Final Evaluation and Impact Assessment of the Programme:

Reducing Poverty through Improved Eye Health in the "Post Health for Peace Initiative" in The Gambia, Senegal and Guinea Bissau 2009-13

Funded by the European Union and Sightsavers

Patient being examined by the cataract surgeon Fatick District Health Centre.

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Acronyms

CHW	Community Health Worker
CON	Community Ophthalmic Nurse
CSR	Cataract surgical rate
DHT	District Health Management Team
DPO	Disabled persons organisation
EU	European Union
FGD	Focus Group Discussion
GoTG	Government of The Gambia
HFPI	Health For Peace Initiative
HKI	Helen Keller International
HMIS	Health Management Information System
HRD	Human Resource Development
HReH	Human Resources for Eye Health
IAPB	International Agency for Prevention of Blindness
IEC	Information, Education, Communication
IEWs	Integrated Eye Workers
INGO	International Non-Governmental Organisations
IOL	Intra Ocular Lens
KAP	Knowledge, Attitude, Practise
LPED	Local Production of Eye Drops
MEL	Monitoring, Evaluation and Learning
MoH	Ministry of Health
MOU	Memorandum of Understanding
MoV	Means of measurement (of indicators)
MTR	Mid term review
NECP	National Eye Care Programme
NEHP	National Eye Health Programme
NPPEH	National Programme for the Promotion of Eye Health
OCO	Ophthalmic Clinical Officer
ON	Ophthalmic Nurse
PAODES	*Programme d'Appui à l'Offre et la Demande de Soins*
PEC	Primary Eye Care
PHC	Primary Health Care
PHFPI	Post Health For Peace Initiative
PMU	Programme Management Unit
PO	Programme Officer
QoL	Quality of life
RAAB	Rapid Assessment of Avoidable Blindness
RE	Refractive Error
REC	Recommendation
RHT	Regional Health Team
RHW	Rural Health Worker
ROM	Results oriented monitoring

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ROTP	Regional Ophthalmic Training Programme (at SZRECC)
SSI	Sightsavers International
TP	Traditional practitioner
UNCRPD	United Nations Convention on Rights of People with Disability
VA	Visual Acuity
Vit A	Vitamin A
ROTP	Regional Ophthalmic Training Programme
SOMA	Senior Ophthalmic Medical Assistant
SZRECC	Sheik Zayed Regional Eye Care Centre
ToR	Terms of reference
WAHO	West Africa Health Authority
WATSAN	Water and sanitation
WHO	World Health Organisation

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Executive Summary

Programme Description

The Post Health for Peace Initiative (PHFPI) 2009-2013 is a three country project implemented in Senegal, Guinea Bissau and the Gambia; it followed on from the successful Health for Peace Initiative (HFPI) 2001-2006 initiated by the Heads of State of Senegal, Guinea Bissau, The Gambia and Guinea Conakry. PHFPI was supported 80% by the European Union (EU) and 20% by Sightsavers. The total budget was Euro 3.6 million. The ***specific objective*** of the PHFPI is to establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in the intervention regions and thus contribute to the ***overall objective*** of contributing to poverty alleviation through the prevention of avoidable blindness.

Purpose of evaluation:

The primary aim of this evaluation is to assess progress and impact of the programme across the sub region. Specifically, the evaluation sought to assess the implementation of project activities against final results with the aim of assessing the achievements, the processes affecting them, their sustainability, key lessons, the contribution to expected impact and the contribution of multi-country collaboration.

Methodology and Analytic Strategy:

This Evaluation and Impact Assessment aimed to assess the impact of the 5–year period of EU and Sightsavers and their partners support to the Post Health for Peace Initiative in the three countries of the sub region. The evaluation team assessed progress towards achieving the overall and specific objectives.

A set of 3 country reports and an overview synthesis report are based on information from PHFPI reporting and through interviews and focus groups with key stakeholders and a survey of 750 eye care users. Triangulation of information enabled construction of a set of findings and conclusions against seven evaluation criteria. Scores using Sightsavers rating scales have been ascribed to each of the country projects and to the programme as a whole.

Overall findings

Overall the programme has succeeded fully in meeting output targets set for the region and provided access to eye health services to at least 60% of the population in the intervention areas. Some of the approaches used may prove sustainable and scalable after the funding period and some unaffordable within sub regional government resources.

Investment in the Sheik Zayed Regional Eye Care Centre (SZRECC) enabled the eye health personnel to be trained for the national programmes. Though the sub regional role of SZRECC was not identified specifically at the design stage the potential for SZRECC to act as a catalyst and focal point for the sharing of experience of best practice was recognised as the programme progressed. Therefore continuous facilitation, including exchanges with national coordinators, review of HFPI protocols, mediation and organisation of

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technical meetings took place. Despite this effort a SZRECC role in the development of sub region wide strategies and policies was not achieved due to a lack of agreement on its ownership and governance.

For the programme overall the theory of change included the expectation that sub regional collaboration and support to country programmes would contribute to the reduction in blindness prevalence and thus the eradication of poverty. While indicators to assess this highest level objective were not tracked the evaluation found that family wealth, life and livelihoods had improved.

Findings by criteria

Relevance: Existing eye service provision varied widely across the sub region. The programme was consistent with needs identified in Rapid Assessment of Avoidable Blindness (RAAB) prevalence studies (see country evaluation reports); it established nascent eye services in targeted areas of Guinea Bissau, strengthened limited services in targeted areas of Senegal and effectively maintained existing services throughout The Gambia.

Outreach strategies and the training and deployment of community level workers and volunteers were designed to reach the poorest.

At regional level eye health personnel were trained and efforts made to reach international standards for staffing eye services. The programme was aligned to national health and eye care policies where they existed. Efforts to advocate for the development of policies were largely unsuccessful due to the late inclusion of advocacy elements in the project after revision in 2012.

Effectiveness: Overall, the programme has strengthened eye health systems including human resourcing and service delivery, although more remains to be done. It has raised the profile of eye care in Guinea Bissau and Senegal but not proved so effective in improving integration, coordination and increasing government prioritisation of eye care. However, PHFPI support to implementation of eye services provided has helped raise the profile of eye care across the different levels – primary to tertiary – for communities.

Eye care services developed across the programme were considered to be available, accessible and affordable to marginalised populations. The existence eye units with dedicated staff was acknowledged as a major achievement.

Programme output targets were met or exceeded in nearly all categories. Cataract surgical rates (CSR) and human resources for eye health (HReH) in the sub region, however, are well below the international Vision 2020 targets for the delivery of comprehensive eye services.

Efficiency: Output tracking and activity oversight were effective though the analysis of data collected was often inadequate or not available in accessible forms. Decentralisation in Senegal greatly facilitated efficient programme management, enabling effective integration of eye health services into the locally managed health systems structures. The vertical and more centrally

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controlled systems elsewhere in the sub region made management and oversight more challenging and dependent on the professional relations built by eye health staff with regional health managers and others, rather than on the formal inclusion of eye health into planning systems.

The restructuring of Sightsavers presence in the region and budget revisions that coincided with the inception period of PHFPI was not helpful in the start-up period of the programme. Some activities were re-planned due to changes in staffing and the need to rebuild understanding of the programme design. This resulted in delays to getting some aspects of the programme underway. Construction and procurement were largely efficient and buildings fit for purpose. There were some design limitations as well as procedural lessons regarding procurement and distribution processes.

The integration of eye health information into heath management information systems (HMIS) varies across the sub region. Current outcome monitoring gaps include surgical outcome, cataract surgical coverage and blindness prevalence rates, two of which require dedicated population-based surveys.

Strong financial management by Sightsavers was consistently transparent and accountable. Rates of expenditure varied and start-up was slow due to initial re-planning and some regions not receiving inputs until year 3.

Cost recovery used to recoup the cost of providing treatment was challenging and there was very limited additional resource mobilisation. There is little evidence of planning how eye services will be financed after PHFPI ends. Services will be underused if charges are increased as a means to cover costs and there will be negative consequences for access by the poorest.

Coherence and Coordination: There were notable successes, particularly in Senegal, in coordinating with broader health delivery actors, especially at decentralised levels of the health system. There is need to share the success factors for achieving good cooperation with governments. Strong communications systems and practice was key to achieving coherence but not uniformly adopted across the programme.

Sightsavers Programme coordination mechanisms largely worked well. Two sub regional experience sharing workshops enabled progress to be reviewed but there were no follow-on activities for the sharing of experience.

Sightsavers established strong field level coordination with partners. Although Sightsavers regional managers undertook high level advocacy work they did not effectively progress policy issues, integration of eye health into plans and budgets, or address the SZRECC governance issues.

Establishment of partnerships and alliances with civil society was largely overlooked. This led to missed opportunities to develop broad and strong lobbies for advocacy on behalf of people with disabilities. The failure in most areas to stimulate and maintain V2020 committees and groups added to the challenges of successfully influencing governments to support eye health care.

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It is questioned whether the attempts to coordinate across the sub region were over ambitious given the differences between the countries – in terms of health systems and the stage of development reached with eye service development. The lesson learning that might have helped level standards is not evident, which was not helped by differences in languages, political and government systems. To achieve coherence and add value to country programmes through regional collaboration more investment in exchanges, lesson learning and policy development was needed. In addition the design of PHFPI did not address the challenges from the previous HFPI phase to improve sub regional coordination, including resolving the status and roles of SZRECC.

Impact: Through the survey the evaluation was able to indicate positive responses by respondents both to treatment received and to eye service provision. Data with respect to CSR, quality of surgical outcome and impact on lives was not available and output data was not, for the most part, analysed. The weak monitoring of outcomes also limited the availability of information on the performance of surgeons and other staff that would help them identify areas for improvement.

PHFPI has made a significant contribution to eye health systems strengthening. If not yet fully comprehensive, the target of eye health services access for over 60% of the intervention area population is met. Eye services have restored sight for substantial numbers of people.

The programme developed neither national nor sub regional influencing strategies aimed at embedding eye health care into overall health plans and budgets. Means to achieve develop and deliver such strategies were not explicit in the design of the PHFPI programme and, with the exception of Senegal, there was limited integration of eye health services into health systems. Sub-regional objectives were not explicitly expressed in PHFPI design or implementation. The pressure to deliver services at country level made it difficult to pursue strategic challenges implicit in sub regional objectives by linking and learning from the achievements in each of the countries.

The regional training centre, SZRECC, was not established as a focal point for the discussion of coherent policy issues and coordination of eye health by governments and other stakeholders across the sub region. There was marked failure to establish clear ownership, governance structures and membership with sub regional participation. This is likely to impact negatively on overall sustainability of the regional training capability as well as HreH at country level.

Although the range of strategies varied across the programme, overall there has been considerable impact on knowledge and awareness levels of communities in eye health care and the availability of services. Those surveyed expressed the perception that knowledge levels have improved. Seventy nine percent of respondents indicated that they had made one or more changes to their habits relating to eye health. The project did not baseline or monitor quality of life but both survey results and FGDs across the

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sub region confirm the significant impact that restoration of sight has had on the quality of life of eye health users. Impact on livelihood is not evidenced but inferred through international studies.

Sustainability: The sustainability of the eye services established are open to question if there is no further support: in The Gambia, a decline in the pre-existing services is already evident while in Guinea Bissau, eye service activities are unlikely to continue unless another donor is found. In Senegal, there was more partner optimism but sustainability will depend on the conviction and commitment of the decentralised health system teams to progress eye health service priorities.

One sustainable strategy has been the training of large numbers of community volunteers and health workers to screen and raise community awareness. Additional approaches adopted such as outreach services and eye camps are costly, logistically difficult and remove eye workers from the static units, thereby undermining walk-in services. It is less likely these approaches can be sustained without external support.

Impact through concerted advocacy of government across the sub region was limited. It would have been a key advocacy success to gain international recognition of SZRECC as a training centre. SZRECC could also then become an important platform for enabling greater effective advocacy for more prioritisation of and funding for eye care in the sub-region.

Replicability and scalability: The service delivery model is successful and replicable but needs further development through greater integration of eye care into health services and pilot health insurance and performance-based financing initiatives.

Across the sub region the service delivery model has not been underpinned by robust impact data. Stronger outcome monitoring and documentation systems would have provided the evidence to influence governments or other donors to allocate funds to scale up and replicate the programme.

Ratings against criteria:

Relevance	Effective-ness	Efficiency	Coherence	Impact	Sustain-ability	Replic-ation
GA	GA	A	A	AR	AR	A

Key recommendations

For post PHFPI in the sub region[i]

- Develop the disengagement strategies for all three countries into practical, supported exit plans to enable continuing development quality and sustainable eye services.
- Support Guinea Bissau to consolidate its services and develop sustainable strategies for implementation. Help resolve the SZRECC

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governance and status issues so it can become a strategic asset for the development of HREH in the sub-region and for advocacy to governments on eye health delivery. Lessons on coordination and coherence from the PHFPI and the earlier HFPI programme should be considered carefully in the future design and planning of cross country and regional programmes.

1 Introduction

1.1 Background

Programme description

The Post Health for Peace Initiative (PHFPI) followed on from the high profile Health for Peace Initiative (HFPI) established by the Heads of State of Senegal, Guinea Bissau, the Gambia and Guinea Conakry; they had recognised that their populations were affected by common health problems and wished to foster peace in the politically volatile border areas. Each member country led the coordination of a particular disease area: Senegal coordinated STDs and AIDS; Guinea-Bissau, Immunization; Guinea, Epidemics and emergency situations; Gambia, Malaria and Prevention of Blindness.

PHFPI started in 2009 as a five year programme designed to facilitate the implementation of good quality eye care services and also promote eye health in three of the countries: Gambia, Guinea Bissau and Senegal. The programme of eye care activities included support to eye health development in each country plus multi-country collaboration on cross-border activities, such as high-profile eye camps and the strengthening of the Sheikh Zayed Regional Eye Care Centre (SZRECC) in the Gambia as a sub-regional training resource.

The PHFPI has received funding of Euros 6,041,392 (£5,135,183) from which the European Commission provided 4,000,000 Euros representing 66.21%, and Sightsavers provided 2,041,392 Euros.

The main stakeholders were the National Eye Care Programmes, Ministries of Health, Regional and District Health Partners and Helen Keller International in the three countries.

The ***overall objective*** of the programme was to contribute to poverty eradication through the prevention of avoidable blindness in Senegal, The Gambia and Guinea-Bissau by the end of 5 years.

The ***specific objective*** was to establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in intervention regions in Senegal, The Gambia and Guinea-Bissau by the end of 5 years (December 2013).

Project implementation was based around three major components linked to capacity building through training, infrastructure building for establishment of comprehensive eye care for service delivery, and partnership building for adequate coordination within the countries and across the sub region.

Context

The sub region countries, Senegal, The Gambia and Guinea Bissau, share common borders and though their populations are of diverse ethnicities they

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share two or more common languages. However, through colonisation each is using a different European language officially (French, Portuguese and English).

In Senegal, by far the largest of the three states, the PHFPI programme was implemented in 10 districts in 5 regions some of which bordered the other two countries. The key particularities of the Senegal context, include a decentralised government structure, a larger and more developed institutional and administrative framework that has traditionally viewed eye care as a hospital speciality, more developed human resources, chronic strike action by health sector staff, high level Ministry recognition of NPPEH and the National Coordinator's positive leadership and intermittent security issues in the Southern Casamance regions of Ziguinchor and Sedhiou.

In The Gambia Sightsavers have supported eye health since 1956. The programme has developed into a nationwide set of secondary eye units with primary and community level outreach through community volunteer 'friends of the eye" - Nyateros, and general community health workers with some eye care training. The Government of The Gambia has come to rely heavily on Sightsavers and other external supporters for financing eye health. The Sheikh Zayed Regional Eye Care Centre (SZRECC) was established in The Gambia as a regional training centre for eye health and has provided support to human resource development to the sub region and internationally.

In Guinea Bissau PHFPI took place in 4 of 11 regions nationally against a background of political instability: implementation began six months after a coup in 2009 and was delayed by another coup in 2012. Since then, there have been disputed and delayed elections. Despite this instability, Sightsavers, the NECP and regional teams have implemented the project and established an in-country presence, recruiting the Guinea Bissau programme manager after the 2012 coup.

Purpose of evaluation

The evaluation is designed to assess the impact and long-term change, outcomes and impact of the programme in the 3 countries in which Sightsavers has been engaged in supporting implementation. The assessment is intended to:

1. Assess the degree to which the programme has contributed to the expected impact (Programme Overall Objective) and outcome (Programme Specific Objective) in the programme log frame and

2. Assess the contribution and impact of multi-country collaboration to the objectives of the post-HFPI programme.

Three country reports were written following filed visits to each country. This report synthesises the main findings from the country report and presents findings, conclusions and recommendations from a sub regional perspective. The Executive Summaries from each country report are annexed and the country reports were shared with key staff within Sightsavers and are available to other stakeholders as a means to disseminate the findings and

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recommendations of the evaluation.

2 Methodology

2.1 Approach

The overall evaluation team was composed of five members: three with social science/international development backgrounds and two West African ophthalmologists with extensive technical knowledge. After an initial phase of document review and analysis and agreement with Sightsavers on the approach proposed in an Inception Report field visits were made to all three countries. Full reports were prepared for each country and are annexes to this synthesis report, which focuses on overall achievements and challenges.

In line with the Inception Report and work plan agreed with Sightsavers two to three team members visited each country. An ophthalmologist undertook a technical assessment of the eye health services provided. This aimed to complete information gaps in the project matrix that summarised achievement against targets and indicators set out in the PHFPI Logical Framework and Project Document. The social scientists conducted a set of semi structured interviews with key stakeholders using a checklist of questions to elicit views on the contribution made to achievement of the PHFPI overall and specific objectives.

Focus groups with community leaders and representatives, primary level health staff and community-level volunteers and clients of the programme (beneficiaries) enabled further insights to be collected and discussed. A survey of a cross section of 250 randomly selected service users was organised in each country, a total of 750 people. The 43 survey questions explored levels of knowledge attitudes and practices towards eye health and the impact of PHFPI supported activities on beneficiaries' quality of life. (See Annex 3 for survey questionnaire).

Analysis of the results of document review, technical assessments, focus group discussions and survey results are presented in this synthesis report and the three country reports.

2.2 Limitations

Time allocated to fieldwork limited the number of districts visited in each country. Deploying two ophthalmic specialists to seek information on the technical quality of service delivery mitigated this. Data was often difficult to retrieve from reports as it was seldom organised and analysed clearly against indicators and targets set in the logical framework. It took considerable amounts of time and effort by evaluators to obtain and cross check relatively straightforward eye data, either not collected or collated by the respective country national eye care programmes or Sightsavers. For example it was not possible to identify how many cataract surgeries in The Gambia were performed through outreach in addition to those (the majority we are told) performed routinely. Across the programme other data had not been analysed to provide clear information against performance targets and outcomes. This

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was compensated by triangulating information obtained from the evaluation surveys, stakeholder interviews and focus group discussions. Through these, it proved possible to gain a thorough understanding of the context of the programme, its strategies, how these have been implemented as a basis for findings and recommendations.

3 Results

3.1 Relevance

This section identifies the relevance of the programme intervention to the needs of people with vision impairment, the extent to which the poorest have been identified and the contribution to national and international policies and strategies.

Overall PHFPI has been highly relevant in strengthening the accessibility and delivery of eye health services to people in need in those areas of the sub region in which it has been implemented. The programme has established facilities in targeted areas in Guinea Bissau and Senegal, where there were previously no services of any substance. In The Gambia, with a long history of eye support to eye health care, PHFPI sought to maintain an effective service and provide training opportunities for eye health personnel from the sub-region and further afield in Africa. This training was to be institution-based at the SZRECC Regional Ophthalmic Training Centre (ROTC) and through internships at eye units around the country.

Project design fit with eye care needs

National rapid assessments of avoidable blindness (RAAB) were undertaken in 2011 in Guinea Bissau and in 2008 in Gambia. In Senegal 2 RAABS were conducted in Kaolack and Fatick regions in 2010/11. Sub regional prevalence rates highlighted the need to increase eye care availability, especially in rural areas. Targeted areas in Senegal were predetermined by the preceding HFPI grant, agreed by NECP and located in districts bordering both Gambia and Guinea Bissau, where services at the two regional referral hospitals were out of reach for many communities (Table 1).

As eye care services in The Gambia already notionally covered the country, PHFPI focused on refurbishing 3 eye unit facilities and strengthening the infrastructure and capability of the SZRECC regional ophthalmic training programme (ROTP) to deliver training for HReH across the sub region.

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Table 1 RAAB findings

Country/ year/pop.	*>50 blind rate*	*Overall blind rate*	*Avoidable blind rate*	*Avoidable Severe VI*	*Avoidable VI cases*	*Cases Operated* *Surgical coverage VA <1/20?*	*Poor outcome of those with IOLs*	*Couching*
Senegal 2011 Kaolack Region 107,147 >50 yrs and 1,085,578	7.5%	0.9%	93.4%	90.9%	87.7%	62%	36%	8.5%
Fatick Region 60,751 > 50 yrs and 615,558	7.6%	0.9%	92.7%	89.6%	91.2%	60%	31%	3.7%
Gambia 2008 1.8m	4.9%	0.6%	81.1%	85.2%	55.3%	65.7%	28%	
Guinea Bissau 2011 1.7m	6.4%	1.2%	92.9%	5.1%	14.5%	37%	49.6%	12%

VI=visual impairment. Population figures rounded and 2013 projections, Wikipedia. Gambia Poor outcome: VA<6/60

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Reaching the poorest and most marginalised populations

In Guinea Bissau, only Cacheu of the four selected for PHFPI support had any previously developed eye care services. Overall, the generic three-country project design was and remains relevant to the eye care needs in the project areas. However, there were some important design issues that clearly impacted on the project's overall effectiveness and its targeting:

- The initial service delivery targets and indicators were generic across the programme and did not reflect the different contexts and relative feasibility of achieving targets or collecting data. When the initial budget submitted to the EU was deemed too high, the cuts resulted in a re-phasing of implementation plans without a strategic review of activities and targets. In Guinea Bissau the partners also found that the budget did not reflect Guinea Bissau prices.
- Phased geographic implementation from central planners resulted, with limited consultation with implementing partners in Guinea Bissau. This was partly due to initial budget restraints as well as the limited number of health cadres available for training at SZRECC. This resulted in the human resources needed to deliver against targets not being available until Years 3 or 4. These changes in

timing affected the relevance and targeting of the programme as planned to reaching the poor and the availability of quality of staff for deployment.

In Senegal, particular effort was put into translating the generic project design to fit local context; as a result the project design successfully accommodated and adapted well to a number of challenges, including a Government restructuring of the Administrative regions involved in the project. There is no national eye health policy or dedicated budget in The Gambia. PHFPI design did not include a concerted advocacy strategy to influence the government to increase its commitment to eye health nor did the design recognise the need for the NECP to develop broader linkages with relevant government and civil society actors. In both Guinea Bissau and The Gambia, the national programmes prioritised HRD, infrastructure and service delivery over building the eye health management capacity of the Regional Health Teams in preparedness for eventual decentralisation; this critical capacity-building component was lacking from the outset.

Sightsavers programme staff acknowledge that participation of a broader range of stakeholders at project design stage would have improved contextual relevance and potential for learning between the countries.

In each country several strategies to extend the reach of the project to more remote and underserved communities were used:

- Outreach campaigns to screen for people with eye problems.
- Assistance with transport for surgery patients in Guinea Bissau.
- Free eye camps or subsidised surgery, medicines and consumables, although in Gambia the Government sets fees to cover the costs of cataract sets.
- Radio announcements of outreach campaigns; in Senegal there was particular emphasis on communications to create awareness.
- The training of community based Nyateros (“friends of the eye”) in Gambia and volunteer *relais* in Senegal and community health workers in Guinea Bissau to spread information.
- All general nurses in charge of health posts in Senegal are trained in eye health and eye health is part of The Gambian general nursing curriculum.
- Cataract surgeons were supported in outreach to health posts, which helped reach the poorest and those unable to travel.

These strategies reflect those used by many other vertical programmes in response to the poverty of the population. Whilst they overcome many of the usual barriers to eye health treatment, some are not sustainable in resource-poor communities, with the pressure on life threatening health conditions and the focus of external funders such as the Global Fund governments are unlikely to prioritise single disease focused volunteer cadres for eye health. In each of the countries volunteers are already moving to assist non-eye health programmes providing training and other donor funded inducements. In Guinea Bissau and Senegal, volunteers are multi-purpose and used for a range of community level health education and mobilisation activities.

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At sub regional level PHFPI set targets for HRD, infrastructure and equipment in line with Vision 2020, which provides a common framework agreed by the International Agency for the Prevention of Blindness (IAPB) and the World Health Organisation (WHO).

An implicit programme aim was to reduce the verticality of eye health delivery by increasingly devolving decision-making and operations closer to communities and integrating eye care into wider health systems. This is being achieved progressively in Senegal, far less so in Gambia and Guinea Bissau where the programme is largely centrally managed alongside other vertically structured health delivery programmes, most of which are also externally funded.

REC: The extent to which these differences stem from the political contexts across the sub region is not entirely clear. What is clear is that any future plans to decentralise should build in lessons from the Senegal model when feasible.

Indirectly the PHFPI programme contributes to the United Nations Convention on the Rights of Disabled Persons (UNCRDP) objectives, ratified by the Governments of the sub region, if not domesticated. To further this agenda the programme design could have placed greater emphasis on linkages with other stakeholders engaging with non-health health areas of poverty reduction.

3.2 Effectiveness

This section explores the extent to which programme objectives in the main result areas have been achieved and how far this has contributed to the programme purpose and the strengthening of the health system in The Gambia, Guinea Bissau and Senegal. It explores the extent to which eye care has been integrated into PHC at district level, the priority given to eye care and gaps for consideration in future programming.

Specific Objective of PHFPI

To establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in intervention regions of The Gambia, Guinea Bissau and Senegal.

In order to achieve the programme objectives four key activity areas were identified:

1. human resource strengthening;
2. service delivery;
3. developing infrastructures and systems;
4. improved coordination and government ownership of eye health.

In considering overall achievement of the programme it is important to bear in

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mind the different start points of the three implementing countries; The Gambia has been developing eye services over a long period whilst in Guinea Bissau and Senegal it has only begun recently. Overall, the project proved effective in the strengthening of human resources and made good progress developing service delivery although more remains to be done in both areas. Whilst it also raised the profile of eye care, especially in Guinea Bissau and Senegal, it has not proved so effective in improving integration, coordination and increasing government prioritisation of eye care.

