figures for the quantity of cataract surgeries carried out were available at the start of the project, and tracking of statistics for each province was only undertaken from 2012 through coordinated efforts on the part of the MoHCC NCD Deputy Director. The project did not manage to achieve its set target of 8,800 cataract surgeries, instead attaining a total number of 7,066. The number of cataract surgeries completed for all three provinces is shown on Figure 7, using Sightsavers performance management data:

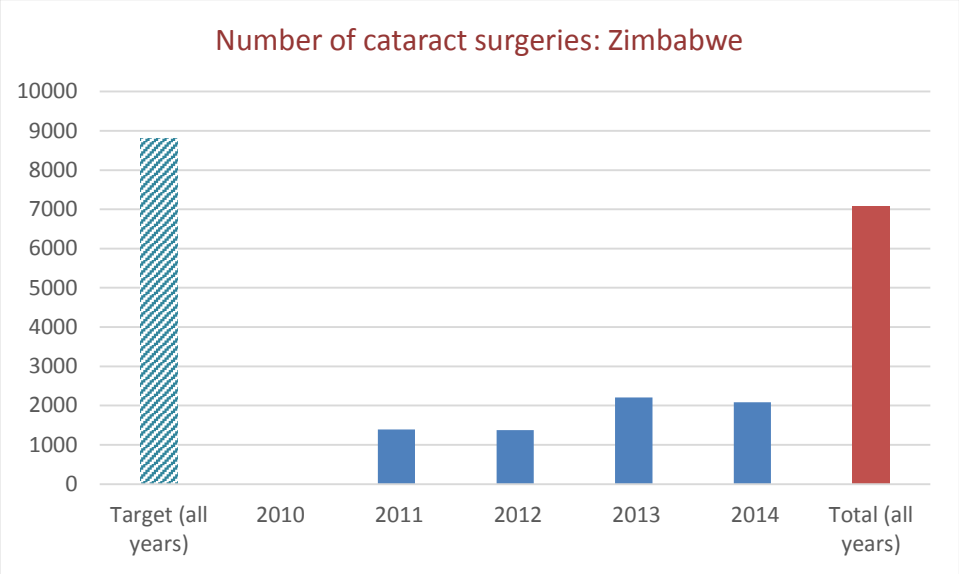

Figure 7: Number of cataract surgeries in Zimbabwe

The graph reflects that, over a two-year period to project end, the quantity of cataract surgeries across the three provinces in Zimbabwe increased moderately in 2013, dropping back again in 2014. Malawi surpassed its targeted number of cataract operations performed by 50%, and Mozambique surpassed the target by 8%.

With regards capacity to reduce the cataract surgical backlog, results varied across the countries. Three out of five cataract surgeons interviewed in Malawi reported that they did not feel able to meet the full existing demand for their services, and reported performing an average of 10 to 15 cataract surgeries a week translating to 480 to 720 per annum. Not all surgeons had specific targets; however, in the two instances where targets had been established, the cataract surgeons reported they were generally able to meet them. In Mozambique, mid-level cadres reported a range of five to ten surgeries a day when working at provincial hospitals, and 15 to 20 a day during outreach activities. Again, no standard targets seemed to be in place but, where targets did exist, mid-level cadres felt they would meet these more effectively with additional outreach activities and additional staff. In Zimbabwe, only one of the four cataract surgeons trained under the project to service target provinces was in post at the time of the end of term review[11]. At his current rate of performance (a maximum of 20 cataract surgeries per month), his annual contribution will reach around 240 cataract surgeries, a low result when compared with his agreed target of 800 cataract surgeries for 2015[12]. State ophthalmologists based in Harare and Bulawayo interviewed during the end-of-project review conceded that making a dent in the estimated current backlog of 60,000 cataracts with current levels of performance in country would be unlikely. This lends weight to a need for continued focus on successful upscaling of cataract surgery capacity in Zimbabwe.

[11] Detail explaining the location of the remaining three cataract surgeons trained is provided in the Zimbabwe section addressing KRA1.

[12] Detail explaining the location of the remaining three cataract surgeons trained is provided in the Zimbabwe section addressing KRA1.

The project introduced a tool for the measurement of cataract surgical outcomes that assesses VA prior to surgery, and then one day/two weeks/six weeks post-surgery[13]. The tool was applied in all three countries; however, it was not consistently being used at the district level where follow-up assessments at two- and six-week intervals after cataract surgeries are conducted. In Zimbabwe, two OPNs stated that they were not familiar with the tool. Only two of the five OPNs interviewed who were operating at district level reported regularly using the tool. All district-based OPNs noted that there was great difficulty in completing post-surgery assessments once patients had left the facilities because patients routinely failed to return for these assessments. In Malawi, the tool was rolled out in the project's zone of operation in the final year, and in Sofala Province in Mozambique was being introduced at the time of the end of project evaluation (March 2015). It appears that use of the cataract surgical outcomes tool at the mid-level requires further strengthening, as mid-level cadres routinely reported challenges with assessing patients who did not present themselves for post-surgery assessments. Mid-level cadres may benefit from structured arrangements to measure patients' surgical outcomes and further instruction on reporting arrangements in this regard.

Through the AHC project, there has been a significant increase in the number of facilities in project areas offering eye health services and in the number of patients receiving eye health care services[14].

4.3.4 Key results area (KRA) 1: A mid-level training institution is able to provide comprehensive training for mid-level cadres

Regional

Generally, the programme contributed to capacity building in curriculum development and lecturer skills of the mid-level training institutions. In all countries, the institutions met or exceeded targets of staff undergoing continuous professional development, and also performed strongly on conducting timely curriculum reviews as well as completing the required assessments of the curriculum. The Malawi College of Health Sciences highlighted in particular how partnering with SADC to house the Ophthalmic Training Centre, as well as the Head of Ophthalmology at Kamuzu Central Hospital under the AHC Programme significantly enhanced the quality of the mid-level curriculum. Collaboration between Malawi and Zimbabwe under the project led to a draft training curriculum from Malawi being adapted by the Nursing Council of Zimbabwe for use with OPNs. This was reviewed during the project and finalised in 2014. The curriculum is now also being used nationally to train OPNs at both UBH and Parirenyatwa Hospital in 2015.

Performance on continuous and refresher training for training institution staff was generally satisfactory, though not all activities could be done as planned. In Mozambique, for instance, the Nampula Health Sciences Institute (NHSI) did go for a two-way exchange with the Beira Health Sciences Institute (BHSI) but did not manage to send anyone to Zimbabwe as planned due to schedule conflicts. Mozambican ophthalmologists did not go for exchanges in other countries but did attend the College of Ophthalmology for Eastern, Southern and Central Africa (COESCA). Staff at the Parirenyatwa School of Nursing reported enthusiastically that they received plenty of opportunities for learning on the project.

[13] The time intervals on this are not exactly compliant with WHO standards for cataract surgery outcomes monitoring; and the tool may require revision to align it more consistently with international standards.

[14] In Zimbabwe all ophthalmic nurses trained under the project had access to ophthalmic kits which were linked to the health facilities in which they were placed. All OPNs interviewed reported that, for the most part they had the required basic tools to carry out most of their work. Three OPNs at district level mentioned specific additional diagnostic tools as additional requests. OPNs and the School of Nursing commented that it was particularly helpful that OPNs had had the necessary tools to carry out their work from the start.

Lecturers at the Malawi College of Health Sciences also participated in CPD and developed a network of part-time lecturers – the Head of Ophthalmology at Kamuzu Central Hospital included – who bolstered teaching capacity at the Institute, as this was a key challenge.

Overall CPD results are shown on Figure 8:

Figure 8: AHC Regional Number of staff undertaking continuous professional development

In addition to providing professional development training for lecturers, the AHC project provided scholarships for mid-level cadres in each of the countries. In Zimbabwe 30 OPN students received partial scholarships for costs of rural attachments, a bus for outreach for students, training and clinical equipment, and kits for use by graduating OPNs. The Parirenyatwa School of Nursing trained Nurses Tutors from Zimbabwe's 45 Schools of Nursing on integration of PEC into PHC. The trained Nurses Tutors went to train student nurses in the Schools of Nursing on PEC for PHC.

Capacity building of OPNs was mentioned as a particular success of the project by both project partners and stakeholders consulted during the end-of-project review. In collaboration with the Parirenyatwa Nursing School, the project successfully ensured that 30 OPNs (100% of target) were trained, graduated and placed. While a small number of them were placed at Parirenyatwa and UBH, the majority of these OPNs were 'bonded' to specific districts (supervisors were instructed not to approve transfer unless within same province) till end of project. All seven OPNs who were interviewed reported that that they felt adequately trained for the type of eye health services they were required to provide and that they were employed in positions that utilised their eye health skills.

Malawi

Malawi has achieved well against nearly all of its targets in KRA1. Critically, the target number of mid-level eye personnel to be trained was attained, comprising 30 OCOs and 18 cataract surgeons. All those who enrolled completed the training, and 95% of all mid-level expressed satisfaction with their training. All teaching staff at the training institution were found to possess the required level of qualification, and all had participated in continuous professional development or some kind of refresher training. The only shortfall found in this area was the number of lecture exchange visits, with four out of a target of five completed.

In Malawi, scholarships were also provided to 30 ophthalmic clinical officers (OCOs) and 18 cataract surgeons as part of the programme supported by Sightsavers and the Malawi College of Health Sciences. Mid-level cadres identified the provision of scholarships and on-the-job support as key to continuing their education and professional development. Only two out of 14 mid-level cadres trained had not received any refresher training since graduation and only one reported to have been working unsupervised. Project partners echoed the importance of supervising newly-trained cadres in order to adequately prepare them for their work, and generally prized quality training and supervision as highly as training a large number of OCOs and cataract surgeons

While there was general agreement that the programme's objectives have been met successfully, there was a higher level of satisfaction with OCO training numbers and management of this cadre compared with that of cataract surgeons. Becoming a cataract surgeon is deemed a smaller advancement in career and appears to be more difficult to manage in terms of incentives for trainees; it also requires certification from the Malawi Medical Council which is an involved process and more practical to pursue at a central, rather than district, level.

Productivity of cataract surgeons has been mixed. It took two years to produce a productive cataract surgeon since there wasn't enough practical experience in the training. Another meeting was planned to address some of the issues and some cataract surgeons had to be retrained. In the selection process, they need to look at who is inherently a surgeon. (Project partner, Malawi)

The sustainability of scholarship provision remains a question in Malawi as the government is expected to take on this responsibility and it has not yet identified an ongoing source of funding for this.

The programme has faced some further limitations around human resource capacity. In the beginning, staffing capacity was a key concern, with sites such as MCHS and district hospitals lacking adequate staff numbers to operate effectively. In terms of training graduates, the first cohort of cataract surgeons needed additional capacity strengthening in order to feel equipped to operate in the field, particularly without supervision. Feedback from cataract surgeons and OCOs highlighted that the training was adequate at theory level but opportunities for practical learning were lacking, limiting their confidence to work in field. Six of the 14 interviewed from these cadres felt this was the case.

Mozambique

Results show that the programme performed well on KRA1. It either met or exceeded targets regarding the strengthening of Mozambican training institutions to provide the quality training for mid-level cadres. These institutions were assessed on the number of health cadres trained; the institution's ability to consistently upgrade lecturer skills; to maintain the essential infrastructure and equipment needed for training; and to develop and implement a process to ensure that training staff are qualified and that the curriculum is of the necessary standard. Of all areas assessed, the only one in which the Mozambican institutions did not perform well was the continuous professional development of teachers and lecturers.

CPD for the training team based in Nampula could have been more successful. The Nampula Health Sciences Institute (NHSI) did go for a two-way exchange with the Beira Health Sciences Institute (BHSI) but did not manage to send anyone to Zimbabwe as planned because suitable dates for such a visit could not be identified. Nampula ophthalmologists did

not go for exchanges in other countries but did attend the College of Ophthalmology for Eastern, Southern and Central Africa (COESCA).

The BHSI recognised the impact the programme had not only on skill levels of the eye health cadres in general – previously specialised operations would be performed by ill-qualified medical staff – but also on the quality of teaching and their own capacity to develop and maintain a curriculum, as one for eye health had not existed prior to the AHC Programme. The mere creation of the course for mid-level cadres – notably with a shared curriculum for both BHSI and NHSI and recognition of their institutional capacity to further train OTs across the country – was considered a notable achievement.

That said, the BHSI did struggle to maintain some key standards of this curriculum including the necessary equipment for student practicals, as well as resources for student transport to provincial hospitals where they would undertake a practical internship. Supervision of students – a requirement of the programme – during the practical section of their training was good at the Beira Central Hospital. Where there was a lack of supervision during training reported, this occurred at a provincial hospital outside the programme scope.

Zimbabwe

To effect work on KRA1, collaboration between Malawi and Zimbabwe under the project led to a draft training curriculum from Malawi being adapted by the Nursing Council of Zimbabwe for use with OPNs. This was reviewed and finalised in 2014. The curriculum is now also being used nationally to train OPNs at both UBH and Parirenyatwa in 2015. Staff at the Parirenyatwa School of Nursing reported enthusiastically that they received plenty of opportunities for learning on the project.

The AHC project provided partial scholarships for 30 OPN students, costs of rural attachments, a Ford Transit mini-bus for outreach for students, training and clinical equipment, and kits for OPNs going out. The programme provided training for 45 tutors in PEC, who then trained 58 nurses and 573 Village Health Workers (VHWs).

Capacity building of OPNs was mentioned as a particular success of the project by both project partners and stakeholders consulted during the end-of-project review. In collaboration with the Parirenyatwa Nursing School, the project successfully ensured that 30 OPNs (100% of target) were trained, graduated and placed. While a small number of them were placed at UBH (a non-project site but linked to the project in that it served as a referral eye hospital for both Matabeleland North and South Provinces), the majority of these OPNs were ‘bonded’ to specific districts until the end of project. All seven OPNs who were interviewed reported that they felt adequately trained for the type of eye health services they were required to provide and that they were employed in positions that utilised their eye health skills.

An positive consequence of the project was that rural attachments that OPNs carried out as part of their training under the AHC project served to increase capacity for eye health services in districts. Another stakeholder, working at provincial level, commented that the difficulty at district level is not so much that there are no longer enough OPNs but that they are poorly distributed, with many of them being clustered within large towns and cities, leaving more rural locations under-resourced. As indicated elsewhere, OPNs in rural setting appear to function more effectively if they operate in pairs. If this logic is to be followed, greater numbers of OPNs are still required to further resource district health facilities.

The project also aimed to increase capacity and delivery on cataract surgery by training four cataract surgeons, particularly in light of the need for additional cataract surgery capacity in its three provinces of focus, none of which have an ophthalmologist at provincial level.

Following discussion with the MoHCC, an agreement was reached that existing medical doctors be identified for accelerated training. Sightsavers in Zimbabwe shared the difficulty of identifying suitable candidates for cataract surgery training, stating that there is a low level of interest among doctors in becoming cataract surgeons.

Four doctors were identified and trained in cataract surgery in 2013; however, despite considerable efforts to train cataract surgeons, only one of the four trained was servicing the provinces of focus at the time of the end-of-project review. This cataract surgeon based at Gokwe North District Hospital in Midlands Province has been providing cataract surgeries at a very low rate of performance, largely because he is also required to provide general medical duties at the hospital, as well as being heavily involved in off-site training of other health professionals. He raised the fact that the cataract surgery outreach work does not carry an incentive and that it is thus not as attractive to staff as other potential areas with more funding. A second cataract surgeon performed well during 2013 (estimated at approximately 900 cataract surgeries during that year). He has since moved outside of the project focus area to undertake training as an ophthalmologist, resulting in his continuing to perform cataract surgeries, albeit at central hospital level. One more trained cataract surgeon has taken up a position as a District Medical Officer and does not have time to carry out surgeries. The fourth cataract surgeon trained under the project has moved to Bulawayo for personal reasons and is no longer located in a target province.[15]

The decision to train existing medical doctors as cataract surgeons set in place a course of action that precluded addressing the issue of cataract surgery capacity predominantly within the fold of advocacy. It was argued by some partners on the AHC project that even if the intervention of training CS on this project did not specifically address the shortage of cataract surgery skills in the provinces of focus, it nonetheless contributed to increased capacity at country level and has inspired one medical doctor to make a long-term commitment to ophthalmology. Nonetheless, impact overall on cataract surgical capacity as envisaged by this project appears very weak currently. A better strategy might have been investment in putting in place the policy framework and regulations to support a cadre of mid-level eye health professionals who could be trained in CS faster than ophthalmologists, and who could have contributed more actively to improved human resource capacity across the provinces of focus under the AHC, as well as the country as a whole.

The strategy adopted by the AHC project of training cataract surgeons within a context where such a cadre is not formally recognised under the health system (even though they are permitted to perform surgery) has not resulted in either the wider acceptance of such a cadre or significantly increased capacity for cataract surgery in the provinces of focus. The ophthalmological profession's opinion that they are the only cadre formally equipped to carry out such work remains endorsed by the MoHCC. In summary, one of the project partners stated baldly:

This issue should have been addressed at policy level first rather than going ahead with training of cataract surgeons in Zimbabwe. (Project partner, Zimbabwe)

It should be noted, however, that the AHC project worked within parameters of the government policy on this issue. Such policy was supported by the Provincial Medical Directorate, with training endorsed by the Permanent Secretary of the Ministry of Health. While the overwhelming majority of health professionals consulted during the end-of-project review felt that an alternative cadre could well be equipped to carry out cataract surgery,

[15] The evaluation team was informed by the AHC RPC in May 2015 that arrangements have recently been made for this cataract surgeon to perform outreach in Matabeleland.

there is not yet consensus on which cadre this should be. One stakeholder expressed frustration at the continuing backlog on cataract surgery, stating that:

Things will really start to move if we train up ophthalmic nurses as cataract surgeons. (AHC stakeholder in state health system, Zimbabwe)

This position was strongly supported by a number of OPNs interviewed, who expressed interest in training as cataract surgeons themselves.

It is noted that concerted efforts were made throughout the project's life to change the status quo but that these have not yet yielded a positive result. AHC project partners, particularly Sightsavers and the MoHCC NCD Deputy Director, intend to pursue this matter further over the coming period, and have already proposed to the MoH that it conduct a study tour to Malawi to observe the workings of the cataract surgery cadre in Malawi. Furthermore, a strategy which outlines the training of clinical nurses as cataract surgeons has been developed and was to be tabled before the Parliamentary Portfolio Committee in March 2015.

4.3.5 KRA 2: Enhanced performance and productivity of mid-level eye care personnel

Regional

Standards concerning the number of people examined, referred and operated on, as well as the quality of operations were generally met. Of particular strength was the number of paediatric cases screened and referred for cataract surgery in Malawi, as shown in Figure 9:

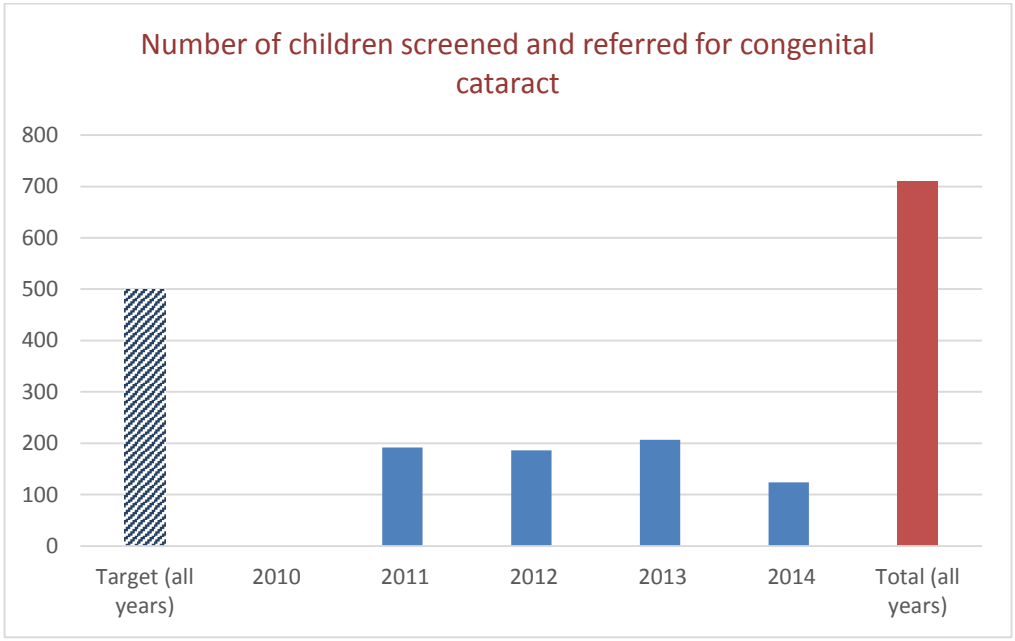

Figure 9: AHC Regional Number of children screened and referred for congenital cataract

The use of existing village health workers, including health surveillance assistants, as well as the creation of a specific cadre of paediatric case finders to identify and refer paediatric cases, contributed to the success of these referrals.

Similarly, the number of people examined at all levels of the health system was 16% above the original target, as illustrated on Figure 10:

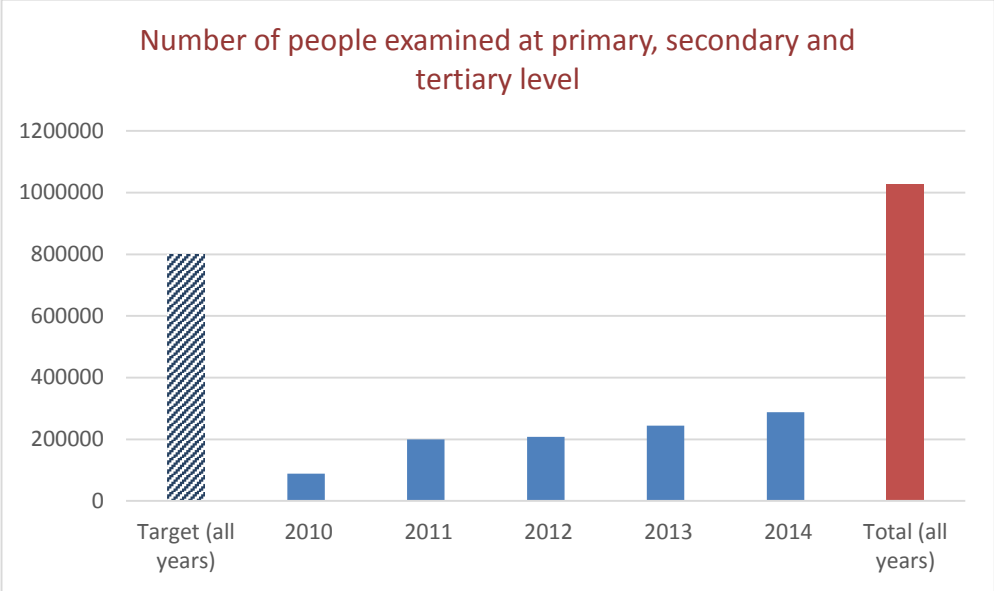

Figure 10: AHC Regional Number of people examined at primary, secondary and tertiary level

Malawi

According to data captured by the programme log frame, the Malawi programme performed exceedingly well in KRA2, surpassing four of its six targets. Particularly good performance was seen in terms of the number of people reached with comprehensive eye care services via a primary health care approach. The target number of people examined at the primary, secondary and tertiary levels was surpassed by 15%, with the target number of cataract operations performed exceeded by 50%. The number of children screened and referred for congenital cataract also exceeded its target by 43%. It was felt that an improvement on clinical output targets is due to the successful creation of demand at community level. Again this was attributed to the strength of the existing health force at the primary level, and in Thyolo district to the activities of the Radio Listening Club.

It was found that double the target amount of outcome monitoring tools were in place. However, the percentage of trained staff reporting health outcomes in line with cataract monitoring tools in particular was under target at 80%. This could be due to the fact that such monitoring tools were only introduced recently in the South West Zone. The Coordinator of this zone mentioned that they have trained OCOs on the use of the cataract outcome monitoring tool, and that these results are collated each quarter. This tool is said to be producing good results. While use of the tool was not witnessed in use, an aggregate report has been developed which demonstrates that use of the tools has begun.

Mozambique

The project met its target for training 30 ophthalmic technicians in Mozambique. A total of 57 OTs graduated from training across the two provinces, 30 of whom were supported by the AHC project. In Nampula Province, at the time of the end-of-project review, 21 of the 30 OTs trained were located in 21 districts, two had died and seven were based at the Nampula Provincial Hospital (NPH). In Sofala, the 27 OTs who were trained were deployed in ten of the province's districts.