Eye care services offered across the programme were considered to be available, accessible and affordable to marginalised populations not previously able to access eye services. A combination of different findings (coverage of PHC nurse training, % population within reach of either primary level health facilities or volunteers, and outreach spread) indicate that the aim of reaching at least 60% of the population in the project intervention zones has been reached, even though no formal indicator was specified. The affordability and accessibility of services was strongly linked to project strategies of frequent outreach and, in Guinea Bissau, free eye camps. As these strategies reduce in intensity (Senegal and The Gambia) or dwindle/halt (Guinea Bissau) now the project has ended, these levels of affordability and accessibility are unlikely to be maintained. In the The Gambia services include meeting RE/LV needs to a degree and in this sense are complete, if not readily accessible; these have yet to develop in Senegal and Guinea Bissau where there are still substantial unmet needs.

Across the programme, secondary and primary-level eye care services, together with community-level linkages, were either strengthened or established where none existed before. The existence of staffed eye units was hailed as a major achievement even though it is recognised that staffing and equipment are at minimum levels and that the eye units require further strengthening. The development, both of services and of community demand has so far been relatively well matched and it will be important that they both continue to develop and do so in tandem.

The sub-regional output targets were met or exceeded in nearly all categories; these were generic at the outset of the project and subsequently adapted to reflect the differing contexts and capacities. Despite this, The Gambia exceeded its service delivery targets whilst even revised targets proved unrealistic for Guinea Bissau; its longer training lead time and less developed primary and community level health structures led to unsustainable strategies being adopted in order to meet them.

Human Resources for Eye Health

In aiming to strengthen human resources for eye health an important sub-regional need has been identified and is beginning to be addressed. However, the combined cataract surgical rates and human resources for eye health from across the sub-region are well below the international Vision 2020 targets recommended for the delivery of a comprehensive eye service (see Table 3 below).

Personnel across the health ministry expressed satisfaction with the eye

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health staff training achievements of the project. In Guinea Bissau there was a longer lead time for getting cataract surgeons in post as candidates needed initial training before attending training in cataract surgery; in Senegal cataract surgery training represents an additional skill for existing eye care technicians as the SZRECC diploma is not formally recognised. SZRECC courses were recognised as relevant to the sub regional operating context but students and some health officials commented that in practice the training needs strengthening: the management, staffing levels, course curricula and arrangements for developing trainees' surgical skills all need improving.

Table 2 Human resources trained

Cadre trained	*Level of health service delivery*	*Sub-Regional Target Total*	*Number Achieved*	*Comments*
Ophthalmologist	*Tertiary*	*2*	*2*	*Training completed but not deployed at time of evaluation*
Non clinical technicians	*Tertiary*	*14*	*14*	*12 instrument technicians and 2 LPED technicians*
Cataract surgeons	*Secondary level health centres*	*15*	*16*	*1 extra trained for Bissau but not yet returned*
CONs	*Secondary and primary level support*	*4*	*9*	*Additional 5 for The Gambia; Bissau cataract surgeons had CON training first*
Non eye health Personnel	*Supporting Primary level*	*712*	*1,245*	*Range includes Midwives*

Figures from programme data

While all the eye health training targets were met with non-eye health staff training targets exceeded, especially in Senegal, only minimum eye health staffing levels have been achieved in Guinea Bissau and Senegal, especially when compared with WHO/Vision 2020 ideal targets (Table 3). In The Gambia, the eye health worker to population ratios are within WHO guidelines but mask an inequitable distribution between urban and rural areas.

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Table 3 Regional/ district eye health staff compared with WHO/Vision 20/20 targets

Population	Vision 2020 Recs	Guinea Bissau		Senegal				The Gam-bia
		Bafata Region	Farim Region	Kaffrine District	Nioro District	Sokone District	Fatick District	N/Wide
	250,000	223,756	54,631	209,595	316,368	165,665	212,558	1,776,000
Ophthalmologist	1	0	1	Supervised by Kaolack Regional Ophthalmologist		No Regional Ophthalmologist so supervised National Coordinator		2
Cataract Surgeon	1	1 + 1 due back	1	1	1	1	1	14
Ophthalmic Nurse	2.5	0		0	1	0	0	19
CON	2.5							15

Note Senegal figures are for specific districts studied and not entire intervention area.

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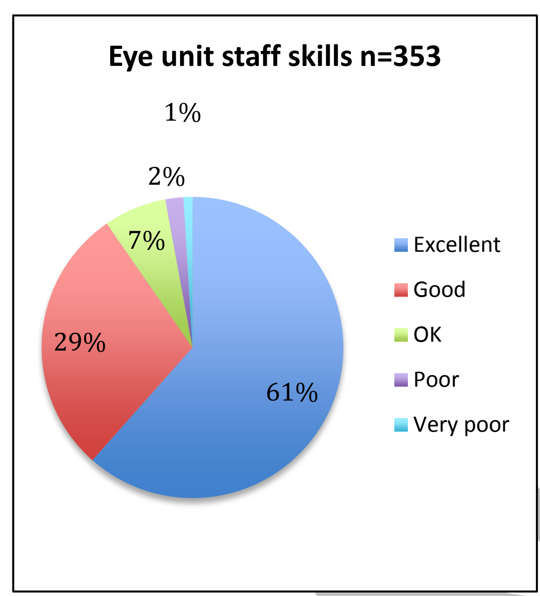
Whilst it would be ambitious to have achieved Vision 2020 recommended staffing levels from the outset, current HR levels are inadequate to maintain and consolidate the services established. Except in The Gambia, there is still a need to build the overall numbers of cataract surgeons and eye unit teams in order to maintain and develop routine eye services for walk in patients as well as outreach screening and supervisory visits to primary level health facilities. Across the programme there are too few ophthalmologists for adequate oversight of eye health services.

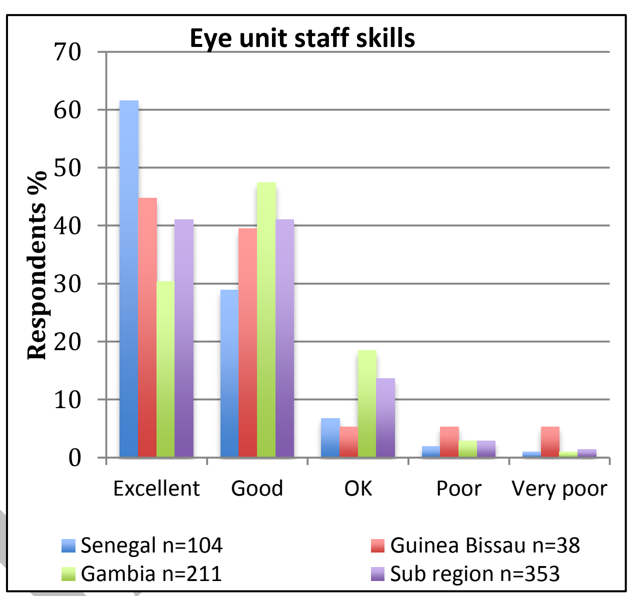
There has been a strong sub regional focus on primary level integrated eye workers and community volunteers although in Guinea Bissau there was less time to ensure adequate coverage and the training provided tended to focus on specific tasks such as Azithromycin distribution. In Senegal, there was a strong focus on both initial and refresher training courses and the inclusion of a wide range of regional and district-level general health managers and practitioners. It has made an important contribution to achieving the decentralisation results of the programme. Across the programme priority was given to building capacity for ophthalmic equipment maintenance and to the training of technicians; with the exception of Senegal, all are still deployed in project zones. For maintaining and extending this progress, PEC should be

further integrated into core PHC training, a process not yet complete in Guinea Bissau or Senegal.

The evaluation technical review confirmed that cataract surgeons have good knowledge levels. Communities surveyed from across the sub region were appreciative of the skills and welcome received from eye unit staff but also suggested that more staff and more training and equipment are needed.

Chart 1 Sub regional overall rating of eye unit staff skills and by country





Across the sub region, arrangements for routine supervision of cataract surgeons by an ophthalmologist were not working satisfactorily With the development of primary and secondary levels of eye health staffing, a corresponding increase in tertiary level capacity for ensuring adequate technical supervision, as recommended by WHO, together with management support is now required.

Infrastructure Equipment and Consumables

All three countries had an infrastructure component of new and/or refurbished eye units, whilst The Gambia also benefitted from the construction of a student hostel, staff and lecturer accommodation plus a private ward at SZRECC. Construction management processes varied: in Senegal it was used as an opportunity to empower and encourage regional and district level ownership whilst in Guinea Bissau the process was controlled centrally with limited regional participation. Although some design issues identified at the mid term review (MTR) were addressed, there are construction quality issues requiring resolution at some eye units in Guinea Bissau and Senegal where construction was managed by the respective governments. All eye units were functional although at the time of the evaluation in Guinea Bissau one was still awaiting commissioning and routine patient flows to the two visited were clearly not developed. In The Gambia, the lecturer accommodation and private ward at SZRECC are under-utilized. This reflects an urgent need to develop a business plan and to market the hospital services and training centre nationally and sub-regionally. For future success the need to clarify

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and establish the position of SZRECC as an international institution with appropriate governance arrangements, academic affiliations and course validation has become critical.

All eye units were provided with a good range of basic equipment for OPD and surgery but the units were not given the biometry equipment needed for achieving good quality cataract surgical outcomes. The project's investment in training and facilitating the work of instrument maintenance technicians was valued and recognised as an important strategy for sustainability.

Frequent stock outs of drugs and spare parts were reported in The Gambia during the project, although the supply of consumables, notably IOLs, was not problematic (See Efficiency section for more on procurement etc systems). The support to Low cost Production of Eye Drops (LPED) in The Gambia and Guinea Bissau was an appropriate initiative but has not resulted in effective long-term results: both countries are experiencing issues with replacement stock owing to poor cost recovery strategies. Furthermore, in The Gambia LPED unit has experienced quality control issues while in Guinea Bissau the LPED unit has no cost-recovery strategy and is not integrated into the health system: there is low regional awareness of the LPED unit and the possibility of ordering eye drops.

Service Delivery

Specific service delivery result areas sought by the project were that:

- The secondary eye units are used and the community eye health worker referral system is operating well
- Comprehensive district eye care services are available, leading to an increase in demand and supply of quality eye care

The sub-regional quantified treatment targets were met and in many cases exceeded, especially in The Gambia where the PHFPI eye care programme started from a stronger base, able to build on 20 years of experience and support. In all countries, the service delivery activities involved awareness raising, screening, referral, basic treatments and surgery. In Guinea Bissau, the longer training lead time was not adequately factored in when setting the targets. Table 4 lists achievements against targets.

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Table 4 Performance against service delivery output targets

Treatment	Guinea Bissau		Senegal		Gambia		Sub-Region		%
	Achieved	Target	Achieved	Target	Achieved	Target	Achieved	Target	
Cataract surgery	2,131	2,682	8,487	6,860	16,924	12,500	27,543	22,042	123
Trichiasis	2,158	4,230	8,127	6,107	1,502	1,000	11,787	11,437	103
Screening	23,933	37,500	138,721*	284,547	534,443	400,000	697,097	722,047	97
RE/LV	-	-	3,429	7,500	15,096	4,000	18,525	11,500	161
Vit A >5s	255,284	166,950	309,370	275,000	365,763	227,000	1930,4173	668,950	139

Source: Data provided to Sightsavers country offices by MoH National Eye Health Programmes of Guinea Bissau, Senegal, The Gambia respectively.

In all three countries, the adoption of an outreach strategy, with eye unit staff visiting primary level health centres for screening sessions, enabled patients who would not otherwise travel to the eye clinics to be diagnosed and access treatment. Eye camps, where people diagnosed with cataract or trichiasis were also offered free surgery, were held in Senegal and Guinea Bissau but not in The Gambia. In Senegal, one profile-raising free camp was held for the opening of each eye unit before reverting to regular outreach screening with patients paying for surgeries; in the first phase districts, support for these activities had already been reduced and a more regular flow of ‘walk-in’ patients had developed but this was not yet the case in the more recent districts. In Guinea Bissau, the need to maximise treatment numbers in the final year meant that a series of free eye camps were held and eye health staff were so busy with these that the eye units were not able to offer continuous services; as a result a regular flow of walk-in patients had not been established by the end of the project.

With the end of project funding for outreach activities, the volume of surgeries is expected to decrease in all three countries, but most dramatically in Guinea Bissau. The services there are not yet well established, the MoH recognises that there is no likelihood of government funding, people have got used to waiting for free eye camps and travel costs to the eye units are a very real barrier for marginalised communities experiencing growing poverty.

Patient referral from community-level to primary level and then on to district level was reported to be working well in The Gambia and Senegal where district and health staff recognised that the community-level volunteers have been crucial to the success of the project. This is reflected in Chart 2 Sources of information for patien; it shows that while family and friends are an important first source of information, CHWs were nearly as frequently mentioned in Senegal. In Guinea Bissau, the less well-established role of the CHWs, assisting mainly with the mobilisation of patients for outreach, as a

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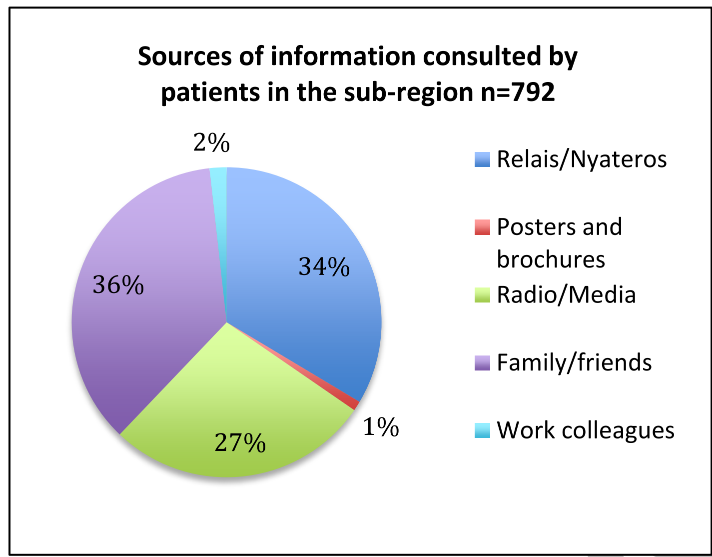
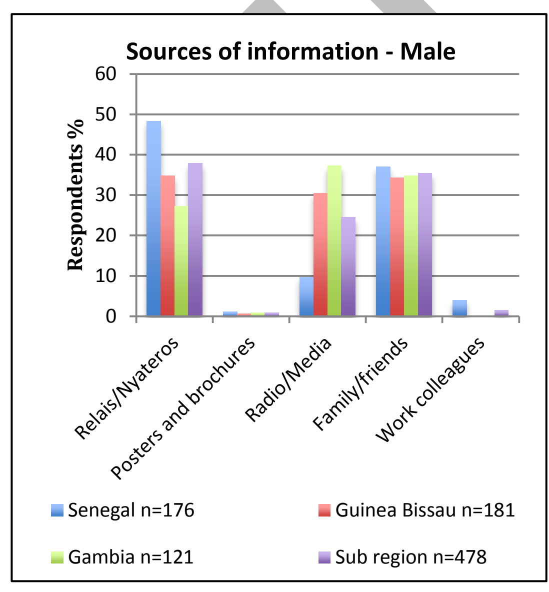
source of information is also evident.

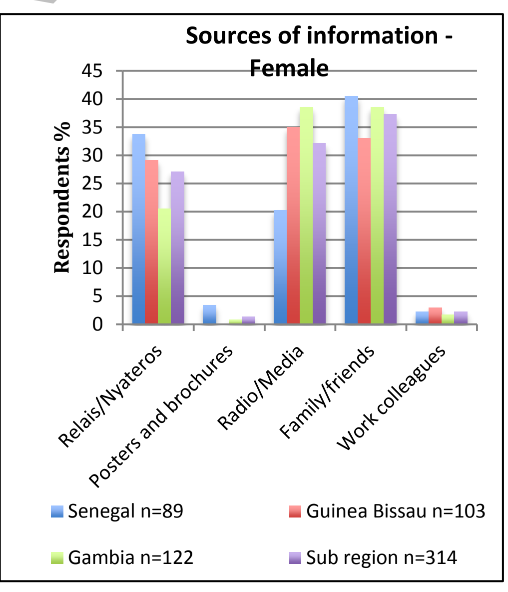
Chart 2 Sources of information for patients



It is also noteworthy that radio and media were noticeably more popular in The Gambia and Guinea Bissau than Senegal; this chimes with patient experiences recounted in qualitative work where many in Guinea Bissau said they heard a radio announcement and rushed to seek treatment.

Chart 3 First sources of information consulted by patients from different countries





It is interesting to note that the long established volunteer Nyateros in The Gambia are less likely to be a first point of reference by patients, compared to Senegal and Guinea Bissau. There was no one explanation offered for this by health workers but many suggest that Nyateros are used by many other incentivised programmes such as Global Fund and thus have less time to commit to the eye health programme than previously. Printed materials were clearly not a key source of information; this is likely to relate to the survey

respondents being visually impaired users as well as partly to low literacy levels but to the quantities produced in relation to the high population numbers reached. The development of effective IEC materials was evident in Senegal where the ‘image boxes’ (laminated sheets similar to a large desk calandar. As pages are flipped over the person sitting opposite sees a picture and the person with the “image box” has questions and text to guide their conversation) for health education were considered most appropriate and consistent messages about the link between poverty and blindness had clearly been communicated; this was less strong in Guinea and The Gambia. Posters were observed at most eye units in Senegal and sometimes in The Gambia with the EU logo clearly visible, but were not seen in Guinea Bissau. More leaflets for distribution, posters and image boxes would have helped reinforce messages and assisted community-level volunteers.

The project also aimed to improve the quality of eye care services offered; the standard key indicator for this is the quality of the outcomes achieved by cataract surgery. 2010 RAAB surveys conducted in Guinea and Senegal revealed generally a poor quality of cataract surgery prior to the project where among cataract patients with IOLs, only 43% in Guinea and 46% in Senegal (This drops to 25% in Guinea and 31% in Senegal, combining results of both RAABs, if all types of cataract surgery are included) had outcomes that WHO classifies as ‘good’ compared with the WHO target of 85%. Similar findings emerged from The Gambia RAAB survey, not accepted by the Government. Despite clear requirements to use the WHO cataract outcome monitoring tool to document cataract surgical outcome, this was not in routine use in any of the project sites visited. To determine any improvement to cataract surgery quality the evaluation technical review therefore reviewed over 200 patient records in 5 different locations (two in The Gambia and three in Senegal.) to analyse the proportions of good, intermediate and poor surgical outcomes. The results showed a noticeable improvement between the RAABs in 2010/11 and the technical review in 2014 with far fewer poor outcomes. There is still need for improvement however to achieve WHO targets of 85% good outcomes, < 10% intermediate results and < 5% poor results (Biometry is not currently used and no equipment for this is provided; this is apparently now under discussion in Gambia and should become central to the SZRECC cataract surgeon training for it to be routinely introduced in all three countries).

Cataract surgeons should work under the supervision of an ophthalmologist. Across the programme, routine supervision visits to monitor surgical skills as well as the general technical, and administrative skills of cataract surgeons are not taking place as they should This is a potential area of programme risk and an important area for improvement, especially in Senegal where there continues to be some establishment resistance to the cataract surgeon cadre.

Patient perceptions of surgical quality did not reflect these concerns however and were positive to one degree or another across the programme, as illustrated in Chart 4.

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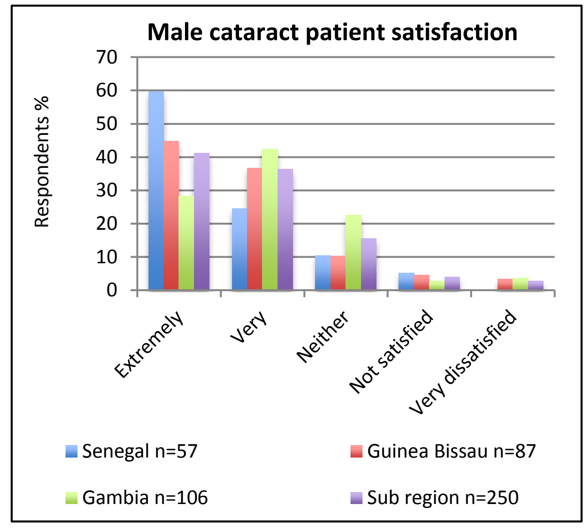
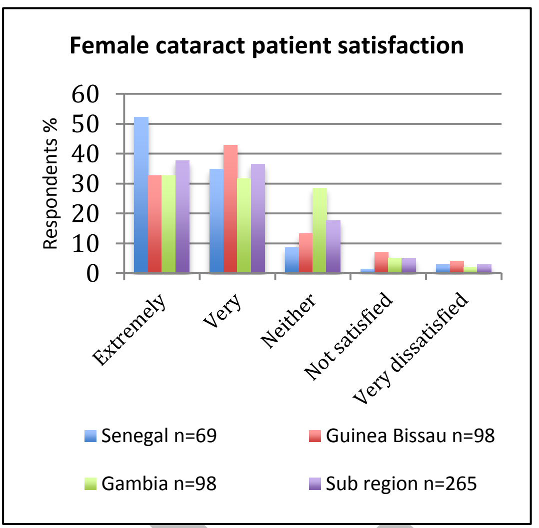
Chart 4 Cataract patient satisfaction with service received (Male/Female)

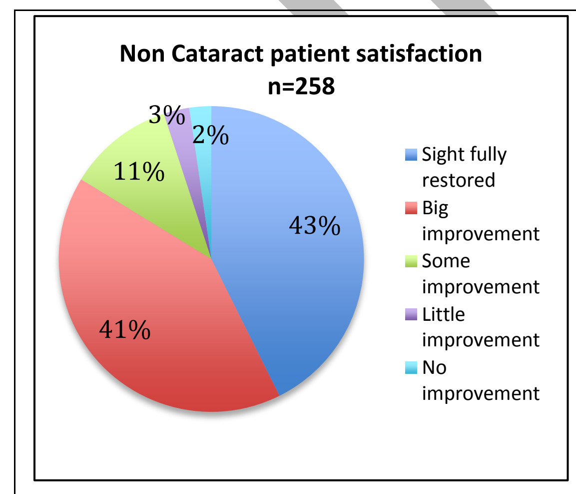


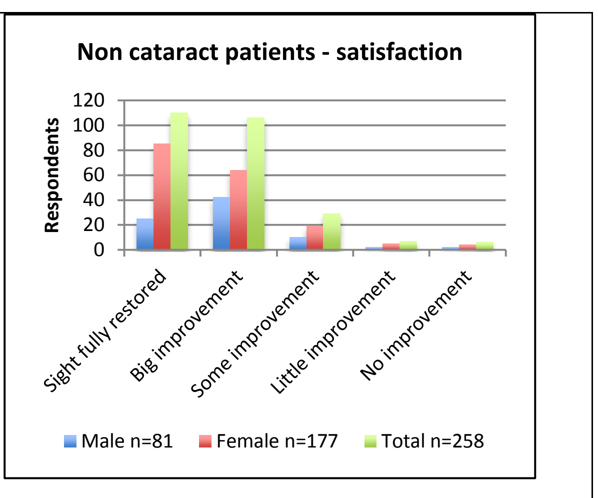


Other 'non cataract' patients receiving trachomatous trichiasis surgery recounted similar satisfaction levels; although this halts damage rather than improve visual acuity. It also brings physical relief from painful, weeping eyes as well as from the stigma associated with this condition.

With no gender quota for the survey, there were over twice as many women respondents as men, reflecting the greater prevalence of trachoma among women. There were no specific mentions in focus groups of trichiasis recidivism; rates of this are not currently tracked but ideally they should be.

Chart 5 Non-cataract patient sight quality





The Gambian approach of drawing on enthusiastic patients with restored vision to work with community-level volunteers to help mobilise patients has been adopted by Senegal and Guinea Bissau. It was evident from the survey and focus groups with patients that awareness of the availability of local eye care services had increased and that news of service availability is likely to grow and spread before eye health education messages do. Although Chart 7 shows perceived improvements in knowledge of eye care from the survey, qualitative findings indicate that this may only relate to the availability of services and that there is a continuing need for eye health education to be

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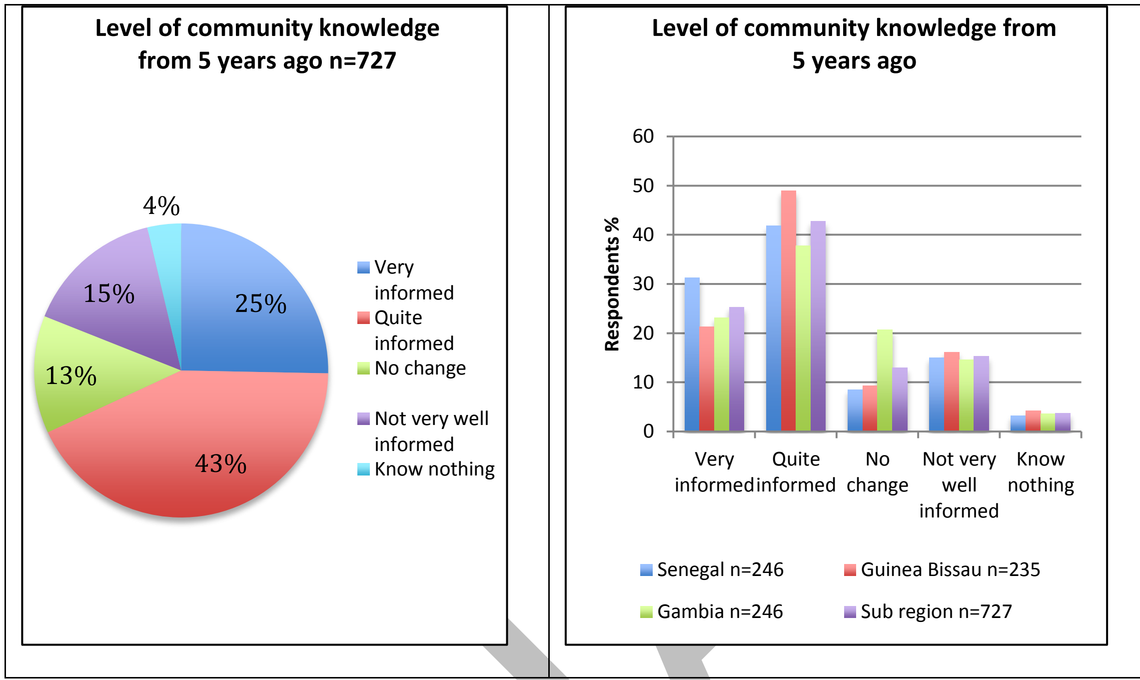
developed and monitored.

Chart 6 Service users perceptions of community knowledge of eye health compared with 5 years ago



Empowerment of Regional Health Teams

This result area was established in the proposal as a key enabler and driver for sustainability given the staffing capacity constraints of the sub regional national eye care programmes. However, the differing country contexts and level of emphasis placed on this aspect nationally has varied widely.

The most marked success has been in Senegal; the general health system is decentralised and Sightsavers and the National Eye Coordination already had experience of decentralising eye care services down to regional level. With the project focus on district level eye services, this was taken a step further. Regional health teams as well as their participating district health teams were supported to plan and manage the provision of secondary and primary level eye care services. Management training and laptops were provided to district level managers and this benefitted secondary health centres as a whole. Health teams acknowledged the contribution of training, clear communications messages and high profile awareness-raising events involving a wide range of community leaders and journalists in building public support and demand for eye services.

In contrast, there was little or no engagement or further progress in this area in The Gambia or Guinea Bissau, where health care planning and decision making is largely vertical and centralised. SOMA and other eye health do participate in relevant committees and management structures of the Regional Health Teams in The Gambia. However, they report having to use professional relationships to achieve cooperation and integration of eye health into annual planning, for example. In Guinea Bissau there has been little evolution in the planning and coordination of health care: it remains centrally

controlled with limited involvement by regional health teams, so local decision making on eye care is also affected. This is despite some moves to decentralise or delegate by other vertical programmes. Although regional health teams were consulted during the design phase and they provide space and utilities for the eye units, they were not involved in routine planning or management of eye care staff or eye care activities. Their involvement was generally limited to the monitoring visits made by Sightsavers staff, project annual review and planning meetings and attendance at one or both of the experience sharing meetings. In Guinea Bissau and The Gambia the National Eye Coordination prioritised service delivery development over the capacity building of regional teams. The only support given to regional teams was with respect to transport. This was evident from the outset but was not addressed during the 2010/11 revision of the budget.

3.3 Efficiency

This section examines the efficiency of the programme's implementation in relation to programme management and oversight; logistics and distribution: monitoring, evaluation and learning; and financial and resource mobilisation. Cost effectiveness and unit cost issues are considered from the perspective of sustainability.

Programme management and oversight

Activity oversight and output tracking have been efficient as evidenced by the achievement of a high proportion of output level targets. Changes and deployment of key staff did however create continuity problems at the outset, delaying implementation schedules and the detailing of plans. For example, the resignation of The Gambia Country Director (the PHFPI architect and Programme Manager) and providing oversight of Guinea Bissau operations from The Gambia until 2012 were problematic. Systems included quarterly and annual reviews with periodic field visits by national coordinators and country programme staff. Senegal was more able to efficiently analyse data and produced fuller reports, largely due to the proximity of the Sightsavers Regional Office, a high degree of decentralisation of the health system and good working relations with local and regional health teams. This enabled tools for project implementation to be developed and agreed with partners in the second year of the project. Although progress against outputs was tracked in The Gambia and Guinea Bissau the evaluators experienced some difficulty in obtaining detailed or analysed data on occasion.

A number of changes in staffing, supervision and management arrangements for Sightsavers at key stages during the project period alongside changes made to PHFPI budgets were unhelpful to expenditure planning. These changes resulted in activities specified in the programme document having to be re-planned. Efficient redesign and management required more technical support than was deployed.

A summary tool developed by the Programme Management Unit (PMU) in 2012 prior to the rights oriented monitoring (ROM) exercise was adjusted to

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include subsequent log frame revisions. This helped in providing consistent quarterly reports, enabling programme staff to systematically view progress against output targets by country as well as for the sub-region. This tool was less successful in linking output progress to the achievement of outcome targets.

Sightsavers expertise on EU procedures, finance, monitoring and evaluation were useful in guiding programme officers.

Logistics and distribution

There were issues with construction in ***Senegal*** and ***Guinea Bissau*** and also with the procuring of eye care equipment. This partly resulted from Sightsavers change to a centralised system for procurement. An apparent absence of eye care expertise within the Sightsavers procurement chain to ensure that orders were correctly specified and complete resulted in some delays and supply of equipment with key items missing. In order to meet central Sightsavers policies inappropriate vehicles were ordered. For example, specifying lower cost 4 wheel drive vehicles for which spare parts are scarce and maintenance knowledge limited resulted in extra running costs and down time in transport availability. In Guinea Bissau Sightsavers "Ford or Tata" was the issue where one vehicle was reported off the road with no spare parts in country and likely to remain so. This suggests either poor communications across supply chains, insufficient decentralisation of decision-making or inadequate deployment of expert advice.

In ***Guinea Bissau*** supplies to facilities were particularly well organised but this was achieved through bypassing health system pharmacies and justified by the need to supply outreach campaigns efficiently. This approach provided surplus supplies for static eye department use. The Gambia project officer provided assistance with procurement and supplies delivery, as there were difficulties with direct importation. While these systems worked efficiently they are not sustainable.

In ***Senegal***, Sightsavers funded the provision of initial consumables for eye units and surgical camps although supplies to eye units were gradually reduced as they became established. During the course of the project, the NPPEH achieved considerable progress supplying consumables with the integration of cataract kits into the standard list of the National Pharmacy. Very few stock outs were reported. This contributed to the achievement of results and the sustainability of services.

Monitoring, evaluation and learning

Monitoring of progress against output targets is highly dependent on assistance from Sightsavers and NECP coordinators. Integration of monitoring as well as reporting with data captured by health management information systems (HMIS) indicators is variable and frequently ineffective. Some eye health indicators are in the process of being integrated into HMIS record keeping systems in Guinea Bissau and The Gambia, while in Senegal eye health data was inadequate at primary level, secondary and tertiary levels. The situation varies across the programme (As for other detailed findings of the evaluation across PHFPI, see the Country Evaluation Reports

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annexed).

Major challenges for M&E concern:

a) Analysing data in ways that can demonstrate progress towards achieving outcome objectives – results that evidence the impact of the PHFPI investment. Even CSR rates are not calculated although the data is available.
b) Providing lessons able to help improve services and be used for advocacy with policy makers.

As seen from other sections of the report (Effectiveness, Impact) a major shortcoming is limited analysis and reporting against outcome indicators. These were centrally defined. It is thus more difficult to comment on the *impact* of activities on people's lives and people's access to and attitudes towards eye services. Current outcome monitoring gaps include surgical outcome, cataract surgical coverage and blindness prevalence rates, two of which require dedicated population-based surveys. Other outcomes including impact on quality of life and satisfaction levels, community eye health attitude and knowledge levels plus budget allocations to eye health, assumed the availability of appropriate data from sources including NECP and UNDP. Some realism as to the feasibility of gathering quantifiable data and agreement on the use of cost-efficient qualitative approaches is advised in the future.

REC: Ensure monitoring systems and the capacity to support their implementation are in place before programmes start.

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Finance and resource mobilisation

Strong financial management by Sightsavers was consistently transparent and accountable and great effort was made by the regional finance manager to support local management teams. Rates of expenditure varied. Start-up was slow due to the initial need to re-plan to reduced budgets, and this led to phased implementation; consequently some regions did not receive inputs until year 3 of the programme giving a reduced implementation period. This was particularly problematic in Guinea Bissau, which was aiming to establish a new and nascent service. The evaluators also learned that re-budgeting was undertaken with limited partner consultation. The revisions delayed the start up of services in some areas of Senegal and Guinea Bissau with consequences for the achievement of service delivery targets. Focus on the earlier training and deployment of staff in Guinea Bissau would have speeded the start up of services in those areas. Gambia has an established eye care service which was largely unaffected by this issue.

Limited additional resource mobilisation was undertaken at national and regional levels across the programme although some contacts were made for future reference. Training in business planning and resource mobilisation would have been useful, particularly for Regional Health Teams (RHT) and District Health Teams (DHT) in Senegal.

For ***Guinea Bissau*** finances were controlled centrally, minimising risk in a country with a poor accountability record and periods of insecurity. Budget

cuts and the unplanned need to finance support to Vitamin A distribution was criticised by the MoH and contributed to some trained staff being deployed only in the last year of the project.

In ***Senegal****,* as in other management and delivery areas, the decentralised health systems worked efficiently in drawing on both government and donor funds. There are functioning accounting systems managed by community representatives sitting in District Health teams. Senegal provides lessons for the other country governments on the value of decentralisation: with the collection and analysis of costs it would be possible to make the case for more efficient, decentralised systems. So far, there is little evidence of sharing lessons of this kind across PHFPI.

The proportion of the total budget allocated and the expenditure by each country programme are shown in Table 5. Just over half the funding was allocated and spent in Senegal, consistent with being the largest of the three countries. The rates of expenditure against budgets year on year are in Table 6. Burn rates increased as the programme progressed in line with observations that there were challenges to start up that required re-planning. The country reports show that burn rates in The Gambia were higher than elsewhere due to mobilisation to complete structures at SZRECC.

Table 5 Proportions of budget and spend by country

	Total exp	Total budget	Percent of total spent	Percent of total budget
Senegal	1,992,451	1,905,959	54%	55%
Guinea Bissau	948,888	922,298	26%	26%
The Gambia	690,280	699,427	20%	19%

Table 6 Budget and spend as a proportion of totals from programme finance returns

	2009	2010	2011	2012	2013	Total
Budget EUR	758144	738937	985640	741771	1113514	3,631,619
Expend EUR	552574	506896	678671	677256	1199515	3,614,912
Rate	73%	69%	69%	91%	108%	99.5%

Figures from finance report supplied. The actual rate apparently was 102%.

REC: (upper two sections) Provide continuity of technical and managerial support with associated systems that recognise the contexts in which programmes are implemented and ensuring full participation of partners and national staff when taking strategic decisions.

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Cost recovery, unit costs and cost effectiveness

Cost recovery has been variously used to recoup the cost of providing treatment, to contribute to the running costs of local health facilities in which eye units operate and to contribute to social funds designed to provide free or subsidised treatment for the poorest. There is no uniform system for managing cost recovery and cross subsidising the poor across the programme. Unit costs are not systematically calculated across the programme due to the complex ways in which funds are routed and the absence of accounts charged with this level of analysis. There is little evidence of planning how eye services will be financed after PHFPI ends. Despite evident continuing levels of need, it is likely that services will be underused if charges are increased as a means to cover costs. The introduction and application of Sightsavers tools for calculating unit costs and costs effectiveness for the supply of services, procurement of supplies etc would have helped place the services in a stronger position as PHFPI closes. Sightsavers should introduce these tools across all programmes in order to strengthen the evidencing of financial effectiveness for Replicability.

The planned production of eye drops and refractive and low vision services would be a source of cost recovery had they been introduced successfully with clear distribution and marketing strategies, an area in which Sightsavers has experience elsewhere. There has been only patchy progress with those activities largely due to poor business planning and inadequate supply chains.

REC: A review of Sightsavers centralised support systems to evaluate not only the efficiency but also the long-term cost effectiveness from different stakeholder perspectives should be undertaken together with how they can be more responsive to the needs of different local cultures and contexts.

3.4 Coherence and Coordination

The project sought to improve planning and coordination of eye health programmes by the key health stakeholders including communities (Result 4.1). It sought to influence the health planning strategies and practices of the ministries of health through advocacy based lessons from good practice shared with partners, including blind and disabled people's organisations Across the sub region the evaluation has explored coordination between the three country projects and teams.

Coordination within MoH systems

The risk with donor-funded initiatives is failure to achieve ownership by government and other stakeholders while support is available. Across the sub-region there was a need to share the success factors for achieving strong cooperation bringing achievements and best practice to the attention of other governments.

Where regional district health authorities have been decentralised, as in Senegal, RHTs coordinate effectively with the district health management teams, but regional eye care staff support and coordination with the district

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eye care staff was observed to be inadequate in the districts visited by the evaluation. The Senegal RHTs reported good communications with NPPEH although this was clearly assisted by facilitation from the Sightsavers PO, which ensured that issues identified received a prompt response. The importance of this facilitation will only be evident after the project end. At national level there is insufficient capacity and time to coordinate adequately. Decisions are needed on integrating eye care into national health systems such as HMIS, health worker training and maintaining progress with the National Pharmacy. These place eye health at risk of being marginalised from central planning and budgeting, despite existing policy commitments.

In contrast, coordination in The Gambia at regional level is hampered by the absence of a decentralised health system. Nonetheless, PHFPI has been able to improve on the previous lack of cooperation between RHTs and the NECP[ii]. Eye surgeons are now included in RHT meetings and report to both NECP and the RHT.

Whilst PHFPI support in ***The Gambia*** and ***Guinea Bissau*** is aligned with broad health strategies there remains scope for further integration. A vision recognising the broader social and economic value of blindness eradication is however largely absent. There is also little acknowledgement of the need to develop staff retention policies for trained professional cadres, the replacement of which has high costs and threatens eye service sustainability. This is especially surprising in Gambia given the long period of support provided prior to PHFPI. Only in 2012 was an agreement reached with WHO to provide a consultant to develop an eye care policy with NECP and MoH, including eye health indicators. This work has not yet been furthered.

In ***Guinea Bissau*** it has proved possible through the NECP Coordinator's efficient control of resources to gain the approval of the project in the face of much more weakly managed health care sectors, but this has been at the expense of operating in parallel to rather than in integration with the MoH health management systems.

In ***Senegal*** the project is directly aligned with the overall aim of the NPPEH to reduce blindness prevalence to below 1%. There has been considerable sharing of plans and budgets and communications across a wide range of stakeholders have succeeded in achieving synergy and integration towards achieving this aim. Decentralisation across the health system has further helped achieve strong links with local level health management teams, with cataract surgeons participating in DHT meetings. Again, this experience appears to have been shared only to a limited degree across the sub region.

Sightsavers coordination mechanisms

Programme coordination mechanisms put in place by Sightsavers have largely worked well. Quarterly and annual reviews collect and collate results against output targets and deadlines are mostly met through a regular flow of information on progress from RHTs to the national coordinator to Sightsavers staff. However, planned meetings and supervisory visits were not always done on schedule, largely due to health staff being unable to make time available and heavy coordinator workloads. Meetings between Sightsavers

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POs and National coordinators were regular and reports widely shared. Sightsavers staff attended annual country reviews and planning workshops along with National programme and RHT staff. Two sub regional experience sharing workshops also enabled progress to be reviewed. However, there were no follow-up activities or complementary opportunities for eye service delivery staff to share experiences in more direct and practical ways during exchange visits.

Sightsavers field level coordination with partners was good, especially in Senegal where Sightsavers staff facilitated NPPEH contact with the RHTs and DHTs over key issues. In Guinea Bissau, quarterly visits made by The Gambia based PO limited the opportunity to assist NECP to develop and strengthen coordination with the MoH and between MoH and RHTs.

Senior Sightsavers regional staff based in Dakar undertook most high level advocacy work. Even in Senegal there was insufficient attention to reaching out to policy decision makers by the National Coordinator and Sightsavers staff. In Gambia there has been limited influence at high levels of government. With frequent changes in top-level officials a successful influencing strategy would require more contact and regular follow up. In Guinea Bissau the regional health managers reported that eye care plans coming from NECP are not communicated in advance, even though they are expected to implement them. This has limited opportunities to help improve the synchronisation of work and services at local level.

External linkage with other eye service providers, rehabilitation organisations, BPO/DPO, INGOs, donors

Alliances with DPOs did not receive much attention in PHFPI plans, so the opportunity to lobby from the perspective of rehabilitation, livelihood support, accessible education and social integration has been largely absent from the programme. Without this broader awareness it is difficult to persuade ministries of health to increase the priority given to eye health care.

V2020 committees can play a central role in influencing public policy on avoidable blindness and catalysing the development of national eye health plans. In Senegal regional V2020 Committees were set up at regional level but did not have time to establish regular activities prior to the end of the project. Given the degree of avoidable blindness, the dormancy of the national V2020 committees across the programme is a matter of concern. Sightsavers could have done more to stimulate and support broad-based cross-sectoral V2020 committees as part of the sub regional agenda, for example by including roles and functions for committee members and small budgets for these to be carried out, thus incentivising interest and commitment. This would have required stronger links to WHO and other agencies with health and rehabilitation mandates. In The Gambia, PHFPI did not capitalise on the nascent partnerships with BPOs and DPOs observed in previous reviews of Sightsavers work in the country (2001, 2004, 2008, 2011).

Linkages were made with schools and the service for school health at regional level for enabling school screening and in some regions these are strong. The distribution of Vitamin A was organised by HKI through country nutrition units;

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the main linkage with eye services has been the involvement of eye unit staff in the distribution campaigns.

The programme collaborates with One Sight in Senegal. This is an international NGO with which Sightsavers has a global strategic partnership and which also works in Gambia. An MOU between Sightsavers and One Sight in The Gambia aims to coordinate respective resources so that RE services are supported as widely as possible. Not all eye units have refraction facilities and One Sight equipment and the national eye care programmes and Sightsavers see training as making an important contribution to the overall programme. It also contributes help with business planning and cost recovery systems.

In Senegal NPPEH has made contact with several agencies working in project districts: PAODES, a Belgian cooperation programme that shares the same aims of improving health system management and improving demand for and the quality of services in districts where it overlaps with PHFPI; likewise with BAOBAB a local NGO that contributed to an eye unit, and Voile Sans Frontieres where collaboration has been encouraged with their optical shop in Fatick region.

Although there are no other eye care INGOs operating in Guinea Bissau, Sightsavers does not appear to have pursued opportunities to collaborate with broader civil society on PHFPI, especially DPOs.

Coordination measures between the three country programmes to learn and share experience and good practice

Two experience sharing meetings were organised by Sightsavers, one in 2010 and one in 2013, for programme partners and stakeholders. Only those districts in Senegal and Guinea Bissau phased into the programme were invited to attend and so the 2010 meeting was much smaller than that organised in 2013. This restriction limited interaction at a key moment as well as limiting programme understanding by some of the key stakeholders. These meetings gave all participants an oversight of project progress as well as providing a forum for exchange of learning, but they did not take a strategic look at the dimension of inter-country collaboration. Guinea Bissau stakeholders considered the meetings useful and Regional health managers identified useful learning from Senegal on the organisation of surgical camps, increasing community involvement and using former patients for mobilisation. These limited opportunities for experience sharing were not followed up as they might have been with exchange visits and other communication, perhaps in part due to language difference.

It is not evident from reports or interviews that these meetings explored influencing agendas or the development of a common platform around regional support for eye services; this remained a gap in the programme. In general, no influencing initiatives emerged from country level to be developed and promoted sub regionally.

Overall, the opportunity presented by PHFPI to continue the ethos of HFPI in fostering greater sub regional collaboration, cross border work and learning

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was not exploited to any degree outside of the two set piece meetings.

A further coordination issue concerns SZRECC. The training centre was intended to be a catalyst for fostering cross regional understanding and lesson learning as well as providing vital training services. These opportunities have received too little attention by those in Sightsavers responsible for coordination across the sub region (and beyond) to issues of SZRECC ownership, governance and management[iii]. The roles SZRECC could play in coordinating exchanges of knowledge and experience were effective through the participation of those who came from the countries for training. However, the opportunities for a broader range of policy and decision makers from across the sub region to exchange experiences through participation in SZRECC ownership and governance were not realised. Now there is a lack of agreement over its future and opportunities have been missed, as exemplified in the failure in recent discussions to achieve agreements and strategies on these key issues. Earlier ongoing attempts to address SZRECC issues do not appear to have been adequate in assisting it realise its potential

From the three country studies for this evaluation it is clear that coordination across the sub region has not been a strong component of PHFPI. It has to be questioned whether attempting a sub regional programme across countries with such a wide range of needs, differences in context, language, government and political systems are a realistic way to coordinate and achieve synergy. It may be investment in country programmes with some economies of scale through coherence of technical support and management are the main gains to be made through linking support across such a diverse set of countries. The added value of lesson learning has proved difficult to coordinate and achieve. There has not been sufficient coordination and coherence across the three countries to justify the investment in PHFPI as a sub regional programme. From the perspective of eye service development regionally there has been little added value. There was need to invest considerably more time and resources into cross regional exchanges and learning to achieve the objectives defined for development of eye services on a sub regional basis.

REC: Lessons on coordination and coherence from the PHFPI and the earlier HFPI programme should be considered carefully in the future design and planning of cross country and regional programmes.

REC: If the SZRECC governance and status issues are resolved, this will be a strategic asset for the development of HREH in the sub-region that would merit further support with advocacy and marketing from Sightsavers if requested. If this does not happen Sightsavers should still continue to support development of human resources for eye health in the sub-region: this is a strategic initiative that needs following through.

3.5 Impact

The evaluation sought to assess the impact of the programme with respect to two key question areas: the key changes to target groups and tangible

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outcomes achieved; and the extent to which the programme fostered and developed cross regional relationships and agendas.

The ***overall objective*** of PHFPI was *to contribute to poverty alleviation through the prevention of avoidable blindness in The Gambia, Senegal and Guinea Bissau by the end of 5 years.* The ***specific objective*** was: *to establish comprehensive good quality, accessible and affordable eye care services reaching at least 60% of the population in intervention regions in The Gambia, Senegal and Guinea Bissau.*

Key Pathways in Theory of Change

The PHFPI theory of change suggests an intervention premise that the achievement of outputs and outcomes will directly lead to the achievement of overall programme goal and purpose.

The intervention logic at goal level is based on internationally accepted studies that establish a close relationship between poverty and blindness and demonstrate that addressing blindness will contribute to improved livelihoods and reduced household poverty levels. At purpose level the theory of change assumes a direct relationship between strengthening the health systems of governments and the delivery of a comprehensive programme of eye care services.

The issue is therefore whether planned results and outcomes have been realised and whether they have led to the desired impact. Whilst recognising that the start point and contexts of the 3 countries are very different, evidence from output data and interviews with a wide range of eye health and other health actors from across the sub region suggests that PHFPI has made a significant contribution to eye health systems strengthening. Although staffing levels remain challenging a broad, if not yet comprehensive a range of eye health services are being provided to over 60% of the intervention area population. This is a sizeable achievement, especially in Guinea Bissau and Senegal, where the programme has established services in districts where there had been largely none. It is also evident that establishing or strengthening eye services has led to sight restoration for substantial numbers of people and thus improved their quality of life, and for some, livelihood.

There are however a number of omissions from the theory of change and some process related adjustments that it would be useful to make explicit in the future: the importance of creating focused advocacy and communications components with clear change agendas; the need to include community level eye health promotion components; including improved access to education for children, ensuring the rights as citizens of those not curable under international conventions for people with disabilities and social inclusion, as articulated in the SIM strategy Sightsavers has now adopted; the time frame - this level of change is likely to take longer than five years and the impact of centralised services on planning and delivery at regional level and on eye health integration prospects. Sub-regional aspirations need to be made explicit both in design and implementation with less attention to service

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delivery and more to strategic challenges, including policy frameworks and the SZRECC governance and management issues impacting on sustainability prospects across the sub region.

Crucially, there needs to be recognition that an enabling context is key to developing a sustainable eye health service. At national level whilst service delivery is of course important, significant effort and resources should be invested in facilitating processes that will lead to supportive policy frameworks, PEC integration into PHC and budgets and decentralisation of services to regional level. The Senegal example could be documented as a case study of where a decentralised and supportive context has enabled significant progress to be made, as well as demonstrating the value of close Sightsavers accompaniment. The Gambia is an example where the continued absence of a policy framework, inert V2020 committee and delayed devolution to regional authorities represent a key threat to sustaining eye services as well as undermining a very significant and long term investment by Sightsavers.

Similarly, PHFPI appears to have been largely implemented as three separate country projects rather than as the one unified sub regional programme in its design. The mismatch between the design and its implementation indicates a greater need for reflection at the planning stage on how this would translate into practice and thus the most appropriate emphasis. More strategic reflection at this point would also have ensured that the outstanding SZRECC governance and management issues carried forward from HFPI were given greater attention and also resolved within the 5-year timeframe of PHFPI.

Whilst output level data has been systematically collected, if not always analysed, this was not the case with the outcome indicators designed to measure impact. This makes them harder to assess, due to limitations in the monitoring system to capture qualitative change as well as change timeframes that in some instances exceed the PHFPI lifetime, as in the case of blindness prevalence. Indicators were neither SMART nor monitored and few baselines were established; this oversight on the part of Sightsavers was evident in all the interim reports, including that of 2012 after log frame revision, and should have been picked up and resolved.

The evaluation team therefore assessed progress against key impact indicators identified at overall objective and specific objective level using monitoring data as well as information from in depth interviews with a range of eye health service personnel. The team also assessed changes to the lives of targeted service users through FGDs plus a survey of 750 people across the sub region exploring service satisfaction levels, quality of life changes, and eye heath knowledge, attitudes and practices. With no baseline for qualitative change indicators such as quality of life, where general UNHDI index was cited as the MoV, the survey design employed a *before and after* questioning line. RAABs conducted in 2010 in Senegal and Guinea Bissau and an unpublished 2008 RAAB in The Gambia provide a baseline for blindness prevalence and surgical coverage rates but will not be repeated for several years. Change may therefore be inferred but not evidenced. The progress made against the overall and specific objective indicators is listed in Table 7.

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Table 7 Results against outcome indicators for overall and specific objectives

Indicator	Result
CSR	Average national CSR across the sub region is 1,218, below the West Africa V2020 target of 2,000 needed to address ongoing incidence. 2013 national averages were 1,760 The Gambia (falling); 980 Senegal (static); 916 Guinea Bissau (increasing). The 2,000 target is said to be the level at which backlogs clear and prevalence begins to fall.
Blindness prevalence	There will be no follow on national studies to the 2008 and 2010 RAABs for several years therefore it is not possible to update the prevalence statistics across the sub region.
Quality of life	No baseline in place and QoL not monitored. Survey of 750 people plus FGDs suggests significant impact on lives.
Percentage of referrals from traditional practitioners	No baseline in place and monitored only in The Gambia (0.2% referrals from TPs in 2013). Referrals not tracked in Guinea Bissau or Senegal HMIS systems; difficult to introduce parallel system.
Surgical coverage	Current surgical coverage unknown, requiring countrywide studies to update 2008 and 2010 RAABs.
Percentage of positive surgical outcome	Audit tool rarely and inconsistently used, records of surgical outcome are not maintained or analysed. Survey results consistent in indicating an average 76% good outcome across the region.
Number of cataract surgeries with IOL	c.100% unless contra-indicated No biometry. Standard lens strength used of 20 and 21 dioptres across the sub region.
Percentage of facilities with stock outs	Stock outs common problem across The Gambia (100%) and Guinea Bissau (81%) linked to inefficiencies in central procurement and distribution system. Senegal reports a lesser problem but no data.
Patients presenting receiving eye care service	Not possible to average as context specific with strong variation – not monitored in Senegal, small numbers presenting in Guinea Bissau, and The Gambia data indicating falling trend in numbers presenting being treated
Percentage of committed	No specific eye care budgets in place across sub region

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expenditure on eye care met	therefore not possible to comment against indicator.

PHFPI aimed to impact in 4 areas:

1. health systems strengthening
2. eye health integration
3. change to target groups
4. sub regional relationships and agendas.

1. Health systems strengthening

Relating directly to the PHFPI specific objective the programme has made an overall positive contribution to maintaining broad if not quite comprehensive eye services nationally in The Gambia as well as introducing and strengthening new eye care services within intervention areas of Senegal and Guinea Bissau. In doing so, PHFPI has succeeded in raising the profile of eye health within the Ministries of Health and the link with poverty, even if this has not translated into increased funding.