Mozambique reported 79% of patients with positive cataract surgery outcomes in the last year of the project, against a target of 95%. This is illustrated in Figure 11:

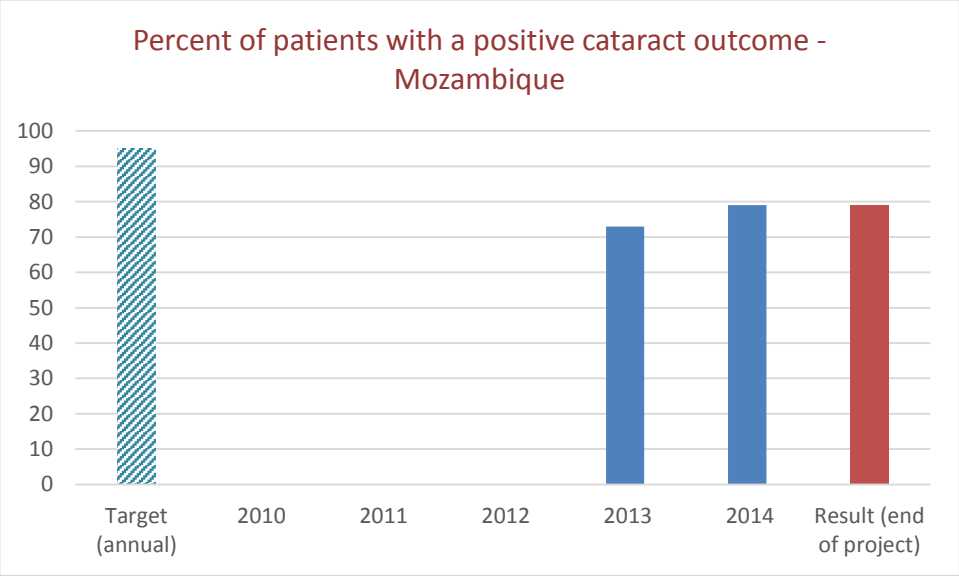

Figure 11: Percentage of patients with positive cataract outcome in Mozambique

It was noted that OTs interviewed by the evaluation team reported difficulty in recording post-surgery results – particularly at seven days or more after surgery – due to patient difficulty with travelling back to the hospital for the recommended post-surgery check. Technicians reported using the standard operating procedures in assessing VA as well as observing and diagnosing conditions, however utilisation of outcome monitoring tools consistent with WHO standards was uneven. Caution is thus recommended in interpreting post-surgery results.

Generally OTs in Sofala felt they were able to meet the demand of patients seeking eye health services, or were able to meet the demand of those people who presented themselves at the health facilities, but did not feel that they were fully able to service their areas of operation. On average OTs reported examining 15 patients a day translating to 5,400 per technician per year. This may have been an overestimation given the programme's final reported number of people examined of 334,871, however it does illustrate that OTs were generally productive.

Zimbabwe

Thirty ophthalmic kits tailored for use at district level were allocated to the health facilities at which these OPNs were placed. This was commented on as particularly helpful by OPNs and the Parirenyatwa School of Nursing, since this meant that OPNs had the necessary tools to carry out their work from the start.

The project saw increased numbers of people presenting for examination at primary and district levels. This is an indication of success in increasing community access to eye health services. OPNs reported that they were seeing between 40 and 60 patients per month, with a very slight increase in the number of women. Despite increased numbers, various factors are reported to have affected the quality of eye health service delivery and access to services over the life of the project.

It is noted that the emphasis of training at village health worker and primary nurse level has been largely effective in promoting referral of eye conditions to district level. No assessment of retained levels of knowledge or effectiveness of eye health assessment practice has yet been conducted with VHWs or nurses working at primary health care level.
OPNs indicated high levels of interest in further learning opportunities. Three OPNs indicated that they would like to study community nursing with a focus on ophthalmology, while one expressed interest in cataract surgery and another in paediatric ophthalmic services.

OPNs working in Harare and Bulawayo were well supported by the ophthalmologists who manage the eye units; and have plenty of opportunity to gain further knowledge through case presentations and internet-based further learning. They were also regularly supervised. OPNs in district locations were supervised via Provincial MoHCC NCD Managers who were focal points for eye health. These provincial focal points shared that they experienced limits on their budgets for travel to districts to carry out supervision and support visits, including for annual planning and review sessions.

One OPN mentioned appreciation for EU support to the Nursing School library on ophthalmic nursing. OPNs at district level shared that they do not generally have access to the Internet in their workplaces and are thus limited in their ability to engage in further learning. One OPN mentioned that the project started a WhatsApp group for OPNs trained on the project, identifying this as an important platform for feedback and support, however the Sightsavers Programme Manager indicated that the group was underutilised by OPNs.

Both focus group participants and district OPNs felt that more regular eye camps in their districts were needed. Eye health camps were felt by both parties to be a major contributor in resolving eye health challenges through an accessible service. One beneficiary explicitly asked:

In between eye camps, where can I get that service? (Participant in FGD, Zimbabwe)

In Midlands Province, it was noted that, because Gokwe North District Hospital has only one theatre, there is little opportunity to book theatre space for extended periods to conduct cataract surgeries. This is an additional constraint resulting in limited output of the cataract surgeon servicing the province. There is a dedicated eye unit at Gweru hospital, however it does not have its own theatre.

4.3.6 KRA 3: Resources mobilised to promote sustainable eye health programmes

Regional

Integrating PEC into PHC – the main objective of advocacy activities – generally saw strong performance in the region as a whole. Malawi and Zimbabwe were particularly effective in organising health workers at the primary level to raise awareness amongst, mobilise, treat and refer patients. Results at regional level are shown on Figure 12:

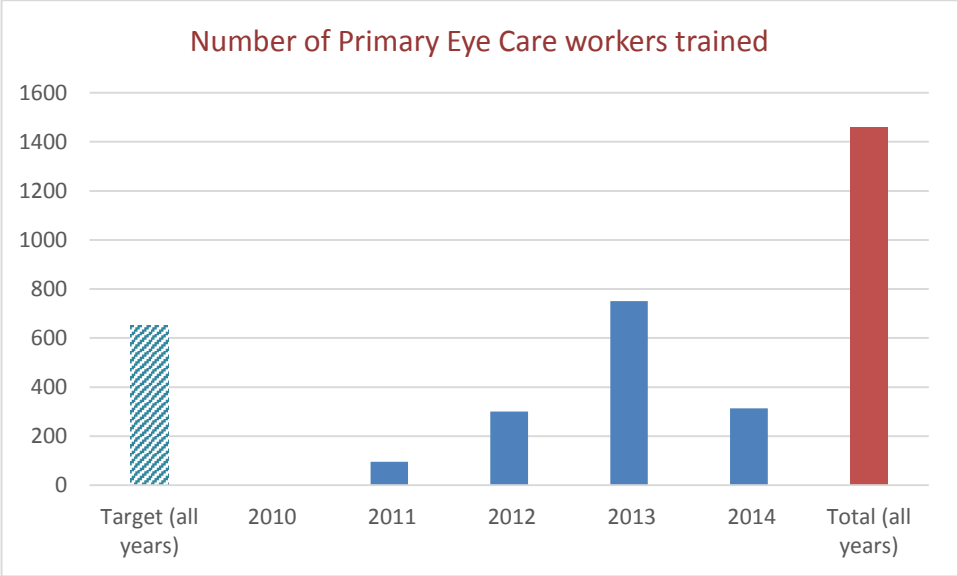

Figure 12: AHC Regional Number of primary eye care workers trained

Overall, the project exceeded expected performance on PEC workers trained by 119%, with Malawi out-performing its goals by 235% and Zimbabwe by 195%. This was primarily due to training of theatre nurses and village health workers at the district level in Malawi, and primary health nurses and village health workers within districts in Zimbabwe. In Mozambique, the number of PEC workers trained actually fell below target by 30.5%, again indicating that staffing and existing infrastructure at the primary level is still in need of further development compared to the other two countries, as well as more limited institutional buy-in at provincial level within the Department of Health than was the case in other countries. It is encouraging that in Mozambique the work of community health workers was increasingly valued by provincial government as the AHC project ran its course, and that their work is increasingly funded in sustainability plans.

The increase in the number of referrals since the project's inception is shown on Figure 13:

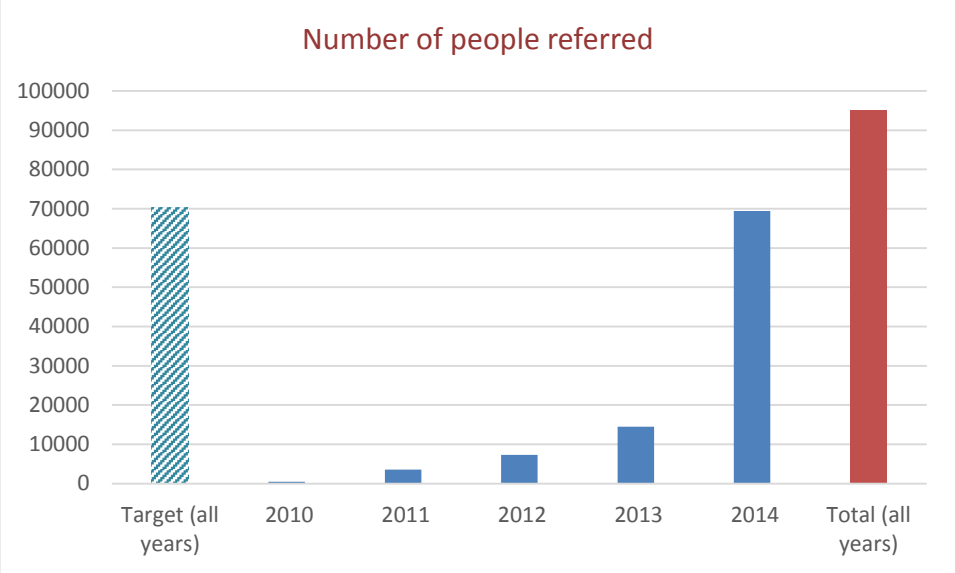

Figure 13: AHC Regional: Number of people referred [16]

Although annual progress was slow over the first four years of the programme, targets for number of referrals were exceeded by 19% by end of term, with Malawi making the greatest contribution to regional performance in 2014. Again, the presence of an existing community health workforce was the main factor behind this achievement. The use of mobile or outreach clinics in all three countries also contributed to the increase in the number of referrals. Mid-level cadres and ophthalmologists reported an improved functioning of the referral system both in terms of number of patients referred and the appropriateness of referrals. Ophthalmic technicians and clinical officers had generally developed strong working relationships with primary level staff and valued their support in increasing demand for eye health care, and mobilising community members to seek assistance at health centres or district hospitals. Referral systems did appear to function better when patients were referred up from primary to district and/or tertiary levels, than when they were referred back down to the primary level. Though measures such as health forms or "passports" have been put in place to track patient outcomes, the costs of accessing health care for post-surgery appointments proved prohibitive to some clients. Mid-level cadres highlighted this as one of the reasons it was difficult for them to track changes in visual acuity (VA) after surgery had been performed.

[16] As per AHC Project indicator Reference Guide: This indicator measures the number of individuals screened for eye health by a PEC worker or institution, and then referred to the appropriate level within the health system.

Village health workers in Malawi reported having done follow-up visits to patients' homes to encourage them to present at district level or to themselves assess the patient's progress. This approach is one that other countries could also consider using more frequently to improve post-treatment and post-surgery monitoring.

Lastly, the programme performed well on the number of partners attending and participating in NPBC meetings, though the number of meetings held was still an area for improvement.

Malawi

KRA3 is another key area in which the Malawi programme has performed very well. A major focus here has been on the integration of primary eye care into the national primary health care system, with targets for output indicators being achieved by more than double. Central to this is the system of referrals between the three different levels of the healthcare system, which was identified by personnel as a major area of success for the programme with referrals improving in both quantity and appropriateness. Under the programme, 2.4 times the target number of referrals were made between different elements of the healthcare system. The number of referrals made in Malawi is shown on Figure 14:

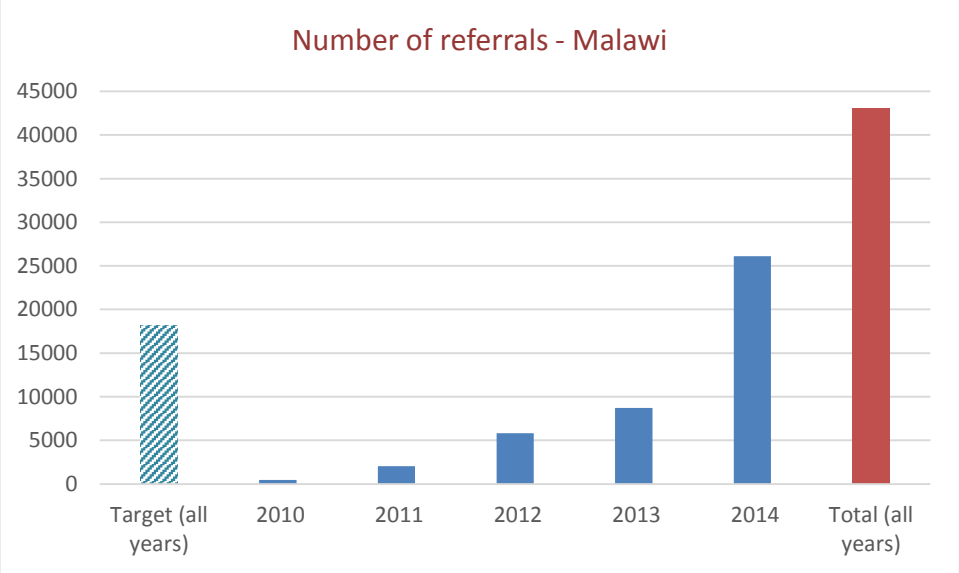

Figure 14: Number of referrals in Malawi

The training of primary eye care (PEC) workers in Malawi has also been key, with the target number of workers trained exceeding the set target by 235%. This is shown on Figure 15:

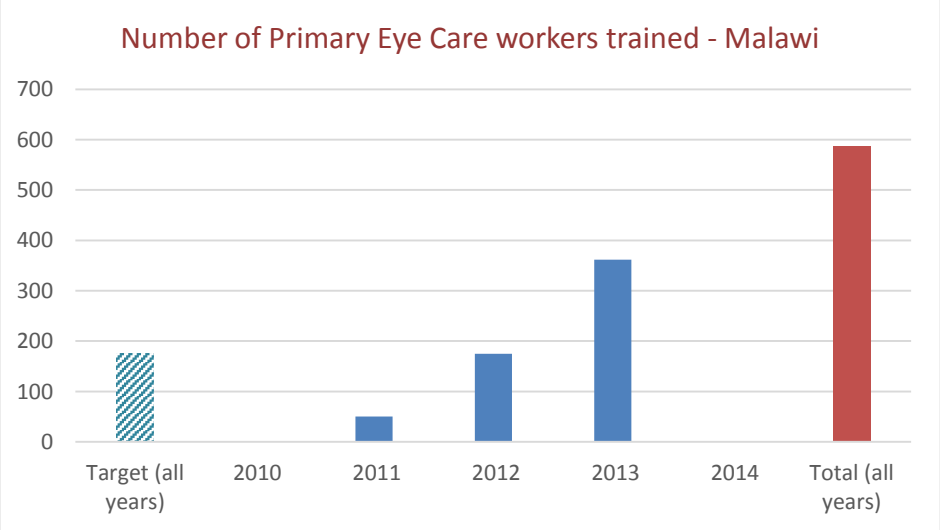

Figure 15: Number of primary eye care workers trained in Malawi

This result is largely attributable that an existing core of community volunteers were already engaged in support to eye health activities at the time that the project started and the harnessing of their energies on the AHC project. There was consensus among MoH and eye health professionals interviewed on the strong performance of PEC trainees and the quality of their work, as well as others active at the district and primary level around PEC objectives such as advocacy, awareness raising, community mobilisation and the contribution made to eye clinics. Progress in this area was deemed as a central and highly successful part of the programme.

The reported capacity of mid-level personnel to perform their work and meet demand varied. IABP suggests that surgeons should be able to perform around 2,000 cataract surgeries per year, at minimum, if they are equipped with adequate support staff, infrastructure and patients who are willing and able[17]. This equates to a monthly average of about 167 surgeries. Of the cataract surgeons interviewed, the reported average monthly rate for performing cataract surgeries ranged from five to 150; however, just less than a third (four out of the 14 interviewed) stated that they were unable to meet the current demand for their services. Of those who felt they were unable to meet demand, two main reasons were given: firstly, that lack of equipment, drugs and consumables impeded their ability to see patients; and secondly, that patients reside in hard-to-reach rural areas, creating difficulties in terms of transport and access to services.

Mozambique

As shown on Figure 16, PEC worker training and integration into PHC in Mozambique proved less successful than in other country locations:

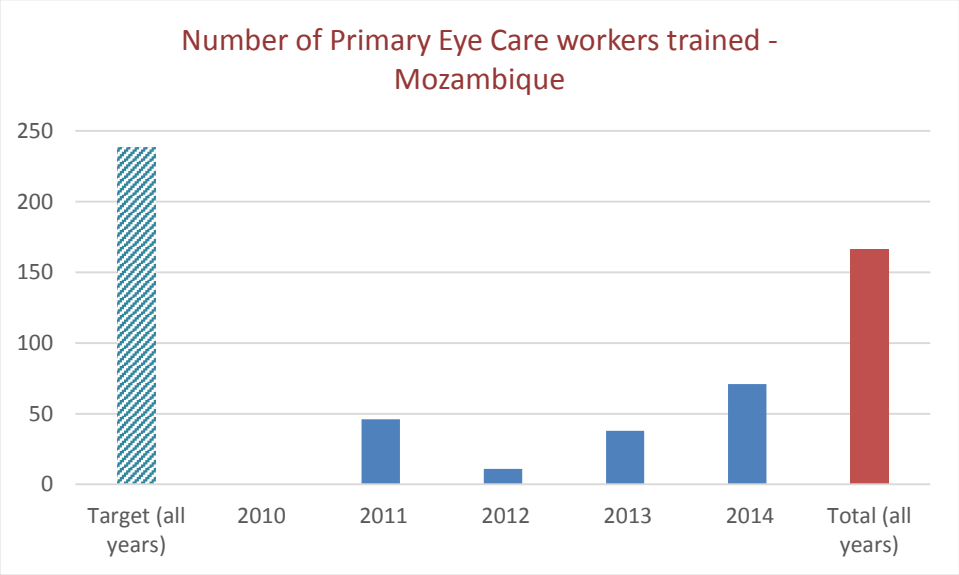

Figure 16: Number of PEC workers trained in Mozambique

Sightsavers Nampula indicated that it had not trained community health workers more extensively because budget constraints did not allow for full implementation of a PEC approach across districts of focus. Instead, Sightsavers tried to raise additional funding for this activity.

Sofala *activistas* were trained on community mobilisation and increased capacity building and recruitment of these community workers was a priority for district hospital clinical directors. Though the Provincial Department of Health expressed strong interest in the expansion of

[17] http://www.iapb.org/vision-2020/what-is-avoidable-blindness/cataract

this cadre, at the time of the evaluation intentions to grow the number of *activistas* extensively had not been put into place. Buzi District, for instance, only had three operating *activistas.*

While the project underperformed on its training of PEC workers, it did facilitate some level of community eye care action and integration of PEC into PHC through the use of mobile clinics. In Sofala, at the time of data collection for this review, eight outreach visits had been scheduled for 2015, three coordinated by the Provincial Department of Health with EC funding and five coordinated by Beira Central Hospital with financial support from LftW. A week is set aside for the senior ophthalmologist from Beira Central Hospital to go to work with the local OTs and *activistas* at the district level who mobilise patients and schedule a day for surgery. The team then diagnoses the patients and, where necessary, they are referred to the relevant district hospital.

Over the duration of the AHC programme, Nampula developed a well-coordinated annual programme for ophthalmologist outreach visits to districts. The procedure in place is that this plan is agreed annually by Sightsavers and the Chief Ophthalmologist at Nampula Central Hospital (NCH). Each outreach runs for 15 days in a particular district, with around 100 cataract surgeries taking place over that time.

OTs reported using radio as well as communication via *activistas* to announce outreach visit schedules. FGD participants in both Nampula and Sofala shared that radio was effective as a means of informing community members of outreach visits in their areas:

When the OT is coming or when the eye doctor is coming, then it gets reported on the radio. We all hear because we all have radios. (Focus group discussion participant, Mozambique)

We found out on the radio, TV and through the activistas. They would tell you that, 'On Wednesday, there will be eye surgery,' …. (Focus group discussion participant, Mozambique)

With regards community awareness-raising around eye health, community members' levels of understanding of their own eye health conditions varied between and within the provinces. They did not appear to be very high in the one FGD held in Nampula Province but this was underscored to some degree by very high levels of confidence in the district-based eye health services. Conversely, in Sofala, all FGD beneficiaries interviewed at Buzi district had undergone cataract surgery and could identify the procedure. They too trusted and were grateful for the eye health services they had received.

The final indicator of the degree to which PEC integration with PHC improved was the functionality of the referral system. The project exceeded its target in this area – the number of people referred – by 59%, a strong sign of improved use of these systems. 1,472 patients in Sofala and 3,737 in Nampula were referred in the project's final year, up from a total of 112 referrals for both provinces in 2011. Increased and more appropriate referrals occurred moving up the health system; however, the functionality of referrals from district- to primary-level health centres was less effective.

One of the main factors limiting the performance of PEC workers trained was the lack of monitoring and support to the recently trained ophthalmic technicians by MoH Provincial Eye Health Coordinators, making the outcome of the PEC worker training difficult to assess. Development of tools to effectively follow up on newly trained ophthalmic technicians would therefore be important in the future.

Zimbabwe

The AHC successfully completed primary eye care training (integrated into PHC) across four districts as a pilot. In all, the project trained 573 VHWs to identify eye conditions and to refer for them, as well as 80 PHC nurses (2 nurses per clinic over 40 clinics in Gokwe North, Mangwe, Nkayi and Hwange District), significantly exceeding set targets for training at this level, as shown on Figure 11:

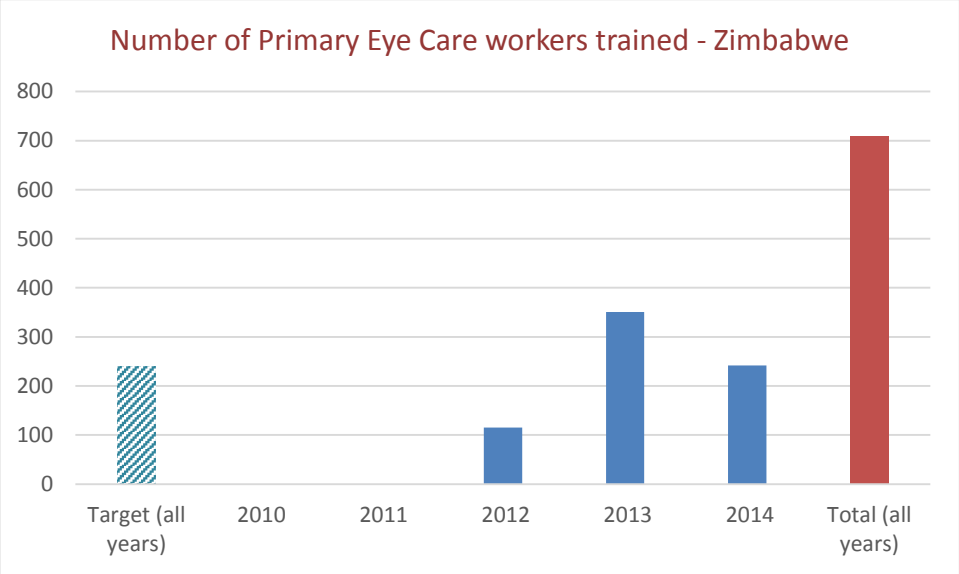

Figure 17: Number of primary eye workers trained by AHC project in Zimbabwe

PHC nurses were each given a Snellen chart and a battery-operated penlight for examining the eye. Ten VHWs (four in Gokwe North and six in Mangwe District) reported that they had been trained in 2013 along with traditional leaders from their communities. This training was very clear in its instruction to health workers: as a result, both VHWs and the PHC nurse within districts of focus were consistent in their description of the patient referral pathway between different levels of care in the health system, as well as their description of course content.

VHWs interviewed reported that they focus on symptom identification, including for traumatic injury, glaucoma, paediatric eye care and cataracts. They reported that they do not see a lot of instances of cataract but do see a range of eye conditions overall. They described their role as being strongly referral oriented. They regularly referred patients to the clinic for further assessment and treatment. The only direct advice they offer is that if people get dust in the eye they can sprinkle water in the eye to help clear it, but should then still go to the clinic. They do follow-up on eye care patients who return from district level after treatment or surgery and also help with mobilising community members when there are outreaches or camps. VHWs also encouraged patients to desist from using traditional herbs for eye problems, and observed that people are no longer using traditional medicines like tomatoes or sugar to treat eyes but rather use the clinic.