With the strategic linkage to One Sight in both Senegal and The Gambia the development of regional optical units will add considerable value to the achievement of comprehensive eye service provision. Importantly PHFPI also boosted the potential of SZRECC to provide training to eye health students from across the sub region, even though its ownership and governance issues reduced its effectiveness as a strategic actor.

User perceptions of eye service quality are attested by high levels of satisfaction recorded in FGDs, interviews and the survey and by the willingness of users to attend facilities. Chart 7 illustrates an 82% sub-regional average of respondents reporting that they always or very often use eye health care facilities compared to 5 years ago, with 10% more men than women stating that they always use the facilities.

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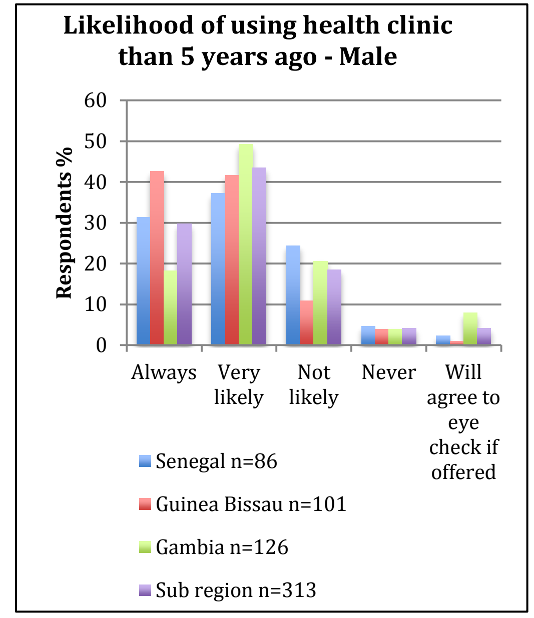
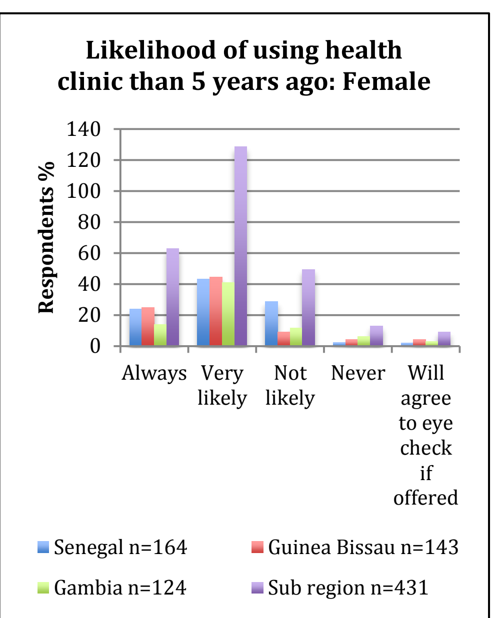
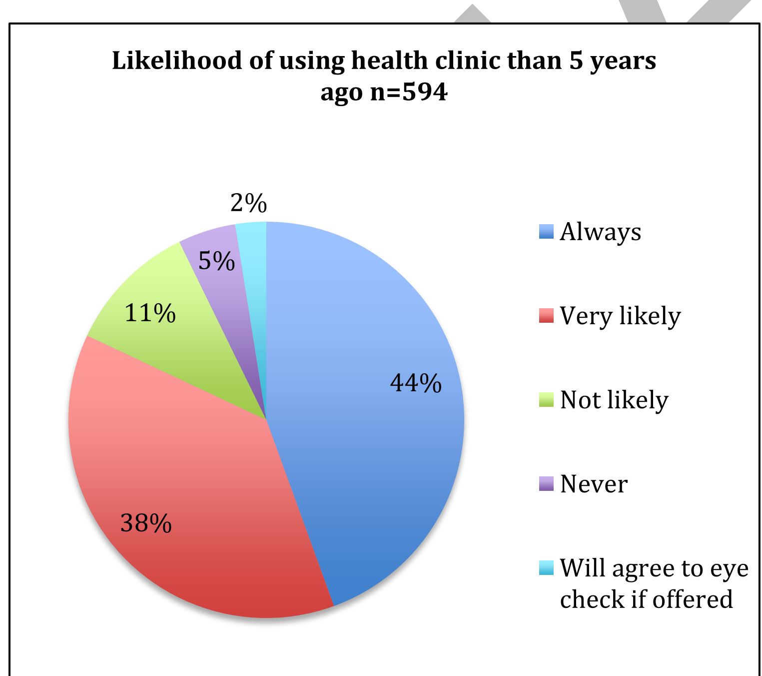
Chart 7 Likelihood of using health clinics than 5 years ago







Affordability is a complex dilemma given the high poverty levels prevalent across the sub region. Cost recovery is important for sustainability reasons yet even with a level of fee waiver is likely to deter the poorest from accessing services. The very poor wait for free eye camps, itself not a sustainable approach to service delivery. There are no simple responses to the dilemma, captured in more detail in the Efficiency sections of each country report. To illustrate: Guinea Bissau eye services were free to date in order to attract patients to the nascent service – an unsustainable approach creating unrealistic expectation; Senegal fees decreased with the integration of eye medicines into the standard list, making services more affordable and increasing take up yet still ensures cost recovery in a decentralised context;

The Gambia has doubled fees to better ensure cost recovery and longer term sustainability of programmes.

CSR trends are captured in Table 8. The sub regional CSR average of 1218 in 2013 shows a 10% increase since 2009. This figure however masks significant disparity between countries (see country report impact sections for statistics). The Gambia CSR levels in 2013 are easily the highest in the sub region, as one would expect from a long established programme but indicating a downward trend since 2009. The start of service delivery in Guinea Bissau in 2011 has positively impacted on CSR with sharp increases recorded from 2012; the Senegal programme is yet to record significant increases to the national CSR average which remain static although 2013 figures are not yet available (the evaluators have assumed no change). The CSR levels achieved suggest that the programme is unlikely to have impacted on current incidence levels or overall prevalence rates. Use of eye services from across borders with neighbouring countries was not tracked and may distort CSR rate calculations.

Table 8 Sub regional national CSR levels

	2009	2010	2011	2012	2013
Senegal	1,000	800	1,000	980	980
Guinea Bissau	169	70	243	432	916
The Gambia	2,151	2,144	2,139	1,935	1,760
S-R Average	1,107	1,005	1,094	1,090	1,218

Surgical outcome is an important indicator of surgical quality. Because of the absence of biometry equipment, standard strength IOLs were used across the sub region. The WHO recommended level for good surgical outcome is 85%. Although the two methodologies are not comparable, not least of which because FGD responses are invariably subjective in nature, beneficiaries in FGDs nonetheless stated that they were very pleased with their surgical outcomes. This was also confirmed through survey where an average 76% of respondents reported that they were very or extremely pleased with surgery outcome. Seventeen percent reported an intermediate outcome. It should be noted however that ROM recommendation for cataract surgeons to consistently use and monitor surgical outcome using the WHO audit tool has not been implemented and this issue remains a problem within the country eye health services. The reasons given for this range from lack of time, to erratic patient return rates, to absence of an effective data base and data inputters.

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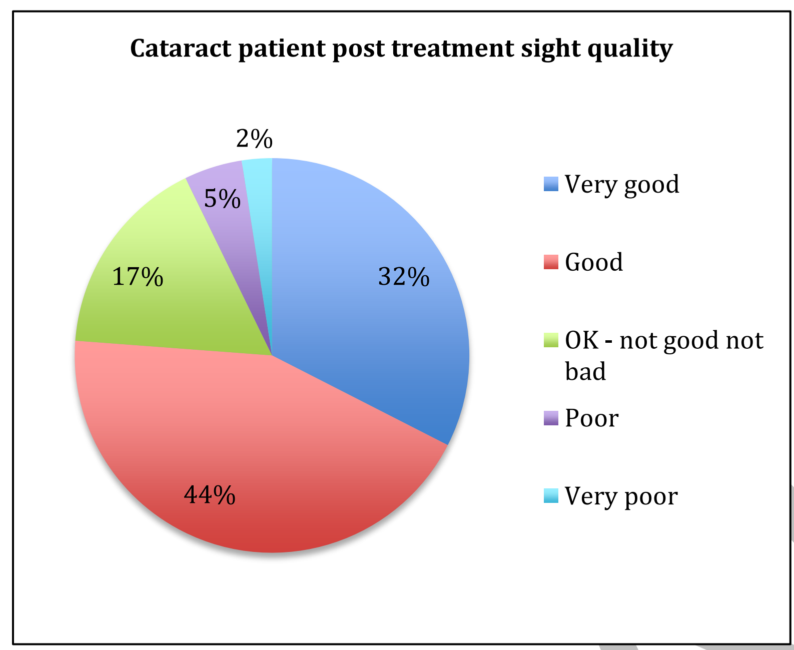
Chart 8 Post cataract surgery sight quality



2. Eye Health Integration

The second area of intended impact is twofold: the integration of PEC into PHC and the integration of eye care into health systems plans and budgets.

None of the 3 country governments involved in PHFPI have specific eye health budgets, a key indicator against the specific objective. It is not possible therefore to indicate the level or trends in eye care funding. The programme developed neither national nor sub regional influencing strategies aimed at embedding eye health care into overall health plans and budgets. This is important if the overall amount of funding available for eye services is to increase.

Decentralisation is realized in Senegal where PEC is integrated into PHC in most respects; this is not the case in Guinea Bissau and The Gambia.

3. Change to Target Groups

Knowledge and awareness: Building community awareness has been an important building block to improving referral rates and access over many years. This has been largely achieved through the work of community-based volunteers, a model used across the sub region. It is also an important contributor in efforts to reduce stigma towards people with visual impairment. Although the range of strategies varied across countries overall there has been considerable impact on knowledge and awareness levels and service user perceptions of knowledge levels.

In the survey, across the sub-region 67% of respondents indicated that they felt quite or very informed about eye health matters and where to go for referral and treatment. The survey also provided evidence of changes in community attitudes and hygiene behaviour, with 71% of respondents reporting quite or very supportive attitudes to people with visual impairment and 79% stating that they have made changes to their daily habits in order to

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maintain healthy eyes.

The survey also explored changes to community eye health knowledge compared to 5 years ago and although only 25% considered themselves well informed 74% of respondents wanted more information on eye health; communities were thought by 73% to be quite or very informed about eye health compared to 5 years ago. Furthermore, 79% of respondents indicated that they had made one or more changes to their habits relating to eye health. These positive survey results are, however, derived from a sample of service users and do not apply to the general population: more work on eye health education and behaviour change is still required.

Quality of Life: Although the project did not baseline or monitor quality of life, both survey results and FGDs across the sub region confirm the significant impact that restoration of sight has on the quality of life of eye health users. The findings and those of the FGDs are consistent with those of internationally recognized studies on the impact of cataract surgery. As a result of changes to the quality of vision, respondents reported greater levels of independence, confidence and self-esteem, and ability to undertake domestic duties and outside activity and resume work, especially farm work.

In the survey 59 % of respondents (Chart 10reported no difficulty with engaging in outside activity after treatment compared to just 7 % before treatment; 46 % had reported moderate or severe difficulty before treatment compared to 11 % after treatment. 60% of respondents (Chart 11) also reported a reduction in their sense of being a burden to their families since receiving treatment compared to 18% beforehand.

Chart 9 to Chart 12 illustrate some of the positive changes experienced by project users.

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Chart 9 Changes to life after treatment

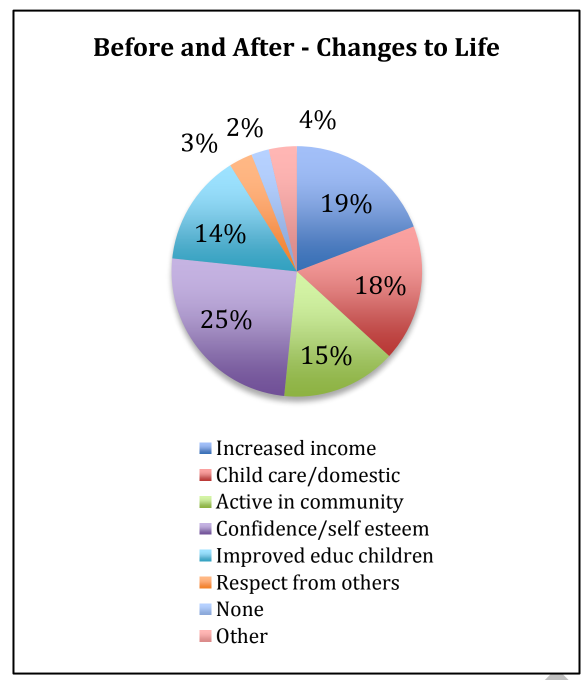


Chart 10 Changes in difficulties outside activity

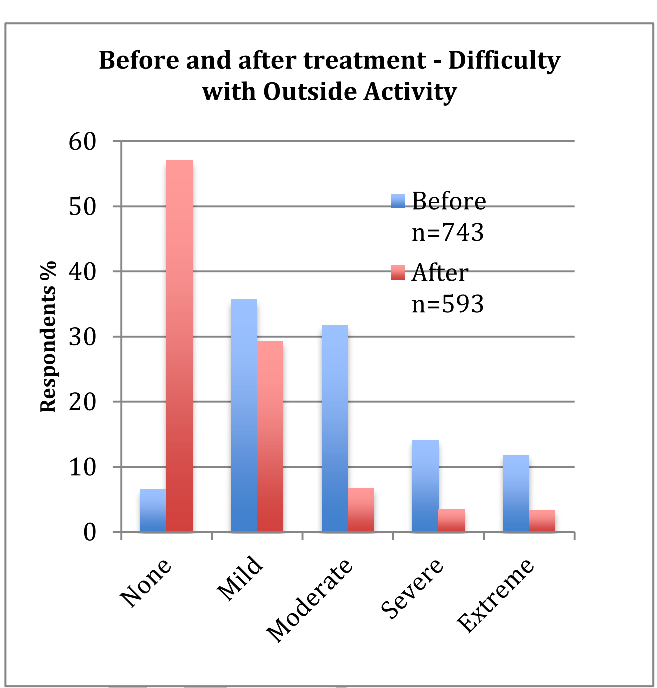


Chart 11 Sense of burden

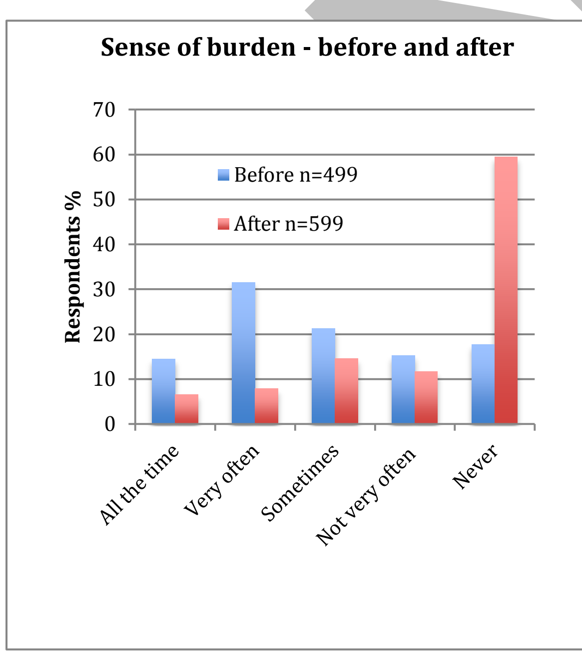
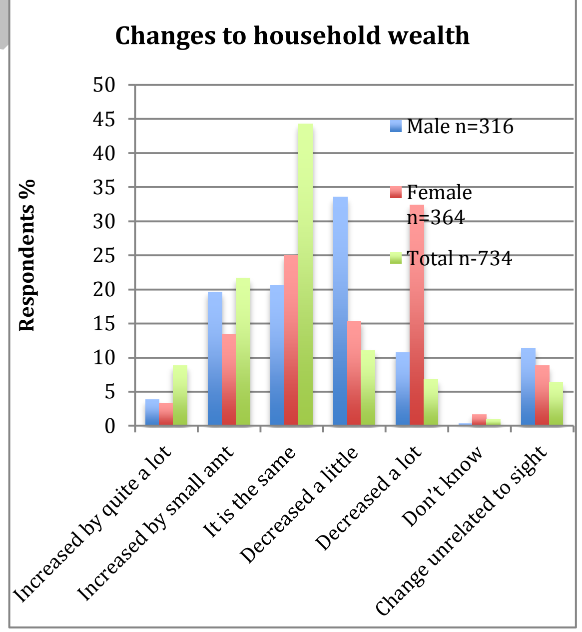


Chart 12 Change in wealth



4. Multi-country collaboration

This section focuses on the extent to which there were transfers of experience, contributions to tackling cross border health issues and the influence and lasting value of cross border collaboration between the 3 countries.

Multi-country collaboration was the key feature of the first Health for Peace Initiative in 2001–2006. The PHFPI project document reflects the spirit of HFPI and mentions three strategies for continued collaboration under PHFPI, but these were not translated into explicit activities or targets in country plans or budgets. A key implicit aim however was the reawakening of sub regional interest and support for the HFPI initiated SZRECC. The construction programme had not been completed and there was a clear risk that it would not develop its intended sub regional training role.

The SZRECC construction programme was intended, in part therefore, to rekindle sub-regional interest. It was hoped that a multi-country partnership would, with support from WAHO, help resolve outstanding governance and management issues. These included board composition, rotation of the board chair position plus sub regional recruitment of the SZRECC Director position. The intended aim was that this in turn would promote greater engagement, ownership and funding from the governments of Senegal and Guinea Bissau, so that the institution became regionally owned as well as financially independent.

The overall sub-regional agenda does not appear to have significantly permeated the fabric of the PHFPI project. Although the SZRECC governance agenda was discussed by Sightsavers regional managers bilaterally and sub-regionally in meetings with ministry officials and WAHO stakeholders, the lack of explicit strategies in the PHFPI project document has been to the detriment of this agenda and progress is slow. The omission represents a significant oversight by Sightsavers, "a missed opportunity" according to one senior Sightsavers manager, and one that limits the overall value addition of the programme as well as presenting a sustainability risk across the programme.. It is also surprising that Sightsavers commenced PHFPI without a clear MOU and timetable in place with GoTG that addressed these issues and without an understanding with WAHO on its potential role in facilitating delicate negotiations. The omission of these sureties resulted in Sightsavers having no leverage to ensure critical actions were undertaken by GoTG with respect to SZRECC governance.

The outstanding SZRECC issues have not been resolved. Discussions commenced again at a December 2013 sub-regional meeting hosted by WAHO in Gambia and funded by Sightsavers. This key meeting highlighted the issues to senior MoH attendees from the sub region but initial minutes from the discussions do not indicate in any obvious progress and there was no agreement on a draft document prepared by WAHO.

The project nevertheless provided an international framework and structure that was crucial for facilitating sub regional training arrangements. Actual activities linked to the broader aim of fostering and developing cross regional relationships and agendas were more limited in scope; specifically there were two meetings held during the 5-year period specifically for experience sharing. There were no cross border programmes or synchronised activities as envisaged in the original proposal. Inter-country collaboration was not mentioned explicitly by sub regional stakeholders as a benefit or perceived weakness of the programme. When probed, most country level health

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commentators suggested that more opportunities to meet, to experience share and to undertake cross border work may have added value but that they were primarily concerned with implementing their own programme.

Sightsavers country and regional level programme staff expressed a sense of lost opportunity, both with respect to driving the SZRECC governance agenda and to making more of the opportunities for fostering genuine collaboration and sharing between the three countries. Although partners were consulted about the experience sharing meeting agendas, the concept of joint planning and synchronisation of cross-border activities was neither raised nor explored. Impact on this aspect of the programme is therefore minimal.

3.6 Sustainability

The evaluation sought to assess key areas with respect to programme sustainability. These include: the systems developed by the programme to sustain project achievements, especially meeting the overall objective of contributing to poverty eradication; the transitional exit strategies in place for when PHFPI funding ends.

This section addresses the questions: To what extent is the programme likely to sustain its achievements and continue implementation after external funding comes to an end? What mechanisms / systems have been put in place to ensure this? How can the needs of targeted groups of people with visual impairments continue to be met? What exit strategies are in place or needed?

Looking across the sub region the factors influencing sustainability may be summarised as:

- Decentralised health systems make it possible to create spaces for eye health to work with district and regional structures, building understanding and mutually beneficial systems for cost recovery, sharing of resources and other structures that can enhance sustainability.
- Lobbying and influencing strategies are essential to achieving eye health recognition as a valid health system component that requires inclusion in plans and budgets and an adequate share of resources.
- Communications strategies at all levels: creating awareness and demand and stimulating responses is necessary to establish a virtuous circle of supply and demand for eye services.
- A planned and implemented exit strategy that includes activities designed to enable the achievement of sustainability.

As noted elsewhere the country programmes started from different bases and have reached different stages of development. The models and systems functioning in each country are dependent on PHFPI resources to varying degrees; governments have assumed only partial responsibility for the costs of service delivery. In Senegal and Guinea Bissau an additional sustainability challenge is to increase geographic coverage.

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The lack of data on the cost of providing eye services by governments and PHFPI make successful lobbying for additional resources challenging. In Senegal, payments are made to cover eye care from general decentralised funds subvented for health care. Cost recovery from eye surgery charges varies; and income distributed across the health sector without calculating the actual costs of delivering the service. It is likely however that the efforts of the RHTs and DHTs alongside the eye service teams will sustain services even if the central government does not fully resource them.

In The Gambia the government pays salaries, supplies basic drugs and provides infrastructure but has no specific budget for service delivery. Frequent re-shuffling of senior government positions limits institutional memory at the highest levels and is a concern for the longer term sustainability of a programme which is often viewed by the GOTG as a Sightsavers' responsibility. This manifests in reduced government ownership with respect to eye health financing and commitment to an enabling policy framework.

In Guinea Bissau health services are projectised and financed by external donors, as there are limited government budgets. Although senior officials clearly value the contribution of PHFPI they prioritise more life threatening health areas. To change this position would require more evidenced-based advocacy on the impact of blindness reduction on poverty eradication.

Across the programme there is high commitment and enthusiasm from eye service delivery staff endeavouring to maintain services within the limitations of reduced funding and supplies. The dedication and commitment of staff is apparent from observation as well as interviews and survey data but the removal of PHFPI salary top ups may reduce motivation. It is therefore likely that access by poor and largely rural communities will decline as funds for outreach and service subsidy reduces. This poses a significant risk in Guinea Bissau where eye care services are not yet consolidated. In Senegal eye services are integrated into the decentralised health structure with supportive regional and district health teams; this should help in maintaining service levels. In The Gambia public demand has grown over a long period with established community level structures more likely to sustain service delivery, albeit on a sliding scale. Failure to maintain staffing levels through high attrition and reduced training for replacement is the greatest single threat to sustainability in ***The Gambia***.

The Gambian experience plus health workers at all levels suggest that a five year period of support to developing new eye health services in Senegal and Guinea Bissau is insufficient to build comprehensive public awareness of these services, despite high levels of expressed awareness in the survey. For some districts the period has been just three years. Service promotion in both countries is dependent on PHFPI-supported outreach activities: taking the services to the community, screening and referring. In Guinea Bissau, patient loads may swiftly reduce without outreach, especially from poor and remote areas.

Medical professionals including cataract surgeons expressed doubt that

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surgery fees are sufficient to maintain the level of outreach required to build a strong demand base for eye services, creating a diminishing returns downwards spiral of demand and supply. In Senegal awareness raising is enhanced through a strong communications and campaigning component. Few if any of these activities are sustainable without PHFPI or other external support. The level of integration of eye health within the broader, decentralised health system is the most optimistic factor to help achieve service and system sustainability in Senegal. In Guinea Bissau the cessation of free surgeries and medicines can be expected to significantly reduce demand.

Realistically, sustained advocacy is needed, forming part of a well-articulated and funded exit strategy designed to influence policy makers. The main elements may vary across the sub region but will include:

- Integration of eye service delivery into planning processes at national, district and regional levels
- Developing enabling national eye care policy frameworks
- Formal eye health membership of RHTs and district management teams
- Ensuring professional supervision across all levels of the service
- Integrating eye service outreach into multi-disciplinary outreaches
- Formally recognising all eye service staff within appropriate health cadres with commensurate terms and conditions
- Increasing accessibility to eye health services for the poorest through performance based financing and health insurance plans
- Integrating primary and other levels of eye data into the HMIS
- Promoting and prioritizing eye health education in schools, communities and other development awareness programmes – e.g. WATSAN, hygiene, health and safety, antenatal education.

Robust evidence of sustainable gains and value for money may help to convince health authorities at national level to fund the eye care approaches promoted by Sightsavers. This has not been achieved within the five year PHFPI period. Sightsavers should continue to produce evidence of the effectiveness, efficiency and impact of the programme but within a framework of clear and persistent advocacy and influencing strategies. Successful advocacy needs to be pursued in partnership and alliances with other actors concerned with the broad needs of the visually impaired and similarly disadvantaged people.

Exit strategies

Sustainability challenges need to be addressed within a set of exit strategies specific to the contexts of each country and building on the lessons of PHFPI across the sub region.

Disengagement plans were discussed between Sightsavers and its partners in April 2013 although not finalised until the final month of the programme. These should have been in place from the programme outset and addressed throughout the implementation period. Alliances and partnership may then have been made with a range of disability actors concerned with education, rehabilitation and forwarding the rights and needs of the poor and excluded.

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This would have enabled lobbying across the needs spectrum.

Attention to the ownership, governance and management of SZRECC would have enabled it to develop into a regional resource for experience exchange on eye care and policy as was intended. Even ROTP may not be sustainable; almost 50% of the 2013 trainee intake was PHFPI funded. The failure to address governance issues has impacted on funding and other supports to SZRECC sub regionally, such as visiting lecturers – with consequences for the future of the training school and teaching quality as numbers decline.

3.7 Replication and Scalability

The evaluation sought to assess how likely is the programme is to be scaled up or replicated by government health ministries and other actors.

The results achieved by the programme in a relatively short period of time have confirmed the replicability of the PHFPI supported model in providing eye care services. The model links high levels of community participation with PEC and district level cataract surgery services. The model works where sufficient finance is available for the upkeep of infrastructure, repairs and replacement of equipment and recurrent costs – salaries, consumable supplies etc. Government funding thus becomes the key issue: as eye health is never likely to compete with mortality-inducing disease more central to international frameworks and priorities.

In Senegal and Guinea Bissau PHFPI has supported eye service development in a limited number of districts. Government political mandates require them to provide adequate and balanced service levels to all citizens. Scale up is therefore an issue for the two governments, an additional burden on limited national budgets. The Guinea Bissau government especially is unlikely to identify funding to pilot additional services, even if it were possible to give eye health greater priority.

Although primary level eye care provision is already well established in The Gambia, sustained advocacy is still required to address the government expectation that eye care will continue to receive indefinite external support and to provide a policy framework for sustaining future service provision.

HReH requires commitment to and investment in training. Whilst the SZRECC regional training centre is able to provide relatively low cost training, it too has investment needs. Ongoing issues with respect to clear ownership and governance as well as an absence of business planning and marketing limits the financial investment sub regional governments are prepared to make. They are also a significant impediment to the sustained viability of ROTP as a respected and preferred sub regional training resource. The increased cost of sending trainees to alternative and more distant institutions in the region may be unaffordable, considering the volume of staff potentially requiring training.

At national level, it is important for replicability to continue to improve the

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integration of eye care into health services and in particular to facilitate the integration of eye care into pilot health insurance and performance-based financing initiatives.

Across the sub region the service delivery model has not been underpinned by robust impact data. Stronger outcome monitoring and documentation systems may have provided a body of evidence in support of the approach that could be used to influence the governments to fund the programme more generously or to encourage its replication by other agencies. Greater attention to cost effectiveness and value for money principles may also have advanced arguments for replication.

4 Summary Conclusions and Recommendations

4.1 Conclusions

The PHFPI programme responded to very real sub-regional needs for addressing avoidable blindness and the development of human resources for eye health. The training of eye health personnel and the establishment of secondary eye units supported by primary and community-level linkages are major achievements, especially given a slow start.

While considerable progress has been made in a relatively short space of time the services established are not yet mature. A lot remains to be done both to consolidate the gains to date and to further develop both services and demand before the overall programme purpose is achieved. In particular, the levels of trained staff achieved in eye facilities are at a minimum level; any staff attrition puts the future of these units at risk. The overall aim of PHFPI was ambitious within the short time frame, especially given the limited capacities of national eye health programmes and their multiple responsibilities. This aspect and other contextual challenges were not explicit in the theory of change, which would have benefited from taking more practical aspects of implementation into account.

The generic components and strategies in the design were relevant but the initial 'per district' targets did not take into account the different levels of development of existing services and human resources. It is therefore not surprising that, even after the 2012 ROM adjustments, the new targets were exceeded in Gambia with its long-established services and were not fully met in Guinea Bissau where longer staff training lead times meant that eye care services only began in later-phase districts in 2012/3. The phased approach clearly disadvantaged the later districts and it was unrealistic to have supposed that they would achieve the same level of results as those in the first phase.

The strategies adopted, of initial free eye camps in Guinea Bissau and regular outreach elsewhere combined with training of PHC and community level volunteers, were appropriate and successful for raising awareness of the availability of new eye care services and for reaching poor and marginalised communities. In Guinea Bissau, however, the continued use of free services has clearly set up unrealistic expectations rather than sustainable health-seeking behaviour change. Integrated strategies for exit and sustainability should ideally have been developed from the outset in order to avoid the targets overwhelming more strategic considerations.

Surgery service users were satisfied with the results of their treatment, but the systems and materials necessary for ensuring and developing service quality and surgery in particular, are not yet adequate. It is important that these are now improved: if not, there is a potential risk not only to programme gains but also to more general acceptance of this service provision model. This is one of several issues requiring more attention at national level and affected by national capacity constraints.

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Although the project succeeded at all levels in raising the profile of eye health services there remains more work to be done in consolidating and embedding eye health education messages and in establishing eye health promoting behaviour changes in the wider population. Eye care is at best only partially integrated into broad community health promotion and provisions. So activities at this level are now very likely to reduce. This may slow down or halt the gains achieved in the programme in accessibility and affordability to marginalised populations achieved during the project.

Greater emphasis on advocacy in the project design would have helped influence policy makers on the importance of supporting the integration of community level eye health into national health systems. Advocacy remains important as there is an ongoing need in the face of competition from other services to improve the integration of eye care into national crosscutting health information systems (HMIS, HR training and national pharmacy inventories).

If advocacy had resulted in SZRECC gaining the status of an international institution running internationally validated courses, this would have been not only a key advocacy success but also have provided an important platform for enabling more effective advocacy for prioritisation of and funding for eye care in the sub-region. This result area in PHFPI design is important for sustainability but the planning process did not establish a realistic route map of key steps and activities nor targets for what it would be realistic to achieve. Arguably if the current issues at SZRECC are not resolved, this may have repercussions for all three countries since for sustaining eye care services in the longer-term, an ongoing supply of trained cataract surgeons is needed.

Assessment of programme impact in the four result areas has been constrained by the lack of suitable indicators for establishing baselines and/or monitoring at outcome and overall goal level. Many of the indicators are very costly to monitor: realistic expectations for how far these would be addressed and evaluated within the life of the programme should have been explicitly agreed at the outset. The need for better tracking of outcomes and impact will continue after the end of the programme since the documentation of the longer-term results is important for evidencing future advocacy for eye care services.

The sustainability of the eye services established are somewhat open to question if there is no further support: in Gambia, a decline in the pre-existing services is already evident while in Guinea Bissau, it is unlikely that eye service activities will continue unless another donor is found. In Senegal, there was more partner optimism but the actual sustainability will depend on the RHT and DHT levels of conviction and the initiatives they take for offering services and for obtaining the national and regional technical supervision and support necessary.

Although the decentralised system in Senegal has proved the most effective for enabling community involvement in eye-related decision-making processes, the introduction of decentralised eye care services involved very close accompaniment and a strong investment in communications. Without

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these it is unlikely that the levels of practical results, and community engagement and ownership would have been achieved. It is clear that close accompaniment should have been present from the outset in Guinea Bissau, which has not only the most challenging working context in terms of political stability and poverty levels, but also a less well-resourced general health system and a different culture and language. This would have made it easier to develop wider engagement in the project at national and regional levels and been more cost-effective in the longer term.

Programme management of activities was generally efficient. However although Sightsavers made financial savings through centralised bulk purchase, this did not always translate into cost-effectiveness from the end-user perspective. These procurement issues form part of a larger dynamic of Sightsavers' provision of centralised expertise; while this benefitted the programme with access to higher levels of expertise, greater attention needs to be given to interfacing with the needs of local working contexts and contracting local expertise, especially where costly components such as construction are involved.

While the international collaboration dimension reflected the spirit of the previous HFPI, it seems to have been assumed that this dynamic would continue. In practice the sub-regional aspect was sidelined and it is clear with hindsight that there should have been more explicit reflection on its relevance and what the participating countries could best gain from it. This would have enabled the identification of the most useful activities and the allocation of an appropriate budget. Nevertheless, the sub-regional programme framework was important for facilitating training in the Gambia and the experience sharing meetings were useful even if too limited in number to establish an ongoing dynamic of collaboration. The failure to address SZRECC governance and management issues was a major shortcoming; one with potential to undermine the longer term sustainability of the national level eye health projects.

4.2 Recommendations

For post PHFPI in the sub region

1. Develop the disengagement strategies for all three countries into practical, supported exit plans to enable continuing development quality and sustainable eye services.
2. Support Guinea Bissau to consolidate its services and develop sustainable strategies for implementation.
3. Help resolve the SZRECC governance and status issues so it can become a strategic asset for the development of HREH in the sub-region and for advocacy to governments on eye health delivery.
4. Strategies should be developed in all three countries for ensuring adequate and systematic supervision and support for cataract surgeons and for continuing to develop the quality of the eye services provided.
5. Sightsavers should aim to provide some further limited support to Guinea Bissau to enable routine walk in services to be consolidated and sustainability strategies to be implemented.

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6. The experiences of the different projects should be followed and documented in detail over the next 3-5 years, including the context for success and in-depth analysis of the financial commitments required and made. This will provide further learning about what can be done to promote sustainability and to encourage replication. (This should ideally involve experience sharing workshops on an annual basis for three years.)
7. Across the sub-region, Sightsavers should consider occasional requests for support to key inputs that partners can show they have tried and failed to mobilise and without which the services will deteriorate (e.g. additional training, key piece of equipment).
8. If the SZRECC governance and status issues are resolved, this will be a strategic asset for the development of HREH in the sub-region that would merit further support with advocacy and marketing from Sightsavers if requested. If this does not happen Sightsavers should still continue to support development of human resources for eye health in the sub-region: this is a strategic initiative that needs following through.
9. The country disengagement strategies should be consolidated with some limited support provided by Sightsavers, working with other civil society actors to ensure effective policy environments and functioning national V2020 committees.

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General recommendations to Sightsavers

1. When developing further programmes, a strategic advisor should be tasked with challenging the design, promoting reflection and ensuring that important strategic, policy and advocacy issues are recognised and not overshadowed by the implementation imperative.
2. A review of Sightsavers centralised support systems to evaluate not only the efficiency but also the long-term cost effectiveness from different stakeholder perspectives should be undertaken together with how they can be more responsive to the needs of different local cultures and contexts.
3. Ensure monitoring systems and the capacity to support their implementation are in place before programmes start.
4. Provide continuity of technical and managerial support with associated systems that recognise the contexts in which programmes are implemented and ensuring full participation of partners and national staff when taking strategic decisions.
5. Lessons on coordination and coherence from the PHFPI and the earlier HFPI programme should be considered carefully in the future design and planning of cross country and regional programmes.

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[i] See final section of main report for full list of recommendations for the sub region and Sightsavers broadly.

[ii] See 2011 NECP evaluation – NECP staff passed over for appointment to Chief Nurse positions in RHT though of highest seniority, lack of inclusion in RHT decision-making bodies.

[iii] Reviews and evaluations of SZRECC as an entity made recommendations on these and several other issues. E.g. in Evaluation of Sightsavers' support to the National Eye Care Programme, Gambia, October 2011.

5 Annexes

Annex 1 Executive Summaries – Country Reports

The Gambia

EXECUTIVE SUMMARY

Programme Description: The Post Health for Peace Initiative (PHFPI) 2009-2013 is a three country project implemented in Senegal, Guinea Bissau and The Gambia; it followed on from the successful Health for Peace Initiative (HFPI) 2001-2006 initiated by the Heads of State of Senegal, Guinea Bissau, The Gambia and Guinea Conakry. The specific objective of the PHFPI is to establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in the intervention regions and thus contribute to the overall objective of contributing to poverty alleviation through the prevention of avoidable blindness. In The Gambia it has been implemented in all 8 regions of the country and importantly also aimed to strengthen the Sheikh Zayed Regional Eye Care Centre (SZRECC).

Purpose of Evaluation: The primary aim of this evaluation is to assess progress and impact of the project in The Gambia. Specifically, the evaluation sought to assess the implementation of project activities against final results with the aim of assessing the achievements, the processes affecting them, their sustainability, key lessons, the contribution to expected impact and the

Methodology and Analytic Strategy: The evaluation methodology comprised: agreement of the approach outlined in the inception report, document review and analysis, field visits to each of the three countries by members of the five person evaluation team, and analysis and triangulation of findings using a common framework. The field visits each included a technical review of a sample of eye units, interviews with national and regional health actors and partners, and focus groups with beneficiaries and community level stakeholders; this was complemented by a quantified survey of 250 service users exploring their experiences, attitudes and the impact on their lives.

Limitations: The 10 day allocation for field work was only sufficient for 2 of 8 regions to be being visited by the evaluators. Much eye health data was not collated or analysed, requiring considerable time investment by the evaluators to obtain and cross check basic data. Baselines and qualitative outcome monitoring systems were not in place.

Relevance: The PHFPI project is a relevant response to The Gambian population's need for accessible, good quality eye care services. In aiming to improve accessible eye care and referral services and to embed eye health care into Primary Health Care (PHC), the programme design is relevant to client needs. Gambia does not yet have a national eye health policy but PHFPI is broadly consistent with the Ministry of Health and Social Welfare (MOHSW) Health Master Plan 2007 to 2020 and coherent with V2020 targets reflecting the sub regional concerns of the West Africa Health Organisation (WAHO). Project design is generic and should have recognised the need to

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increase the capacity of regional health teams to coordinate, plan and embed eye health into local health services, better integrate eye care into planning processes as well as identify strategies to address SZRECC governance and management issues that impede international recognition and sub-regional financial participation. Failure to do this undermines sustainability prospects.

Effectiveness: Through strengthening infrastructures at SZRECC the programme has made a significant contribution to human resource development, in Gambia and across the sub region. Although an eye health Human Resource Development (HRD) strategy remains outstanding the project target of training and deploying six health cadres was met. Steady Community Ophthalmic Nurse (CON) and nyatero attrition if left unaddressed will undermine primary level preventive and referral services. The low number of ophthalmologists working in country is a concern although the programme met its target of training one ophthalmologist. The project met or exceeded its output targets and eye health services are accessible at all levels. Surgical outcome quality was not monitored and remains a persistent challenge, although patient satisfaction levels in the survey were consistent with an analysis of audit forms indicating 74% good outcome rate. Whilst high, this remains below the World Health Organisation (WHO) target of 85%.

Large numbers of teachers and community volunteers were trained as part of a strategy to increase screening levels in communities and schools. 61% of survey respondents indicated feeling more informed about eye health issues compared to 2009 although a broader range of communications strategies may have increased impact. School eye health promotion in particular requires more consistent input. Three secondary eye units were refurbished as well as major construction undertaken at SZRECC. Buildings were completed on time and to a good standard. Sustainability is undermined by the absence of a business plan and marketing strategy for the regional ophthalmic training programme (ROTP).

The programme was less effective in improving government ownership of eye health. Decentralisation has not happened and the programme did not invest in building capacity of regional health teams (RHTs). Regional planning processes do not include eye health, which remains largely a vertical programme. Sustained advocacy is needed with other sectoral actors to influence NEHP and the MOHSW to devolve authority to regional level and then formally embed eye care services into health care planning and budget setting.

Efficiency: Available resources were generally used to good effect. Overall, there was strong management and oversight of implementation, coordination of project activities and monitoring of progress towards outputs. Close financial monitoring by the finance manager ensured accountability and compliance with Sightsavers and EU regulations. Oversight towards achieving project outcomes and impacts was less satisfactory however. Narrative reports reflect the service delivery focus with little reporting on indicators set to assess progress made towards achieving outcomes. In general, the limited emphasis on monitoring, evaluation and learning challenges the ability of Sightsavers and NEHP to learn lessons, make informed management

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decisions and to document and measure change and impact.

The burn rate of expenditure against budget in The Gambia was consistently high. There is insufficient data to calculate unit costs and cost effectiveness – a deficiency that should be addressed in any future programmes. PHFPI did not address cost recovery issues and financial sustainability.

Coherence and Coordination: Although there is certainly need for greater integration, eye health is aligned with the health systems in The Gambia. The project is broadly consistent with the objectives of The Gambia health strategy although eye health indicators are yet to be articulated within the framework of a country eye health strategy. This has been planned since 2012 with WHO and NEHP but not yet completed. Programme coordination mechanisms put in place by Sightsavers have largely worked well. Stronger technical coordination and closer collaboration was possible at regional and local levels, within RHTs, secondary health centres and village health posts. However, this is still largely dependent on strong professional relations, as eye health care is not yet formally integrated into district annual health planning processes. Poor coordination evident between national coordinator and RHTs. Coordination with wider civil society, especially the disability movement was not evident. The sub regional aspirations of the programme were not addressed including SZRECC governance, opportunities for cross border engagement, and consolidating sub regional sharing and learning.

Impact: Output data and interviews with eye health and other health actors indicate that services are well established with over 60% coverage and that, although staffing levels remain challenging, a comprehensive range of eye health services are being provided, especially since collaborative work with One Sight begins to establish optical services at regional level.

Many of the impact indicators either lacked recent baseline data or require a specific population based survey for measuring change. Qualitatively, the project has clearly had impact on the lives of service users although The Gambian authorities have yet to address the structural issues limiting eye health services, including decentralization and policy initiatives. As there is no recent prevalence data it is not possible to comment on overall impact on prevalence although health system actors suggest that cataract backlogs have been cleared. The national cataract surgical rate (CSR) figure (including urban services) masks declining regional CSRs. While numbers presenting to project facilities has risen, the actual proportion of those receiving eye health care services is declining. Screening figures both for schools and communities are reducing. These trends require further exploration, but initially suggest that eye health services may be declining in rural Gambia, reinforcing a disputed 2008 RAAB portrayal of increasing blindness prevalence.

The new facilities at SZRECC enhance its potential to provide training to eye health students in The Gambia and across the sub region. With no resolution of outstanding SZRECC governance and management issues the facility is still not owned at sub regional level nor is it perceived to have maximised its potential value, especially sub-regionally.

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Focus groups and user survey suggest that the large majority of service users are happy with the skills and welcome of eye unit staff and satisfied with the outcomes of their surgery. The public perception is one of improving services and less hesitation to use them. The survey 'before and after surgery' line of questioning confirmed very noticeable improvements in quality of life and for many the ability to resume previous activities; for a minority this included improvements in their income level.

The Gambian government already funded many aspects of eye health service delivery, including salaries, drugs, basic utility and some fuel costs. However, there is no dedicated eye health budget, a key PHFPI indicator The programme did not develop influencing strategies aimed at embedding eye health care into overall health plans and budgets and it is recognised that progress would have been difficult given public finance constraints. Nor did the programme engage with empowering the RHTs.

Sustainability: Eye care services in The Gambia are well established and will continue beyond the life of the programme although they remain dependent on Sightsavers for human resource development, infrastructure development and supplies of some materials and equipment. Outreach activity remains essential to accessing hard-to-reach groups and maintaining surgery numbers as many people are not able to attend secondary health centres. Many medical professionals have expressed doubts about whether the cost of outreach services can be funded by the Government of The Gambia (GoTG) and further increases in fees will create barriers to access by poor people that over time may reduce demand and undermine the financial viability of the eye units.

The level of integration of eye care into health services is a determining factor for their sustainability. Decentralisation of decision making and devolution of funding to regional health teams has not yet taken place and represent a major challenge to integration. Although significant cooperation takes place regionally there is little to suggest that Sightsavers and NEHP forwarded the integration of eye care into national health plans and budgets nor proactively promoted policy development. Insufficient attention was given by Sightsavers and NEHP to developing, communicating and actioning a clear exit strategy including post-project sustainability and business planning during the final year of the programme. Without marketing and business plans in place the likely falls in student numbers from 2014 will significantly impact on SZRECC ROTP sustainability. Unaddressed, SZRECC governance and management significantly undermine ownership and sustainability across the sub region.

Replication and Scalability: The potential for the NEHP approach in The Gambia to improve service delivery at primary and secondary levels, positively impact on user confidence as well as increase the number of people accessing eye health at primary level has been proven. Although the model is effective, it is not underpinned by robust data on its impact. Stronger outcome monitoring and documentation systems are needed to provide a body of evidence in support of the approach. This could be used to influence the government to fund eye health initiatives more generously and to encourage replication by other agencies. Greater attention to cost effectiveness and

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value for money principles would support arguments for replication.

Implications of findings: PHFPI exceeded clinical targets and service delivery was well executed. This has been achieved at the expense of addressing some strategic challenges inhibiting impact and sustainability. It did not develop influencing strategies on a national eye care policy, strengthen regional health bodies in preparation for eventual devolution, lobby for integrating eye care into health care plans/budgets or engage with re-establishing the National Vision 2020 committee (V2020). Crucially, the project did not address SZRECC governance and management challenges, with potential consequences for overall sustainability in Gambia, Senegal and Guinea Bissau. Lessons include the value of having key fundamentals established at the outset of the programme: a monitoring, evaluation and learning (MEL) system that can track and document indicators of change; an memorandum of understanding (MOU) with government on exit strategies and respective role and responsibilities after the end of the programme funding period; and cost recovery and business plans that can deliver long-term financial sustainability

Key Recommendations

Exit strategies: a/ Ensure The Gambia PHFPI disengagement strategy is funded and actioned b/ Agree an MOU with MOHSW on the scale of support to be provided over time as part of a negotiated exit strategy from the country programme c/ A country exit should not be considered until a functioning V2020 committee and national eye care strategy are in place and until RHT capacities have been strengthened to fully engage with devolution d/ a country exit should not be considered until an MOU is agreed with GoTG articulating roles and responsibilities with respect to resolving SZRECC governance.

SZRECC: a/ Support SZRECC to develop and action a business plan and full marketing strategy b/ Support deficiencies identified in the training programme c/ Sightsavers with WAHO to urgently support and facilitate resolving the outstanding SZRECC governance issues. An MOU with GoTG should be agreed establishing actions and timeframes.

Assessment ratings by evaluators.

Relevance	Effective-ness	Efficiency	Coherence	Impact	Sustain-ability	Replication
GA	A	A	AR	AR	A	AR

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Guinea Bissau

EXECUTIVE SUMMARY

Programme Description: The Post Health for Peace Initiative (PHFPI) 2009-2013 is a three country project implemented in Senegal, Guinea Bissau and the Gambia; it followed on from the successful Health for Peace Initiative (HFPI) 2001-2006 initiated by the Heads of State of Guinea Bissau, the Gambia and Guinea Bissau. The specific objective of the PHFPI is to establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in the intervention regions and thus contribute to the overall objective of contributing to poverty alleviation through the prevention of avoidable blindness. In Guinea Bissau it has been implemented in 4 of the 11 regions of the country. The total budget was EUR 922,298.

Purpose of evaluation: The primary aim of this evaluation is to assess progress and impact of the project in Guinea Bissau. Specifically, the evaluation sought to assess the implementation of project activities against final results with the aim of assessing the achievements, the processes affecting them, their sustainability, key lessons, the contribution to expected impact and the contribution of multi-country collaboration.

Methodology and Analytic Strategy: The evaluation methodology comprised: agreement of the approach outlined in the inception report, document review and analysis, field visits to each of the three countries by members of the five person evaluation team, and analysis of the findings using a common framework reflected also in the three reports. The field visits each included a technical review of a sample of eye units, interviews with national and regional health actors and partners, and focus groups with beneficiaries and community level stakeholders; this was complemented by a quantified survey of 250 service users exploring their experiences, attitudes and the impact on their lives.

Limitations: The time allocated to fieldwork was insufficient, resulting in 2 of 4 project regions being visited by the evaluation team. Much eye health data was not collated or analysed, requiring a considerable time investment by the evaluators to obtain and cross check basic data with PNSV and Sightsavers. Outcome indicators did not have baselines and had not been monitored.

Relevance: There were clear unmet needs for eye care services in the Guinea Bissau intervention areas before the project began with a high level of blindness in adults aged 50+ and a much higher proportion suffering from avoidable causes than WHO estimates. All stakeholders agreed the project was highly relevant to eye care needs in the intervention areas.

The project design was appropriate for addressing eye care needs in the project areas and it remains relevant to ongoing needs. However, there were some weaknesses in the generic project design that did not take account of the specificities of the Guinea Bissau context. In particular, the phased approach, starting in one region each year, combined with the longer lead time for staff training, meant that the human resources necessary for

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delivering the eye care service delivery targets were not in place in time to introduce service delivery until much later on in the project.

Effectiveness: Given its low starting point, human resource training needs and political context good progress was achieved by the end of the project period in achieving training and infrastructure targets. In meeting some of its service delivery targets however the project was required to adopt strategies unsuitable to establishing sustainable health seeking behaviour patterns amongst the population.

Outreach campaigns have made eye care accessible to remote rural regions: awareness and acceptance of eye care services increased considerably. At national level, there is greater recognition of the importance of eye care within the Ministry of Health. However, there has been little evolution in the planning and coordination of eye care; it remains centrally controlled with limited involvement by regional health teams. Although eye care services have been established in the four regions, they are new and fragile; comprehensive eye care service provision, including refractive error and low vision services, are not yet available in response to need. Clinical targets of the project, excepting Vitamin A distribution were not achieved.

The Guinea Bissau training targets however for eye health and non-eye health cadres were met and/or exceeded and those trained are capable of meeting most common eye care needs and promoting community eye health. A system of routine supervision and refresher training to consolidate and further develop skills is being taken forward.

Infrastructure targets for refurbishing and constructing 6 eye units were met. Some design issues were addressed after the MTR but shortcomings to design and construction quality remain. Targets for equipping the eye units were met; eye care equipment is aligned to IAPB guidelines and found to be adequate in type/quantity, in working order and good condition.

The referrals of patients between different levels of the health service are not routinely tracked and the numbers of 'walk-in' patients presenting at eye units not recorded systematically by the HMIS nor by eye unit staff. However, it is evident that the outreach strategy has raised awareness of eye health services and community attitudes are beginning to change: there is less fear of eye treatment and more willingness to seek treatment.

The project has been less successful in building organisational capacity. Regional health teams (RHTs) were involved in initial project design and welcomed the project but were not included by PNSV in routine planning and management of project activities. The PNSV focused its coordination efforts on eye health staff with little direct contact with the RHTs, who do not have a sense of ownership. The only capacity-building support for RHTs took the form of transport logistics.

Efficiency: Effective programme management is essential for making best use of project resources, mitigating risks and ensuring that opportunities and challenges are closely monitored and acted on. Overall, there was a good

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level of oversight of project activities but less attention was paid to the volume of service delivery outputs, the nature and volume of the outcome indicators and to addressing strategic issues in Guinea Bissau, such as that of integration of eye care within the overall health system.

The project's level of financial transparency and accountability was a considerable achievement. The procurement of capital items and consumables was relatively efficient, but was not integrated into national systems. This creates a challenge in terms of sustainability, particularly in respect of medicines and consumables. The financial management system ensured centralised control and minimised potential risks to Sightsavers but created some inefficiencies and missed opportunities in project implementation. There was insufficient data to calculate unit costs and evidence on cost effectiveness is anecdotal. A senior Ministry of Health (M0H) source said that this is considered among the ministry's most cost-effective projects but without good data, it is difficult to demonstrate that the project is cost effective.

Coordination and Coherence: Eye health is aligned with the health systems in Guinea Bissau and the programme is consistent with the objectives of the guinea Bissau health strategy. In common with other vertical programmes in Guinea Bissau, eye health operates largely as a vertical service with centralised decision-making and resource flows and is not well integrated into general health management systems. Sightsavers does not appear to have pursued opportunities to collaborate with broader civil society on PHFPI, especially disabled persons organisations (DPOs). This could have added significant value to the programme, through more inclusive planning and review mechanisms and in forwarding influencing agendas.

Impact: Despite the lack of robust baseline and monitoring data, the programme achieved some significant gains. Cataract surgery rates (CSR) increased after a strategy of successive outreach campaigns was adopted. Key outcome indicators have not been tracked by the project however. Although a national CSR of 916 achieved in 2013 is up substantially from 111 in 2009, it remains below the WHO target of 2000. Cataract surgeons trained in The Gambia received training in the use of the monitoring tool but despite this the cataract outcome monitoring tool is not being used to monitor the quality of surgical outcomes. It was not therefore possible to assess whether the RAAB good outcome figure of 25.2% has improved.