Many people who are working with crops get chemicals from spraying in their eyes. We advise them to wear protective clothing, including goggles for their eyes. (Village health worker in group discussion, Zimbabwe)

VHWs attend monthly supervision and reporting meetings at the clinic. They use a standard form for reporting, which has space for reporting on cataract cases and other eye health cases referred to the clinic. The Community Nurse working in Gokwe District indicated that groceries are also sometimes provided to VHWs. She cited the Global Fund as a major

current donor that provides for allowances for VHWs (for activities other than eye health), but noted that not all VHWs fall within the Global Fund's geographical focus areas.

There is also evidence that the health system already loses many potential patients through their inability to afford travel to district level for their eye conditions. This is most likely to continue to affect those who are already marginalised and vulnerable (with some additionally disabled due to avoidable blindness). A common theme in focus group discussions was the economic constraints experienced by community members wishing to access eye health services. This factor was largely outside the scope of the AHC project to address but is important to note since it ultimately affects the quality of eye service delivery overall. A primary barrier repeatedly mentioned was that of the cost of travel to district based eye-health services:

It's a great distance to the service. We don't have money. It's difficult to get money for transport. (Participant in FGD, Zimbabwe)

I need to go to the district. Last month I had the money but then I had to use it for something else so now I can't go. (Participant in FGD, Zimbabwe)

Provincial focal points for Midlands and Matabeleland North indicated that OPNs are expected to go out within their districts and screen eye conditions, making bookings for mature cataracts as they go. They refer cataract patients to the facility which is nearest to where the patient is living. OPNs at district level raised the fact that they cannot provide as much time for outreach work to conduct assessments, do follow-ups and carry out community education work. This weakens the overall impact of the project.

A challenge experienced by OPNs is that they can get sucked into general nursing duties at district hospitals. This was identified as a risk by the Chief Ophthalmologist and Provincial focal points for eye health. OPNs are largely left to self-manage the provision of eye care services in addition to other duties allocated to them at hospital level on a daily or more irregular basis. Those OPNs who were working in pairs or in teams appeared more functional and better able to carry out a wider range of services at community level, as reflected in the exceptional comment below regarding the output of a pair of OPNs at a district hospital:

We have monthly outreach services including cataract surgery, refraction with referral to Richard Morris and we got equipment from the EU. We did awareness raising in 2014. (Stakeholder at district level, Zimbabwe)

Outreach activities and eye camps have gone some way to enhancing access to eye health to hitherto economically marginalised populations, but more such activities are required on a regular basis within all districts. Considerable work still needs to be done to ensure that ophthalmic nursing services are more accessible within districts rather than at district hospitals alone. Some OPNs spoke about the need to do more community awareness raising to create increased demand for their services. In addition, follow-up training is required if recent gains are to be consolidated.

A further limitation is that nurses are not allowed to drive motorbikes to conduct outreach (this is only permitted for health technicians) and so they remain dependent on vehicles. Overall, OPNs reported high levels of enthusiasm to expand their efforts through outreach within their communities. This is, however, not yet consistently followed through by the sharing of outreach plans and institutional backing to carrying out outreach activities at community level. Some but not all OPNs had at the time of the review, developed district outreach plans, including in line with other planned outreach activities within their districts so

as to defray the cost of transport. OPN district outreach plans did not always enjoy management support and prioritisation within their institutions. Constraints impacting on OPNs at district level were summarised by one stakeholder as follows:

The key challenge we have regarding eye health is scaling it up. We need more campaigns and more funding to raise awareness at community level. We have not seen an increase in referrals for eye health as yet. Fuel, accommodation and food costs make outreaches costly and there is no funding at district level for these, but this is the best way to reach people [rather than referring them to district level]. (Stakeholder at district health level, Zimbabwe)

Senior-level 'champions' of eye health at district level could majorly improve the overall functioning of many OPNs at district level, particularly those working on their own.

4.3.7 KRA 4: Effective collaboration between actors involved in human resource development for eye health work in Southern Africa

Regional

This final key result area measured the extent to which the project brought together key national and regional actors in health and human resource development to support its ultimate goal of strengthening human resource capacity in eye health. Regional results are shown in Figure 18:

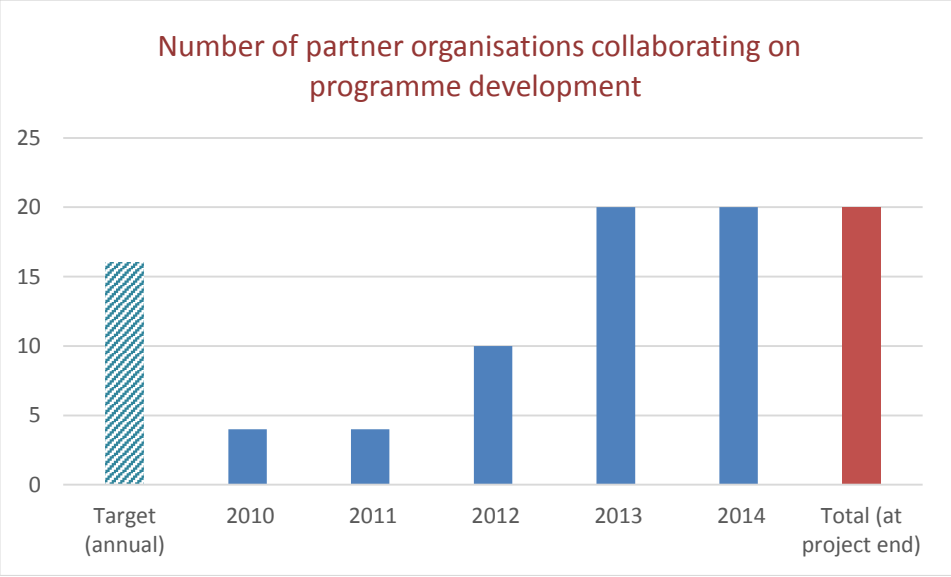

Figure 18: AHC Regional Number of partner organisations collaborating on programme development [18]

The programme out-performed its target on the number of organisations involved in programme development by 25% in 2013. Stakeholders consistently identified the project's consortium approach as one of its key success factors. Generally the programme was successful in including the most important actors in government to support its implementation.

Similarly, the advocacy component was particularly effective at including key eye health and disability organisations at the national level in advocacy groups or as targets of advocacy activities, as shown on Figure 19:

[18] The AHC Project Indicator Tracking Tool did not reflect any results for 2014, which is why this year's result reflects as zero on the table.

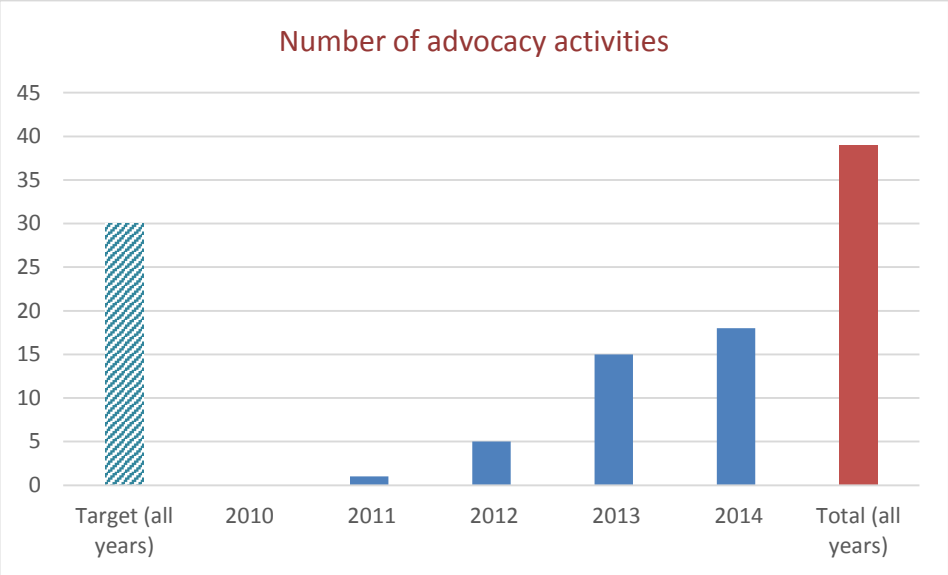

Figure 19: AHC Regional: Number of advocacy activities

The programme exceeded its targets for number of advocacy activities by 60%, with all countries outperforming their targets, and Zimbabwe in particular by 83%. Accelerated activity is reflected for the last two years of the project's life (2013 and 2014). Advocacy activities at the country level aimed to facilitate PEC integration into PHC, and in some cases to improve resource allocation to eye health at the national and district level. Malawi and Mozambique also had a particular focus on ensuring a regular supply of equipment and consumables to the sector. Each country produced a position paper and policy brief on eye health and, in particular, the integration of PEC into PHC. Leaders of the national advocacy groups – HelpAge International in Mozambique and HelpAge Zimbabwe, and Eye for Development and Malawi Health Equity Network in Malawi – presented these briefs and papers to the Ministries of Health in all countries. Advocacy groups also inputted into relevant governing documents on health and eye health in the country, such as the National Eye Health Strategy 2014–2018 in Zimbabwe and Vision2020 National Action Plan in Mozambique.

At a sub-regional level, advocacy activities were led by Sightsavers and HelpAge International, with support from IAPB in lobbying continental bodies such as the African Union. The project aimed at influencing the development of a human resource development strategy on eye health that would clearly prioritise eye health in SADC. The project successfully produced a policy paper and position paper outlining a regional position for SADC's reference. This was shared with the SADC Health and Pharmaceutical Division in 2014; however, SADC has not developed an eye health strategy.

Furthermore, sub-regional and global advocacy activities included critiquing the AU's Africa Health Strategy 2007–2015, as well as meeting with the World Health Organisation's Africa Regional Office in order to cement eye health as a priority in their non-communicable disease and conditions (NCDC) work, and garner support for the SADC eye health strategy. These activities generally succeeded in highlighting the importance of human resource development for eye health in the region. There is still plenty of opportunity for the further development of key advocacy themes emerging as crosscutting to the project going forward.

Malawi

As identified in the Final Progress Report for the Advocacy Component, two advocacy groups were established in 2012 and led by Eye for Development (EFD) and Malawi Health Equity Network (MHEN). The groups each developed strategies and took responsibility for separate

objectives: EFD for the inclusion of eye health services in the district implementation plans of Thyolo and Mwanza districts, and MHEN for sensitising and mobilising communities on promoting eye health and demanding eye care services in these districts.

At a review in 2013, the advocacy groups decided to maintain their focus on national level advocacy issues and establish the Mwanza District Eye Health Advocacy Group to continue implementing the two previous advocacy objectives. A new national objective was devised around human resources for the eye care sector; namely that government funds be allocated for training and support of OCO and cataract surgeons by 2015.

Advocacy activities included conducting a policy analysis and situation analysis, and subsequently holding a validation workshop with a number of relevant stakeholders. The workshop was attended by a wide audience, including the private sector, OCOs, District Health Management Teams, the Mwanza District Executive Committee (DEC), the District Health Officer and the District Commissioner. Advocacy group members encouraged on the members of the DEC to support the District Health Office in addressing eye health challenges in the district.

It was noted that advocacy activities in Malawi have been instrumental in raising the profile of eye care and encouraging the inclusion of eye care into District Implementation Plans (DIPs), with a number of districts integrating eye care into both DIPs and budgets.

Mozambique
The AHC programme provided the opportunity for NGO project partners to increasingly integrate eye health into Ministry of Health planning and to grow their voice in eye care. As in the other countries, advocacy work focused on PEC integration into PHC, and also on greater resource allocation to eye care within the MoH budget. In addition to published position papers and policy briefs on PEC/PHC integration, advocacy activities in Mozambique resulted in the development of a National Vision2020 Action Plan, as well as advocacy training and strategy development with the MECC.

The establishment of the project's advocacy group that worked within the MECC came at a slightly inappropriate time for the government. At that point, the government had already developed an action plan on key changes in its structure that would facilitate achievement of some of the advocacy objectives. The advocacy group managed to make some policy changes specific to the district and provincial level, and could still input into this action plan that included planning for ophthalmology.

Using Avedos, a community-based advocacy group, as the lead partner in Nampula Province, the project did advocacy work on the theme of integrating eye health into district health plans. The advocacy group established for eye health (including four organisations, being Avedos, UniLurio, ACAMO and AFDC) was first trained in eye care concepts and the Mozambican context. It then focused on the theme of the integration of eye health into district health plans. It gathered evidence in the six districts of focus, held meetings with District Health officials to share findings, and worked with HelpAge Mozambique on developing and distributing the AHC policy brief and position paper. In the six districts of focus, health plans have integrated eye care, but in the remaining 17 districts in the province, this work has not yet been done.

A monitoring system is now in place in Nampula, and soon to be implemented in Sofala, to measure the outcome of cataract surgery. However, both provinces have experienced great difficulty in collecting all information required for full measurement of surgical outcomes because of the high number of follow-up visits required and associated cost to patient.

Overall, performance on KRA4 appears to have met targets (and exceeded them in many cases in Nampula Province).

Aspects that could potentially have been developed more effectively were capacity building of PEC nurses and a more structured programme to support *activistas*. Project partners indicated that the resource allocation as defined in the country's approved AHC budget did not cater for extensive activity at this level.

Advocacy efforts at a local level yielded useful data on three specific districts of Nampula Province. However, such work only ran for just over one year and would thus have been much more effective if it had been undertaken over a longer period of time.

Zimbabwe

With regards KRA4, advocacy activities undertaken to influence health planning policy initially focussed on two themes: the integration of PEC into PHC and provision of a budget for eye care. Through consensus, it was agreed that integrating PEC into PHC should be the primary focus for the AHC project.

A major success of the advocacy work in Zimbabwe was the development of a common language and agreed key messages for eye health. HelpAge Zimbabwe took the lead in country in developing a position paper and policy brief on eye health through collecting data from key MoH officials in three provinces in Zimbabwe (including one of the target provinces for the project, being Matabeleland South). Resources developed have successfully been used as tools for engaging with the MoHCC: the AHC Management Team presented the brief and paper to MoHCC Minister, Deputy Minister and Permanent Secretary for Health in Zimbabwe. These resources also fed into the National Eye Health Strategy 2014-2018.

It was noted that Zimbabwe still needs a RAAB to determine the exact extent of avoidable blindness. No firm plans are in place for completion of this. At the time of the end of project review, Sightsavers was also looking at carrying out detailed situational analyses of eye health capacity within the three AHC project provinces later in 2015.

With regards evidence of the project sharing its results at a broader regional level, Zimbabwe partners reportedly attended training in use of the IAPB database late in 2014. However, the benefits of such training were not yet evident at the time of the GreaterCapital desk review, which could not trace data on eye health in Zimbabwe on the IAPB website providing for country profiles. This matter was not pursued and it is possible that backlog in uploading such data could exist at IAPB level rather than at the level of supply of data from Zimbabwe AHC partners.

4.4 Efficiency

Regional	***Rating*: Satisfactory**	
Malawi	***Rating:* Satisfactory**	
Mozambique	***Rating:* Satisfactory**	
Zimbabwe	***Rating:* Satisfactory**	

4.4.1 Regional

From mid-point, the project put in place supportive management at regional level and provided more dedicated HR for the project at country level. Systems and supporting documents to enable a shared understanding of the project were developed, as well as project management tools and regular reporting and forward planning sessions at regional level. For instance, during regional meetings (annually), country offices presented on their progress and could request assistance from others in addressing shortfalls on targets. This shared use of resources between countries worked particularly well in helping to reach overall targets. A flexible and supportive approach to budget reallocations between countries also assisted in ensuring that all partners stayed focused on outputs rather than tying up funds that they could not expend within available timeframes.

International coordination efforts were also highlighted as further contributing to a culture of sharing and transparency: these included joint planning; regional best practice workshops; thorough explanations of targets, indicators, monitoring systems; and visits from technical experts.

To address the different provinces of operation and different lead partners in each province in Mozambique, budgets for the two provincial components were managed separately and communications took place directly between the Regional AHC Coordinator and each provincial office, with cc on emails to the other in-country partner. This worked well on the ground and resolved the challenge of Sightsavers Mozambique communicating with Sightsavers at regional level only via the lead partner in country (LftW). Quarterly results from both provinces were consolidated into country-based reports by LftW and then forwarded to the Regional AHC Coordinator. This unorthodox but successful solution to internal difficulties in project management within Mozambique resolved difficulties which were evident at the time of the mid-term review.

Regional advocacy activities generally had a limited budget and less flexibility than programme activities to allocate resources. As the advocacy component relied on the volunteer services of its national group members, a small budget of approximately $2,500 was made available for six months of advocacy activities. CEOs of member organisations were encouraged to provide some financial support to these groups. The AHC Regional co-ordinating body did provide some technical support to advocacy activities particularly at the sub-regional level in conceptualising SADC policy briefs and policy papers.

4.4.2 Malawi

The programme has generally functioned well in terms of efficiency. There was consensus that, once targets were clarified, resources were well managed throughout the second part of the programme, and that adequate technical support was provided in defining and achieving

programme targets. While Malawi experienced some programme management staff turnover during the course of the project, technical support in clarifying targets, their definitions as well as monitoring templates generally resulted in more efficient monitoring and reporting of results in the second half of the project. It was noted that there were some delays, particularly with procurement of equipment which was handled locally and not by Sightsavers. The Ministry of Health also delayed the deployment of students, which proved challenging as it was promised that they would be deployed sooner. Understaffing at MCHS was also a challenge, with the college struggling to recruit extra faculty as the programme grew.

4.4.3 Mozambique

A strong team was in place in the Sightsavers Nampula office, with clearly defined roles covering in-depth programme delivery (project officer), national advocacy (director) and resource allocation (finance manager). Sightsavers was regarded as supportive, efficient and helpful partner by all stakeholders involved in eye care that were interviewed for the end-of-project review.

Relationship issues that were hampering performance and overall management on the project during its first half were resolved with the support of the Regional AHC Coordinator. From mid-term, LftW took an active lead in country-level reporting and altered budgeting planning and timelines to better align with internal processes and planning. While they highlighted continued challenges with administering some of the management tools and data collection indices such as the Quality of Life questionnaire, LftW coordinated monthly and quarterly reporting, with detailed inputs from both provincial lead partners (Sightsavers for Nampula and LftW for Sofala) on a monthly and quarterly basis. While Sofala project partners reported some delays in fund disbursement from LfTW, generally administering of budgets improved since the mid-term review. Clear reporting and communication lines, specific roles for both Sightsavers Nampula and LfTW, and the relative autonomy with which Sightsavers Nampula operated provided a successful solution to management challenges experienced during 2010–2012, allowing for improved performance over the remaining project period.

4.4.4 Zimbabwe

Efficient use of country resources during the second half of the project was successfully enabled through transparency amongst partners about what resources were available and a strong partnership approach led by the MoHCC Deputy Director for NCDs. This was a major achievement considering the short period of time that the AHC partnership functioned at optimal level in Zimbabwe (approximately 2.5 years).

An additional factor which improved project efficiency during 2013–2014 was clarity around roles and responsibilities amongst project partners. This enabled all partners to make an active and clear contribution that supported the AHC project as a whole.

A major challenge experienced by the AHC project at start-up and until well into the third year of the project was the absence of any accurate data on eye health service delivery or prevalence of eye health conditions in country. Strong efforts were made through the AHC project to remedy this issue through active institutional strengthening of the health system data management system, with an emphasis on the integration of eye care into existing health care surveillance systems. The AHC project team also met with the Health Information Department at national level in 2014 to propose the inclusion of specific eye health indicators within the national health surveillance system. This matter was reported at the time of the end-of-project review to be ongoing.

Data currently collected at national level only captures the number of cataracts seen, number of other eye conditions seen and number of cataract surgeries carried out. The MoHCC NCD Deputy Director reported encouraging all provinces to voluntarily report using new forms but this still needs formal endorsement from national level to be institutionalised within the national health surveillance system. The NCD Deputy Directorate was able to produce increasingly comprehensive data on service delivery in the three provinces of focus for the AHC project over the past three years.

In the four target districts for training in the integration of PEC into PHC, a data collection system is operating to track eye health activities of village health workers and PHC nurses. Use of forms to capture eye health data was verified by the evaluation team at relevant points of data collection in Midlands and Matabeleland North: reports on file reflect consistent reporting templates and up-to-date monthly reports at VHW, clinic and district levels in provinces of focus.

It is, however, also noted that the existence of systems and structures for management of health services does not always translate into application thereof in practice. During field visits to provincial sites, GreaterCapital noted different levels of application of newly-developed management practices for eye health activities (with more apparent success observed in Matabeleland North than in Midlands Province). This is probably associated with the severe capacity and financial resource gaps within the Ministry of Health, as well as the gradual (rather than fully-fledged) emergence of institutional support for eye health at various levels within the MoHCC; and is understandable, considering that the project did not have much time to entrench such systems before drawing to a close. The following discrepancies between intended procedures within the health system and actual practice were reported during field visits:

- The three provinces serviced by the project have vacancies in the position of provincial state ophthalmologist. This issue has been provisionally addressed through the MoHCC Director for NCDs designating the responsibility of focal point for eye health activities in these provinces to the Provincial Managers for NCDs.
- The buy-in of district medical officers (who manage health services overall at district level) on the issue of eye health varied considerably. Where support did exist, it was noted by OPNs as a major facilitating factor in their achievement of eye health duties.
- Many of the OPNs interviewed at district level spoke of their challenges in trying (often without much support) to balance their workloads between OPN and other general nursing duties within hospitals. OPNs who were working in pairs or larger teams generally appeared more productive, focused and motivated.
- District-based OPNs frequently spoke of the difficulty they had in securing time and transport to conduct outreach and follow-up activities at community level within their districts.
- It was also apparent that primary health care facilities are stretched and cannot always provide dedicated time for eye health examinations.
- Services at both primary health care and district hospital levels are also currently limited due to the non-availability of eye health medications and supplies for common conditions.
- Village health workers and others working at primary health care level also noted that, while a clear referral system has been established, this cannot always be operationalised because of the absence of suitable medication at primary and district

health care facilities, as well as the costliness of transport for community members travelling to access health facilities.

A particular challenge faced in Zimbabwe was that it was the only one of the three countries under the AHC project that had three provinces of focus. Along with the massive backlog in terms of existing systems and structures for effective eye health service delivery, this resulted in the AHC project in country being spread very thinly. In order to allow for effective operationalisation of the project, the project made a pragmatic decision to adopt a tailored focus on specific districts within the provinces. This enabled most efficient use of available resources, also allowing for measurable achievement in specific districts of focus.

In all, it appears that, while the project has successfully strengthened the health system infrastructure for eye health delivery at a structural level, the entrenchment of systems and structures for managing eye health at different levels of the health system still requires considerable nurturance and reinforcement over coming years in order for these to become standard practice.

4.5 Impact

Regional	***Rating*: Satisfactory**	
Malawi	***Rating:* Highly satisfactory**	
Mozambique	***Rating:* Highly satisfactory**	
Zimbabwe	***Rating*: Satisfactory**	

4.5.1 Regional

The following overall impacts were achieved by the project:

- Enhanced human resource capacity in eye health at district and primary levels
- Increased understanding and visibility of eye health at the district level as well as increased demand for eye care
- Improved referral systems
- More skilled training institutes
- Production of relevant policy briefs and position papers at country and regional level
- Inputs into global health priorities: post-2015 Sustainable Development Goals to include wording on disability of which eye health is a part
- Influencing regional approach to eye health:
  - Critique of AU Africa Strategy for Health 2007–2015
  - Wording on eye health to be incorporated into final SADC NCD Strategic Framework
  - Lobbying WHO-Afro to continue to prioritise eye health in NCD strategy, and to encourage SADC to finalise inclusion of eye health in SADC NCD Strategic Framework.
- The development and publishing of an Advocacy Training of Trainers manual.

There is evidence of successful achievement of strengthened human resource capacity in all countries, and health systems strengthening (of formal health system) in Mozambique and Zimbabwe. The project made a significant contribution to the development of human

resources across mid-level eye health cadres in each of the countries but did not yet manage to have major impact in terms of increasing cataract surgery human resourcing across the regional programme. Work on policy and an enabling environment for this is ongoing in both Mozambique and Zimbabwe.

The project has strengthened the platform for eye health advocacy work at national level and regional level, and produced documentation to guide this (position and policy papers). Successful integration of PEC into PHC was achieved in as far as advocacy activities increased community awareness and understanding of eye health, and impacted positively on the health seeking behaviour of patient beneficiaries. At the district level, some evidence of increased prioritisation of eye health was seen in the specific provision for eye health in District Implementation Plans in Malawi, for instance.

Successful partnerships that crosscut state, development partner and training institution sectors have been built (particularly in Mozambique and Zimbabwe which had less experience in similar projects prior to this one) and exist for harnessing on future eye health activities/projects. This is a major achievement because it was a new experience for many of the partners involved to work in such a collaborative way.