There is some evidence that the programme is reducing cultural reticence to seeking eye health treatment. The sensitisation programmes, plus positive outcomes of surgical interventions, is making a difference to attitudes. Both survey results and focus group discussion (FGDs) evidence the significant impact of restoration of sight on the quality of life of eye health service users, confirming changes to quality of vision, confidence and self-esteem. Cataract patients in the FGDs spoke of greater independence and reduced sense of burden, ability to assist with domestic duties, look after children and care for themselves.

The programme has been less successful in developing influencing strategies

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aimed at integrating eye health care into overall health plans and budgets. Overall there is little evidence of a sustained influencing strategy being pursued at country level by Sightsavers acting alone or in conjunction with wider civil society. Progress was hampered by the fact that until 2012 there was no permanent presence in country to promote the Sightsavers brand or to strategically network.

Inter-country collaboration was not mentioned spontaneously by stakeholders in Guinea Bissau as a benefit or as a perceived weakness. When probed, it was evident that more opportunities to meet and visit might have been useful, but stakeholders were primarily concerned with their own programme. The working context, administrative culture and stage of development of eye health services in Guinea Bissau means that models and policies are not always transferable.

Sustainability: Although outreach to poor and hard-to-reach groups had a significant impact on surgery numbers in Guinea Bissau in 2013, it is not a sustainable approach and also prevented the establishment of continuous service provision from the eye units for walk-in patients.

An integrated supply system to regional eye units and pharmacies needs establishing. At national level, funders need to liaise with government on integrating eye health into health plans and budget lines. This work should be underpinned by improved information systems capable of providing evidence that the eye care approaches developed under PHFPI deliver sustainable gains as well as value for money.

Without further external finance, it is unclear how eye care services will be funded with little evidence that introducing cost recovery will generate sufficient funding to cover outreach or medical consumable costs. Sustainability therefore presents a major challenge. The view of the evaluation team is that the withdrawal of Sightsavers funding at this stage could significantly undermine progress made to date and that it should consider a financial contribution to support basic inputs for a further two-to-three year period.

Currently there is no overarching exit strategy in place for the sub regional programme although a Guinea Bissau disengagement strategy was developed in May 2013 and finalised in September 2013. It is unclear whether this has been widely shared or is being actioned.

Replication and Scalability: The model of using eye health system professionals in coordination with primary and community level health professionals and community-level actors and volunteers reflects similar approaches adopted by other vertical programmes in Guinea Bissau. The MoH would like to replicate this programme in other districts and ministry planners are hoping to find other potential partner or donor organisations.

While the general model is valid, the way in which it is replicated in Guinea Bissau will need to be informed by what happens after the withdrawal of PHFPI. In particular, eye health services should be integrated into the RHTs

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by giving these teams some planning and management responsibilities for the eye units. Outreach activities and a new system of procurement needs establishing as the current system is not scalable given PNSV capacity.

Implication of Findings: PHFPI faced greater challenges in Guinea Bissau than in Senegal or The Gambia. At the outset, there were limited eye care services in only one part of the intervention area, a lack of suitable people to be trained, poor communications infrastructure and, during the project itself, periods of political insecurity. Given this context and the time taken to get trained eye health staff in place, excellent progress was achieved during the final year: five (soon to be six) eye units now exist in the four northern regions and the profile of eye health has been raised throughout the health system.

The challenge is to build on this investment and sustain gains achieved. Eye units have relied on intensive outreach campaigns to reach the population and, in so doing, have not established routine walk-in services. Without further external funding to consolidate eye care services there is a risk that they will cease to function. Given Guinea Bissau's challenging context and limited eye health resources compared with the other two countries, a longer funding period was clearly indicated from the outset.

Any further period of funding needs to address both structural and information deficits and consolidate the quantity and quality of progress achieved so far.

Assessment ratings by evaluators.

Relevance	Effective-ness	Efficiency	Coherence	Impact	Sustain-ability	Replication
GA	A	A	AR	R	R	R

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Senegal

EXECUTIVE SUMMARY

Programme Description The Post Health for Peace Initiative (PHFPI) 2009-2013 is a three country project implemented in Senegal, Guinea Bissau and the Gambia, funded by the European Union and Sightsavers with a budget of EUR 1,905,958 for Senegal. It followed on from the successful Health for Peace Initiative 2001-2006 initiated by the Heads of State of Guinea Conakry, Guinea Bissau, the Gambia and Senegal and covering 4 different disease areas. The specific objective of the PHFPI is to establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in the intervention regions and thus contribute to the overall objective of contributing to poverty alleviation through the prevention of avoidable blindness. In Senegal it has been implemented in 10 health districts in border areas, spread across five different health regions.

Purpose of the evaluation The primary aim of this evaluation is to assess the progress and impact of the project in Senegal. Specifically, the evaluation has sought to assess the implementation of project activities against final results with the aim of assessing the achievements, the processes affecting them, their sustainability key lessons learnt, the contribution to expected impact and the added value of multi-country collaboration.

Methodology and Analytic Strategy The evaluation methodology comprised: agreement of the approach outlined in the inception report, document review and analysis, field visits to each of the three countries by a subset of the five person evaluation team, and analysis of the findings using a common framework reflected also in the three separate reports. The field visits each included a technical review of a sample of eye units, interviews with national and regional health actors and partners, and focus groups with beneficiaries and community stakeholders; this was complemented by a small quantified survey of service users exploring their experiences, attitudes and the impact on their lives.

Relevance The Post HPFI project is well aligned with national policy and the vision for eye health reflected in the recent renaming of the National Programme for the Promotion of Eye Health (PNPSO) and with the broader strategic directions of the health system as a whole. Senegal national policy is fully aligned with the international Vision 2020 framework adhered to by the West Africa Health Organisation (WAHO).

The project responded to a very high need of the population with an estimated overall blindness prevalence of 1.4% blindness; this was later confirmed to be 7.5% in people aged over 50 years of which 93% is avoidable. At the outset, eye care services were only available from two Regional Hospitals and were insufficient for the 3.1 million regional population, and inaccessible to rural populations. Many people either went blind without seeking treatment or

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consulted traditional practitioners or went to the Gambia. Surveys confirmed a high level of avoidable blindness with cataract as the leading cause.

Sightsavers Senegal team ensured that the generic project design was very well adapted to their working context. The adjustments that were made included a very strong emphasis on communications, resourcing the training of community volunteers (relais) and taking account of decentralisation and advocacy opportunities; these changes were recognised to have been key to the success of the project.. The emphasis on primary and community level activities and the involvement of a wide range of community stakeholders in project activities and monitoring ensured a highly relevant response to the eye health needs in the intervention districts.

Effectiveness The project met or exceeded nearly all its output targets in Senegal and, as a result, eye care services are accessible and available at both 10 new district level eye units and from 238 primary Health Posts for communities that previously had very little access. The presence of 10 functioning district eye units with trained eye health staff and a good range of basic eye equipment for OPD consultations and surgeries is recognised as a major achievement, although there are minimum levels of trained staff. The infrastructure is functional but not all is purpose-built or ideal owing to construction issues encountered. The equipment is adequate and well maintained due to the emphasis on maintenance and the training of district-level instrument technicians; however despite this, some items are showing signs of wear before they should.

The training in eye health and primary eye care has been a particular strength and has included not just eye health staff - 10 cataract surgeons and 238 health post nurses, but also 1,414 people from all levels of the health system from regional and district management teams to primary and community levels. . Eye care activities are integrated into the decentralised regional and district planning and management systems. The linkages and referrals between the community, primary and secondary levels have been working well with a pattern of regular outreach visits by the cataract surgeons. This has been evident in the increase in routine cataract and trichiasis surgeries undertaken, particularly by the first phase of districts that have had time to become established; the later districts have been disadvantaged by a much shorter period of project support.

Eye care has also become much more affordable not only through the proximity of services, reducing transport and accommodation costs but also through the inclusion of eye care medicines and cataract kits, in the National standard list of essential medicines. In parallel with the development of the eye service offer, the demand for eye health services has been increased through the strategies of outreach visits, linkages with community-level volunteers for awareness-raising and extensive communications work with community leaders. Given the coverage of primary facilities it is considered that the eye care services are now accessible and affordable to well over 60% of the population in the project districts.

The visibility of eye health and the relevance of secondary and primary eye

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care services have increased markedly from community up to national level but this is unlikely to translate into increased priority for eye care in relation to other programmes

While good progress has been made during the project, more work is now needed for consolidating progress to date, and further developing the provision of comprehensive and quality eye services. There are currently few refractive error and no low vision services, more trained eye health staff are needed together with a focus on eye health education, rather than awareness-raising. There is a clear need to continue improving the quality of services: the documenting of surgical outcomes and the supervision of the cataract surgeons were found to be inadequate.

Efficiency The available resources were generally used to great effect. After the initial slow project set-up, overall there was excellent management and oversight of implementation, coordination of related project activities and monitoring of progress towards outputs; this was achieved by the Sightsavers team working closely with regional and district partners and PNPSO. Close financial monitoring by the PHFPI Finance Manager ensured accountability and compliance with Sightsavers and EU systems and formats. However, higher level strategic oversight of progress towards achieving project outcomes and impact and of some technical aspects was less satisfactory. The construction, equipment procurement and outcome indicator establishment processes presented some challenges and would benefit from improvement.

The health centres charge for consultations and cataract surgery; the fees cover costs but no routine calculations of cost-effectiveness or net profits are made. District Health Committees pay for running costs and have made some extra contributions but there has been little or no mobilisation of other external resources.

Coordination / coherence Communications, coordination and stakeholder participation have been a key strength of project implementation in Senegal. The decentralised RHTs reported good coordination with PNPSO and with Sightsavers and excellent collaboration was built between PNPSO and Sightsavers who facilitated communications at levels. Within the decentralised regions, there were good management and communications between RHTs and DHTs but the coordination between regional and district eye care staff in the districts visited was not so satisfactory where supervision and referrals are concerned. There was close coordination between Sightsavers programmes and finance personnel.

At national level, the PNPSO has a clear vision for the directions of eye care but has capacity constraints where the coordination with other MoH services for the integration of eye care into the health system is concerned. This also affects coordination with external agencies: more collaboration needs developing at national level. More staffing is required for PNPSO if it is to fulfil both national coordination role and its support and technical supervision role

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at regional and district levels. At regional level, high profile Vision 2020 committees were recently formed to promote the coordination of eye care activities amongst a wide range of government and community stakeholders but their effectiveness is not yet evident.

Impact Many of the impact indicators either lacked baseline data or require a specific population based survey for measuring change. Qualitatively, the project has clearly had considerable impact for the health system and in the lives of service users.

Although there is no recent prevalence data, health system commentators said that the surgery numbers indicate a reduction in blindness levels. With the project only intervening in some but not all districts of each Region, the regional cataract surgical rates do not directly reflect project surgeries; they show fluctuating CSRs and recent increases in two regions where previously there were no services.

Regional and district authority staff now realise the value and feasibility of offering district and primary level eye care services supported by linkages at community level. Health centre managers commented that the eye services have also contributed to increased patient flow for other services in the health centre. Both health staff and community representatives have clearly understood the link between blindness and poverty and the benefits of sight restoration; the communications messages and inclusion of journalists in the eye health training played a key role in this.

The large majority of service users were happy with the skills and welcome of the eye unit staff and satisfied with the outcomes of their surgery. The survey 'before and after surgery' line of questioning confirmed very noticeable improvements in their quality of life, with no difficulties doing their usual work or outside activities and for many the ability to resume previous activities; for a minority this specifically included improvements in their income level.

The multi-country structure of the project provided an invaluable framework for facilitating the training of government personnel at SZRECC in the Gambia but with no resolution of the SZRECC governance or management issues, was not perceived to have had other benefits at national level. The two experience sharing meetings were of more interest and use to regional and district level staff; they were stimulating but isolated and not complemented by other visits exchanges or jointly planned activities.

Sustainability The level of integration of eye care into health services is a determining factor for their sustainability. In Senegal, eye care is now well integrated into the decentralised planning and management structures at regional and district levels and into staff supervision mechanisms at district level. At national level, a notable success has been the integration of eye care consumables and medicines into the National standard list of Essential Medicines; there are other national-level integration gaps that still need attention, most notably the HMIS where eye care is absent in primary level indicators and not adequately take into account at secondary and tertiary levels.

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Regional and district health system stakeholders showed a strong sense of ownership, in their management of the eye services: instigating reviews, allocating support personnel and organising repairs. ,They clearly wish to maintain the eye services, but there are a number of challenges that will need to be overcome, spread across district, regional and national levels. With the end of the intensive communications and community awareness-raising, the visibility of eye care will now reduce, especially in districts where the eye units began in 2011/2 and have not had time to consolidate routine services. The maintenance of national and regional support and improved supervision of the cataract surgeons will be vital for ensuring the continued smooth functioning of the eye units: this currently represents a potential risk for the eye care programme as a whole.

Replicability/Scalability The scale of results achieved by the project in a relatively short time has confirmed the replicability of this approach: regional stakeholders now want to ensure that eye care services are accessible in all districts. However replication initiatives will face ~~the~~ a number of challenges, including understanding the extent to which the eye units are covering demands from neighbouring districts and, not least, finding external funding for essential components that the Government of Senegal is very unlikely to fund. It will be important for replicability to increase levels of collaboration at national level and to continue improving the integration of eye care into health services, and into new health insurance and financing initiatives.

Implications of the Findings/Conclusions A remarkable amount has been achieved in a short space of time; the national picture for eye care provision has changed. However, the achievements are vulnerable and sustainability remains uncertain. While the decentralised regions and districts can do much to maintain the services, this still requires ongoing efforts for maintaining the integration of eye care into national systems and improved technical supervision and coordination by regional and national levels. All districts, particularly those in the later phase, are likely to require some external resource mobilisation. There is a clear need for some support, monitoring and learning from progress to be continued.

Recommendations: In addition to more detailed suggestions contained in the text, the evaluation identifies the following key recommendations:

1. Develop and implement a strategy for improving the quality of services offered at district level eye units, in particular the supervision arrangements This is important for protecting ~~the~~ and consolidating the progress achieved. (Sightsavers & PNPSO)

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2. For offering quality services, plans should be developed for providing biometry equipment for cataract surgery and the associated range of IOLs needed.

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3. Use the opportunity of the new trachoma project for consolidating the gains made by PHFPI in districts covered by both projects. This will require a clear communications strategy. (MoH)

4. Follow up and strengthen the integration of eye health into the national health system, with particular emphasis on the inclusion of eye care data collection in the HMIS. (PNPSO Direction Nationale de la santé)

5. Undertake a detailed assessment of how current initiatives developing health insurance coverage and results-based financing are being designed and implemented with a view to optimising the integration and provision of eye care services at secondary, primary and community levels (MoH).

6. Document project implementation as an example of good practice and eye unit case studies setting out in detail how the eye unit was set up, how the services and the demand developed and, most importantly resource mobilisation strategies and the costs involved. This is important for replication and will require monitoring of lessons learnt from the eye units for 2-3 years (PNPSO, Sightsavers).

7. Learn from effects of the phased approach in this project and in any future such multi-location projects should look to phase the activities across all locations at once in order to avoid disadvantaging the later locations, starting with the training of human resources.

8. The effectiveness of accessing expertise and services from Sightsavers UK office should be reviewed with a view to improving their efficiency and responsiveness to programme working environments. Specifically, the needs for different areas of technical expertise at programme level should be routinely assessed and all key programme and financial documents and technical glossaries should be provided in the relevant languages. *(Sightsavers Management)*

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Assessment ratings by evaluators

Relevance	Effective-ness	Efficiency	Coherence	Impact	Sustain-ability	Replication
G	GA	GA	GA	GA	A	GA

Annex 2 Terms of Reference

Impact Assessment of the programme:

Reducing poverty through improved eye health in the "Health for Peace Initiative" in the Gambia, Senegal and Guinea Bissau

Background

The Post Health for Peace Initiative (PHFPI): 'reducing poverty through improved eye health' was set up with the support of the European Commission and Sightsavers in 2009. The PHFPI is a five-year programme designed to facilitate the implementation of good quality eye care services and also promote eye health in The Gambia, Guinea Bissau and Senegal.

In 2001, the heads of states of The Gambia, Guinea Bissau, Guinea, and Senegal, to foster peace in a politically volatile region, recognizing the common health problems affecting their populations and knowing that disease has no boundaries, agreed to start The Health for Peace Initiative. Each member country led the coordination of a particular disease area: Senegal coordinated STDs and AIDS; Guinea-Bissau, Immunization; Guinea, Epidemics and emergency situations; The Gambia, Malaria and Prevention of Blindness.

In 2009, the Gambia, Senegal and Guinea Bissau, in partnership with Sightsavers, launched this innovative project aiming at strengthening their health care delivery system and particularly the fight against blindness under the "Health for Peace Initiative". This holistic programme is one of several components of the overall fight against poverty by improving the lives and social wellbeing of those who are visual impaired, particularly in the porous neighbouring border countries where long-term conflicts still exist.

The PHFPI has received funding of Euros 6,041,392 (£5,135,183) from which the European Commission provided 4,000,000 Euros representing 66.21%, and Sightsavers provided 2,041,392, the remaining 33.79% of the budget to be implemented from 2009 to 2013.

The main stakeholders were the National Eye Care Programmes, Ministries of Health, Regional and District Health Partners and Helen Keller International in the three countries.

The overall objective of the programme was to contribute to poverty eradication through the prevention of avoidable blindness in Senegal, The Gambia and Guinea-Bissau by the end of 5 years.

The specific objective was to establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in intervention regions in Senegal, The Gambia and Guinea-Bissau by the end of 5 years (December 2013).

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The project implementation was based around three major components linked to capacity building through training, infrastructure building for establishment of comprehensive eye care for service delivery, and partnership building for adequate coordination.

Purpose of the Impact Assessment

This study will assess the long-term change, outcomes and impact of this programme in the 3 countries in which Sightsavers has been engaged in supporting implementation, i.e. Senegal, The Gambia and Guinea-Bissau. The assessment will be based around 2 main parts.

1. To assess the degree to which the programme has contributed to the expected impact (Programme Overall Objective) and outcome (Programme Specific Objective) in the programme log frame
2. To assess the contribution and impact of multi-country collaboration to the objectives of the post-HFPI programme.

Findings and conclusions from the assessment will be shared with stakeholders involved in this project development, assessment and phasing-out: Sightsavers headquarters in UK, government of Senegal, Guinea Bissau and the Gambia, PDAs, Helen Keller international and West Africa regional office.

Specific Objectives of the Impact Assessment

The selected consultant/team will work closely with Sightsavers staff to develop further details of the design and methodology. It is anticipated that Sightsavers staff may carry out some of the data collection for example it is still to be decided if a RAAB[iv] will be carried out. However, it is expected that the consultant/s will be responsible for collating all data and writing and producing the draft and final reports. The objectives below are therefore to some degree indicative and subject to further discussion with the successful candidate.

Objective 1. To assess the degree to which the programme has contributed to the expected impact (Programme Overall Objective) and outcome (Programme Specific Objective) in the programme log frame.

a. Report on indicators at the impact (Overall Objective) and outcome (Specific Objective) level of the programme log frame
b. To identify key pathways in the underlying theory of change as understood by key stakeholders, and explore and assess the extent to which programme outcomes support this theory.

a) Log frame indicators

Impact level objective: to contribute to poverty eradication through the prevention of avoidable blindness in Senegal, The Gambia and Guinea-Bissau by the end of 5 years

Log frame impact indicators include:

- Cataract surgical rate (CSR)

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- Prevalence of blindness
- Quality of life
- Percentage referrals from traditional practioners/healers

In some cases baselines for these may already exist, for example RAABs have been carried out in Senegal and Guinea Bissau. In other cases, the baseline situation and data will need to be established retrospectively, either from primary data collection (e.g. quality of life) or secondary data collection (e.g. cataract surgical rate). The suggested data sources for these indicators will be discussed with the consultant/team at the outset of the assessment in order to establish what the scope and best approach to data collection should be.

Outcome level objective: To establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in intervention regions in Senegal, The Gambia and Guinea-Bissau

Log frame outcome indicators include:

- Cataract Surgical coverage
- Percentage of patients seen classified as having positive cataract surgical outcomes
- Number of cataract surgeries with IOL
- Percentage of facilities experiencing stock outs of essential medicines and equipment
- Number of patients presenting at project facilities receiving eye health care services
- Percentage of committed expenditure on eye care met

b) Underlying theory of change: In order to assess how and why change has or hasn't occurred in the area of the programme objectives, a mapping of key pathways in the theory of change underpinning the intervention logic outlined in the programme log frame should be carried out. It is envisaged that this would be done through project documentation review supplemented by key informant interviews, and where necessary a series of short participatory workshops in with implementing partners, and any other key stakeholders in each of the programme countries. However, it is recognized that in the time available this may need to be a broad, shallow approach to retrospective theory of change. Nevertheless, it is anticipated that an assessment of the theory of change will also allow this evaluation to report in a more qualitative and explanatory way on the extent to which achievements in capacity and infrastructure building within the programme have contributed to the establishment of comprehensive, good-quality eye care services.

Objective 2. To assess the contribution and impact of multi-country collaboration to the objectives of the post-HFPI programme

The post-HFPI programme is based on the recognition of the commonality of health problems facing the neighbouring countries and aims to support peaceful relations between countries in the region, and has aimed to foster cross-border joint activities, and the sharing of experience, expertise and

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systems.

Therefore the second area of the impact assessment will evaluate the degree to which effective collaboration has occurred in regard to eye health during the post-HPFI programme of 2009-2013. The assessment will consider the degree to which experience gained from the Gambia eye care programme has been transferred to Guinean and Senegalese counterparts, particularly the community participatory approach to services and the use of "Nyateros" and "Relais". It will also investigate the extent to which a unified intervention has been implemented and has contributed to tackling cross-border eye health issues, and the influence and lasting value of this cross-national collaboration between the 3 countries. This assessment should include, but not be limited to, the following questions:

- What evidence is there of partnership building through the 2009-2013 programme of work?
- What has worked well and what have been the challenges within the collaborative process, governance arrangements and any joint delivery mechanisms?
- What has been the additional value of collaboration within the programme in comparison to what would have been achieved under individual country programmes?
- Has there been a discernible change in policies and practice as a result of the joint programme?

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Review Team

The team's lead evaluator will have as minimum the following core competencies – public health specialist, possess projects/programme analysis, comprehensive understanding of public health policy (national and global) and demonstrate knowledge of Health Systems Strengthening. S/he should have extensive experience in conducting large scale evaluations. The evaluation team should include personnel with professional background and experience in public health, preferably eye health, health systems strengthening. Prior experience in the West African region is helpful. Prior impact assessment experience would also be desirable. The consultant/team must possess excellent spoken French and English and excellent written English skills.

The selected consultant/team will work in collaboration with key Sightsavers staff. Sightsavers Evidence and Research team and Country Office teams will design and manage the RAAB surveys, where these are planned. Sightsavers will also design any Quality of Life surveys in conjunction with the consultants but it is likely that the selected team will recruit, manage and coordinate survey staff and carry out data analysis. Other areas of data collection will be lead by the consultant/team with input from Sightsavers staff. The exact scope of work will be finalised in discussion with the successful applicant.

Proposed Methodology

The assessment should review all aspects of the current programme in Senegal, the Gambia and Guinea Bissau.

The team should detail their approach and methodologies to be used to indicate how they will fulfil the requirements of the ToR in their Expression of Interest application. These may include qualitative and quantitative tools as appropriate to conduct this evaluation.

The consultant/team is responsible for developing the impact assessment methodology, in consultation with Sightsavers, in order to address the key impact assessment questions. The consultant/team will define an appropriate sample size for those areas of data collection, which they are leading on, and specify to what mechanisms will be adopted to avoid selection bias. The impact assessment should meet the principles of participation involving both male and female beneficiaries.

As a minimum, the impact assessment should include the following key steps:

- Review relevant reference material, as listed in Section Five below.
- *Development and application of appropriate data collection tools (e.g. questionnaire schedules and tools, interview checklists and focus group templates) for interviews and discussions with stakeholders*
- *Visit to districts in Senegal, The Gambia and Guinea Bissau.*
- *Interviews/focus groups/workshops with project implementers, partners, donors, other relevant actors in the sector and service recipients/beneficiaries. The assessment should seek a representative sample of service recipients from relevant groups.*
- *A debriefing session for partners and stakeholders at the end of the field work period.*
- *Analysis and report writing.*

Reference Material

Various sources of information will be made available to the consultant/team. These will include relevant project documents such as:

- Project document
- Quarterly and annual reports (Narrative and financial),
- Publications,
- Survey data,
- Reports of meetings with partners,
- Workshops and training programme reports ,
- Training materials,
- Minutes of meetings of the Programme Management Unit (PMU),
- Mid-term Report and ROM reports
- Audit report
- MOUs
- M&E plan

Timeframes

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Duration of ACTIVITY

The duration of the assignment will be approximately 3.5 months from December 2013 – 30th March 2014. Planning and literature review is envisaged in December and early January. Field work must be carried out in January and February and report writing in March to submit a final report by 30th March 2014.

Maximum number of days inputs by evaluator/evaluation team

As the exact scope of work will be decided once the candidate has been selected. However, indicative days to be worked on this evaluation are as follows:

Phase I - Desk study and Inception Report production: Review of documentation and elaboration of field study [up to 7 days]

The evaluator/s will review relevant documentation from section 5 above (Reference material). Based on this review, they will produce an inception report which will include an elaborated plan, methodology and sampling strategy of the data collection for this study. A standardised methodology will be developed which will be applied consistently in each of the programme countries. The evaluation will only proceed to the next stage upon approval of this inception report. An appropriate inception report format will be made available to the team as part of this TOR.

Phase II: Field Data Collection [25 days]

This phase of the evaluation will seek to collect data in the 3 programme countries on the key assessment questions explained under scope of work and issues to be covered. The evaluator/s will use the agreed plan, methodology and sampling strategy from phase 1 to conduct the field work.

Phase III – Data analysis and production of evaluation report [10 days]

The team will draw out key issues in relation to assessment questions and produce a comprehensive report. This analysis should draw on the wider issues in the development sector.

Outputs/ Deliverables

Inception report

The inception report should be available to Sightsavers by 16th Dec (TBC). Feedback will be provided within seven days following acknowledged receipt of inception report. The report should describe the conceptual framework the evaluator will use in undertaking the impact assessment and should contain the study methodology, quantitative and qualitative data collection method and instruments, the assessment questions, sampling methodology, work plan etc. The report should reflect the team's review of literature and the gaps that the field work will fill.

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Field work will only commence once this report has been reviewed and agreed with the designated representatives (consortium) of the Stakeholders.

Draft Report

A draft report should be submitted to Sightsavers within five working days after completion of the field activities. The draft report will be presented internally during a debriefing session and will be circulated for comment to all stakeholders and appropriate Sightsavers staff. Sightsavers will provide feedback on the draft version to the evaluation team within 3 weeks after acknowledged receipt of the draft report.