At a sub-regional level, the project was overly ambitious on how much change it could bring about at SADC level, however there has reportedly been a gradual improvement in understanding and buy-in around the importance of eye health within SADC and potential support for this work from WHO-Afro[19].

While the project may not be able to show palpable changes at the level of SADC integration of eye health into primary health, this discussion has started. AHC Regional Co-ordinator

The project proposal and mid-term review included a specific focus on gender aspects of the project. While the project improved on gender programming in the second half by tracking beneficiaries accessing eye health services by gender, there is little evidence of changed strategies at country level to increase the number of females reached or to adopt specific approaches targeting either gender (such as older women for cataract, or working men for trauma). This was a lost opportunity in terms of potential project impact. Gender-focused work requires thoughtfulness, depth and long-term commitment if it is to be successful.

4.5.2 Malawi

Key programme achievements in Malawi were:

- Realising the target of training 112 mid-level staff, being 90 OCOs and 22 cataract surgeons
- An improvement in the functionality of the referral system between different levels of service, in terms of both the number and accuracy of referrals
- Greater integration of primary eye care services into primary health care via the training of staff at primary level and the stimulation of demand for these services
- The regular scheduling of eye clinics and outreach services, with ophthalmologists conducting surgery at district level on a quarterly basis
- Performing cataract surgery on paediatric patients, with Malawi being the only one of the three AHC countries to have an explicit target for this service.
- High level of beneficiary satisfaction with eye health care services received.

Overall impact on three levels of the health care system

[19] As reported by AHC RPC and AHC regional staff involved in advocacy and HReH.

At tertiary level, the programme had the positive impact of reducing the burden of unnecessary referrals. Simple, routine cases which were previously referred are now able to be dealt with at primary and district levels of the health system. It has also allowed for skills development of ophthalmologists in tertiary healthcare settings, as well as the cataract surgeons who work alongside them. There have been some challenges in managing the role of being a teaching hospital as well as a general hospital, but generally the impact has been positive.

A significant level of positive impact has also been felt at the mid-level of the healthcare system. At the crux of this is the reported improved ability of mid-level cadres to handle general eye care conditions, such as refractive errors, trachoma and trichiasis; and the performance of cataract surgery at sites that are sufficiently equipped. Following from this, better screening is reported to be taking place and referrals to the tertiary level have become more efficient. District Health Management Teams are also reported to be taking eye care more seriously, however improved resource allocation does not always follow as a result of this. Awareness of eye health has generally improved, both within hospitals and communities.

The primary level has also seen significant impact, despite not being the primary target group for training and strengthening. As with mid- and tertiary levels, referrals have improved as has the capacity to treat basic conditions. At this level, mid-level eye health professionals reported that they have seen greater demand for eye care services in the wake of community mobilisation and advocacy.

*Before the AHC programme you couldn't talk much about eye health at the community level, but we can now talk about it. (*Project partner, Malawi)

Human resource capacity

The focus on HR development aimed at not only a quantitative increase in staff, but also improved productivity, ability to meet demand, skill levels and depth of outreach to communities. These improvements have been generally achieved, with a number of positive impacts seen in these areas. Specifically, the programme has served as a motivator for mid-level eye health professionals. As an example, most project-trained cataract surgeons in Malawi reported that they operate on an average of 50 patients per month with a high success rate. Mentoring is another aspect which seems to be operating successfully. This appears to happen on a somewhat informal basis in the districts, based on the timing of ophthalmologists' visits, while those working at a central level or with cataract surgeons are receiving mentoring on an almost daily basis. Only one case was observed where no mentoring or supervision was occurring. Most also reported having participated in refresher training, particularly around paediatric cases.

There were some areas identified in which HR practices could improve. OCOs generally feel that they are able to meet the demand which is presented to them in a hospital setting. However, they feel that they are constricted by a lack of mobility and lack of equipment in meeting wider community eye care needs. Furthermore, the time and effort needed to produce a strong cataract surgeon who is able to work independently may have been underestimated; and prospects for career development are unclear and may serve to de-motivate workers and prompt them to explore working in other areas.

Depth of outreach

It appears that the depth of eye care service provision has been significantly improved via such activities as home-based follow-ups after operations, hospital reminders and improved follow-up through presentations at relevant meetings or on radio. While this is a great result,

it could benefit from greater resourcing. The development of district implementation plans should be able to assist in prioritising key areas and how to budget for this.

Integration of PEC into PHC

There was consensus that integration of PEC into primary health care (PHC) has been generally very positive. This appears to be due to efforts around awareness raising and a strong alignment with existing community structures; HSAs have played a critical role in this regard through improving the understanding of eye care among the community. Nurses and medical assistants have additionally played a role in identifying cases and providing a strong level of personal attention and follow-up to patients. It is necessary to think through how this will continue if it is not resourced.

Functioning of referral system

The programme has served to improve the functioning of the referral system; not only are more people being referred, but referrals are being made more accurately. Formalised processes for making referrals are common and functioning well, using tools such as forms and health passports as a means for capturing and relaying patient information. It was noted that occasionally the information received back was not always of the same quality. Personal follow-ups at the local health centre level are of immense value, as the need to travel to a district hospital can be a deterrent, especially if a patient sees immediate improvement after treatment.

Referrals to and from district level are generally functioning well, with health surveillance assistants following up with beneficiaries in their homes post-surgery and post-treatment. While the formal referral systems are generally functioning smoothly, informal means of communication such as radio and sending messages by ambulance are still used for messages and follow-up.

Beneficiary and community impact

Overall, there was a great level of satisfaction at the beneficiary and community level. There was strong agreement among beneficiaries that treatment had changed their lives for the better, and that they would recommend the services they received to others in their community. While patients did not always display a good understanding of the condition they were suffering (except parents of paediatric patients), they showed a high level of approval, particularly for ambulance services to the hospital and around follow-up sessions at health centres.

Life is better, much better. Life has really changed for us. We can now do farming, reading, any household chores. Before the children had to do everything in the house, but now we can do our own household chores. (FGD participant, Malawi)

The primary challenge identified by beneficiaries was that of transportation. It was commonly mentioned that long distances, combined with the cost of transportation, were the most difficult factors in obtaining eye care services. Although satisfaction was overall high, buy-in and understanding around the need for follow-up appointments was not yet fully realised; changes in community perception are happening slowly.

4.5.3 Mozambique

In general the programme was successful in building human resource capacity for eye care particularly at the mid-level and increasingly the primary level, and improving access to eye health care and health seeking behaviour amongst communities.

In Nampula overall the programme has had major impact in a number of areas: building solid long-term working relationships across a range of partners involved in eye health; making a dent in the CS backlog; developing OT capacity across almost all districts of the province (with some districts to be serviced with the completion of training of 15 additional OTs by mid-2016). The project was essentially successful in increasing access of rural communities to mid-level eye health assessment and cataract surgery services. Sightsavers also benefited in the longer term through developing capacity in training on primary eye care (PEC) through Light for the World (LftW), using the Helen Keller manual.

While Sofala did not perform as strongly as Nampula, there was evidence of improved functioning of the mid-level health care system and satisfaction from both staff and patients with the overall impact of the programme on patient livelihoods.

Patient satisfaction with eye health services was high at the one FGD held at Namapa District Hospital in Nampula, and at Buzi District Hospital in Buzi. Participants agreed as follows:

Thank you to the OT and the district hospital for my treatment. I am very grateful. The OT is working well and he treats everyone very well. He has a very good way of attending to patients. (Participant in FGD, Mozambique)

On the day I was operated on, there were many people coming for the same surgery – about 200. One man was brought from his home. Other people living in Gwangwara were brought to hospital by a mobile unit. They did a very good job bringing people. (Participant in FGD, Mozambique)

FGD participants also relayed positive outcomes in terms of improved quality of life:

Before, we could not do anything for ourselves. Even simple things. We could not see the fish on our plate or feed ourselves or even go to the toilet ourselves. Now we can see and are independent again. We can see people clearly again. (Participant in FGD, Mozambique)

These positive outcomes were in sharp contrast to the reportedly dehumanising treatment experienced by those who had been visually disabled, as captured in the following comments from FGD participants:

People were taking advantage of me. They would steal my plate away from me while I was trying to eat. People would laugh at me. I am very grateful that it is no longer like that for me. (Participant in FGD, Mozambique)

Some people believe that others have been bewitched if they have eye problems while other know it is a sickness. You get children with cataracts as well and sometimes people think these children have been cursed. We are trying to teach people the right way. (Participant in FGD, Mozambique)

The overall picture in terms of access to services for both provinces is that it is well oriented to cataract detection and referral but other conditions are not always being addressed with the same level of effectiveness.

The OTs are supposed to include patients with other eye conditions but most of those we see during outreaches are with cataracts. What we are seeing is that patients don't use services so much now in some districts because we have checked the main settlements for cataract. (Project partner, Mozambique)

Those located closer to larger rural health posts and with more access to financial resources are more likely to access services. This was confirmed in the Nampula FGD where participants mentioned the following:

Transport is very expensive. Even travelling here by bicycle is difficult because the roads are so bad. (Participant in FGD, Mozambique)

FGD participants in Nampula Province were also eager to see expanded service delivery for eye health in their district:

The only problem is that the OT can only come to the community at certain times. There is a great need. The project needs to expand. It needs to reach into deep rural areas where there are many people in need. (Participant in FGD, Mozambique)

Nampula Province in Mozambique emerged as a location with specific challenges regarding gender. Many fewer women accessed services than men during the life of the project. This was mirrored in the Nampula Province FGD, where 11 of the 13 patients were male, and where only one female had had cataract surgery compared with seven males. OTs at district level and partners involved in advocacy activities conceded that there are serious gender discrepancies that prevail with regards females' access to service compared with males. Women are not generally permitted to travel unaccompanied by at least their husband, sister or another close family member. This raises the costs of using health services since double the transport and other allowances are required. Women's roles in the home and as primary caregivers of children also prevent their being able to take time out to attend to health concerns. The project missed an opportunity to developed highly tailored information, education and communication (IEC) materials to encourage women's uptake of cataract services in particular.

Gender differences in access to eye health services were less clear in Sofala, where there was a more even split between male and female participants in both FGDs: out of ten participants in the first FGD, four were female, and of three participants in the second, one was a woman. Women reported similar outcomes and changes to their lives as a result of surgery to men: improved mobility, the ability to do basic chores and a sense of regained independence, though the types of activities they were able to do differed from their male counterparts.

OT and other partners in Sofala also gave mixed feedback on health-seeking behaviour trends of males vs females, though most agreed that women tended to present themselves at eye health services more often than men. OTs in Sofala reported that they generally examined more women than men, and that they had seen an overall increase in the number of female patients over the lifetime of the project. As they spend most time with children and bring them to hospital for other reasons, women were seen as more likely to be exposed to

information about available eye care services and also more likely to act on this information. One OT speculated that, because two out of three *activistas* working in the district were female, women were more comfortable to follow through on accessing eye care. Most of the respondents were, however, speculating on these reasons for women's access to healthcare and there is a lack of evidence of systematic analysis of the number of female vs. male patients and reasons for observed trends.

With regards to OT support and career development, overall mid-level cadres enjoyed their work and were driven by the ultimate goal of helping to restore their patients' eyesight. The availability of job support and career development including CPD, on-the-job mentorship and supervision as well as a reliable supply of consumables and equipment varied amongst the Mozambican OTs. Less than half could confidently say that they regularly had the supply of consumables they needed to do their work.

Most OTs in Sofala had received some form of formal refresher training that focused on refraction errors and fundoscopy. Where mentorship and supervision were available, OTs operating at the district level received this support twice a year on average. Only one OT reported working completely unsupervised. In Nampula, support to OTs at district level was weaker, with district-based OTs indicating they had only received one supervision visit since entering their OT positions with no clear DPS plan in place for their ongoing supervision.

In Nampula Province, OTs (with one exception) appeared highly motivated and productive. A number of OTs expressed that they were very keen to train as cataract surgeons. A longer-term concern is that this could deplete the current institutional experience being built up across this cadre if a sufficient pipeline of additional OTs is not in place to replace them if they train as cataract surgeons. However, this is not an immediate challenge since protocols in country do not currently make allowance for the cadre of cataract surgeon, and this matter is still under discussion between the MECC, NECC and MoH in an effort to put in place a framework for human resourcing before training takes place.

4.5.4 Zimbabwe

The project has made a solid contribution to building a strong strategic foundation for eye health in Zimbabwe. This is evidenced through the following achievements, which have a lasting impact beyond the life of the project itself:

- The formulation and adoption of a National Eye Health Strategy by the Government of Zimbabwe
- The development of a position paper and policy brief on eye health in Zimbabwe, providing a common language and agreed priorities regarding advocacy priorities
- Increased human resource capacity across community, primary and mid-levels, including systems for a strong referral system
- Development of functional district-level eye units through the provision of kits for the work of OPNs
- The existence of trained OPNs reported having the capacity and confidence to handle a cross-section of eye challenges, with some OPNs conducting minor surgeries and others supporting ophthalmologists conducting cataract surgery.
- Development and utilisation of cataract surgical quality outcome tool and eye health data capture tool
- Increased eye health awareness resulting in increased demand
- Improved referral system due to trained PEC health workers (Nurses and VHWS)
- Strengthened eye health coordination at national and provincial levels

- Increased capacity at national level to provide for OPN training, as reflected through the Parirenyatwa School of Nursing's comments that it is now equipped to provide training to additional numbers of ophthalmic nursing students because of additions made to their teaching and lab equipment; also through a second ophthalmic nurse training school opening at UBH.

We currently have 19 more OPNs in training. We were only training ten per year before 2010. (Project partner, Zimbabwe)

Some mid-level health professionals noted that incentives were sorely lacking for eye health by comparison with other programmes. The practice of sharing available allowances across all staff involved in outreach (as has reportedly taken place through the intervention of DMOs and DNOs in some districts) is to be strongly encouraged. Another key financial resourcing gap on the programme is allowances for VHWs.

As commented elsewhere, the training of cataract surgeons under the project has not provided a solution to the shortage of skills to perform surgeries in the three provinces of focus under the project. In Midlands specifically, because there is no ophthalmologist, it has been very difficult to establish a clear programme for eye clinics. There is also evidence of insufficient institutional support for CS service delivery at district level within Midlands Province. Referral to the cataract surgeon at Gokwe North District Hospital is not taking place in a structured manner and the service is currently underutilised. The cataract surgeon indicated that he works on a drop-in basis and is not in a position to provide a regular schedule for performing cataract surgeries on set days per month. At the time of the review, he had not yet set in place a firm plan for any outreach clinics for the province to provide for cataract surgeries at district level.

Servicing Midlands Province also comes as a secondary priority after ophthalmologists in other provinces have first attended to their own provincial needs. Furthermore, the cataract surgeon at Gokwe North District Hospital intends to take up studies as an ophthalmologist at the start of 2017. This will mean that he will be out of circulation in Midlands Province for three years but hopefully available to work as a provincial ophthalmologist thereafter.

Cataract surgery service delivery in Matabeleland North and South continues to take place via eye camps (using staff from the Richard Morris Eye Unit at UBH) which take place in different districts in accordance with an annual schedule and the availability of funds generated by the Council for the Blind. As described by a stakeholder working within the health system in Matabeleland North Province:

We are reliant on capacity of UBH to do surgery. We currently only have 2015 dates confirmed for outreaches in two districts this year…. (Stakeholder working in health, Zimbabwe)

Because of the Government of Zimbabwe's continued dependence on external funding for core service delivery (as at early 2015 and going forward), the following potential factors could negatively influence the medium- to long-term impact of this programme over time:

- Financial resource constraints not allowing for further eye health systems and activity development, particularly if there is a loss of human resources cultivated under the programme at the same time.

- Attrition of key leadership figures before another wave of local leadership pushing for eye health services can emerge.
- Limited opportunities for continuing professional development (refresher training and further training) of human resources trained on the programme, being a concern noted by OPNs, VHWs and the PHC nurse interviewed during the review.

4.6 Sustainability

Regional	***Rating*: Satisfactory** 
Malawi	***Rating*: Satisfactory** 
Mozambique	***Rating:* Highly satisfactory** 
Zimbabwe	***Rating*: Caution** 

4.6.1 Regional

The main focus of sustainability measures on the project was a concerted effort over the second half of the project to strengthen the eye health systems in each of the countries.

This has been achieved to varying degrees:

- Zimbabwe has been very challenging in this regard because the MoHCC has no self-generated funds for eye health and is almost entirely dependent on funding inputs from the development sector. While this is not a sustainable approach, there is evidence in the attitude of the MoHCC and the contents of the newly developed National Eye Health Strategy (2014 – 2018) that the ultimate goal of sustainability has not been forgotten. Furthermore, considerable effort has been made to earmark the limited resources available to the MoHCC to advance human resources around eye health, with the training of OPNs in Zimbabwe and for an additional school for the training of OPNs opened in Bulawayo being supported through resourcing channelled through the MoHCC.
- Mozambique also presented hurdles with regards sustainability because national commitment in the MoH and provincial DPSs to eye health was very weak over much of the project's life. This has changed at national level over the past two years with the appointment of the new NECC since the start of 2013. The MECC has been strong throughout this project and has facilitated the building in future sustainability into the national plan for eye health (still to be approved), such as an earmarked budget and agreed list of consumables that need to be provided by the MoH. Good progress was made in Mozambique in piloting and agreeing procedures for integrating eye care into district health care plans. This has helped to increase provincial government understanding and appreciation of their role in building infrastructure to sustain eye health care at the mid-level.
- From inception, the Malawi project intentionally aligned with existing government structures to facilitate the MoH leading the project after the EC's exit. How effectively the Ministry can do this will remain to be seen as it itself is challenged by low financing for health. Efforts to strengthen MoH lobbying capacity by including representatives in the advocacy group may prove effective in raising money required for eye health at a national level, however current indications suggest that fundamental aspects of the programme to be sustained will need to be identified in order for the Ministry to assume responsibility for them. Stakeholders initially suggested a focus on PEC into PHC, provision of mid-level cadre scholarships, the

procurement and maintenance of equipment and medicines as key areas to be taken forward.

The advocacy component drew up a number of options to sustain national advocacy activities. These options primarily focus on fundraising and shared responsibility for funding amongst the advocacy group members organisations. Additionally, partnering with other international NGOs, continuing to engage with Sightsavers, LftW and other organisations already involved in the project was another suggested sustainability strategy. Finally it was also recommended that advocacy activities leverage the increased focus on Trachoma TT and align with these projects in order to sustain their work.

At a sub-regional level, sustaining and building on the work done to raise the profile of eye health and human resource development in eye health will require a clearer strategy and assurance of resources to support that strategy. IAPB in its own capacity has taken on continuing to integrate human resource development in eye health into a new human resources for eye health (HReH) policy for Mozambique. There are plans to do the same in Malawi from September 2015 and in Zimbabwe from 2018. From the AHC Advocacy Component Final Report, it was not clear how advocacy efforts at the sub-regional level will continue. Sightsavers will need to decide on the ongoing strategy for eye health lobbying and integration at the sub-regional level and whether they will align with work to be done by IAPB.

4.6.2 Malawi

For eye health service delivery, the services are being planned and carried by the respective central hospitals in the zone.

HR development and service provision around eye health were already part of the wider government mandate at the start of the AHC programme, and this remains the case at project end. To ensure ownership of eye health activities addressed under the AHC programme, the partnership approach in Malawi included joint planning of AHC activities with government. This will serve to support the sustainability of future efforts that extend the scope and impact of the AHC project going forward.

As the training of various cadres is central to the programme, the continuity of this aspect is vital to the programme's long-term sustainability. While the Ministry of Health has already been engaged for some years in training eye health professionals and intends to continue with this, other sources of donor funding will need to be secured to support such training, particularly for the scholarship component inherent within the AHC model. Staffing availability at MCHS, particularly with regards technical advisors, has been limited thus far, and it is unclear what the outcome of this will be. As an additional training measure for the sector, a Bachelors Degree in Ophthalmology is being developed which will assist in meeting eye care training needs.

The procurement of equipment and consumables is another area that will impact on the sustainability of the programme. Core concerns in this area are the costs associated with equipment and consumables, as well as technical knowledge of the equipment. It is expected that the Ministry of Health will take the lead on procuring and maintaining equipment, although the budget for this is yet to be determined. Other bodies could possibly be lobbied to provide support in this regard, such as the Ministry of Finance or other NGOs.

Progress was made around the goal of integrating primary eye care into primary health care, but this has not yet been fully realised. DIPs are likely to be key here in identifying the major

backlogs at the primary level in order to determine the most useful strategy for moving forward, whether it be greater investment in technology, investment in vehicles, or strengthened partnerships with advocacy groups.

In terms of recruitment and deployment of trainees, there was full agreement at district level that the work is rewarding from all 14 CSs and OCOs interviewed. It is felt that the informal aspects of support for trainees, such as mentorship, will continue as long as surgeries continue to be carried out.

4.6.3 Mozambique

A discussion regarding sustainability of AHC project activities has been ongoing and has involved all AHC partners in Nampula. With leadership on this more recently stemming from the NECC, this is located at a broader level than just specifically the AHC project or province of focus. The National Eye Health Coordinator who has been in place for past two years is regarded as a major asset in facilitating a long-term sustainability plan that shares a similar approach to MECC. The question of continuing key aspects of the programme beyond its official end is also one that Light for the World and the Sofala Provincial Department of Health had started to plan for and discuss with other implementing partners. Activities beyond the project's end date are generally going to be funded by both the Ministry of Health and Light for the World, in the medium-term – the long term plan for securing the resources necessary to continue mid-level training, procurement and maintenance of equipment, and PEC/PHC integration was less clear.

Eye health practitioners (OTs and ophthalmic teams doing outreach from Nampula Central Hospital (NCH)) delivering eye care services on the ground and OTs at district level in Nampula Province) remain largely reliant on Sightsavers resources for consumables for surgeries, transport costs for outreach and refresher training going forward. As is the case with Sightsavers Mozambique in Nampula Province, there is an ongoing commitment by LftW to support the Sofala Provincial Eye Care Programme with consumables and equipment. This is in recognition of the fact that funds from Ministry of Health coffers do not currently make adequate provision for materials necessary to provide effective eye health service delivery.

It was noted that, for the first time in history, there is now commitment from national level to including consumables and equipment for eye care in the health budget going forward.

The AHC plan for continued activities for Sofala in 2015–2016, jointly owned by the Sofala Provincial Department of Health and LftW, contains significant detail on elements addressing sustainability of AHC activities. Significant provision has been made to continue human resource development activities and, in particular, the supervision of OTs in ten districts, refresher training on monitoring cataracts and other topics for mid-level cadres, and the training of PEC workers and *activistas.* The plan also factors in a provision for equipment costs. Notably, the plan emphasises the continuation of clinical services for eye health, especially outreach clinics and campaigns for 2015–2016 with earmarked resourcing for awareness raising via radio communication in six districts, fuel costs and staff costs (including ophthalmologists, OTs, optometrists and drivers). Finally, the plan also makes a considerable contribution to continuing advocacy activities with particular attention on funding for celebration and observation of relevant holidays such as World Sight Day. It is very encouraging to see the continued weight placed on developing mid-level human resource capacity, an increased emphasis on PEC capacity building, and some commitment to the procurement and/or maintenance of equipment. Quite noticeably absent from the plan however, was provision for a pipeline of consumables or any particular factoring in of gender data and dynamics.

Considerable progress was also made with development of the National Eye Health Strategy during the life of the AHC project, (although at the time of the review, this was still to be approved by MoH). A detailed budget to support the National Eye Health Strategy has yet to be developed but is expected over next year or two.

A clear and well-mapped out vision for sustainability is in place in Nampula Province; however, this does involve considerable medium-term dependence on INGO resourcing to produce sustainable outcomes ten to twenty years down the line.

Mozambique's vision of developing a cadre of cataract surgeons is ground-breaking and is well supported from within the ophthalmologist community. Formal approval of this cadre and training thereof will go a long way to ensuring the necessary capacity to address the cataract backlog, especially in Nampula Province.

The Nampula Health Sciences Institute is well positioned to build on and amplify its role in servicing the national eye health training needs of future OTs and possibly other cadres that may emerge in future (cataract surgeons and ophthalmic surgeons) but does not articulate strong marketing capacity or strategic vison regarding its potential long-term contribution. It regards its role as predominantly one of responding to MoH driven HR agenda. High level of dependence on Sightsavers were indicated, for instance through a request for ongoing donation of OT kits indicated rather than any indication of efforts to raise funds independently for such materials.

The Beira Health Sciences Institute has similarly shown strong potential to continue to play a central role in maintaining the human resource capacity for eye health in the province. At the time of the evaluation, a second training course for mid-level cadres had already been agreed to, and the institute's new directorship had taken strong initiative to get this underway in partnership with the Provincial Department of Health. The Director had ambitious goals and aspirations for future training to be offered in the area of eye health and emphasised that capacity building should take into account paediatric blindness as well as treating disabled patients. Though not linked directly to this project, LftW also plans to construct an eye clinic in the Sofala province that will complement the Provincial Department of Health's continuation of the project.

The complementary programming approach taken by Sightsavers allows for support for other eye conditions when screening and treating for trachoma (new TT+ programme). This means that elements of the AHC project can continue to enjoy support through other projects managed through Sightsavers Nampula going forward.

4.6.4 Zimbabwe

Overall, self-supported continuation of the achievements of the AHC programme by the MoHCC cannot be fairly expected under the circumstances under which state health services are currently provided within Zimbabwe. There are huge limits on funding for all aspects of MoHCC work. Heavy reliance (almost 100%) on donor funding means that the MoHCC is unable to provide for more than a very basic level of health services in most cases, with communicable diseases, maternal and child health, and nutrition programmes tending to be better-resourced elements. The MoHCC NCD Deputy Directorate itself operates on a shoestring since it receives around 10% of what it actually budgets for each year.

One sustainable element of the programme is the capacity of the School of Nursing to provide training of OPNs has increased. This includes the existence of an agreed curriculum, experienced staff and the existence of equipment for teaching and practicals.

Sightsavers will also partner with HelpAge Zimbabwe to provide for further scale-up of PEC into PHC training activities in additional districts.

The Chief Government Ophthalmologist reported that while the National Eye Health Strategy 2014-2018 is in existence, there is currently no specific and incremental plan in place to address the specific elements essential to the sustainability of eye health services within the country. He confirmed that key costs associated with the provision of eye care services that require ongoing donor funding are:

- Consumables required for eye surgeries (including Intra Ocular Lenses) and treatment of other conditions (at all levels of the health system, including at district and clinic levels)
- Transport and per diems for outreach
- Further rollout of PEC into PHC training and refresher training for those working at PHC level (VHWs and clinic nurses)
- Continuous professional development for OPNs
- Eye health kits for all district hospitals where OPNs are based.

Sightsavers has entered into an agreement with the MoHCC NCD Deputy Directorate to provide continuance funding of $8,400 per year for 2015–2018. This will enable the MoHCC NCD Directorate to:

- Support National Prevention of Blindness Committee meetings three times a year
- Carry out national coordination of eye health activities (including support, supervision, admin and strategy development); and
- Carry out 900 cataract surgeries per annum (covering transport, outreach costs, cataract surgery kits and consumables).

No funds have yet been earmarked to support state budgets for eye health service at district level, including fuel, consumables, medication and stipends for OPNs. Patients will need to be referred to the nearest pharmacy for prescribed medication. At national level, the MoHCC and Sightsavers Country Director reported that some progress has been made to incorporate new medications for eye conditions onto the national essential drug list but that further work would need to be done to ensure this is enacted in practice through the identification of regular funds to purchase supplies and the development of a pipeline for eye health medications and other supplies. To support the costs of transport and allowances for outreach activities, some district health facilities have agreed to share their outreach allowances to cover the costs of OPNs doing such work. This is still the exception rather than the rule.

For support, some OPNs occasionally call colleagues, or even contact the Parirenyatwa School of Nursing or state ophthalmologists in Bulawayo or Harare if they are seeking advice. No set schedule is in place for regular supervision visits to mid-level eye health professionals because of the absence of budget to cover transport and associated costs incurred during district-based visits by provincial focal points for eye health.
There is no planned refresher training or further education that district based OPNs know of. It was confirmed at management level that funding for CPD for OPNs or others trained is not in place.

4.7 Coherence/Coordination

Regional	***Rating:* Highly satisfactory** 
Malawi	***Rating:* Satisfactory** 
Mozambique	***Rating:* Satisfactory** 
Zimbabwe	***Rating:* Highly satisfactory** 

4.7.1 Regional

The programme consciously worked to embed itself at Ministry of Health level in each of the three countries in which it operated. This deliberate strategy was enacted through partnership arrangements which saw the active engagement and involvement of key government departments involved in national eye health coordination, as well as state training institutions responsible for health human resourcing. This strategy worked very well to ensure that there was shared ownership of the project and ongoing commitment to its goals beyond the life of the project.

One of the strengths of the programme was that it had very strong government representation in all three countries for the management of the programme more generally and within the advocacy groups. (Partner, Regional level)

Coherence on the project greatly improved during the second half, with coordination demonstrated successful partnering. Key elements actively cultivated by regional level across the project to support strong partnering included fostering personal relations and adopting a facilitative role with partners. The project's success depended upon all partners taking ownership of achieving overall project goals.

This was not a Sightsavers Programme but ours. Everyone is important and needs to perform, not just some of us. (Project partner, Regional level)

The most valuable learning for me is about stakeholder participation. You have to have a participative approach where everyone has space and works together. (Project partner, Regional level)

The introduction of joint regional meetings hosted in each of the countries facilitated learning and also allowed for improved monitoring of the programme. Joint learning and flexible decision making and use of resources were some of the key strategies that accelerated performance in the second half of the project. Resources were shared between and in the case of Mozambique, within countries depending upon capacity and targets reached. For example when Zimbabwe fell behind in cataract surgeries performed, this funding was shifted to Malawi that had more capacity and was already outperforming its targets in that area. The Regional Co-ordinating body was able to secure buy-in for this process amongst all countries, and therefore contributed to more transparent management.

Coordination of advocacy activities at a sub-regional level effectively divided duties and responsibility between the leaders of the sub-regional advocacy so each had a clear focus. HelpAge Zimbabwe led efforts in advocacy in general, while Sightsavers brought in specialised advocacy experience in eye health. Occasionally the two worked closely with

IAPB, especially since it's reach and influence goes beyond the Southern Africa sub-region. The team was thinly stretched and with the recent resignation of the Global Advocacy Co-ordinator, will have to clarify clear steps for the continuation of sub-regional level advocacy and programme activities.

4.7.2 Malawi

Coherence at a national level in Malawi is strong, having been implemented through existing national structures. The country's pre-programme experience contributed greatly to this co-ordination as evidenced by the effectiveness of activities at the primary level in particular. As has been highlighted, the regional programme structure and co-ordinated goals and resource allocation also contributed to Malawi's very successful implementation of PEC activities. There appears to be a strong sense of collaboration within districts, in terms of knowledge sharing and well as sharing of expertise and equipment where necessary. Referrals seem to function well across primary, district and provincial levels. Regionally, greater alignment could be sought at the SADC level.

4.7.3 Mozambique

The project has echoed the identified need across sub-Saharan Africa to increase HReH, articulated priorities of IAPB Africa and the Sightsavers regional office. The role of the regional AHC Coordinator was experienced as facilitative and helpful in ensuring delivery on programme. Systems outlining roles, responsibilities and systems for reporting/planning across all partners took some time to develop but functioned well over the AHC project's fourth and fifth years, and have enabled all partners to interact in a transparent and open manner.

Sightsavers has developed much stronger relations with all partners as a result of this programme. These provide a firm foundation for future work. Particularly noteworthy is the impact of the advocacy component of the project which will continue to push for improved resource allocation for eye health with the national government, and work towards a finalised Vision2020 Action Plan.

Training partners at the NHSI appreciated exchange opportunities with Sofala, but were unable to identify suitable dates for an exchange outside Mozambique.

The Head Ophthalmologist for Nampula Province has put in place good coordination mechanisms based on referrals from OTs at district level. The project can thus demonstrate success in contributing to strengthened referral and service delivery network on cataract surgery.

The project's relationship with the DPS requires ongoing nurturing and effort, which is unlikely to change substantially in future. Provision needs to be made for the additional time and energy required to maintain this relationship. In Sofala there currently is evidence of a good relationship between LftW and the DPS, as LftW will be contributing 41,200 Euros to the DPS Sustainability Plan for the project, which represents approximately 44% of the total budget. This indicates that the project benefitted from LftW's already-existing relationship with the Sofala DPS and that it is very likely that this will continue in future.

4.7.4 Zimbabwe

The project demonstrated considerable success in developing an inclusive partnership. As summarised by one of the project partners:

We were always mindful and respectful of the fact that NGOs will not be here forever and that MoH needs to take the lead. Our role was always to complement MoH. We budgeted for planning and review meetings. Everyone was aware of what (project) resources were available and what needed to be done to fill the gaps. If there were shortfalls on funding, then we would look collectively at how to address these. (Project partner, Zimbabwe)

This partnership was reported to be rooted in relationships of trust, cultivated through:

- Transparency
- Participatory decision-making including around resource allocation and across-project problem-solving
- Emerging champions of eye health (within MoHCC, Sightsavers, HelpAge Zimbabwe and amongst OPNs)
- Clear definition of essential roles for all partners, and
- A shared commitment to common objectives.

The AHC Project Management Committee in country reported that it had benefited greatly from the facilitative management style of the Regional AHC Coordinator.

4.8 Replicability/Scalability

Regional	***Rating:* Satisfactory**	
Malawi	***Rating:* Satisfactory**	
Mozambique	***Rating:* Satisfactory**	
Zimbabwe	***Rating:* Satisfactory**	

4.8.1 Regional

The project model and design can be replicated in other countries where Sightsavers is working, as well as additional geographical areas within the three project countries. Taking into account the project's key success factors – a consortium approach in each country with strong regional support; clear and contextualised performance targets and monitoring framework; alignment with and input into health policy – and learnings, this is a scalable model. The biggest improvements to make would be to ensure a thorough situational analysis is conducted before inception and to begin sustainability activities to strengthen government capacity to continue programme) early enough for resources to be identified.

The Malawi programme, in deploying mid-level cadres outside of the project area has the potential to gain some experience testing the scalability of this model. A few of the mid-level cadres interviewed had been deployed out of the South West Zone, though they had been placed in areas with experienced OCOs and/or another NGO that was active in the area, so they did still benefit from some support with mentorship and access to drugs and consumables.

The approach of the advocacy component can be used beyond this project and in other sectors. The key steps of an advocacy strategy – setting an objective, gathering evidence, building a coalition, identifying targets, developing and delivering the advocacy message – are applicable in other contexts. The success of the MoH in increasing national budget allocation for eye health will be a good test of the approach's effectiveness beyond the life of the programme.

4.8.2 Malawi

There is some evidence that small steps toward scaling up the programme are already underway. A representative from the MCHS commented that, although only 14 places had been planned for one study programme, 29 students were trained in total, and that graduates had even been deployed outside the programme area.

Key focus areas have been identified that are relevant for enhancing the scalability of the programme. These include curriculum development; a greater level of support for top management; and increased coordination between all structures. Enhancing the scalability of the programme will also benefit from a revision of equipment procurement in terms of cost, the life of the equipment and the extent to which the equipment needs upgrading.

4.8.3 Mozambique

Capacity developed at Nampula Health Science Institute now allows for OTs from across the country to be trained under the curriculum developed on this project. Nampula's high population and high prevalence of cataract make the AHC project in this province an excellent case study for how to address a provincial cataract backlog at provincial level with minimal resources.

As highlighted in the previous section, the Beira Health Institute has already agreed to and began taking steps to roll-out a second instalment of the mid-level cadre training. This too could be replicated in other parts of the country after the Ministry of Health's true capacity to fund key elements of the project has been proven.

4.8.4 Zimbabwe

The AHC Project Management team has considered all elements of the project and how to best taken them forward in country. Sightsavers has made a commitment to support key interventions aimed at ensuring that national coordination of eye health activities can continue, that cataract surgical kits are available for use and that PEC into PHC training can be scaled up to include additional districts.

4.9 Lessons Learnt

Two repeated themes that fell outside the immediate scope of the AHC project's delivery but were consistently raised by mid-level eye health professionals during the end of term review as critical, ongoing challenges were:

- Difficulties with procurement and maintenance of consumables and equipment for work at mid-level; and
- Retention of mid-level cadres.

In order to ensure that these critical programming elements are fully considered on future eye care programmes, the reader is referred to Appendix F: Crosscutting Challenges Affecting Eye Health Programming in Resource-Poor Settings. This provides detail on the inputs made by stakeholders and beneficiaries in all three countries on these two themes.

4.9.1 Regional

The AHC programme's initial poor performance and subsequent turn-around offer important learnings in implementing a project of this nature.

Almost all stakeholders emphasised the need to have better understood the context of eye health in each country and at a sub-regional level before beginning programme activities. Thorough situational analyses, the collection of baseline data and the establishment of relevant performance targets and a monitoring system at onset, would have saved the project time and allowed it to achieve its full potential. This would involve understanding key elements such as the requirements of a curriculum, costs (training, supervision, career development) of producing and retaining mid-level cadres, supply chain for and maintenance of equipment and consumables, any capacity building needs at the primary level, and detailed understanding of regional bodies' strategies on health and eye health in particular.

The importance of the consortium approach was also strongly highlighted across the project, as well as having the flexibility to allow for enough autonomy of each partner institution while still driving them towards a common goal.

The advocacy component achieved momentum in the last two years of the programme, but was often highlighted as one of the strongest aspects of the programme. Not only did in-country activities raise awareness of eye care, and therefore help to generate demand at the community level, but advocacy work also educated other stakeholder groups (provincial government, national eye care co-ordinators) on eye care.

Sightsavers is not predominantly a research organisation but seeks to develop increased rigour in data collection methodology and the sharing of results to inform future strategy and project development. A project such as this offered many opportunities for learning. The project did not fully harness this opportunity. Factors limiting the embedding of a consistent lessons learning approach and development of documentation to support this were slow development of project management systems and unevenness in management capacity and resources within the individual countries of operation over the first half of the project life.

Key lessons learnt and success detailed above on partnering across multi-location projects can usefully inform future project development within Sightsavers. Although a lessons learnt workshop for AHC project partners and stakeholders was held in November 2014, the project has not yet produced a consolidated document reflecting key lessons learnt that can be shared with stakeholders outside of the AHC project as yet, for instance with IAPB or with the broader eye health development sector.

4.9.2 Malawi

One of the primary lessons learnt is that the programme needs to be sufficiently planned and resourced from the outset. At the beginning of the programme, some time was wasted as there was a lack of clarity on how to move forward. Sufficient planning needs to include a thorough, evidence-based understanding of need; an identification of partners to be involved and cementing of these relationships; and systematic management and monitoring systems.

Targets should subsequently be based on this comprehensive planning, such that they are achievable and that important programme elements such as supervision are properly implemented. A consortium approach will function well with proper planning in place.

It would also be useful to assess which cadres should be targeted for additional training in order to bring about the most impact, whether it be OCOs, cataract surgeons or at the primary level. Primary eye care itself could also be strengthened in terms of identifying clearer outcomes and broadening the approach to encompass more than just training; collaboration with other partners and sectors could be explored and innovative communication strategies could be employed in order to access hard to reach groups, such as those with low literacy.

It was agreed that the programme as it exists now should be continued. There was a suggestion that government should begin to build its capacity for ensuring the longevity of the programme when the current programme cycle is finished, including ensuring the continuity of the provision of scholarships. Finally, extending the opportunities for practical training for students and ongoing supervision post-graduation was identified as something which would significantly strengthen student capacity and confidence.

4.9.3 Mozambique

The strongest lesson from implementation in Mozambique was the importance of understanding the context of the project in detail and establishing all management systems before beginning activities. This learning was highlighted not only by the lead partners responsible for regular programme reporting and management, but also by the Beira Health Institute with regards to the appropriateness of the initial curriculum developed.

Mobilising and building capacity of primary eye care workers is an important aspect of the programme that may not have been adequately provided for in the project's conception. Training efforts at the primary level were constrained by funding limits, therefore the project did not benefit from the full potential of PEC workers. District level stakeholders ear-marked the mobile clinics and community mobilisation and awareness-raising work of the *activistas* as highly valuable. This was true for the Clinical Directors of district hospitals, patient beneficiaries and OTs.

4.9.4 Zimbabwe

Notably, the strong foundation built in partnering remains and can be harnessed for future interventions. Effective sharing of learnings on this project which show a full appreciation of the partnership model it has used can provide valuable learning within Sightsavers on the management of consortiums and partnerships. Realistic and tailored target setting is essential. This must take stock of country-specific contexts and potential. The team that needs to carry out the project should be recruited to be in place by the time that the project starts so that a good foundation can be built from the start and so that time for implementation of project activities is not compromised.

5. Recommendations

The recommendations below refer to successful lessons learnt on the AHC project that can potentially be embedded on future projects, as well as challenges and shortfalls.

5.1 Regional

Programme Conceptualisation and Planning

1. **Preliminary research.** Conduct detailed in-country situational analyses as part of proposal development and collect quality baseline data in the first year of new programmes.
2. **Human resource provision.** Consult expertise at regional and country offices on feasibility and existing needs, and to develop any specific programme elements - gender focus, monitoring and evaluation & programme management approach etc. Planning for each country should include all members of relevant teams from the start, including both programme and finance staff, and ensure that highly skilled project staff are recruited for implementation.
3. **Monitoring & management systems.** Develop tools, systems (including meeting cycles) within the first six months of project and ensure targets are tailored to country specific contexts and are realistic given circumstances at project start-up. Develop a resource guide that includes definitions of the 'common and shared language' embedded within the project and associated with specific activities and targets.

Overall Programme Management

4. For any multi-location programmes involving multiple partners, embed management approach and activities within project design to actively cultivate successful elements of and relationships supporting partnership approach. Regional Programme Coordinators should embody this approach.
5. The complementary programming approach taken by Sightsavers Nampula – which allows for support for other eye conditions when screening and treating for trachoma (new TT+ programme) – should be adopted wherever possible by other projects addressing trachoma.

Programme Learning

6. **Learning from tool development & research**. Tools developed by the project (e.g. quality of life tool; situational analyses of readiness for integration of eye health into district health plans) and other potential tools (e.g. to understand gendered access to health care) can be developed, and learning from this shared internally and with key regional eye health forums (such as IAPB Africa).
7. Provide for IT-based CPD for mid-level eye health professionals in each of the three countries. For instance, develop a structured programme housed at the training institute that facilitates online discussion groups, case discussions/case studies, advice/problem solving, and regularly updated links to resources and best practices involving available ophthalmologists/cataract surgeons and other mid-level eye health professionals. Zimbabwe, having started some similar activities, is a potential site for testing this approach.

Programme Evaluation

For future project reviews employing FGDs:

8. Ensure that evaluation team is advised well before the time on the indigenous language requirements of groups so that appropriate arrangements can be made for interpreting of indigenous languages.
9. Request the evaluation team to develop a checklist outlining criteria for composition of groups to ensure that clinic staff involving in recruiting groups can use the checklist in their selection of a representative sample in line with evaluation requirements. Obtain collective verbal consent at the start of FGDs rather than formal written consent.

Advocacy

Key opportunities that have emerged through this programme and can be implemented at a regional level:

10. Document and share evidence and approaches to key advocacy activities such as the development of policy and position papers, introduction of policy change and training curricula, lobbying for equipment and consumables at regional level; and understanding of community attitudes and traditional practices to cure blindness, and how to address these.
11. Support push for increased cataract surgery capacity through development of cadres that are recognised within the national health system and have a clear career path. Ensure that the cadres developed are aligned with possibilities within each country (e.g. Malawi to introduce training on OPNs for cataract surgery) and that this support is available and career paths mapped before training mid-level eye health professionals.
12. The Sightsavers Regional office should continue to engage with SADC's Health and Pharmacy Division around the integration of eye health into primary health in order to ensure that the gains made thus far are not lost. Given efforts needed to achieve this commitment, it would be in Sightsavers' interest to develop a clear strategy on how this will be pursued.
13. At programme inception, develop sustainability strategy for advocacy group member organisations performing advocacy work on a voluntary basis.

5.2 Malawi

Budgeting and sustainability

1. One of the primary determinants of this project's long-term impact will be the Ministry of Health's ability to continue key elements of the programme including training of mid-level cadres and the procurement and maintenance of equipment and consumables. Key to this will be improving the Ministry of Health's ability to advocate for an increased budget from the Ministry of Finance.

Advocacy sustainability

2. Concerns about the continuation of the national advocacy component were raised by a number of stakeholders given that advocacy groups are made up of voluntary members. It is recommended that the project adopt a clear strategy for how this key component – and the capacity developed – will be sustained. One option suggested by stakeholders is for advocacy to be incorporated into the activities of the Trachoma TT+ programme starting in Sightsavers Malawi.

Career and skills development for mid-level cadres

3. There is a need to clarify the career path and manage expectations of mid-level cadres. Amongst cataract surgeons interviewed, feelings of having been misled about possible promotion were widespread, and the Ministry of Health will need to explain the current position and career path of this cadre to prevent high turnover. It is also recommended that low-cost options for continued learning be explored for this cadre as well as for primary health workers involved in eye care. There was a strong desire to improve basic skills – and to acknowledge current skills in eye care –amongst HSAs, medical assistants and theatre nurses. It would therefore be equally important for the project to think through the various options of skills development (for example, use of online training) that would be appropriate at the mid- and primary levels of the health system, and to invest in low-cost recognition and retention strategies (such as certificates for theatre nurses trained in eye care).

5.3 Mozambique

Addressing cataract backlogs in low-resource settings

1. Nampula's high population and high prevalence of cataract make the AHC programme in this province an excellent case study for how to address a cataract backlog. It is recommended that key success factors enabling this element be written up by Sightsavers Nampula with support from the AHC Regional Programme Coordinator in a PowerPoint presentation, and shared within Sightsavers and with other eye health players within the region.

Supporting *activistas*

2. The role of the *activistas* was strongly appreciated by district hospital staff (mid-level cadres as well as Clinical Directors), patient beneficiaries and the Sofala DPS. In future, cost-effective ways of supporting the development of this role should be explored so as to improve demand for eye care services.

Further development of training institutes

3. Both training institutions in Mozambique greatly benefited from the AHC programme in terms of skills development, improved infrastructure and quality management tools. There is room for these institutes to take a more proactive role in joint decision-making on priority areas for mid-level cadre deployment with the DPS, in making suggestions for further research into the field in order to keep the curriculum current, and in becoming more proactive about seeking funding for eye health training components. In Beira, the Institute's new leadership was very interested in expanding its knowledge – and in future course offerings - to include paediatric eye care, as well as visual disability among the disabled.

Tailored gender programming

4. Tailored gender interventions are needed if the restrictive cultural factors limiting women's access to eye health services are to be addressed and a more equitable service to be provided based on prevalence of eye conditions across the genders. This is particularly critical in Nampula Province where such cultural factors are reported to play a strong part in continuing to limit women's access to eye health services.

5.4 Zimbabwe

Embedding learning on successful partnership development:

1. It is recommended that Sightsavers Zimbabwe and the AHC Programme Coordinator develop a PowerPoint presentation describing practical actions taken in successfully establishing and maintaining the AHC partnership in Zimbabwe:
    - Leadership style, and relationship with MoHCC in particular
    - Observance of country-based protocols and norms
    - A shared commitment to common objectives.
    - Structure, including clear definition of essential roles for all partners and accountability of partners for carrying out such roles
    - The cultivation of emerging champions of eye health within the partnership
    - Transparency and participatory decision-making, including around resource allocation and across-project problem-solving.

    This PowerPoint can be shared internally within Sightsavers, as well as within eye health forums at regional level and beyond.

Deepening impact

2. Continue to provide annual funding for health systems strengthening as already undertaken for 2015 and implied through the Memorandum of Understanding between Sightsavers and MoHCC until 2018
3. Systems strengthening activities - increase human and financial resourcing at national, provincial and district levels. Support a structured approach to recruitment for the training of additional mid-level eye health professionals, and active tracking of actual mid-level eye health professional capacity.
4. Strengthen data collection and referral systems (including institutional ownership of reporting tools at district level and use thereof for analysis and planning at management level within districts and provinces; reinforcement of referral between different levels of eye health services; and operationalisation of cataract surgical outcome monitoring tool aligned with WHO standards).
5. Emphasise the development of district-based institutional support and leadership (district-based champions) for dedicated time and HReH services (including both outreach and static services).

Sustainability

To reduce the MoHCC's future dependence on donor funding, as well as in line with Sightsavers' commitment to health systems strengthening and sustainability and the shared understanding that 'NGOs will not be around forever':

6. Sightsavers Zimbabwe to work with MoHCC and other eye health service providers to translate the National Eye Health Strategy into a practical, year-by-year, five-year sustainability plan that is sets realistic but incremental targets to decrease the MoHCC NCD's dependence on donor funding for eye health activities, and that is regularly tracked through annual review and forward planning on national eye health. This sustainability plan should include the following elements:
    - Detailed annual planning for provincial and district eye health service delivery, including budgets and actual earmarked funding for eye health service at provincial and district levels. This should include: consumables, medication, replenishment of OPN kits and supply of additional kits as required, outreach costs (fuel and per diems), PEC-into PHC training, and eye camps for district-

based eye health services; and coordination, supervision and CPD costs at provincial level.