Final Report

The Final Report will be submitted to Sightsavers within 5 working days after receiving the feedback from Sightsavers on the draft report. The final report should be a detailed report of not more than 40 pages (excluding annexes), written in English and translated into French.

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 the original transcribed qualitative data gathered during the exercise. These data sets should be provided at the time of submission of the final report.

Summary findings

On submission of the final report, the 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.

Reporting Format

Detailed guidelines on how to structure the evaluation report will be provided to the evaluation team prior to commencement of the activity, and reporting templates will be provided which the team should use for the Inception Report and the Evaluation Report.

Please note that penalties up to 10% of agreed fees will be imposed for noncompliance with the requirements 7.1 to 7.4 and reporting format provided.

Administrative/Logistical support

Please include the following generic statements, unless there is a special arrangement due to the nature of the evaluation, partnerships involved etc.

Budget

The consultant should submit to Sightsavers an Expression of Interest

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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 (bed, breakfast and even meals taken at the place of accommodation)
- Stationery and supplies
- Meeting venue hire and associated equipment e.g. projectors

Sightsavers usually cover the above costs, unless otherwise stated.

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

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%

MODE OF PAYMENT

As agreed by Sightsavers and the consultant.

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Annex 3 Documents consulted

PHFPI Evaluation: List of Documents Reviewed

- EU Project document 2009
- EU log frame and revised 2012 log frame
- EU Interim Narrative Reports 2019-12
- Sightsavers Annual project reports 2009-12
- Sightsavers Financial Report 2009-13
- PHFPI Mid Term Review report 2011
- Sightsavers management response to MTR 2011
- NECP Final Evaluation 2011
- Sightsavers management response to NECP evaluation 2011
- ROM Reports 2012
- Sightsavers ROM management response 2012
- RAAB 2010 Senegal and Guinea Bissau
- RAAB 2008 The Gambia
- MOU 2009 Sightsavers and GoTG
- Sightsavers Quality of Life Appendix
- PHFPI country disengagement strategies 2013
- PHFPI output statistics against targets 2009-13
- Report of 2013 experience sharing meeting
- WARO west Africa country strategy paper 2010
- Recommendations of WARO meeting 2013 on SZRECC issues
- HR for Health: Country Profiles Guinea Bissau and The Gambia – GHWA 2010
- Sightsavers: HReH in West Africa: Ronnie Graham 2008
- Gambia: health is wealth policy framework 2007-20
- Gambia: MoH strategic plan 2010-14
- Gambia: Sightsavers country exit plan Gambia

[iv] Rapid Assessment of Avoidable Blindness

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Annex 4 PHFPI Survey Questionnaire

		PHFPI SURVEY FORM							
	Country								
	Enumerator Code		**Date:**		**Respondent Code**				
	READ INTRO TO RESPONDENT then ASK Qs 1A and 1B.								
	Respondent Details								
	Age in years	Under 15	15-18	18-45	45-60	Over 60			
	Village and district			**Urban sector**					
	Male/Female	Male	Female						
	VI/ TB/ Sighted	Blind/Low Vision	Sighted	Multi disability					
	Marital status	Single	Married	Divorced	Widowed				
	Paid employment (i.e. has a job with employer?)	Yes	No						
	Farmer (income earned from working on land)	Yes	No						
	Small trader	Yes	No						
	Self employed	Yes	No						
	Not working	Yes	No						

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				Responses			Enumerator Comments		
	Question	1	2	3	4	5	Responses	Other	Comment
	EYE HEALTH CARE						6	7	8
1A	Have you had treatment for an eye problem during the last two years? IF YES, When was the most recent occasion? Tick 1 box	No - **THANK & CLOSE INTERVIEW**	Yes but over 2 years ago - **THANK & CLOSE INTERVIEW**	Yes 13-24 months ago	Yes 7-12 months ago	Yes in the last 6 months			
1B	What eye problems have you had treated in the last 2 years IF OTHER THAN CATARACT AND TRACOMA THANK AND CLOSE INTERVIEW	Cataract	Trachoma - Lid Surgery	Trauma	Red Eye	Other - state			
	I WOULD LIKE TO ASK YOU ABOUT YOUR EXPERIENCES ON THE MOST RECENT OCCASION YOU HAD TREATMENT FOR AN EYE PROBLEM.								
2 G	How much time passed between when you first noticed this eye problem and when you decided to consult someone? LISTEN to responses and tick 1 box	Over a year	6-12 months	1-5 months	1-4 weeks	Less than a week		Don't know	
3 G	Who did you consult first for advice or help with your eye problem? DO NOT read responses and TICK relevant boxes	Family / friends / neighbours	Nyateros / Relais Community eye health volunteers	Traditional healer /practitioner	Lopitan Ndingo staff with knowledge of eyes	VHWs or CHWs Community health volunteers		OTHER State	

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4	If you went to Lopitan Ndingo, what treatment did you receive? <u>READ out responses and tick the boxes that apply</u>	Did not go to Lopitan Ndingo. IF DID NOT GO TO LOPITAN NDINGO THEN GO STRAIGHT TO Q 6	None did not get treatment at Lopitan Ndingo	Was referred to Lopitan Baa	Operation/surgery	Medicines e.g. eye drops, pills	VI eqt e.g. glasses, visual aids, white cane)		
5	ONLY ASK IF WENT TO LOPITAN NDINGO: What was your opinion of the skills and knowledge of the Lopitan Ndingo staff. <u>READ out responses and tick one box</u>	Excellent, the staff very skilful and knowledgeable	Good, the staff are skilful and knowledgeable	OK, the staff have some good skills and knowledge but there are some gaps	Poor, they did not have the skills necessary for diagnosing/treating me	Very poor; there was no-one with any skills/knowledge useful for my condition.			
6	ONLY ASK IF DID NOT GO TO LOPITAN NDINGO: Why did you not got to the Lopitan Ndingo? <u>DO NOT read out responses and tick the boxes that apply</u>	Too far away	I did not think they had the skills or medicines needed for my eye problem	Poor Staff Attitude	I prefer traditional medicine	No-one able to accompany me.		OTHER Specify	
7	ASK ALL: Did you go to the Lopitan Baa: Were you referred or not and, if so, who by? <u>READ out responses and tick 1 box</u>	Referred by Lopitan Ndingo	Referred from eye camp	Self-referred	Other (SPECIFY)	Told to go by traditional healer			

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8	ASK IF WENT TO LOPITAN BAA What treatment did you receive at the Lopitan Baa? READ out responses and tick the boxes that apply	Surgery	Non-surgical treatment: eye drops/medicines - pills or ointments	Glasses	Low Vision Devices	None		Other	
9 G	ASK IF WENT TO LOPITAN BAA: What was your opinion of the skills and know-ledge of the staff READ out responses and tick 1 box	Excellent, the staff very skilful and knowledge able	Good, the staff are skilful and knowledgeable	OK, the staff have some good skills and knowledge but there are some gaps	Poor, they did not have the skills necessary for diagnosing/treating me	Very poor; there was no one with any skills/knowledge useful for my condition.			
10 G	FOR PEOPLE WHO WENT TO LOPITAN BAA If there was anything difficult about using the service, what was it? Do not read out responses. Tick the boxes that apply.	Long waiting times	Long distances	Cost	Attitude of staff	Finding someone to accompany me	No Drugs or eye drops	OTHER State	
11 G	**Q Cataract Patients Only** How satisfied are you with the result of the operation? **If not happy then state the reason.** READ out responses and tick one box	Extremely Excellent vision my sight is fully restored	Very Significant improvement to my vision	Neither satisfied nor dissatisfied - Some improvement but would have liked more	Not satisfied Very little change and had hoped for more than this	Very dissatisfied - no change to vision or it is worse	Still Waiting for operation		

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12	**<u>Cataract Patients Only</u>** After your cataract operation what follow up checks or support did you receive from the Lopitan Baa or community health worker?	Returned for checks	Given an eye test and spectacle if needed	Referred to social services or similar place for help with rehabilitation	Helped to get a job/work	Included in a support scheme for livelihood - loan, access etc			
13 G	**<u>Q Non- Cataract Patients Only</u>** How satisfied are you with the result of your treatment? **If not happy then state the reason.** <u>READ out and tick one box</u>	<u>Extremely</u> Excellent vision my sight is fully restored	<u>Very</u> Significant improvement to my vision	<u>Neither happy nor unhappy</u> - Some improvement but would have liked more	<u>Not satisfied</u> Very little change and had hoped for more than this	<u>Very dissatisfied -</u> no change to vision or it is worse		Not treated	
14 G	**<u>FOR EVERYONE Q 14 Onwards</u>** - How affordable did you find the treatment? Read out and tick one	It is easily affordable (or free).	A bit costly	Very costly and difficult to afford	Too costly/ not affordable so I did not get treatment	I am still trying to find / pay off the cost of treatment			
15 G	Did you receive a fee waiver?	Yes	No						
KAP	**NOW I WOULD LIKE TO ASK YOU SOME GENERAL QUESTIONS ABOUT EYE HEALTH - THESE Qs ARE FOR EVERYONE**								
16 G	From where have you mostly learned about eye health? <u>DO NOT read out responses and tick boxes that apply</u>	Relais/Nyateros Community eye health volunteers	Posters and leaflets	Radio/Media	Family/friends/ neighbours	Work colleagues		OTHER State	

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17	How well informed do you think you are about eye health and eye problems READ out responses and tick 1 box	Yes - I am very well informed	No – there should be a lot more information made available to the public	No, I would like my local health volunteers to engage more with the community on eye health care and services	No, I would like more eye health information materials to be available at local health clinics and other places	No, I would like more radio programmes and jingles to tell me what to do about seeking help			
18 G	Do you do anything differently now in your life as a result of information you have on eye health? READ out responses and tick 1 box.	Yes, I have changed my habits to reduce risk to my eyes	Yes, I have made 1 or 2 changes that will reduce risk to my eyes	I know what changes to make but do very little about them	I don't know what I should do to take care of my eyes to prevent disease but want to know	No, I do not believe that there is much connection between eye health and what I do.			
19	Do you think that in general your local community is better informed about eye health than it was 5 years ago? READ out responses and tick 1 box	Yes, people are very informed compared to the past	Yes, people are quite informed compared to the past	It is the same - no better and no worse	No, people generally are still not very well informed	No, people generally still know nothing or very little about eye heath			

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20 G	Which of the following statements are TRUE **What causes trachoma?** READ out and tick boxes that apply	Infection from flies	Dirty water or no water for washing hands, face and body	Dirty insanitary surroundings	Bad luck or bad behaviour	Other - state	Don't Know		
21 G	Please tell me 3 things you/your family can do to keep your eyes healthy? DO NOT read out responses. Tick boxes that apply	Keep face/eyes clean	Eat green leafy vegetables	Do not rub eyes or put things in them	Protect eyes when doing certain/ dangerous tasks	Avoid putting traditional medicines in eyes	Don't Know	OTHER State	
22 G	How likely are you, compared to 5 yrs. ago, to go to your Lopitan Ndingo for an eye check. READ out responses and tick 1 box	Always	Very likely	Not likely	Never	I would agree to have eyes checked if offered by the clinic			
23	How big/widespread a problem does you think eye problems are in your community? READ out responses and tick 1 box	Very big problem compared to other health problems	Quite a big problem compared to other problems	It is no different a problem than other health problems	It is not much of a problem compared to other health problems	Not a problem at all compared with other health problems			

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24	How would you describe the attitude of people in your local community to people who are blind/visually impaired? DO NOT read out and tick 1 box	Very supportive and they are made to feel part of the local community	People are quite supportive, are friendly and often include them in community events	People are accepting of them and they are sometimes included	People are polite but do not seek out their company	People ignore or reject them			
	GENERAL Eye Health Care - Qs FOR EVERYONE								
25	In your opinion, have there been any changes in the eye health services at Lopitan Ndingo and village posts compared with 5 years ago? READ out responses and tick 1 box	Yes, they are a lot better	Yes, they have improved a bit	No, they have stayed the same	No, they are worse	Don't know			
26	In your opinion, what changes have there been in the eye health services at Lopitan Baa compared with 5 years ago? READ out responses - tick 1 box	They are a lot better	They have improved a little	They have stayed the same	They are worse	Don't know			

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27	Do you have any suggestions for eye health services could be improved? **IF YES, ASK What? PROBE**								
	QUALITY OF LIFE								
28	Overall, how would you rate your eyesight using both eyes - with glasses or contact lenses if you wear them? READ out responses - tick 1 box	Very good	Good	Moderate	Bad	Very Bad			
29	Overall, have there been any changes in your life as a result of your eye treatment? **IF YES? What? PROBE for full answer and record in detail**								
30	SINCE having treatment for your eye problem and nowadays, how much difficulty do you have in going to activities outside the home on your own? (E.g. social, sporting events, shopping, religious events). READ out and tick 1 box	None - I have no problems	Mild - I have a few problems	Moderate - I often need some assistance	Severe, I can only go out if I have someone to accompany me	Extreme / cannot do		OTHER State	

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31	And BEFORE treatment for your eye problem, how much difficulty did you have in going to activities outside the home on your own? E.g. social, sporting events, shopping, religious events). READ out and tick 1 box	None - I had no problems none	Mild - I had a few problems	Moderate - I often needed some assistance	Severe, I could only go if I had someone to accompany me	Extreme / cannot do			
32	SINCE having treatment and nowadays do you now have difficulty with any of these activities? READ out responses and tick boxes that apply	Doing activities that require you to see well close up e.g. sewing, using tools, reading	Recognising the face of a person standing nearby	Noticing obstacles when walking	Seeing after a few moments when you come inside after being in bright sunlight	Seeing because of the glare of bright lights		NONE	
33	And BEFORE receiving treatment for your eye condition, did you have difficulty with any of these activities? READ out and tick boxes that apply	Doing activities that required you to see well close up e.g. sewing, using tools, reading	Recognising the face of a person standing nearby	Noticing obstacles when walking	Seeing after a few moments when you came inside after being in bright sunlight	Seeing because of the glare of bright lights		NONE	
34	SINCE Treatment and nowadays: Because of your sight how often do you feel that you are a burden on others? READ out responses and tick 1 box	All the time	Very often	Sometimes	Not very often	Never			

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35	BEFORE Treatment: Because of your sight how often did you feel that you were a burden on others? READ out responses and tick 1 box	All the time	Very often	Sometimes	Not very often	Never			
36 G	Since you had treatment for your eye problem, have there been any noticeable changes in your life due to improved sight or not **-** **Read out responses, tick all applicable and rank in order of importance**	Increased income	Ability to care for children/do domestic tasks	Playing active role in community activities	Confidence/self esteem/ happiness	Improved education of children	Respect from family and friends	OTHER State	NONE
37 G	SINCE Treatment and nowadays, because of your eyesight, how much difficulty do you have in carrying out your usual work? READ out and tick 1 box	None	Mild	Moderate	Severe	Extreme/cannot do			
38	BEFORE Treatment for your eye condition, how much difficulty did you have in carrying out your usual work? READ out responses and tick 1 box	None	Mild	Moderate	Severe	Extreme/cannot do			

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39	In a scale of 1 to 10 how well off is your household in your opinion? **Where would you place yourself in a scale of 1 to 10 where 1 = very poor and 10 = wealthy. Use spare sheet.** DO NOT read out responses**.** Tick the box that corresponds most closely to their answer	1 - 2 Very Poor	3-4 Poor	5-6 Moderate	7 - 8 Quite wealthy	9 - 10 Wealthy	Would not disclose		
40 **G**	In your opinion how well off are you compared to others in your community/village? READ out responses and tick 1 box	A lot better off	A little better off	The same as others	A little worse off than others	A lot worse off than others			
41 **G**	In your opinion, has your household wealth changed at all as a result of having treatment for eye problem? Listen to their answer and tick the box that most closely fits	It has increased by quite a lot	It has increased by a small amount	It is the same - no better and no worse	It has decreased a little	It has decreased a lot	Don't Know	There is change but not due to eye problem	

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42 G	FOR PEOPLE TICKING COLUMN 1 and 2 IN Q 41. If wealth has increased, Why is this? <u>LISTEN to their answer and tick boxes that most closely fit</u>	I have a job now and earn a wage	I can look after family/ children	I can work on land now and grow crops for market	I can do petty trading for small income	OTHER - state			

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Annex 5 Technical Check List

EYE HEALTH FACILITY TECHNICAL CHECKLIST

Country
District/Region
Name Health Facility

GENERAL	TOP LEVEL OUTCOME INDICATORS
1	The CSR rates for surgeon productivity. You will need to derive a figure if it has not already been calculated using the SSI CSR Tool
2	Cataract surgical coverage – if the PMU has not been monitoring this then you will need to obtain figures and calculate
3	Surgical outcome - are eye units relying on the biometry? The project doc highlights the need to use an audit tool, so you need to explore this and id the issues. Surgical outcome is a high level indicator so you will need to derive a figure on % of patients seen classified as having a positive cataract surgical outcome. Also the number (%) of cataract surgeries using IOL. If there is no data then analyse a random sample and calculate using patient records or other means.
4	Look at ratios between specific health cadres to popn; deployment and loss; productivity; using data provided by PMU and/or health authorities
5	Blindness prevalence – are there any proxy indicators or other studies that may indicate a change in prevalence rate since the last RAABs were undertaken?
EQUIPMENT	**and SURGICAL TOOOLS**
6	List and check the equipment provided by the project and identify maintenance or other issues. E.g. quantities/condition of surgical sets. Is equipment appropriate to the work/staffing/patient through-put of the unit? Equipment list available from PMU
7	What planned equipment wasn't provided? - Information from PMU
8	Check equipment against standard list and guidelines e.g. SSI, V2020
9	What proportion did health authority provide? By other providers?

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10	Is equipment in good working order – regularly serviced (review service records)
11	How well does procurement, supply and distribution system work? What is level of stock outs and spare parts? Review stock registers and stock audit records. No of cat sets per surgeon? Number of trachoma lid sets per surgeon?
12	How well does the eye drop production and distribution system work? What are the issues?
13	Is there biometry equipment? Is it in use?
14	Have staff been trained to use the equipment?
	INFRASTRUCTURE
15	Facility – New / Refurbished?
16	Dedicated OPD clinic available?
17	OPD well ventilated – sufficient sitting space; hygienic; sanitation
18	OPD Equipment: Slit Lamp; A scan; Keratometer; Retinoscope; Direct ophthalmoscope; Indirect ophthalmoscope; Goldman tonometer; Yag laser
19	OPD has back up power and surge protector?
20	Op theatre – surfaces/fixtures of suitable materials? Min retention of dust and dirt. Adequate sterilising equipment and operating sets/consumables; sterile areas.
21	Are there suitable patient flow arrangements in OPD?
HEALTH	**WORKFORCE**
22	What eye health staff positions are there for each eye unit? Please list.
23	Which positions are actually filled?
24	What are the gaps? Is staffing appropriate to needs/level?
25	Record the number of primary health care workers with LV training in post
26	Record the number of optometric technicians in place and level of training - are plans/actual types of staff in place and appropriate?
27	Record number optometrists in place and level of training - are plans/actual types of staff in place appropriate?

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28	What are the deployment rates of people trained by the programme – is there an even distribution throughout the country? Explore staff retention and loss for IEWs, surgeons, ONs, CONs etc. To what extent is this a problem?
29	What are the views of eye care professionals whether they are seen as a recognised cadre within health system – interviews with cadres trained in LV
30	How high are the overall professional knowledge (use checklist) and skills levels (link to surgical outcome, productivity etc)?
31	What training has been provided? Where were they trained? SZRECC? If not, then why not? Is this enough? What training needs are there?
TRAINING	**SZRECC**
32	Check SZRECC has capacity to provide quality training
33	Number of faculty staff reflect V2020 guidelines
34	Do trainers have required experience and qualifications and skills
35	Ratio of trainers to trainees (talk trainers and trainees)
36	Are necessary infrastructure, equipment and supplies available for classroom and practical clinical training
37	Interviews with students and staff on training quality
	Training Methods - theory v practical experience
38	Curriculum has clear objectives and learning outcomes. How does it fit with those of countries in the region?
39	Check teaching aids, equipment - quantity, quality, appropriateness, languages
40	Comment on trainee access to materials, books, manuals, journals, IT
RECORD	**SYSTEMS**
41	Look at eye health record systems – what systems are in place for collection, analysis, dissemination and use of data. Which are computerised?

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42	Surgical outcome audit tool. Who has it? Who uses? Why not?
RURAL	**HEALTH FACILITIES**
43	Look at actual staffing levels against recommended levels, level of knowledge and skill on eye care, and whether they are familiar with the national eye care strategy
44	Record the number of primary health care workers and CBR workers with LV training in place. What is focus of health volunteers – awareness? And/or ID/referral?
45	Look at level of basic equipment and drugs in clinic – does it conform to guidelines?
46	Are IEC materials displayed and distributed to people?

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Annex 6 Summary matrix of results – Sub region

All 3 countries		
Target	**Total 5yrs results**	**Percentage achieved**
None stated	Average national CSR across the sub region is 1218, below the West Africa V2020 target of 2000 needed to address ongoing incidence. 2013 national averages were 1760 Gambia (falling); 980 Senegal (static); 916 Guinea Bissau (increasing). The 2000 target is said to be the level at which backlogs clear and prevalence begins to fall.	n/a
None stated	There will be no follow on national studies to the 2008 and 2010 RAABs for several years therefore it is not possible to update the prevalence statistics across the sub region.	n/a
none stated	No baseline in place and QoL not monitored. Survey of 750 people plus FGDs suggests significant impact on lives.	n/a
none stated	No baseline in place and monitored only in the Gambia (0.2% referrals from TPs in 2013).	n/a
non stated	Current surgical coverage unknown, requiring country wide studies to update 2008 and 2010 RAABs.	n/a

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non stated		Audit tool inconsistently used, records of surgical outcome are not maintained or analysed. Survey results consistent in indicating an average 76% good outcome across the region.	n/a
non stated		100%. No biometry. Standard lens strength used of 20 and 21 dioptres across the sub region.	n/a
non stated		Stock outs common problem across Gambia (100%) and Guinea Bissau (81%) linked to inefficiencies in central procurement and distribution system. Senegal reports a lesser problem but no data.	n/a
non stated		Not possible to average as context specific with strong variation – not monitored in Senegal, small numbers presenting in Guinea Bissau, and Gambia data indicating falling trend in numbers presenting being treated	n/a
0		No specific eye care budgets in place across sub region therefore not possible to comment against indicator.	n/a
CAT	**22,042**	29,907	136%
RE/LV	**11,500**	18,525	161%
TT	**11,337**	11,787	104%
CHB	**15,000**	16,095	107%
Dia	**-**	-	0%
-	722,047	697,097	97%
-	669,020	930,417	139%
-	-	493,157	
-	78	95	122%

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-	100%	93,3%	
-	25.00	25	100%
-	23.00	29	126%
-	712.00	1,245	175%
-	19.00	19	100%
-	4.00	4	100%
-	284.00	470	165%
-	24.00	23	96%
-	38.00	38	100%
-	15.00	17	113%
-	3,032.00	3,704	122%
-	3,132.00	3,076	98%
-	3,860.00	1,530	40%
-	3,700.00	7,402	200%
-	230.00	694	302%
-	26.00	25	96%
-	60.00	68	113%
-	14.00	14	100%
-	40.00	44	110%

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-	4.00	6	150%
-	14.00	16	114%
-	20.00	77	385%
-	-	-	

Annex 7 Stakeholders met/ interviewed

Stakeholder List 2 PHFPI Evaluation: Guinea Bissau

IN DEPTH INTERVIEWS

National Level

Dr Samedo, Director of Planning, MoH

Marie Aramatulai Injai, Director of Human Resources, MoH

Dr Nicolau Almei, Director General Prevention and Health Promotion

Sr Samba, Director of Finance

Dr Menu Nabicassa, National eye care programme coordinator

Wilson Idrisa, Admin Assistant, National eye care programme

Musa Samati, National eye care programme accountant

Head of nutrition unit, MoH

Dr Alvarenga, WHO prevention manager

Dioneza Santiago Gomes Alves, LPED Technician

Diamantino Gomes, ophthalmic Instrument technician

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Regional Health Authority and Medical Staff

Antonio Pedro Sidjanho, Regional Health Director, Bafata region

Zito Sambu, Deputy Director, Bafata hospital

Regional Health Team, Bafata region

District Health Personnel

Antonio Lingo Florida Da Silva, TT surgeon, Bafata

Pedro Vaz**,** Hospital deputy director, Farim

Silvio Coelho-Hospital director, Farim

Fatima Sana Sambu, Cataract surgeon, Bafata

Fanta Pires Cassama, Cataract surgeon, Farim

OIC, Countoboel health post

Other Stakeholders

Fransual Dias, President of Disabled People Federation

Spenser Gomez, National Federation for Disabled Persons

Malam Dramé, Health Economist, WHO

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Sightsavers

Victor Caperuto, programme manager Sightsavers

Balla Musa Joof, project officer PHFPI

FOCUS GROUP DISCUSSIONS

Stakeholder Group	*Districts*
Traditional healers, x 2	Farim, Bafata
Women's group x 2	Farim, Bafata
Service users x 3	Countuboel, Farim, Bafata
IEWs x 1	Countuboel
Community health workers x 1	Bafata

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Stakeholder List PHFPI Evaluation: The Gambia

IN DEPTH INTERVIEWS

National Level

National eye care coordinator

Permanent Secretary MoH

Director of Planning and Information

CEO SZRECC (by telephone)

Courses Coordinator, SZRECC

Chief Nursing Officer

Cataract surgeon, SZRECC

Instrument technician, SZRECC

(Meeting sought with Director of Health but could not take place)

Regional Health Authority and Medical Staff

Regional Health Director, West Coast 2 Region

Deputy regional health director, Upper River Region

Senior community health nurse, RHT, Upper River region

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Sightsavers

Health education officer, RHT, Upper River region

Cataract surgeon, Brikama health centre, West Coast 2 region

Cataract surgeon, Basse health centre, URR

8 RHT members, Brikama, WCR2

OIC, Basse Health Centre, Upper river region

Assistant PHO, WCR2

District Health Personnel

3 Community ophthalmic nurses, Fatoto, Diabugu, Bata Kundu health centres,URR

3 Community ophthalmic nurses, Brikama, Brufut and Gunjur health centres, WCR2

Other Stakeholders

GOVI CEO

WHO, prevention manager (by telephone)

HKI Coordinator Gambia and Guinea Bissau

Deputy Director, NaNA

Sightsavers

Regional Director

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Former Regional Director

PO PHFPI

PM, Sightsavers

Finance Manager, PHFPI

Finance Manager, Sightsavers

FOCUS GROUP DISCUSSIONS

Stakeholder Group	*Districts*
Village development committee x 1	Brikama
Regional Health team members x 1	Brikama
Beneficiaries x 2	Basse, Brikama
Nyateros plus village health workers x 2	Basse, Brikama

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Stakeholder List PHFPI Evaluation: Senegal

IN DEPTH INTERVIEWS

National Level

Director of Disease Control, Ministry of Health and Social Action

National Eye Care Coordinator

Focal Point for Eye Health, National Service for Health Information and Education.