- Translation of EDLIZ booklet outlining provision of essential eye health drugs and arrangements for regular supply thereof into practical plan of action that is monitored and assessed for performance. This would allow for full service delivery at district-based hospitals and primary health care clinics, as well as the development of provincial procurement plans for eye health drugs and spectacles, and delivery thereon.[20]
- Further rollout of PEC into PHC training and refresher training for those working at PHC level (VHWs and clinic nurses).

Impact in advocacy

7. Sightsavers Zimbabwe and HelpAge Zimbabwe to actively support efforts to advocate for the development of a recognised and accessible national qualification for cataract surgeons. Progress against this goal to be monitored at key milestones.

Complementary programming

If Sightsavers were to develop complementary projects addressing HReH in Zimbabwe, it should prioritise the following additional focus areas:

8. CPD plan and support for activities for Nursing School staff, mid-level eye health professionals and PEC for PHC, including mainstreaming the use of ICT (e.g. access to computer and Internet for mid-level health professionals, internet based learning forums)
9. As noted by tutors at the Parirenyatwa School of Nursing:
    - Training in computer skills, financial management and planning skills, and skills to do research in eye health (research could also potentially contribute to an additional revenue stream for the Nursing School over time).

10. As noted by OPNs, especially those in district hospitals:
    - Practical, low-cost solutions to provide them with regular supervision and support, including the exploration of ICT solutions.

[20] This seeks to address the articulated need raised by mid-level eye health professionals and beneficiaries for improved access to spectacles to support service delivery by OPNs at district level (on site for presbyopia, and through a coordinated order system in each of the provinces for other refractive error conditions).

6. References and Appendices

6.1 Sightsavers Documents Provided for Initial Desk Review

Terms of Reference

1. Terms of Reference for the end of programme evaluation of the Advancing Healthy Communities: Affordable, Accessible and Quality Eye Care in Malawi, Mozambique and Zimbabwe Programme

AHC Programme Management

2. Annex 1: Contract Narrative Signed Memorandum of Understanding: Programme Advancing Healthy Communities – Affordable, Accessible and Quality Eye Care in Malawi, Mozambique and Zimbabwe
3. End of Programme Meeting and Lessons Learnt Report (November 2014)

AHC Tools/Guides

4. Quality of Life Index Tool: Zimbabwe
5. Quality of Life Index: Concept
6. Advancing Healthy Communities Programme Framework and Tracking Tools 2012 – 2014 (Draft final supplied by Tapiwa Huye, March 2015)

AHC Programme Reports

7. Advancing Healthy Communities Narrative Report (October 2013 to September 2014)
8. Advancing Healthy Communities Narrative Report, 2010 – 2014 (Draft final supplied by Tapiwa Huye, March 2015)

Financial

9. Interim Financial Report for the period up to 31 October 2014

Midterm review

10. Sightsavers final AHC report including final changes (GreaterCapital, 11 March 2013)
11. Evaluation Management Response EC AHC Programme

ROM 2012

12. EC ROM Report Malawi
13. EC ROM Report Mozambique
14. EC ROM Report Zimbabwe
15. EC ROM Report Regional

ROM 2013

16. EC ROM Report Malawi
17. EC ROM Report Mozambique
18. EC ROM Report Zimbabwe
19. EC ROM Report Regional

Position papers and policy briefs

20. Regional Policy Brief: Strengthening Human Resources for Eye Health in SADC Countries. Regional Eye Health Advocacy Group (November 2014)
21. Position Paper: Strengthening Human Resources for Eye Health in SADC Countries. Regional Eye Health Advocacy Group (November 2014)
22. Malawi Primary Eye Care Primary Health Care Position Paper
23. Malawi Primary Eye Care Primary Health Care Policy Brief
24. Mozambique Primary Eye Care Primary Healthcare Position Paper

25. Mozambique Primary Eye Care Primary Healthcare Policy Brief
26. Zimbabwe Primary Eye Care Primary Healthcare Position Paper
27. Zimbabwe Primary Eye Care Primary Healthcare Policy Brief

6.2 Documents Accessed during and following Field Data Collection Process

28. AHC indicator Reference Guide Version 3; August 2013
29. National Eye Health Strategy Zimbabwe 2014–2018
30. Kimani K. Rapid Assessment of Avoidable Blindness (RAAB) Nampula Province, Mozambique. Sightsavers International; 2011.
31. Chagunda, M, Roba, A. & Machissa, T. Rapid Assessment of Avoidable Blindness (RAAB) Sofala Province, Mozambique. Light for the World, Provincial Health Directorate of Sofala, Beira Central Hospital; 2013.
32. Malawi AHC Mid-level Cadres and their Deployment Statistics. 16 April 2015. Michael P. Masika. Malawi Ministry of Health National Eye Care Co-ordinator
33. Indicadores do Programa EC 2014 Q4 (Mozambique only). 6 March 2015. Tapiwa Huye, Sightsavers AHC Regional Programme Coordinator via Klaus Minihuber Light for the World
34. Orcamento DPS, 2014 – 2015. Department of Provincial Services, Sofala Province Mozambique. 6 March 2015. Tapiwa Huye Sightsavers AHC Regional Programme Coordinator via Nunes Sampaio Light for the World
35. AHC Final Progress Report: Advocacy Component.31 March 2015. Supplied by Tapiwa Huye.
36. Advocacy Trainers Handbook. 9 April 2015. Douglas Lackey, HelpAge International
37. Sustaining Advocacy Groups. Eye Health Powerpoint. 9 April 2015. Douglas Lackey, HelpAge International
38. Case Study. Eye health advocacy groups. 9 April 2015. Douglas Lackey, HelpAge International

6.3 Documents Accessed Through Internet-based Search

39. Community Eye Health Journal Vol. 25, Issue 78, 2012. Title article: ‘Putting patients at the centre’.
40. IAPB Africa Human Resources for Eye Health Strategic Plan 2014–2023. Vision for Africa; Phase 1 (2014–2018)
41. IABP Africa conference 2014 Mozambique Presentation
42. Mapping Human Resources for Eye Health in Sub Saharan Africa: Progress towards VISION 2020. Malawi Country Fact Sheet
43. Mapping Human Resources for Eye Health in Sub Saharan Africa: Progress towards VISION 2020. Zimbabwe Country Fact Sheet

Appendix A: Consultancy Terms of Reference

Terms of Reference for the end of programme evaluation of the Advancing Healthy Communities: Affordable, Accessible and Quality Eye Care in Malawi, Mozambique and Zimbabwe Programme

1. Background

1.1 Programme name: Advancing Healthy Communities – Affordable, Accessible and Quality Eye Care in Malawi, Mozambique and Zimbabwe

1.2 Programme duration: 1st January 2010 to 31st December 2014

1.3 Programme budget: EUR 3,415,149.10 (EU 75%: €2,561,361.83; Others 25% (Sightsavers €353,787.28; Light For The World €200,000.00; HelpAge €150,000.00; Fred Hollows €150,000.00)

1.4 Programme partners: Malawi College of Health Sciences, HelpAge Zimbabwe, University of Lurio, Mozambique, Ministry of Health Mozambique, Light For The World, HelpAge International

1.5 Key stakeholders: Ministry of Health Malawi, Ministry of Health Mozambique, Ministry of Health and Child Care Zimbabwe, Parirenyatwa School of Nursing in Zimbabwe

1.6 Project rationale

Health workers, as an integral part of health systems, are a critical element in improving health outcomes. Sub-Saharan Africa faces the greatest challenges in human resourcing for health. While it has 11 percent of the world's population and 24 percent of the global burden of disease, it has only 3% of the world's health workers[21]. The three targeted countries of Malawi, Mozambique and Zimbabwe are characterised by a grave shortage of ophthalmologists, with only 42 ophthalmologists for a population of 44 million[22] most of whom are based in the urban centers and mid-level eye health cadres. The eye health needs of the population will not be met by ophthalmologists alone even in the long term, given the low physician to population numbers and other factors. There is a need for non-physician, middle level eye health personnel to fill the ever increasing gap between what is required and what is needed. These personnel are essential to enhance the efficiency of delivery of eye care services, particularly to rural and marginalised regions. Progress on the global targets for blindness prevention will not be met without investments in human resource development.

1.7 Programme design, goal, objectives, and outputs.

The advancing healthy communities programme is a five year, regional programme implemented in Malawi, Mozambique and Zimbabwe. The Overall Objective of this action is to contribute to poverty eradication and the prevention of avoidable blindness by year 2020. The Specific Objective of this action is to improve the quality and quantity of cataract and other eye care services.

The programme has four component outputs namely,
a) Three mid-level training institutions are able to provide comprehensive training for mid-level cadres in their respective countries
b) Enhanced performance and productivity of mid–level eye care personnel in target countries

[21] Kovin Naidoo, Poverty and Blindness in Africa
[22] IAPB Southern Africa Durban Workshop March 2008

c) Resources mobilised to promote sustainable eye health programmes
d) Effective collaboration between actors involved in human resource development for eye health work in Southern Africa

2. Purpose of Evaluation

The purpose of the end of programme evaluation is to establish to what extent the programme has contributed to improved eye health and to the prevention of avoidable blindness through the development of human resources at the middle level of human resources for health, and improved quality and quantity of cataract and other eye care services in Malawi, Mozambique and Zimbabwe. The end of programme evaluation will measure the extent to which the AHC programme has fully implemented and delivered outputs and attained outcomes, by assessing programme results. Importantly, the evaluation will also measure cross-country learning and initiatives that have contributed to the programme and have provided value-added to the regional structure. At the broader level, the evaluation will contribute towards shared learning and provide accountability to partners, beneficiaries and donors.

The evaluation will assess the overall programme performance in reaching its objectives, efficiency, effectiveness, coherence/coordination, impact and scalability and sustainability of the programme. The end of programme evaluation will involve a process, outcome and impact assessment. Results of this evaluation will be shared with partners and donors and disseminated within Sightsavers. Key lessons will be factored in planning for similar programmes that might be implemented by Sightsavers and its partners.

Specifically, the objectives of the end of programme evaluation will include to:

a) Analyze and verify the achievement of intended results and outputs as described in the project logical framework, and assess the performance of the programme against its set objectives as well as the challenges that the programme faced over the implementation period
b) Assess whether or not the action, design and implementation strategies were consistent with the overall goal of the programme.
c) Establish the extent to which the programme and its activities have effectively contributed towards building the capacity of three mid-level training institutions to provide comprehensive training for mid-level eye cadres.
d) Generate substantive evidence based knowledge on best practices and lessons learned through the implementation of the programme that could be useful to other development interventions at national and international level.
e) Come up with recommendations which will be shared with key stakeholders of the programme and used by the implementing agencies to guide and inform future similar projects and programmes.

3. Evaluation criteria

In order to generate the information needed to achieve this goal, the consultant(s) will utilise the seven criteria used by Sightsavers, as explained below. The consultant(s) will develop specific evaluation questions to answer the following questions under each of the criteria.

3.1 Relevance

- To what extent are the objectives and design of the programme fitting with the current global/regional/national policies and laws of the three countries.
- To what extend are the objectives and design of the programme fitting with the current eye health priorities of intended beneficiaries, the specific objectives, role and comparative advantages of Sightsavers.

3.2 Effectiveness

- To what extent did the programme achieve its outputs and outcomes as reported in the log frame and Final Programme Report?
- In what others ways, if any, did the programme demonstrate effectiveness?
    - For example, what can be learnt from the approach and design which combined human resource institutional development together with service delivery while working with the multiple partners? Did this present management challenges? Did it affect implementation focus?

3.3 Efficiency

- To what extent did the programme convert its resources and inputs (such as funds, expertise and time) economically into results in order to achieve the maximum possible outputs, outcomes and impacts with the minimum inputs?
- Was budget management and disbursement of funds efficient and timely?
- How efficient was the regional structure in supporting programme delivery?
- How efficient has monitoring and reporting of programme activities and results been, especially since the mid-term review?

3.4 Impact

- What has been the operational impact of the training of mid-level cadres in programme districts and what has been the subsequent reach of services?
- How have other parts of the health system helped or hindered realisation of the potential impact of the operationalisation of newly trained cadres?
- What has been the impact on patient beneficiaries in terms of numbers served and improved quality of life and livelihoods in programme districts?
- What has been the extent of any unintended effects or impacts, if any, at the sector or community or household or individual level?
- How has the programme taken into account any differential impacts on male and female members of target groups or beneficiaries, and are there any implications for future programming and/or continuing management of services?

3.5 Sustainability

- To what extent is there a likelihood of programme results and outcomes continuing to deliver benefits after the programme end?

3.6 Scalability/replication

- To what extent is the programme, or aspects of the programme scalable or replicable, specifically what would be the probable implications of scaling in terms of costs, cost-effectiveness or efficiency?

3.7 Coherence/coordination

- **External coherence:** To what extent was the programme designed around, and coordinated with existing structures and initiatives in eye health in each country region?
- **Internal coherence:** To what extent did the regional programme structure contribute to internal coherence of the programme?

3.8 Lessons learned

To what extent has the programme generated learning and/or incorporated lessons learned throughout the programme period to improve management, delivery and outcomes of the programme?

4. Scope of the programme and evaluation

The physical scope of this work is South West Zone and Lilongwe (Malawi), Nampula and Sofala provinces (Mozambique), and Matabeleland North, Matabeleland South and Midlands provinces and Harare (Zimbabwe).

The scope of evaluation content will cover the performance against key parameters including the programme's relevance, effectiveness, efficiency, sustainability, scalability, coordination and timelines of activity implementation, and its strengths and weaknesses, promising best practices, lessons learnt, and recommendations. The evaluation exercise will be guided by the EC evaluation criteria of relevance, efficiency, effectiveness, impact, and sustainability as elaborated above.

5. Evaluation Team

The consultant/s shall have demonstrated competence in having undertaken similar work before, including experience in programme design and management, planning, monitoring and evaluation. The consultant(s) must demonstrate knowledge and skills in the following areas:

Essential

- Experience with programming and evaluations in public health;
- Strong analytical, writing and presentation skills;
- Experience in working and/or evaluating regional multi-country projects.
- Knowledge of the regional dynamics in the health sector in Southern Africa.

Desirable

- A Masters/Postgraduate degree in Public Health, Development or other relevant Social Sciences
- At least 5years experience working with Ministries of Health in Southern Africa or elsewhere in Africa;
- Working knowledge of the eye care sector in Southern Africa;
- Understanding of the health systems approach in health sector development;
- A member of the team must have a working knowledge of Portuguese language

6. Methodology

The consultant(s) shall prepare comprehensive participatory methodology for undertaking this evaluation. The methodology must include among others things, literature reviews, interviewing, field/programme site visits. The consultant(s) will define an appropriate sample size in a way that will avoid selection bias. The evaluation should meet the principles of participation involving both male and female beneficiaries. The field visits and contact sessions with beneficiaries must attempt to reach/meet 25% of the target.

7. Reference Material

- EC Advancing Healthy Communities Programme Contract
- Logical Framework and Indicator Tracking Tool
- Interim Narrative and Financial Reports
- End of Programme Final Narrative and Financial Report
- Mid-term Review Report
- EC Results Orientated Review (ROM) reports
- Retrospective Baseline Survey, Gender Mainstreaming and Database Report
- Advocacy programme reports, policy briefs and position papers

8. Timeframes

The evaluation will take approximately 45 the days. These days will include time for desk review, field activities, travels and report writing. The consultant(s) will submit a carefully designed work plan that will take into consideration the geographic distances to be covered between the locations of programme activities. It is proposed that the evaluation will take the following phases and days:

Phase	Activity	No of Days
Phase I – Desk study: Review of documentation and elaboration of field Study	Desk research /literature Review	2 days
	Inception Report	2 days
	Development of Data Collection Tools & Pre-Testing	1days
	Revision of tools based on feedback from the reviewers of the Inception Report	1 day
Phase II: Field Data Collection	Field Visits & Data-collection	30 days
Phase III – Analysis and production of evaluation report	Presentation of preliminary Findings & Feedback to regional programme staff	0.5 days
	Data analysis and preparation of Draft report	4.5 day
	Review and revision of Draft Report based on Feedback.	3 days
	Submission of final report	1 day
Total		**45 days**

9. Outputs/ Deliverables

The consultancy deliverables will include:

9.1 Inception report

The inception report will detail the consultant's understanding of the programme, proposed methodology and tools and a detailed work plan. The inception report will be submitted NOT LATER THAN 4 Days after the signing of the contract and prior to any field work. The inception report needs to be agreed and signed off by Sightsavers before field work can begin.

9.2 Draft report

The draft report shall be sent to the contact person who will circulate among the relevant persons concerned. Feedback on the report will be given within 15 working days in the form of consolidated written feedback which the consultant should respond to appropriately in any due revisions of the report.

9.3 Final report

The final report will be expected to be submitted to the contact person as per agreed dates in soft copy in word processor (Microsoft Word).

9.4 Data sets

The evaluation team will be expected to submit complete data sets (in Access/ Excel/Word) of all the quantitative data as well as appropriate qualitative data gathered during the exercise. These data sets should be provided at the time of submission of the final report.

9.5 Summary findings

On submission of the final report, the evaluation team is expected to submit a PowerPoint presentation **(maximum 12 slides),** summarizing the methodology, challenges faced, key findings under each of the evaluation criteria and main recommendations.

9.6 Reporting Format

Below is a guideline on how to structure the evaluation report and the evaluation team should conform to this format.

The consultant/s will write and produce a precise final report (maximum 45 pages excluding annexes) written in simple and understandable English. The Sightsavers report template will be provided. One consolidated report will be submitted covering all the locations in Southern Africa, with annexes where necessary. The report will be presented in the following format:

i. Cover page: (Title of the evaluation with the title of the Action, names and logos of the partners and donor, consultants'/firms name and address, dates of the evaluation and dates of the report)
ii. Table of contents; executive summary (a maximum of 3 pages); main report including the findings, structured according to the seven evaluation criteria, conclusions, lessons and recommendations (maximum 40 pages)
iii. Annexes

- Terms of Reference;
- List of persons / organisations consulted;
- List of literature and documents consulted;
- List of sites visited;
- Summary data sets and other sources of evidence for findings
- List of abbreviations.

Please note that penalties up to 10% of agreed fees will be imposed for noncompliance with the requirements 9.1 to 9.6 and reporting format provided.

10. Administrative/Logistical support

10.1 Budget

The consultant should submit to Sightsavers an Expression of Interest indicating their daily rates for the assignment. Sightsavers will assess Expression of Interests submitted according to standardized quality assessment criteria, as well as on the basis of their competitiveness and value for money in line with the budget available for this evaluation. The daily fees proposed by the applicant should exclude expenses such as:

- Economy class airfares and visas. (where applicable)
- In-country transportation
- Hotel accommodation
- Sightsavers flat rate per diem for days in field work away from consultant's home base (£25)
- Stationery and supplies
- Meeting venue hire and associated equipment e.g. projectors

Sightsavers will cover the above costs, unless otherwise stated.

The consultant(s) is expected to cover all other costs and materials not mentioned above related to this exercise as part of their daily fees or equipment (e.g. laptops).

10.2 Schedule of payment

The following payment schedule will be adhered to:

- On signing the contract: 20%
- On submission of draft report: 30%
- On submission of final report: 20%
- On acceptance and approval of final report: 30%

11. Estimated time of the evaluation exercise

February – May 2015 with field work envisaged in March.

12. How to apply

Interested applicants should submit an Expression of Interest using the standard template indicated, indicating their approach and daily rates for the assignment. The expression of interests will be assessed according to standardized quality assessment criteria, as well as on the basis of their competitiveness and value for money in line with the budget available for this evaluation.

Application should be sent latest **open of business on the 15th December 2014**.

Appendix B: Evaluation Questions

Relevance

1. How well do the programme's objectives fit with country and regional priorities for eye health in particular and health care in general?
2. To what extent has the programme contributed to the mid-level eye health human resourcing needs of each country?
3. To what extent has execution of the AHC programme included key actors responsible for policy making at the regional and national level?
4. To what extent has Sightsavers' experience on the AHC programme enriched its contribution to regional planning around PEC and eye care within sub-Saharan Africa?

Effectiveness

1. How well has the programme performed against targets for output and outcomes?
2. To what extent has the programme approach and design facilitated effective performance and achievement of targets?
3. What proactive measures were taken during the course of the programme to adapt its approach in order to facilitate improved performance, and how successful were such measures?
4. How responsive was the programme to managing unforeseen challenges?
5. How effective were monitoring tools and systems in enabling quality and accurate reporting against outputs and objectives?
6. How were you treated during the time that you accessed eye health services? (Did you understand what was happening; were you assisted with any practical problems you faced; were you treated with respect?)
7. What was the outcome of your using the eye health services and how do you feel about this result?
8. Would you recommend using the eye health services to another member of the community? Please explain.

Efficiency

1. What unanticipated challenges regarding efficiency arose during the course of the programme's implementation and how were these addressed at country and regional levels?
2. How well did the regional coordinating body manage the allocation of resources and inputs across and within countries to achieve maximum possible and intended outputs of the programme?
3. What specific measures were undertaken by regional management to support country programmes in delivery on the programme? How efficient and timely was the support provided? (overall coordination, advocacy and financial management)

Impact

1. What specific changes have occurred at different levels of the health care system in each country as a result of the AHC programme?
2. How has the programme provided for improved integration of PEC into PHC at country level?
3. What impact has the programme had on the capacity of human resources for eye health care in each country? How has the programme impacted on the lives of beneficiaries of eye health care services? What specific positive or negative impacts has it had for such beneficiaries with regards gender; cost of services; quality of life and disability status?
4. What impact has the programme had on the quality and productivity of mid-level cadres?
    - For cataract: The number of surgeries performed, success rate of eye surgeries, level of skill as measured by the industry
    - For other mid-level services: Depth of service and capacity to respond to needs as presented by community beneficiaries
    - Across all cadres: harmonisation of access to essential equipment and consumables to enable service delivery; replacement of equipment as required and consistency of pipeline on consumables.
5. How has the development of capacity at primary health care level impacted on the mid-level eye health care service delivery? Specifically:
    - demand for eye health services
    - type of eye conditions addressed at primary level, disaggregated by gender
    - type of eye conditions addressed at mid-level, disaggregated by gender
    - institutional buy-in for referral systems and functionality of such systems.
6. What evidence is there at country level of improved allocation of resources and institutional support for eye health service delivery? How is this articulated in commonly agreed policies, procedures and systems to enable eye health service delivery (e.g. eye health national plans, allocation of national-level personnel, budgets, protocols for management)
7. To what extent have regional approaches to human resource development in eye health been affected by the programme?

Sustainability

1. What measures were undertaken by the programme to plan for sustainability? To what extent did sustainability planning:
    - identify those elements of the programme that need to continue in order to maintain positive outcomes and
    - make resource provision for the continuation of these elements?
2. To what extent were key stakeholders (regional and national health policymakers; district and provincial hospitals; advocacy agents / institutions; government ministries) and beneficiaries involved in sustainability planning?
3. To what extent were recommended sustainability measures functioning by December 2014? Specifically:
    - How will continuous training of mid-level cadres continue beyond programme end? What resource provision has been made for this?

   - How will district and provincial hospitals continue to source and maintain necessary equipment and consumables to maintain and further programme achievements?
4. To what extent will integration of primary eye care into primary health care (regional and national plans, policies, and skills development of primary health workers) continue beyond programme end?
5. How will implementation of the sustainability plan or continuation of identified programme elements be monitored? To what extent does the sustainability plan take into account differential outcomes and impacts on beneficiaries (specifically male vs. female beneficiaries; rural beneficiaries and those marginalised through extreme poverty)?

Replicability/Scalability

1. Has Sightsavers conducted a cost-benefit analysis of the AHC programme to consider the feasibility of scalability?
2. Have key replicable elements of the programme been identified and key success factors for replication delineated at country and regional levels? If so, what are these?
3. Have resources that would support replication been identified, particularly at Sightsavers regional level and within MoH in each country?

Coherence

1. To what extent did the regional programme structure contribute to successful achievement of the programme within each country? (coordinated goals, communication, resource allocation/management)
2. How effectively did the programme interface and align with national structures addressing eye health in each country?
3. To what extent did the programme contribute to improved regional eye health planning and coordination?

Lessons learnt

1. What elements of the implementation of the programme provided ongoing challenges, and how did you address these?
2. If you could repeat this programme, which elements would you definitely retain, expand or cut out? And why?
3. What is the most valuable learning you have gained from working on/interfacing with this programme?

Appendix C: Data Collection Tools

Appendix C1: Focus group discussion guide for use with community members receiving eye health services

Administration

Country	
Focus group discussion (FGD) number	
Location of FGD (name of place and district)	
Implementing partner	
Date of FGD	
Type of group	
Number of participants	
Gender of participants	M: F:
Facilitated by	
Interpreting by	
Notes completed by	

Notes of clarification

This outline assumes that around 50% of participants will have undergone cataract surgery and that the remainder will have accessed a range of different services at different levels of the health system.