(Meetings sought with DG, MoH, HKI and Senegal Representative to WAHO were sought but could not take place)

Regional Health Authority and Medical Staff

Chief Medical Officer, Kaffrine Health Region

Director of Kaolack Regional Hospital

Chief Medical Officer, Kaolack Health Region

Head of Social Action Service, Kaolack Health Region

Manager of Kaolack Health Region

Head of Regional Unit for Health Education & Information

District Health Personnel

Chief Medical Officer for District of Kaffrine

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District Medical Officer of Nioro du Rip

President Nioro District Health Committee

Treasurer Nioro District Health Committee

Administrator of Nioro Health District

Administrator of Kaffrine Health District

Kaffrine Adminitrative and Finance Service

Kaffrine Health Education Officer

Cataract Surgeon, Nioro District

Health Aide, Eye unit, Kaffrine District

Cataract Surgeon, Fatick District

Cataract Surgeon, Sokone District

Health Post Nurse, Gniby, Kaffrine

Health Post Nurse, Boulel

Other Stakeholders

President of Federation of DPOs of Kaolack Region

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President of Sokone Association of People with Disabilities

Sightsavers

Regional Director

Project Manager

Project Officer

FOCUS GROUP DISCUSSIONS

Stakeholder Group	*Districts*
Community leaders x 2	Kaffrine, Nioro
Community volunteers, representatives and journalists x 2.5	Kaffrine, Fatick, Sokone
District Health team members and IEWs x 2.5	Kaffrine, Fatick, Sokone
Beneficiaries x 2 (one planned in Nioro did not take place)	Fatick, Sokone,

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Annex 8 Question Checklist for In-Depth Interviews

Relevance:

a/ - Is the Post-HFPI programme as developed relevant to the needs of people in Senegal/Gambia/Guinea Bissau (notably the poor) with eyesight problems?

Prompts – What are the eye problems people have? What help to avoid them is needed? What treatment is needed? What other support and help do visually impaired (VI) people need?

Have needs changed in any way? How?

Have there been any changes in context – opportunities/threats – what?

If changes, how has HFPI adapted to these changes?

Effectiveness

a/ - How effective is the programme at meeting the eye care needs of the people in the intervention areas?

Prompts – Do you think those that need help are able to get it? Who is included? Who is left out and why? Is treatment (including spectacle supply, surgery, help for VI people, including the totally blind) available? Who can afford treatment and who cannot? Where do people go for treatment – those who cannot afford from the public health service, those who can and choose to pay for private services?

b/ - How is the programme performing against expected results and what are the gaps

Prompts – were these clear at the outset? progress in systems strengthening, policy framework, skills development, management information systems, leadership and governance, accessibility and broader coverage.

c/ - Has the quantity and quality of eye health services improved for the targeted users a/ at community level b/ at district level? In what ways? How does quality compare over time – is it improving, or not?

d/ - How accessible are eye health services offered by the project to target communities? Distance, buildings/ environment, reception/ language/supportive – or not.

e/ - What needs to be done to make eye care equally available to all – including women, children, those who are poor, those living in difficult to get to places?

f/ - How effective is Sightsavers in adding value, promoting programme learning for improvement, building partner organizational effectiveness, and to innovate?

G/ added value of regional dimension / SZRECC?

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Efficiency	**a/** - How and to what extent have providers and project partners understood and applied principles of cost effectiveness, unit cost analysis and cost effectiveness as a management tool? b/ - How appropriate and efficient has the PMU been as a management mechanism in providing management, coordination, monitoring, technical assistance an financial support ? c/ - how effective have any monitoring systems been in capturing change and promoting programme learning **d/** - Are financial and other resources applied in the most efficient manner? Please give examples. Prompt: budget burn rates, which components not demonstrating efficiency and why, deployment of staff and their access to equipment/supplies for working efficiently; procurement, availability of supplies, payments to staff, timeliness of subventions – Sightsavers, Government, other sources? **e/** - How efficient is the Post-HFPI programme in delivering services – in your opinion? (i.e. is it a Cost-effective way to provide eye care?) Prompts: Discuss who can afford the services and who cannot. What other priorities compete with eye services when people are deciding if they can afford eye treatments (see also effectiveness – cost and quality issues). Identify ways to improve the affordability of the service for poor people without risking collapse of the services. **f/** - What measures are in place to make treatment affordable to the poor – cross subsidy, cost recovery? How well are these working, managed, how fair are they? G/ adoption of MTR recommendations eg docs in French/Portugese
Impact	**a/** - To what extent has the Post-HFPI eye health care programme become a part of wider health systems and structures and has it extended to other parts Senegal/Gambia/Guinea Bissau? Has it provided an example for other for other countries? Prompts: Do you think that eye care is provided alongside other health care in Government (and private) clinics? Do health workers know enough about eye care to advise people what to do when they have eye problems? What needs to be done to improve this? b/ - In what ways and to what extent has the programme contributed to and facilitated stronger cross national collaboration and partnership and what has been the value addition of this approach? Prompts: what has worked well and what challenges in the collaborative process? Is it sustainable? What is the evidence of lasting partnership? Is the greater more than the sum of its parts? What changes in policies and practice has been brought about through the joint programme? Perceived contribution /effects on prevalence of blindness – given that no

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RAAB, are there any qualitative pointers to impact of PHFPI on this?

c/ - In what ways has the project changed the way eye health care is managed and delivered at district and community levels?

d/ - In what ways has the project changed human resources dedicated to eye health in target communities and at district level?

e/ - What changes to targeted users' lives has the programme contributed to, both positive and negative? What have been the intended and unintended consequences of the programme? What conditions led to success or failure (external, internal). Changes in functioning, morale, living standards of individuals, poverty of community as a whole? Examples at community level?

f/ - Any changes observed in eye health KAP in community? In relation to traditional healers?

What choices do people make when they need eye health care – has the project improved people's confidence in the services it has developed and supported over time?

g/ In what ways has access to the programme and its benefits by service users been influenced by gender, age and wider exclusion. What specific mechanisms did the programme put in place to ensure equal access including policy influencing.

If came back in 5 years, what would we see? What other dynamics/projects contributing to impact? (Of reducing blindness prevalence, and/or alleviating poverty?)

Sustainability

a/ - What steps have been put in place to ensure that the services delivered by the project are sustainable e.g. plans for project closure and handover, exit strategies, cost recovery systems, increased funding commitment by MoH – budget line for eye care?, planning for future funding

b/ - How are interventions likely to be sustained? What exit strategies exist to support sustainability (e.g. leveraging funding from other sources, policy adoption, or building capacity of actors to deliver services to monitor service delivery authorities

Decentralisation vs centralization as strategies?

c/ - How well are these sustainability strategies working? What evidence is there to suggest this? Which programme aspects are sustainable, which are not – why?

Partner capacities in planning, M&E, advocacy? Adequate? Improved?

d/ - What use is being made of cost recovery and cross subsidy as a means to help finance and sustain services? Are these in line with other charges made for other health services? How do they compare with costs of other service providers? How is pricing impacting on the choice people make to use the services and consequently what is the impact on the sustainability of services developed of people choosing to go elsewhere for treatment?

(This question only after the previous more open questions).

e/ - What levels and areas of support do you consider are needed for the

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	programme to continue into the future – to be sustainable and improve? Who should make this happen? <u>Prompts</u>: Government, private health and care providers, NGOs, communities etc. **f/** - What is the evidence for sustainable gains/improvements in eye health, especially for the poorest and most marginalized people **g/** - What aspects of the programme are integrated into health systems and structures? Integration of PEC into PHC? (supplies in standard list; indicators in NHMIS, eye care modules in healthworker basic training curricula)?
Coherence/ Coordination	**a/** - How is this eye health programme coordinated and linked with the work of other eye health and health actors both nationally and across the three countries? Alignment with V2020, WAHO milestones and strategies? **b/** - To what extent does the project work with and complement other initiatives implemented by national and district level partners: eye service providers, DPOs, BPOs, INGOs etc. How have partnerships functioned? Learning and exchange processes at all levels? **c/** - How have activities been coordinated with similar or other sectoral interventions/approaches at district and national levels? **d/** - How well has coordination of the project been integrated with regular health management and monitoring mechanisms within Senegal/Gambia/Guinea Bissau? How has its performance and management compared with other such regional initiatives?
Scalability/Replicability	Is this an approach/initiative that could be scaled up? Or all/some components replicated? **a/** - Are you familiar with Sightsavers' aims and strategy? (If no, provide a brief description). What are your views on this strategy? What changes, if any, are needed in the ways Sightsavers and its partners work to improve the scalability and replicability of the programme as you perceive it? **b/** - What are your views on the successes and challenges of using the model, experiences and lessons to improve eye care in the rest of Senegal/Gambia/Guinea Bissau and beyond in other countries? **c/** - What other views and advice do you have for taking forward eye care in Senegal/Gambia/Guinea Bissau and more widely.

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Focus Group Questions and Prompts

Q1 Is the Post-HFPI programme as developed **relevant** to the needs of people (notably the poor) with eyesight problems in Gambia, Senegal and Guinea Bissau?

Prompts – What are the eye problems people have? What help to avoid them is needed? What treatment is needed? What other support to people with VI need? From where are they getting support?

Q2 How **effective** is the programme at meeting the eye health needs of the population in Gambia, Senegal and Guinea Bissau?

Prompts – Do you think those that need help are able to get it? Who is included? Who is left out and why? Is treatment (including spectacle supply, surgery, help for totally blind and partially sighted people) available? Who can afford treatment and who cannot?

Q3 Do you think there is enough support to people with long term visual impairment to overcome their difficulties?

Prompt: Who needs support? What support is available? Who should provide it? What is the role of government, communities, NGOs, others in providing support?

Q4 Does the Post-HFPI/Sightsavers and partners' services provide **value for money** – in your opinion? (Is it a Cost-effective way to provide eye care?)

Prompts: Discuss who can afford the services and who cannot. What other priorities compete with eye services when people are deciding if they can afford eye treatments, education and other help available. Include not only cost but also the barriers people experience accessing the services – accessibility, distance, stigma etc. Identify ways to improve the affordability of the service for poor people or ideas to improve services for those that find it hard to access the support available.

Q5 What changes **(impacts)** do you feel the Post-HFPI programme has had on the lives of lives of visually impaired people with eye health needs?

Prompts: Looking back, are VI people with eye health needs in a better position than before? What has happened to improve or make worse their situation?

Q6 What levels and areas of support do you consider are needed for the programme to continue into the future – be sustainable and improve? Who should make this happen?

Prompts: Government, private health and care providers, NGOs, communities etc.

Q7 To what extent has the Post-HFPI eye care services become a part of wider health systems in Gambia, Senegal and Guinea Bissau? Has it provided an example for other parts of the country and for other countries?

Prompts: Do you think that eye care is provided alongside other government, NGO and private services? Do eye care service workers know enough about eye care to advise people what to do when they have eye

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problems? What needs to be done to improve this?

Q8 What needs to be done to make eye care equally available to all people in Gambia/Senegal/Guinea Bissau – including women, children, those living in difficult to get to places?

Q9 What do you think the Government should be doing to improve eye care, not only prevention and treatment but to ensure people with visual impairment are included as fully as possible in society – get education, work, can vote, participate in community decision-making etc.

Q10 Who should take responsibility for improving eye health, care and support to the disabled in Guinea Bissau/Senegal/Gambia? What suggestions do you have to improve the eye health of people and support those with visual impairment?

Annex 9 Field work itineraries

	Itinerary The Gambia	
DATE	**WHO TO MEET - Lynda Kerley**	**Dr Maria Hagan**
Wednesday 29th Jan 2014		
09:0am - 10:00am	Briefing with the PMU and Sightsavers team at Sightsavers Conference Room, Banjul	
10:15am - 11:15am	Courtesy call at the Ministry of Health and Social Welfare (**Director of Health Services, Permanent Secretary, the Chief Nursing Officer** and possibly the Hon. Minister of Health & Social Welfare)	
12:00pm: 1:00pm	Meeting with the Manager of the National Eye Health Programme, SZRECC , Kanifeng	
Thursday 30th Jan 2014		
09:00am - 10:0am	Meeting with Programme Manager, Sightsavers- Gambia Office, Pipelnie	
10:15am - 11:15am	Meeting with Staff of NaNA, Mile 7	
11:20am - 12:20pm	Meeting with Courses Coordinator, Regional Ophthalmic Training Programme, SZRECC, Kanifeng	
12:20pm - 1:20pm	Meeting with Senior Ophthalmic Training Programme, SZRECC, Kanifing	
1:20pm - 1:30pm	Meeting with Instrument Technician, SZRECC, Kanifeng	
2:00pm - 3:00pm	Meeting with Pharmacist and LPED Technician, Edward Francis Small Teaching Hospital, Banjul	
3:30pm - 4:30pm	Meeting Director of Health Promotion and Education, Ministry of Health & Social Welfare, Kotu	
4:30pm - 5:00pm	Meeting with the Director of Planning, Ministry of Health & Social Welfare, Kotu	
5:00pm	Meeting with the Permanent Secretary, Ministry of Health, Banjul	
Friday 31st Jan 2014		
08:30am	Consultant and Balla depart for Brikama	

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09:45am - 10:45am	Meeting with Senior Ophthalmic Medical Assistant of Brikama Secondary Eye Unit and his team, Brikama, WR2	
10:45am - 11:45am	Meeting with head teacher,teachers and pupils of Brikama Basic Cycle School	
12:00pm - 1:00pm	Focus group discussion with service users, Brikama	
3:00pm - 4:00pm	Meeting with Regional Director, West Coast Health Region 2 and his team, Brikama	
4:00pm	Consultant and Balla return to Sightsavers	
5:30pm - 6:00pm	Meeting with National Assembly Member for Basse, Sightsavers office	
Saturday 1st Feb 2014		
09:00am - 5:00pm	Trainng of enumeratrors and data entry clerks on the data collection tools, NaNA	
Sunday 2nd Feb 2014		
09:00am - 5:00pm	Pre-testing of the data collection tools, Bakau, Kanifeng	
6:00pm - 8:00pm	Printing of questionnaires	
Monday 3rd Feb 2014	**DATA COLLECTION STARTS IN WESTERN REGION 1**	
09:00am - 10:00am	Meeting with RHT Team, West Coast 2, Brikama	
11:00am - 12:00pm	Focus group discusion with nyateros around Sukuta health centre	
12:10pm - 1:00pm	Meeting with the CON at Sukuta Health Centre	
2:00pm - 3:00pm	Meeting with the CON at Brufut Health Centre	
4:00pm - 5:00pm	Focus group discusion with a village development committee or women's group, Gunjor	
6:20pm - 7:00pm	Meeting with the Regional Director, West Coast 2, Brikama	
Tuesday 4th Feb 2014	**DATA COLLECTION STARTS IN UPPER RIVER REGION**	
09:00am - 10:00am	Meeting with the Director of Planning, MoH, Kotu	Maria Hagan arrives
11:00am - 12:00pm	Meeting with the Permanent Secretary, MoH, Banjul	
12:30pm - 1:30pm	Meeting with the Director of Health Services	

2:30pm - 3:30pm	Meeting with the Director of Gambia Organisation for the Visually Impaired, Banjul	
4:00pm - 5:00pm	Meeting with Pharmacist Small Teaching Hospital	
Wed 5th Feb 2014		
08:00am	Balla & 2 consultants depart for Basse	a.m. SZRECC
3:00pm - 4:00pm	Meeting with Senior Ophthalmic Medical Assistant, Basse Secondary Eye Unit and his team, Basse	p.m. Brikama health centre, WR2
5:00pm - 6:00pm	Meeting with Women's Group, Basse	
Thurs 6th Feb 2014		
09:00am - 10:00am	Meeting with Regional Director, Upper River Region and his team, Basse Mansajang	a.m. Sukuta and Brufut health centres, WR2
10:15am - 11:15am	Meeting with the **Governor**, Upper River Region, Basse	
12:00pm - 1:00pm	Meeting with Nyateros/IEWs, Basse health centre	
2:00pm - 3:00pm	Travel to Diabugu	p.m. drive to Basse
3:00pm - 4:00pm	Focus group discussion with service users, Diabugu	
4:00pm	Team return to Basse	
Fri 7th Feb 2014		
09:00am - 10:00am	Visit a school in Basse (meet head teacher, teacher trained by the programme and interview pupils)	all day: visit Basse, Diabugu and Fatoto health centres
10:00am - 11:00am	Meeting with Regional Education Office, Basse	
11:00am - 12:00pm	Focus group discussion with CONs from Diagubu, Baja Kunda and Fatoto, Basse health centre	
12:00pm - 1:00pm	Meeting with the Community Development Officer, Basse	
1:00pm	Balla and consultants depart for Banjul	
Sat 8th Feb 2014		
09:00am - 12:00pm	Consultant supervise data inputters and prepare presentation	a.m. visit Bansang eye unit, drive Banjul
4:00pm - 6:00pm	Debriefing at Sightsavers	
Sun 9th Feb 2014		
7:30am	FGD students SZRECC, Depart for Guinea Bissau via Ziguinchor HKI Coordinator	a.m. FGD students SZRECC, drive Bissau via Zinguinchor HKI coordinator

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DATE	PLACES TO VISIT
Tues 4th Feb 2014	Maria arrives in The Gambia
Wed 5th Feb 2014	
09:00am - 1:30 pm	Visit to Sheikh Zayed Reginal Eye care Centre
3:00pm - 6;30	Brikama H/c
Thurs 6th Feb	
09:00am - 1:30pm	Visit Sukuta and Brufut H/C
2:00pm	Depart for Basse
Friday 7th Feb	Basse H/C, Diabugu and Fatoto
Saturay 8th Feb 2014	Return to Banjul via Bansang
Sunday 9th Feb	Travels to Bissau

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Itinerary Guinea Bissau

DATE	LYNDA'S ITINERARY	ELEANOR'S ITINERARY	MARIA'S ITINERARY	NOTES
Sun 09 Feb 2014	**The team departs Banjul for Guinea Bissau**			
Mon 10 Feb 2014	Meeting with Director of Finance, Ministry of Health **12:00pm - 1:00pm** Meeting with Director of Prevention and Health Promotion **3:00pm - 4:00pm (Joint meeeting)** Meeting with **Dr Alvarenga** of WHO **5:00pm - 6:00pm**	Meeting with Human Resources **12:00pm - 1:00pm** Meeting With with Coord of Eye Health Programme **1:00pm - 3:00pm (Joint)** Courtesy call to Director of Planning, Ministry of Health **Courtesy Call (Joint)** Meeting with President of DPO - Guinea Bissau **5:00pm - 6:00pm (Joint at Malaika Hotel)**	**Travel to Farim Regional Hospital- 10:00am** Courtesy call on Deputy Regional Director Meeting with Cataract Surgeon Meeting with TT Surgeon **Travel back to Bissau by 4:30pm**	**Review of fhe day's work at Hotel Malaika, 7:00pm**

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Tues 11 Feb 2014 **LYNDA AND ELEANOR DEPART FOR FARIM AT 8:00AM**	Meeting with the Regional Health Team of Farim Visit a school in the region Conduct an FGD with service users Meeting with traditional healers/IEWs	Meeting with the Hospital Director of Farim Meeting with two Eye Health Workers Conduct an FGD with Women's Group/VDC Visit an ordinary health centre	**Travel to Bafata - 8:00am** Courtesy call on Regional Director Meeting with Cataract Surgeon **Lunch Break** Meeting with **two** TT Surgeons **3:20pm - 6:20pm** **Close for the day at 6:20pm and spend the night in Bafata**	**Fanta to notify the school and make arrangements fofr the FGD with the service users** **Night stop at Bafata** Accomodation to be arranged by the Cataract surgeon for the following: - 3 consultants - 2 translators - 2 drivers

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Wed 12 Feb 2104 **FULL DAY IN BAFATA**	Meeting with the Hospital Director Meeting with the cataract surgeon FGD with Women's Group/VDC Meeting with eye health workers (trichiais surgeons) in Bafata	Meeting with the Regional Health Team Visit a school in the region Condiuct an FGD with service users Visit a health centre with an IEW	**Travel from Bafata to Countubel , 8:00am** Meeting in Countubel Meeting with the **IEW** in Countubel Visit an **ordinary health centre** Drive back to Bafata Lunch at Bafata **Drive back to Bissau, 3:30pm**	**Fatima to notify the school to be visited and make arrangements for the FGD with the service users** **The team will spend a second night in Bafata**

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Thurs 13 Feb 2014 **FULL DAY IN COUNTUBEL** **THE TEAM DEPART BAFATA AT 8:00AM** **THE TEAM HAVE LUNCH AT BAFATA AND DEPART FOR BISSAU BY 3:30PM**	Meeting with the Cataract Surgeon Meeting with a group of service users Meeting with some traditional healers	Meeting with the Officer - In-Charge of Countubel Health Centre Visit a school Meeting with IEWs	Meeting with Instrument Technician, **9:00am - 11:00am** Meeting with LPED Technician **11:30am - 1:30pm** Lunch Break, **1:30 - 2:30pm** Meeting with PNSV Coordinator, **2:40pm - 4:40pm**	

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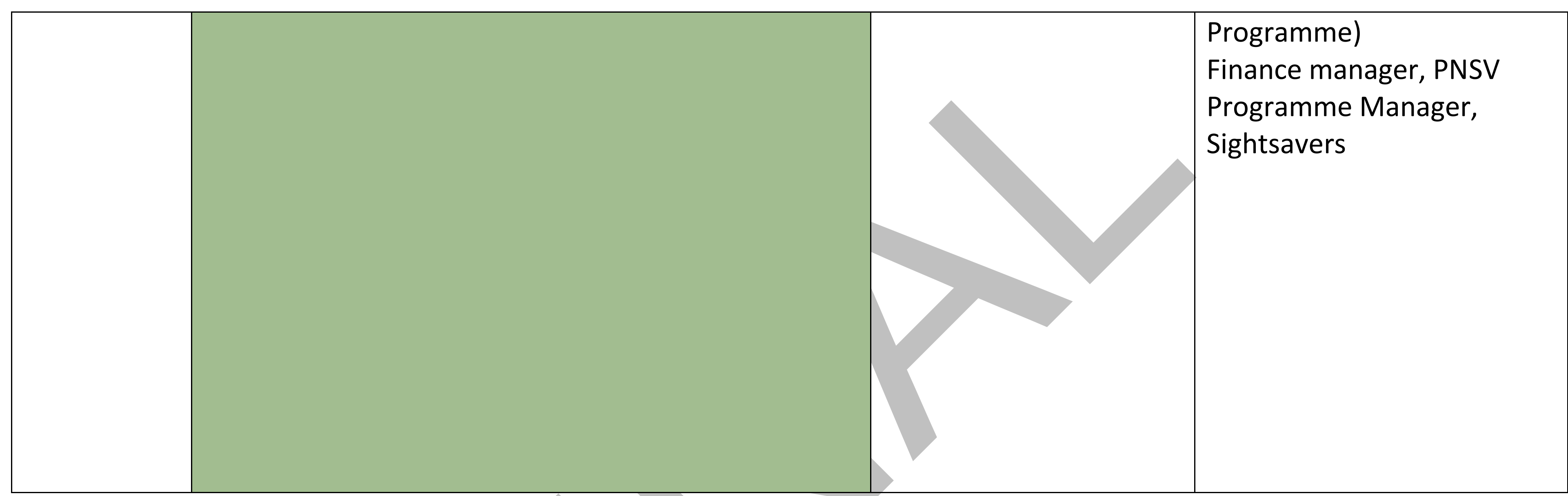
Fri 14 Feb 2014 **FINAL MEETINGS IN BISSAU**	Meeting **with** Director of Planning, Ministry of Health Meeting with the Nutrition Unit, Ministry of Health Meeting with the Evangelical Church Clinic	Visit to the Central Medical Stores (CECOME) Meeting with the Ministry of Social Welfare Catch up on missed meetings	No programme	Dr Maria Hagan travels back to Ghana. Flight time to be confirmed
Sat 15 Feb 2014	Debriefing at Sightsavers/SNV Conference Room		No programme	**The following people should be invited to the debriefing:** Dr Nicolau Quintino Almei Dir of Prevention and Health Promotion Maria Aramatulai Injai, of Human Resources Dr Meno Nabicassa, Coord , PNSV (Eye Health



			Programme) Finance manager, PNSV Programme Manager, Sightsavers

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Post HFPI Itinerary in Senegal

Date	am/ pm	Eleanor Cozens	Dr Doulaye Sacko
Friday 28th February		Arrival Dakar	
Saturday March 1st	All day	Training of interviewers for quantitative survey	
Sunday March 2nd	am pm	Training of interviewers Travel to Kaolack	
Monday March 3rd	am	Introduction to Chief Medical Officer of Region Interview with Chief Medical Officer of Kaffrine District Discussion with neighbourhood representatives and religious leaders	
	pm	Discussion with Community Health Workers, relais and women's group representatives Discussion with IEWs and members of district health team Interview with Chief Medical Officer of Region	
Tuesday March 4th	am	Interview with Kaolack Regional Hospital Director Interview with Chief Medical Officer of Kaolack Region Interview with Head of Social Action of Kaolack Region Interview with Manager in	

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		Health Region of Kaolack	
	pm	Interview with Regional Health Promotion Officer	
Wednesday March 5th	am	Travel to Fatick Discussion with 5 beneficiaries in Fatick District Discussion with 9 relais ; 2 relai/journalists in Fatick District Discussion with Health Post Nurses, District Health Team and representative of Health Post Committee	
	pm	Meeting with cataract surgeon in neighbouring district Interview with CMO of Nioro District Return to Dakar	
Thursday March 6th	am	Review of programme for following week, logistics etc Meeting with Sightsavers Regional Director	
	pm	Meeting with Sightsavers HFPI Programme Manager	
Friday March 7th		Travel to Guinea Bissau Training of interviewers on survey tool	
Saturday March 8th		Interview with Secretary of State for Health, Follow-up conversations with NECP staff Review of Interviewer progress	

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		Training of data entry clerks Follow-up issues with Sightsavers	
Sunday March 9th		Return from Guinea Bissau Work on Guinea Bissau report and Senegal preparations	Arrival in Dakar Briefing meeting with co-evaluator
Monday March 10th	am	Introductions to Sightsavers Staff; review of itinerary Meeting with focal point of National Service for Health Promotion and Education Meeting with National Eye Care Coordinator Meeting with Director of Disease Control	Introduction to Sightsavers Staff; review of itinerary Meeting with focal point of National Service for Health Promotion and Education Meeting with National Eye Care Coordinator Meeting with Director of Disease Control

Annex 10 Country Reports (link)

Annex 11 Survey data sheets (link)

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