This tool is only for use with adults aged 18 or older.

- Anyone under the age of 18 who arrives at a focus group discussion will not be able to participate.
- In the event that parents of children who have received eye health services present at focus group discussions, they can be included in groups.

Introduction

We welcome everyone here today. Thank you for coming. My name is ------- and this is my colleague ------- We work for an organisation called GreaterCapital, which is based in South Africa. We have been appointed by Sightsavers to carry out a review of its Advancing Healthy Communities project which has been operating in Malawi, Zimbabwe and Mozambique over the past five years. We are completely independent of Sightsavers.

One of our tasks is speak to community members like yourselves who have used the eye health services supported by this programme. That is why we are holding groups like this in different places. We would like to hear from you about how you found using the services and what changes it has brought about for you. We will ask you some questions about your experiences and views. The information you share with us will be used anonymously as part of our assessment of how well the project has worked.

We are here today to learn from you. We will be taking notes of the group's discussion. The notes will be kept safe and confidential.

We want this group to be a safe place for you to be honest. Your participation and the things you share with us are confidential. When you speak, we will not make a record of your name.

I will be the person who leads the discussion. My colleague [say name of data collector] will translate for us.

We'll be spending about an hour and 30 minutes together today. During that time, we want to be respectful of each other. Some of the rules we want to set for our discussion are:

- One voice at a time.
- Don't interrupt others.
- Everyone's opinions are important. Be careful not to criticise anyone.
- Confidentiality: what is shared in the meeting today should not be shared with other people.
- Please turn off your cell phones.
- If you want to leave the room to go to the bathroom, please leave and return quietly when you need to.

You can decide how you participate in the focus group discussion. If you decide to participate now but later change your mind, you can leave the group at any time. However, we would value your participation to the end.

Do you have any questions for me right now?

Warm-up questions

To begin, let's all get to know each other. We'll go around the circle so that you can each say your first name and the name of the place where you live.

Please can you share with us what eye health problem you had or have.

Which eye health services did you use?

- Community eye health workers
- Health post/local clinic
- District health facility/district hospital
- Provincial hospital

Effectiveness

What was the most difficult thing for you about using eye health services?

- How did you overcome this difficulty?
- Did you get help from anyone?

What was the best thing – that helped you the most – when you were trying to find help with your eye health problem?

What was the outcome of your using the eye health services?

- Did you get the help you were looking for? Did your condition improve? Please explain.

- How do you feel about this result?

- Do you understand what caused your eye health problem?

Impact

On attitudes of health professionals towards eye health beneficiaries:

Please explain how were you treated when you used the eye health services? i.e. when coming into contact with:

- community eye health workers

- primary health care staff

- staff at district health posts/hospitals, and

- doctors at provincial hospitals?

Did you have a chance to ask questions and to understand what was happening? Please explain.

Did you get help with solving any worries or difficulties you may have had? Please explain.

On community members' understanding of the importance of follow-up:
Do you need to go back to the health service about your eye/s?

If yes:

- How often?

- What for? Who will you see and what will they do when you go back?

- What will happen if you don't manage to go for follow up?

Referral of others

Have you spoken to others in your community about your experience using eye health services?

Can you recommend the services you received to other people?

What advice would you give to someone who is looking for the same services as you used?

Gender

For those of you who are female:
How has the eye service you received made changes in your life?

For those of you who are male:
How has the eye service you received made changes in your life?

Attitude to services, quality of life and disability

Is having an eye health condition treated as a disability in your community?

- Do people treat community members with eye conditions differently in any way?

How do people in your community feel about using eye health services?

Has your life become easier in any way since you received attention for your eye health condition?

- Your daily work?

- Your place in the home?

- Your place in the community?

Closure

We have reached the end of our time together. Thank you for talking with us. We appreciate your participation. We wish you everything of the best going forward.

Appendix C2: Consent form for participation in a focus group discussion

I, _____ *(name)* agree of my own free will to participate in a discussion about my experiences as a community member who has used eye health services during the past five years. I understand that the notes from this discussion will be used to draw up a report on the eye health services that Sightsavers had supported through its Advancing Heathy Communities programme that ended in December 2014.

I have been told that the discussion will last about 1 hour and 30 minutes and is being run by GreaterCapital. I understand that GreaterCapital does not work for Sightsavers and is doing an independent evaluation of Sightsavers' work.

I understand I am allowed to raise my hand if I do not understand the questions that are asked during the group discussion. I also understand that I am free to speak my mind in the group and that my opinions will not affect me negatively.

I understand that the information I share here is confidential and will not be shared with the staff who work at the health care facilities/posts where I go for eye health services. My name will not be used in any report and that the information that I provide will not be traced back to me specifically.

I understand that I will not be paid in money, food or some other form of payment for participating in this discussion.

I also understand that if I would like to leave the discussion at any time, that I am free to do so.

Signed:_____

Name: _____

Date: _____

Appendix C3: Interview form for use with mid-level eye health professionals receiving training through the programme

Administration

Country	
Lead partner	
Interview number	
Location of interview (name of place and district)	
Date of interview	
Name of person interviewed	
Gender of person	Male Female
Cadre of person	
Interviewed by	
Interpreting by	
Notes completed by	

Introduction

We welcome everyone here today. Thank you for coming.

My name is ------- and this is my colleague ------- We work for an organisation called GreaterCapital, which is based in South Africa. We have been appointed by Sightsavers to carry out a review of its Advancing Healthy Communities project which has been operating in Malawi, Zimbabwe and Mozambique over the past five years. We are completely independent of Sightsavers.

One of our tasks is speak to mid-level eye health professions like you who have been through training supported by the programme. We are looking at what difference the training has made and what key challenges remain in your work going forward. The information you share with us will be used anonymously as part of our assessment of how well the project has worked.

We will ask you some questions about your experiences and views. The interview will take approximately one hour.

If you decide to participate in this interview but later change your mind, you can leave the interview at any time; however, we would value your participation to the end.

Do you have any questions for me before we start?

Background

1. What training did you take part in?

2. How long did you go for training and when did you complete your training?

3. When did you begin working in this field?

4. How many years have you worked in eye care up to the present?

5. Prior to training, what was your highest level of qualification?

6. Had you done any training in eye care specifically prior to this training?

Relevance

7. Did your eye health training prepare you adequately for the type of eye health services you are required to provide?

   YES NO

   Please explain.

8. Are you employed in work relevant to the training you received?

   YES NO

If NO:

9. What are the reasons you are not employed in this capacity?

If YES:

10. Was this post made accessible to you through the training you received?

11. Is your current position a new post or was it a replacement for someone retiring or leaving?

Effectiveness

12. Over the past year, has there been a regular supply of the consumables you need to carry out your work?
    YES NO

    Please explain.

13. Who has supported the costs of your equipment and consumable needs until the end of 2014?

14. Do you have currently enough equipment to carry out the work you are required to do?
    YES NO

    Please explain.

15. What refresher or further education training (Continuing Professional Development) have you attended since you completed training?
    [*prompt for: how many hours of training; who provided the training; did it include practical sessions to practise and polish skills; was there any form of assessment following such training?]*

16. What arrangements have been in place to provide you with mentorship and/or supervision since you began working in this position?
    [prompt for: who has supervised/mentored you? how often have you had contact with your mentor/supervisor? what structured arrangement exists for your mentorship/supervision? What type of issues can you address with your mentor/supervisor?]

17. What challenges have you faced in doing your work?

    - How have you addressed these?

On cataract surgery :

18. What evaluation tool is your health facility using to measure visual acuity for pre-/post-cataract surgery?
    [Ask to see copy of tool and check that it is standardised version across all respondents interviewed]

19. Is this used consistently on all those who undergo cataract surgery?

    YES NO

    Please explain.

20. What factors are influencing the results your facility currently attains?

Impact

21. How has the AHC programme affected the capacity of human resources for eye health care in your province?

22. On average, how many people do you treat for eye health during a month?

Break down (as relevant) per

- examinations
- surgeries
- treatments.

23. How does this compare to what you are expected to reach (expected productivity)?

24. How has the development of capacity at primary health care level impacted on your work at mid-level? Specifically:
    - type of eye conditions addressed at primary level

    - type of eye conditions addressed at mid-level

    - demand for eye health services

25. Are you able to meet the current demand for your services?

YES NO

If NO:

26. What are the factors preventing you from meeting current demand?

27. How do you manage the demand exceeding your capacity? What systems do you use?

If YES:

28. What are the factors preventing more referrals?

29. Would you be able to treat more patients if more referrals were made?

YES NO

If YES:

30. How would you manage such a situation of increased demand?

31. Have you noticed an increase in the number of women who have been using your services?

YES NO

If YES:

32. What factors have contributed to this increase?

Sustainability

33. Who is supporting your equipment and consumable needs going forward?

34. What systems are in place to provide you with a regular pipeline of the consumables you need to carry out your work?

    - How well are these systems functioning?

35. What arrangements are in place to provide you with mentorship and/or supervision going forward?

36. What systems are in place to provide you with replacement and servicing of equipment over time?

37. What arrangements are in place to provide you with further training and refresher training (continuous professional development) in future?

38. Do you feel satisfied with the work that you do?

- Do you enjoy it?

- Is the salary level satisfactory?

39. What goals do you have for yourself with regards eye health over the next five years?

Coherence

40. How do you work in collaboration with other eye health services, including:
    - Community eye health workers?

    - Primary health post/clinic level?

    - Colleagues in eye health within the same district as you?

    - Provincial level eye health services?

41. What systems and methods of communication do you use to manage referrals to and from:
    - Community eye health workers?

    - Primary health post/clinic level?

    - Colleagues in eye health within the same district as you?

    - Provincial level eye health services?

Closure

We have reached the end of the interview. Thank you for talking with me. I wish you everything of the best going forward.

Appendix C4: Key Informant Interview Guide for use with AHC advocacy partners and AHC HReH regional staff

Administration

Key informant organisation	
Name of person interviewed	
Interview number	
Country	
Interview completed by	
Notes completed by	
Date completed	

Introduction

My name is ------- and this is my colleague ------- We work for an organisation called GreaterCapital, which is based in South Africa. We have been appointed by Sightsavers to carry out an end of programme review of the Advancing Healthy Communities project. We are completely independent of Sightsavers.

One of our tasks is to speak to a range of key informants, including advocacy organisations (like yourself) that have also been involved in implementing the AHC project in each country. The information you share with us will be used anonymously as part of our assessment of how well the project has worked. The interview will take approximately one hour and 15 minutes.

Do you have any questions for me before we start?

Background

1. Please can you detail over what period your organisation was active on this project.

2. Please explain to me what your organisation's role on the AHC project was.

3. Who have your key contacts on the AHC project been? What issues did you liaise with them around?

Relevance	
Interview question	**Response**
How well do the programme's objectives fit with country and regional priorities for advocacy around eye health in particular and health care in general?	

To what extent has the programme contributed to the mid-level eye health human resourcing needs of each country?	
To what extent has execution of the AHC programme included key actors responsible for policy making at the regional and national level? Please explain to demonstrate your response.	
To what extent has your organisation's experience on the AHC programme enriched its contribution to regional planning around primary eye care and healthcare in general within sub-Saharan Africa? Please explain to demonstrate your response.	

Effectiveness	
How well has the programme performed against advocacy targets for output and outcomes?	
To what extent has the programme approach and design regarding advocacy facilitated effective performance and achievement of targets?	

What proactive measures were taken during the course of the programme to adapt its approach in order to facilitate improved performance on advocacy deliverable, and how successful were such measures?	
How responsive was the programme to managing unforeseen challenges regarding advocacy?	
How effective were monitoring tools and systems for advocacy in enabling quality and accurate reporting against outputs and objectives?	
To what extent was your organisation able to include community members in your country in advocacy activities? Please explain what strategies and activities you undertook to do this.	

Efficiency	
What unanticipated challenges regarding efficiency arose during the course of the programme's implementation and how were these addressed at country/regional levels?	

How well did the regional coordinating body manage the allocation of resources and inputs for advocacy work across and within countries to achieve maximum possible and intended outputs of the programme?	
What specific measures were undertaken by regional management to support country programmes in delivery of advocacy activities? How efficient and timely was the support provided?	

Impact	
What specific changes have occurred at different levels of the health care system in each country as a result of advocacy activities on the AHC programme?	
How has the programme provided for improved integration of PEC into PHC at country level?	
What impact has the programme had on the capacity of eye health care advocates in each country?	

How did the advocacy work impact on the lives of beneficiaries of eye health care services? What specific positive or negative impacts has it had for such beneficiaries with regards: - Primary vs. mid-level/tertiary focus - Gender - Cost of services - Quality of life - Disability status?	
What evidence is there at country level of improved allocation of resources and institutional support for eye health service delivery? How is this articulated in commonly agreed policies, procedures and systems to enable eye health service delivery (e.g. eye health national plans, allocation of national-level personnel, budgets, protocols for management)	
To what extent have regional approaches to human resource development in eye health been influenced by the programme? Please demonstrate through specific examples.	

Sustainability	
What measures were undertaken by the programme to plan for sustainability around advocacy activities? To what extent did sustainability planning: - identify those advocacy elements of the programme that need to continue in order to maintain positive outcomes - make resource provision for the continuation of these elements?	
To what extent were key stakeholders (advocacy bodies; regional and national health policymakers; district & provincial hospitals; advocacy agents / institutions; government ministries) and beneficiaries involved in sustainability planning for advocacy activities?	
To what extent were recommended sustainability measures for advocacy activities functioning by December 2014?	
How will implementation of the sustainability plan or continuation of identified programme elements supporting advocacy be monitored at country and regional levels?	

To what extent does the sustainability plan take into account differential outcomes and impacts on beneficiaries? Specifically: - primary vs.mid-level and tertiary levels - integration of primary eye care into primary health care - male vs. female beneficiaries - rural beneficiaries - those marginalised through extreme poverty.	
Replicability/Scalability	
Has Sightsavers conducted an analysis of potential scalability of advocacy activities on the AHC programme in various locations? If so, please explain what elements have been identified for scale-up or replication.	
Regional level only: Have key replicable elements of the advocacy work and success factors for replication been identified at country and regional levels? If so, what are these?	
Have resources that would support replication or scale-up of advocacy work been identified, both at regional level and within MoH in each country?	

Coherence/Coordination	
To what extent did the regional programme structure contribute to successful achievement of advocacy objectives on the programme within each country? (coordinated goals, communication, resource allocation/management)	
How effectively did advocacy elements interface and align with national structures addressing eye health in each country and in the region?	
To what extent did the programme contribute to improved regional eye health planning and coordination around advocacy activities?	

Lessons learnt	
What elements of the implementation of the programme provided ongoing challenges, and how did you address these?	
If you could repeat this programme, which advocacy-related elements would you: - Definitely retain - Expand - Cut out? And why?	
What is the most valuable learning your organisation has gained from working on this programme?	

Conclusion

Is there anything else you would like to share with me before we close this interview?

Thank you for meeting with me to complete this interview. I wish you everything of the best for your work going forward.

Appendix C5: Key Informant Interview Guide for use with AHC Regional team, lead partners and NGO implementing partners

Administration

Key informant organisation	
Name of person interviewed	
Interview number	
Country	
Interview completed by	
Notes completed by	
Date completed	

Introduction

My name is ------- and this is my colleague ------- We work for an organisation called GreaterCapital, which is based in South Africa. We have been appointed by Sightsavers to carry out an end of programme review of the Advancing Healthy Communities project. We are completely independent of Sightsavers.

One of our tasks is to speak to a range of key informants, including lead partners and NGOs (like yourself) that have also been involved in implementing the AHC project in each country. The information you share with us will be used anonymously as part of our assessment of how well the project has worked. The interview will take approximately one hour and 15 minutes.

Do you have any questions for me before we start?

Background

Please explain to me what your organisation's role on the AHC project has been thus far.

Who have your key contacts in Sightsavers on the AHC project been? What issues did you liaise with them around?

Relevance	
Interview question	**Response**
How well do the programme's objectives fit with country and regional priorities for eye health in particular and health care in general?	
To what extent has execution of the AHC programme included key actors responsible for policy making at the regional and national level?	
To what extent has Sightsavers' experience on the AHC programme enriched its contribution to regional planning around PEC and eye care within sub-Saharan Africa?	

Effectiveness	
How well has the programme performed against targets for output and outcomes?	
To what extent has the programme approach and design facilitated effective performance and achievement of targets?	
What proactive measures were taken during the course of the programme to adapt its approach in order to facilitate improved performance, and how successful were such measures?	
How responsive was the programme to managing unforeseen challenges?	
How effective were monitoring tools and systems in enabling quality and accurate reporting against outputs and objectives?	

Efficiency	
What unanticipated challenges regarding efficiency arose during the course of the programme's implementation and how were these addressed at country and regional levels?	
How well did the regional coordinating body manage the allocation of resources and inputs across and within countries to achieve maximum possible and intended outputs of the programme?	
What specific measures were undertaken by regional management to support country programmes in delivery on the programme? How efficient and timely was the support provided? (overall coordination, advocacy and financial management)	

Impact	
What specific changes have occurred at different levels of the health care system in each country as a result of the AHC programme?	
How has the programme provided for improved integration of PEC into PHC at country level?	

What impact has the programme had on the quality and productivity of cataract surgeons? - The number of surgeries performed, success rate of eye surgeries, level of skill as measured by the industry	
What impact has the programme had on the quality and productivity of OCN/OCOs? - Depth of service and capacity to respond to needs as presented by community beneficiaries	
What impact has the programme had on the quality and productivity of services with regards: harmonisation of access to essential equipment and consumables to enable service delivery; replacement of equipment as required and consistency of pipeline on consumables	
How has the development of capacity at primary health care level impacted on the mid-level eye health care service delivery? Specifically: - demand for eye health services	

- type of eye conditions addressed at primary level, disaggregated by gender - type of eye conditions addressed at mid-level, disaggregated by gender - institutional buy-in for referral systems and functionality of such systems	
What evidence is there at country level of improved allocation of resources and institutional support for eye health service delivery? How is this articulated in commonly agreed policies, procedures and systems to enable eye health service delivery (e.g. eye health national plans, allocation of national-level personnel, budgets, protocols for management)	
To what extent have regional approaches to human resource development in eye health been affected by the programme?	

Sustainability	
What measures were undertaken by the programme to plan for sustainability? To what extent did sustainability planning: - identify those elements of the programme that need to continue in order to maintain positive outcomes	

- make resource provision for the continuation of these elements?	
To what extent were key stakeholders (regional and national health policymakers; district & provincial hospitals; advocacy agents / institutions; government ministries) and beneficiaries involved in sustainability planning?	
To what extent were recommended sustainability measures functioning by December 2014? Specifically: - How will continuous training of mid-level cadres continue beyond programme end? What resource provision has been made for this? - How will district and provincial hospitals continue to source and maintain necessary equipment and consumables to maintain and further programme achievements? - To what extent will integration of primary eye care into primary health care (regional and national plans, policies, and skills development of primary health workers) continue beyond programme end?	

How will implementation of the sustainability plan or continuation of identified programme elements be monitored?	
To what extent does the sustainability plan take into account different outcomes and impacts for community beneficiaries? Specifically: - male vs. female beneficiaries - rural beneficiaries - those marginalised through extreme poverty.	
Replicability/Scalability	
Has Sightsavers identified elements of the AHC programme that could be scaled up?	
Have key replicable elements of the programme been identified and key success factors for replication delineated at country and regional levels? If so, what are these?	
Have resources that would support replication been identified, particularly at Sightsavers regional level and within MoH in each country?	

Has Sightsavers conducted a cost-benefit analysis of the AHC programme to consider the feasibility of scalability?	
Coherence/Coordination	
To what extent did the regional programme structure contribute to successful achievement of the programme within each country? (coordinated goals, communication, resource allocation/management)	
How effectively did the programme interface and align with national structures addressing eye health in each country?	
To what extent did the programme contribute to improved regional eye health planning and coordination?	
Lessons learnt	
What elements of the implementation of the programme provided ongoing challenges, and how did you address these?	

If you could repeat this programme, which elements would you: - Definitely retain - Expand - Cut out? And why?	
What is the most valuable learning you have gained from working on/interfacing with this programme?	

Conclusion

Is there anything else you would like to share with me before we close this interview?

Thank you for meeting with me to complete this interview. I wish you everything of the best for your work going forward.

Appendix C6: Key Informant Interview Guide for use with AHC Government stakeholders and coordinators

Administration

Key informant organisation	
Name of person interviewed	
Interview number	
Country	
Interview completed by	
Notes completed by	
Date completed	

Introduction

My name is ------- and this is my colleague ------- We work for an organisation called GreaterCapital, which is based in South Africa. We have been appointed by Sightsavers to carry out an end of programme review of the Advancing Healthy Communities project. We are completely independent of Sightsavers.

One of our tasks is to speak to a range of key informants, including lead partners and NGOs (like yourself) that have also been involved in implementing the AHC project in each country. The information you share with us will be used anonymously as part of our assessment of how well the project has worked. The interview will take approximately one hour.

Do you have any questions for me before we start?

Background

4. Please explain to me what your role has been on the AHC project.

5. Who have your key contacts in Sightsavers on the AHC project been? What issues did you liaise with them around?

Relevance	
Interview question	**Response**
How well do the programme's objectives fit with country and regional priorities for eye health in particular and health care in general?	
To what extent has the programme contributed to the mid-level eye health human resourcing needs of each country?	
To what extent has execution of the AHC programme included key actors responsible for policy making at the regional and national level?	
Effectiveness	
How well has the programme performed against expected outputs and outcomes?	
What proactive measures were taken during the course of the programme to adapt its approach in order to facilitate improved performance, and how successful were such measures?	

Efficiency	
What unanticipated challenges regarding efficiency arose during the course of the programme's implementation and how were these addressed at country level?	
Impact	
What specific changes have occurred at different levels of the health care system in each country as a result of the AHC programme?	
How has the programme provided for improved integration of PEC into PHC at country level?	
What impact has the programme had on the capacity of human resources for eye health care in each country?	
What impact has the programme had on the quality and productivity of mid-level cadres? - For cataract: The number of surgeries performed, success rate of eye surgeries, level of skill as measured by the industry - For other mid-level services: Depth of service and capacity to respond to	

needs as presented by community beneficiaries - Across all cadres: harmonisation of access to essential equipment and consumables to enable service delivery; replacement of equipment as required and consistency of pipeline on consumables	
How has the development of capacity at primary health care level impacted on the mid-level eye health care service delivery? Specifically: - demand for eye health services - type of eye conditions addressed at primary level, disaggregated by gender - type of eye conditions addressed at mid-level, disaggregated by gender - institutional buy-in for referral systems and functionality of such systems	
What evidence is there at country level of improved allocation of resources and institutional support for eye health service delivery? How is this articulated in commonly agreed policies, procedures and systems to enable eye health service delivery (e.g. eye health national plans, allocation of national-level personnel, budgets, protocols for management)	

Sustainability	
What measures were undertaken by the programme to plan for sustainability? To what extent did sustainability planning: - identify those elements of the programme that need to continue in order to maintain positive outcomes and - make resource provision for the continuation of these elements?	
To what extent were key stakeholders (regional and national health policymakers; district & provincial hospitals; advocacy agents / institutions; government ministries) and beneficiaries involved in sustainability planning?	
To what extent were recommended sustainability measures functioning by December 2014? Specifically: - How will continuous training of mid-level cadres continue beyond programme end? What resource provision has been made for this? - How will district and provincial hospitals continue to source and maintain necessary equipment and consumables to maintain and further programme achievements? - To what extent will integration of primary eye care into primary health	

care (regional and national plans, policies, and skills development of primary health workers) continue beyond programme end?	
How will implementation of the sustainability plan or continuation of identified programme elements be monitored?	
To what extent does the sustainability plan take into account differential outcomes and impacts on beneficiaries? Specifically: - male vs. female beneficiaries - rural beneficiaries - those marginalised through extreme poverty.	
Replicability/Scalability	
Have resources that would support replication been identified, particularly at Sightsavers regional level and within MoH in each country?	

Coherence/Coordination	
How effectively did the programme interface and align with national structures addressing eye health in each country?	
Lessons learnt	
What elements of the implementation of the programme provided ongoing challenges, and how did you address these?	
If you could repeat this programme, which elements would you: - Definitely retain - Expand - Cut out? And why?	
What is the most valuable learning you have gained from working with this programme?	

Conclusion

Is there anything else you would like to share with me before we close this interview?

Thank you for meeting with me to complete this interview. I wish you everything of the best for your work going forward.

Appendix C6: AHC Key Informant interview guide for use with training institution partners

Administration

Key informant organisation	
Name of person interviewed	
Interview number	
Country	
Interview completed by	
Notes completed by	
Date completed	

Introduction

My name is ------- and this is my colleague ------- We work for an organisation called GreaterCapital, which is based in South Africa. We have been appointed by Sightsavers to carry out an end of programme review of the Advancing Healthy Communities project. We are completely independent of Sightsavers.

One of our tasks is to speak to a range of key informants, including training institutions (like yourself) that have also been involved in implementing the AHC project in each country. The information you share with us will be used anonymously as part of our assessment of how well the project has worked. The interview will take approximately one hour and 15 minutes.

Do you have any questions for me before we start?

Background

6. Please explain to me what your organisation's role on the AHC project was.

7. Please detail what specific training you provided on the programme, as well as target groups and numbers enrolling, graduating and place in mid-level eye health positions.

8. Who have your key contacts on the AHC project been? What issues did you liaise with them around?

Relevance	
Interview question	**Response**
To what extent has the programme contributed to the mid-level eye health human resourcing needs in your country?	

Effectiveness	
How do the human resource targets reached on this programme compare with output of mid-level human resources for eye health five years ago?	
How did your training programme for mid-level eye health professionals address: - assessment of geographical areas requiring eye health professional and appropriate placement of those trained? - supply of equipment and consumables to enable the work of mid-level eye health professionals? - practical assessment of the quality of work of those trained? - continuous professional development needs of those trained? - Supervision/mentorship to ensure quality and ongoing learning	
What proactive measures were taken during the course of the programme to adapt its approach in order to facilitate improved performance, and how successful were such measures?	

Efficiency	
What unanticipated challenges regarding training arose during the course of the programme's implementation and how were these addressed at your training institution?	
Impact	
What specific changes have occurred at different levels of the health care system in your country (or province) as a result of the AHC programme?	
How has the programme provided for improved integration of primary eye care into primary health care at country (or provincial) level?	
What impact has the programme had on the capacity of human resources for eye health care in your country?	
Please describe what commonly agreed policies, procedures and systems your institution participated in over the past five years to enable eye health service delivery (e.g. eye health national plans, allocation of national-level personnel, budgets, protocols for management)	

How has the development of capacity at primary health care level impacted on the mid-level eye health care service delivery? Specifically: - demand for eye health services - type of eye conditions addressed at primary level, disaggregated by gender - type of eye conditions addressed at mid-level, disaggregated by gender - institutional buy-in for referral systems and functionality of such systems	

Sustainability	
To what extent was your institution involved in sustainability planning to ensure the ongoing training of mid-level eye health professionals?	
To what extent has sustainability planning: - identified those elements of the programme that need to continue in order to maintain positive outcomes - made resource provision (particularly funds) for the continuation of these elements?	
To what extent does the sustainability plan take into account different outcomes and impacts for community members using the services? Specifically: - primary level needs vs. needs at mid- or tertiary levels - male vs. female community members - community members in rural locations - those marginalised through extreme poverty.	
How will implementation of the sustainability plan or continuation of identified programme elements be monitored?	
To what extent were recommended sustainability measures functioning by December 2014? Specifically:	

- How will continuous training of mid-level cadres continue beyond programme end? What resource provision has been made for this? - How will district and provincial hospitals continue to source and maintain necessary equipment and consumables to maintain and further programme achievements? - To what extent will integration of primary eye care into primary health care (regional and national plans, policies, and skills development of primary health workers) continue beyond programme end?	
What ongoing arrangements is your institution involved in to ensure: - assessment of geographical areas requiring eye health professional and appropriate placement of those trained? - practical assessment of the quality of work of those trained? - supervision/mentorship to ensure quality and ongoing learning	

Replicability/Scalability	
Is your institution involved in any efforts to replicate mid-level eye health professional training in other provinces or at national level? If so, what are these?	
Have resources that would support such replication been identified? Please explain.	
Coherence/Coordination	
How effectively did the lead partner and other implementing partners collaborate during the implementation of the programme?	
To what extent did the programme contribute to improved provincial and national eye health planning and coordination?	

Lessons learnt	
What elements of the implementation of the programme provided ongoing challenges, and how did you address these?	
If you could repeat this programme, which elements would you: - Definitely retain - Expand - Cut out? And why?	
What is the most valuable learning your institution has gained from working on with this programme?	

Conclusion

Is there anything else you would like to share with me before we close this interview?

Thank you for meeting with me to complete this interview. I wish you everything of the best for your work going forward.

Appendix D: Data collection planned and carried out

Regional level

Target group	No. planned	No. completed
Lead: Regional Coordination (Sightsavers AHC Regional Programme Coordinator; Sightsavers Regional Director, Sightsavers Regional Finance Manager)	3	3
Implementing partners: Advocacy (HelpAge International Regional Programme Coordinator; HelpAge International Advocacy Officer, Sightsavers Global Advocacy Coordinator), IAPB Director of Human Resources for Eye Health	2	4

Malawi

Target group	No. planned	No. completed
Lead: Sightsavers Malawi (Country Director, Programme Manager, Finance Manager)	2	3
Implementing Partners: Advocacy (Eye for Development Executive Director; MCFTB Advocacy group - Mwanza District Advocacy and Malawi Union for the Blind)	2	2
Implementing Partners: Ministry of Health (National Eye Care Coordinator, Chikwawa District Health Officer, District Health Officer SW Zone)	2	2
Implementing Partners: Malawi College of Health Sciences (Head of College; OCO Training Coordinator)	1	2
Implementing Partners: Hospitals (Heads of Ophthalmology at Queen Elizabeth Central Hospital and Kamuzu Central Hospital)	2	2
Implementing Partners: Hospitals (12 Paediatric case finders; 5 Theatre nurses, Mwanza)	17	17
Implementing Partners: Coordination (South West Zone Coordinator)	1	1
Beneficiaries: Mid-level cadres trained (4 cataract surgeons, 9 OCOs at Queen Elizabeth; 1 cataract surgeon at Kamuzu)	13	14
Beneficiaries: Radio Club listening members	0	8
Beneficiaries: PEC workers trained	9	9
Beneficiaries: Community members (19 eye care patients, Lirangwe Health Centre; 6 paediatric patients, Chikwawa District Hospital)	2 focus groups	2 focus groups conducted

Mozambique

Target group	No. planned	No. completed
Lead (for province): Sightsavers Mozambique(Country Director, AHC Project Manager, Finance Officer)	3	3
Implementing partners: Light for the World: Country Director and AHC Project Manager (Joint interview). (Finance manager unavailable)	2	1[23]
Implementing partners: Provincial Directorate of Health (Director of Medical Services & Head of Medical Services)	1	1
Implementing partners: Provincial Department of Health (Sofala)	1	1
Implementing partners: Training (Head of Institute & Coordinator for OT Training; Nampula Health Sciences Institute; Head of Pedagogic Services, University of Lurio)	2	2
Implementing partners: Beira Institute of Health Sciences (Director and Professor of Ophthalmic Technician training)	1	1
Implementing partners: Provincial Heads of Ophthalmology Departments (Head of Ophthalmology, Nampula Central Hospital)	1	1
Implementing partners: Ophthalmology Department, Beira Central Hospital	1	1
Implementing partners: Advocacy (Avedos)	1	1
Beneficiaries: those trained as ophthalmic technicians during 2011 - 2013 (OTs at Namapa District Hospital (1), Nampula Central Hospital (3) and Alua Hospital (1)	4	5
Beneficiaries: Those trained as ophthalmic technicians during 2011 – 2012 (Sofala and Nhamatanda)	3	5
Beneficiaries: Community members using direct services (Namapa Central Hospital)	1 focus group with 8–12 participants	1 focus group with 13 participants
Beneficiaries: Community members using direct services (10 in Buzi and 3 in Nhamatanda)	1 focus group with 8–12 participants	1 focus group with 10 participants.1 focus group with 3 participants24

[23] The AHC Finance Manager was unavailable for interview.

24Planned FGD only included beneficiaries of cataract surgery so additional members who received general eye health services were requested to join. An additional FGD was also planned in second district to make use of time and add to sample. Planned FGD included 10 cataract beneficiaries. No non-cataract beneficiaries could be confirmed for this discussion. Additional FGD included three non-cataract beneficiaries.

Zimbabwe

Target group[25]	No. planned	No. completed
Sightsavers Zimbabwe	1	1
Implementing partners: Ministry of Health, Provincial Departments of Health: • National Deputy Director for NCDs • Midlands Provincial Focal Point for NCDs • Matabeleland South Provincial Focal Point for NCDs • *Gokwe North District Medical Officer* • *Mangwe District Medical Officer* • *Gokwe North District Community Health Nurse*	3	9
Implementing partners: Training (Parirenyatwa School of Nursing)	1	2 (3 people in total)
Implementing partners: Provincial Heads of Ophthalmology Departments (Parirenyatwa SKH Eye Hospital, Harare*; Richard Morris Eye Hospital, Bulawayo*[26]	1	2
Implementing partners: Advocacy (HelpAge Zimbabwe)	1	1 (2 people)
Beneficiaries: those trained as ophthalmic nurses (Parirenyatwa (1); Gokwe North (1); Gokwe South (1); Kwekwe (1); Chikwingwizha (1); Gweru (1); Richard Morris (1); Plumtree(1)	8	7
Beneficiaries: those trained as cataract surgeons (Gokwe North District Hospital, Gokwe North)	1	1
Beneficiaries: community members using direct services(Chireya Mission Hospital, Gokwe North; Mangwe Clinic, Mangwe District)	2 focus groups with 8 – 12 participants	2 focus groups with total of 16 participants (9 + 7)
Beneficiaries: PEC workers trained	*0*	*11*

[25] Those indicated in italics were not on the agreed list for data collection but were nonetheless interviewed for insights they could offer on district management of mid-level eye health activities and PEC integration into PHC.
[26] Richard Morris Eye Hospital was not a formally identified partner on this project but contributed largely to ensuring cataract service delivery across two of the three target provinces throughout the project period, attachment for one of the cataract surgeons and further advancing the skills of OPNs trained under the programme and placed at Richard Morris following training.

Appendix E: Summary Results from Focus Group Discussions with Community Beneficiaries

Focus groups were conducted at district level in each country with groups of beneficiaries who had received a range of eye care services. Two focus groups were conducted in both Malawi and Zimbabwe, and three were conducted in Mozambique.

A. Efficiency

Knowledge of eye care services

Participants seem to have become aware of available services via a number of means, but typically through primary health care services or public notices. A mother in Malawi stated that a doctor visiting her child's school became aware that her child was blind, and subsequently located the mother and accompanied her to the local clinic where the child was then referred to a central hospital for treatment. Others had come to know about their local eye care services through a public notice board and information that was disseminated by their clinic at their local church school. Others mentioned that they became aware of eye care services through announcements on the radio or television, or via community activists.

When the eye doctor is coming, then it gets reported on the radio. We all hear because we all have radios. Beneficiary, Nampula Mozambique

Eye care services used

Beneficiaries at the focus groups typically gained treatment for a range of conditions, such as cataract, a foreign body in the eye, blurred vision, tears and itchy eyes, eye injuries and infections. The services accessed covered the spectrum of available eye health services at primary, district and central levels.

Accessibility

As mentioned above, mobility was the primary impediment to service mentioned by beneficiaries. Of those who did not live close to a hospital, many struggled to afford the transportation costs to attend appointments for treatment and follow-up. Some in Malawi and Mozambique were transported by ambulance, but had to bear the cost of returning home.

B. Effectiveness

Beneficiary satisfaction

Focus group participants across all countries were generally very satisfied and displayed much gratitude for the eye care services they had received. Most beneficiaries agreed that they received the results they had been expecting, and spoke of improvements in their quality of life that have been a direct result of their eye care treatments. Many agreed that their increase in ability to walk and perform chores independently has changed their lives dramatically for the better. They mentioned essential tasks such as personal care, preparing food, working in fields and caring for children they could now do alone, and that less reliance on family and others to support them has assisted them to feel more capable and autonomous. Participants asked that the project be continued and expanded.

I am very satisfied with the result. I am comforted because in the past my daughter couldn't see. We are very satisfied as a family. Beneficiary, Chikwawa, Malawi

Difficulties in accessing eye care service

By far the most problematic issue for beneficiaries in accessing eye care services was that of transport. Focus group participants across the three countries stated that transport was a primary barrier due to long distances and cost. Beneficiaries in Malawi were particularly grateful for the ambulance service which brought them to hospital for treatment; one respondent in Mozambique mentioned they were able to access a similar service. Despite these positives, transportation was mentioned throughout the focus groups as a major limitation to accessing services at all levels, including initial assessment, appointments for treatment and follow-up appointments.

It's a great distance to the service. We don't have money. It's difficult to get money for transport. I need to go to the district. Last month I had the money but then I had to use it for something so now I can't go. Beneficiary, Gokwe North, Zimbabwe

Some beneficiaries also mentioned depth of community outreach services as an area which could improve. They mentioned that they would like community-based services to be offered more frequently, and that such services should penetrate more deeply into rural areas. Participants also requested greater provision of medicines and glasses, stating that these items were often not available at local health clinics.

C. Impact

Quality of life

Beneficiaries were overall very positive about the impact that eye care treatment had had on their lives. One of the strongest themes emerging from the focus groups in terms of impact for beneficiaries was the sense of beneficiaries regaining their independence. Participants stated that they were now able to be more self-reliant through being able to attend to their own personal care needs without assistance and having personal mobility, (walking without a person or external aide such as a walking stick to assist). Following receiving treatment for their eye conditions, most beneficiaries reported being able to carry out basic household chores that they were previously unable to do unassisted, such as cooking and cleaning, as well as better able to attend to their children's needs.

The renewed ability to read surfaced as a common theme across the focus groups. One respondent mentioned that she was now able to read the Bible in church, while another is grateful that she could now help her children with their homework, which she was unable to do before. The mother of a child who had received treatment for bilateral cataract stated that her child was now able to play with other children and had made friends, reducing the social isolation that the child previously felt and removing the burden of care from the mother.

Gender

Both men and women reported similar impacts resulting from their treatment. Women participants mentioned many improvements in their quality of life after treatment, particularly around daily tasks such as eating, looking after children, making fire,

farming, reading and travelling longer distances. One participant in Mozambique stated that she is now an active member of a women's organisation in her community as a result of her treatment. For men, benefits mentioned had largely enabled their capacity to generate income or produce food, such as the ability to farm and to work in construction. Both men and women felt a strong appreciation for their regained independence.

Before we could not do anything for ourselves, even simple things. We could not see the fish on our plate or feed ourselves or even go to the toilet ourselves. Now we can see and are independent again. We can see people clearly again. Beneficiary, Buzi, Mozambique

Interaction with health professionals

There was a common feeling among beneficiaries that they had been treated very well by eye professionals at the services they engaged with. It was generally felt that hospital workers were patient and understanding. Beneficiaries in Malawi who engaged with multiple levels of the health system commented that they had received good treatment at both district and central levels. One patient in Zimbabwe stated that she was treated very well, including being given a place to sleep for herself and her carer.

The OT here is very good. The eye part of this hospital is very active. Sick people are treated very well here. Thank you to the OT and the district hospital for my treatment. I am very grateful. Beneficiary, Nampula, Mozambique.

Understanding the importance of follow-up

Many beneficiaries seemed to understand the need for follow-up. Some were able to give specific details about the requirements of their follow up appointments, including timeframes, the reasons for follow-up and required actions in the meantime such as use of eye drops. Others stated that they had not been to their follow-up appointments, mentioning that transportation issues prevented them from attending. Transport as an obstacle to follow-up attendance was echoed by a number of participants across the three countries, who felt that the cost and distance were major constraints.

We were supposed to go this month, but could not because there was no ambulance to take us there. Beneficiary, Chikwawa, Malawi

Patients' understanding of their eye conditions was mixed, as was their understanding of the consequences of not attending follow-up sessions. Some expressly stated that they did not know what had been wrong with their eye/s and had no understanding of their conditions; some also stated they did not know what would happen if they did not attend subsequent appointments. Some felt that they would again become blind if they did not attend follow-ups.

Recommendation of services

There was a general sense that participants had spoken to others in their community about their eye treatments. Many said that they were willing to recommend these

services to others and that they had already done so. However, there was again mention of access as an issue, particularly in Zimbabwe where participants said they did not know when the next outreach clinic would occur or felt that it happened too infrequently.

I can definitely refer people but we don't know when the outreach is happening again. Beneficiary, Gokwe North, Zimbabwe

Community attitudes

There was a general sense among focus group participants that those who are blind or suffering eye problems are often treated badly within their communities, and suffer a range of unwanted social consequences. Participants in all three countries mentioned that some community members would label them as bewitched or cursed if they or their child had a serious visual impairment. The mother of a paediatric patient said that she was encouraged to keep her child at home rather than send her to school, as it would be a waste of time. Beneficiaries from all countries mentioned being ridiculed and laughed at, as well as sometimes being called names for being blind or wearing glasses. Participants mentioned that they believed that some people were reluctant to wear glasses out of fear of being ridiculed. Participants also reported being taken advantage of, even by their family members who might steal food and other items from them or abandon them.

People were taking advantage of me. They would steal my plate away from me while I was trying to eat. People would laugh at me. I am very grateful that it is no longer like that for me. Beneficiary, Nampula, Mozambique.

Beneficiaries also mentioned some degree of mistrust of modern medical practices within their communities, with many community members scared to receive treatment. Common fears cited were that doctors would cut their eyes, remove their eyes or cause them to go blind. A number of participants mentioned that through speaking to their peers and through being living examples, they were attempting to change community attitudes and perceptions so that people understand that medical practices can be very helpful. One beneficiary who was ridiculed prior to his treatment stated that the people who taunted him before are now ashamed of their actions.

Appendix F: Crosscutting Challenges Affecting Eye Health Programming in Resource-Poor Settings

Two repeated themes that fell outside the immediate scope of the AHC project's delivery but were consistently raised by mid-level eye health professionals during the end of term review as critical, ongoing challenges were:

- Procurement and maintenance of consumables and equipment for work at mid-level; and
- Retention of mid-level cadres.

GreaterCapital provides this appendix in order to detail these concerns, which we understand to be crosscutting challenges that that are likely to reoccur on future projects of a similar nature. It is GreaterCapital's assessment that the level of emphasis placed on these issues by stakeholders and beneficiaries alike necessitate that they need to be considered during project design and management in future.

Procurement and Maintenance of Equipment and Consumables for mid-level work

A challenge that was repeatedly raised during interviews with mid-level eye health professionals was the provision and maintenance of equipment and consumables for training institutions, district-based and primary-level eye health services. While it was not a specific objective of the programme to provide equipment or a full pipeline of consumables – that mandate falling largely to the Ministry of Health of each country – mid-level eye health professionals felt very strongly that in order them to use all the skills in which they had been trained and to improve community access to effective service delivery on a wide range of eye health conditions, a regular supply of consumables and equipment was required. This was not available in many of the locations visited during the end of term review.

Malawi

A key challenge identified by stakeholders at all levels in Malawi was around the procurement and maintenance of equipment and consumables. Aside from Thyolo, which reported few problems with levels of medication and equipment, there was generally an ongoing challenge with maintaining a regular supply of medication and equipment in district hospitals. Beneficiaries noted that they were not always able to obtain medication, while clinical staff stated that they could not always assist patients and had to refer them to better stocked district or central hospitals to purchase medication. While it seems this may have at times resulted from a misunderstanding of procurement processes at primary and district levels, it is generally clear that remaining sufficiently stocked with consumables is a challenge.

The maintenance of equipment was identified as a further challenge In Malawi. Current equipment has been in use since the beginning of the programme, meaning that items are around four years old and showing signs of wear. Occasionally, workers use equipment that is available from other departments or other pieces of equipment that are inadequate but function similarly, such as microscopes. It appears those working in the South Eastern Zone were coping better in this regard due to additional supplies provided by NGOs.

One of the most significant challenges for Malawi has centred on the procurement, distribution and maintenance of equipment and consumables. It seems that primary and district level sites struggled to maintain a regular supply of drugs and consumables, however this was not as pronounced at central level. It was also felt that equipment was generally worn, having been used since the programme's inception, and at times equipment was borrowed from other departments or unsuitable substitute equipment was used.

Mozambique
In Mozambique, there was a marked improvement in supply of consumables at facilities located in provincial and some district capitals compared with more remote district services. In Sofala, where these were not available, it was usually due to unreliable transport to and from district hospitals that caused delays in delivery. OTs in Nampula reported low levels of stock of medicines required in order to treat conditions they are seeing on a daily basis. The pipeline for distribution on consumables from provincial to district level appears weak, and is further limited by insufficient stock at provincial level (Nampula Central Hospital) to service district-level needs (apart from for CS itself). Project partners attributed under-supply to the lack of budgeting at provincial level for eye health consumables.

FGD participants in Mozambique confirmed such shortages:

Sometimes it takes time to get new eye drops. Stock needs to be available. Sometimes we receive eye drops but they don't work. Sometimes we don't have access to eye glasses because the stock is finished. Most people need this. On surgery day you can find the stock getting finished. (Participant in FGD, Mozambique)

Equipment supply was more reliable in Sofala and, where the necessary equipment was not available, staff were able to compensate with alternatives.

At the time of the review, almost all the specific medications and consumables available for eye care in Zimbabwe were provided through donor funding, and the majority of these were not available for use at district level except when surgery-focused eye camps took place. Eye health medicines are incorporated into the Essential Drug List of Zimbabwe; however, the availability of these drugs is limited by inadequate funding.

Zimbabwe
In Zimbabwe, it was observed that while provincial hospitals appear to have the required consumables and medication they require for their work, this is seldom the case at the five district hospitals visited, and not the case at the two primary health care clinics visited. OPNs spoke extensively about their efforts to access medication and consumables to facilitate their work, but overall reported an irregular supply at best and, more commonly, no supply at all. Of the seven OPNs interviewed, only the two working at Parirenyatwa (Harare) and University of Bulawayo Hospital reported that they had the necessary medications and consumables to carry out their work. At district level, all five OPNs interviewed commented without prompting that they are unable to treat the full range of eye health services for which they have been trained because of a lack of essential medication (such as conjunctivitis because they do not have the correct eye drops). The most common strategy for addressing this was to refer patients to the nearest chemist to purchase the required medication, even though they conceded that most of the patients they saw would not be able to afford such purchases.

Constraints on full utilisation of available capacity are imposed by the severely limited provincial funding for medication, consumables, refresher training and eye camps.
While the project can show significantly improved numbers of patients assessed/examined and referred for eye health conditions, resource shortfalls in the form of medications limit the effective treatment of community members' eye conditions at district-based and primary levels of the health service.[27]

[27] The GreaterCapital team encountered numerous mentions from both health workers (at district and primary levels) and community members of eye health services not being accessed because of transport to facilities being too costly or because required medication or equipment (spectacles) were not available at health facilities for treatment.

Retention of mid-level cadres

Mid-level cadres across the programme raised opportunities for career development and recognition as a shared concern that may impact on their retention.

Malawi
An ophthalmologist in Malawi noted that retention of OCOs has been a challenge and should be addressed in order to retain key workers after they have been trained. While most mid-level health professionals interviewed expressed that they were keen to remain working in the same field over the next five years and undertake further training, nine of the 14 stated that they were also dissatisfied with the level of pay they received, which may impact on retention rates.

Career advancement for mid-level cadres, particularly cataract surgeons, was identified as difficult to manage in terms of trainees' expectations for deployment and career development, and for maintaining motivation. Cataract surgeons in Malawi reported that they were promised promotions; however, these did not eventuate and surgeons were unsure as to why. This was demotivating for individuals who had been working in the field for around four years and were expecting some career progression through participation in the programme. The Malawi Ministry of Health agreed to explain the career progression process to cataract surgeons, emphasising that their current role does not represent enough of an increase from their previous ranking to justify an improved grade on the salary scale. The mentoring and supervision aspect of trainee support appeared to generally work well, aside from some exceptions; and only one case was noted where no supervision was happening at all. Supervision sessions were organised and typically aligned with monthly surgeries at district level, or occurred quarterly.

Mozambique
Most OTs in Mozambique reported that their salaries have remained at the same level as before they received training i.e. a nursing salary (i.e. for past 2–2.5 years). While it may be common that adjustment of salaries relating to government staff taking up new positions can take up to three years, this may lead to discouragement and an outflow of OTs responding to other opportunities if not addressed urgently. The process for getting approval for salary adjustments based on additional training is extremely bureaucratic and involves many parties in approval of application. Potentially District Health Office managers could be requested to play a more proactive role in actively supporting such applications to enable retention of newly trained OTs in their positions.

Zimbabwe
An additional challenge to the sustainability of project achievements that was mentioned during field data collection in Zimbabwe was the retention of OPNs trained on the project. Some OPNs reported that other OPNs had moved away from more rural districts towards better resourced facilities or urban areas over the past few months (i.e. since the end of their period of being 'bonded'). The project reported that this was only the case for two OPNs who had moved to join their spouses in other locations, and that all movement of OPNs is preapproved by the MoHCC.