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

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ACRONYMS

CHW	Community Health Worker	OIC	Officer In Charge
CON	Community Ophthalmic Nurse	PEC	Primary Eye Care
CSR	Cataract Surgical Rate	PHC	Primary Health Care
DPO	Disabled Persons Organisation	PHFPI	Post Health For Peace Initiative
EU	European Union	PMU	Programme Management Unit
FGD	Focus Group Discussion	PO	Programme Officer
GOTG	Government of The Gambia	RAAB	Rapid Assessment of Avoidable Blindness
HFPI	Health For Peace Initiative	ROM	Result Oriented Monitoring
HMIS	Health Management Information System	RHT	Regional Health Team
HRD	Human Resource Development	ROTP	Regional Ophthalmic Training Programme
HReH	Human Resources for Eye Health	SOMA	Senior Ophthalmic Medical Assistant
IAPB	International Agency for Prevention of Blindness	SSI	Semi Structured Interview
IEC	Information, Education, Communication	SZRECC	Sheikh Zayed Regional Eye Care Centre
IEWs	Integrated Eye Workers	TB	Tuberculosis
IOL	Intraocular Lens	TOR	Terms of Reference
KAP	Knowledge, Attitude, Practise	UNCRDP	United Nations Convention on the Rights of Disabled Persons
LPED	Local Production of Eye Drops	VHWs	Village Health Workers
MOU	Memorandum of Understanding	V2020	Vision 2020
MOHSWSW	Ministry of Health and Social Welfare	WAHO	West African Health Organisation
NaNA	National Nutrition Agency	WHO	World Health Organisation
NEHP	National Eye Health Programme		

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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. 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 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 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 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 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, as was envisaged in the Decentralisation Act to devolve authority and funding to the regions has not happened. Whilst there is certainly greater integration of eye care into regional health services this is not the same as a government backed decentralisation of funding and decision making to the regions, as in the case of Senegal. The programme did not invest in building the capacity of regional health teams (RHTs) to better manage, plan and coordinate resources should devolution of authority have taken place. 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: baselines

against key outcome indicators were not evident and six of ten outcome indicators were not monitored. 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 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. WHO confirmed that whilst the request was forwarded to regional HQ in 2012 a consultant has still not been identified, partly because no-one, from MOHSW, or WHO The Gambia has been chasing it. 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 is evident between the 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. Whilst recognising that some work took place, the evaluation team felt that there could have been greater opportunities built into the programme to foster the sub regional aspirations of the programme, including 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 full 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 areas of The 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.

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 either forwarded the integration of eye care into national health plans and budgets or 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 with senior officials from Senegal and Guinea Bissau suggesting that there could be greater future investment in ROTP if the issues were resolved.

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 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 The 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
						

1 INTRODUCTION

1.1 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 follow-on initiative to the high profile Health for Peace Initiative (HFPI) established by the Heads of State of Senegal, Guinea Bissau, The Gambia and Guinea Conakry, in recognition of common health problems and a desire to foster peace in politically volatile border areas. HFPI began in 1999 with each country taking coordination responsibility for one of four main disease areas; The Gambia led on Malaria and Prevention of Blindness and the programme of eye care involved multi-country collaboration on cross-border activities. It established Sheikh Zayed Regional Eye Care Centre (SZRECC) in The Gambia as a sub-regional training resource
A Mid-term review of PHFPI was undertaken in 2011 and a Results Oriented Monitoring (ROM) by the EC in 2012. Key recommendations included log frame improvement, decentralising programme planning and management and meeting the WHO cataract surgery rate, ensuring cataract surgical outcome monitoring, and establishing an exit strategy.

1.2 Purpose of Evaluation

The aim of the PHFPI final evaluation is to assess the project's achievements and impact in The Gambia, Senegal and Guinea Bissau over the past 5 years. The specific objectives, using the Sightsavers framework of relevance, effectiveness, efficiency, coordination/coherence, sustainability, impact and replication/scalability are to evaluate:

- the implementation of project activities and outputs against final results, with the aim of measuring project sustainability and performance;
- the processes affecting achievement of project results
- the monitoring and evaluation system established and its outcomes
- key lessons learned during programme implementation including best practices
- the degree to which the programme contributed to expected impact and outcome including an exploration of the intervention logic
- the contribution and impact of multi-country collaboration to programme objectives

The study also seeks to assess long-term change, outcomes and impact of the programme, in 2 areas:

- The degree to which the programme contributed to expected impact and outcome including an exploration of the intervention logic
- The contribution and impact of multi country collaboration to the objectives of the programme.

This report focuses on the implementation of PHFPI in The Gambia and is one of three country-level reports forming the basis for the overall evaluation synthesis report, which contains the full Terms of Reference.

1.3 Programme Description

The PHFPI is a five-year programme designed to facilitate implementation of good quality eye care services and also promote eye health in The Gambia, Guinea Bissau and Senegal. This holistic project is one of several components in 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 overall impact level objective of the 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*. In order to achieve this outcome, four main components were outlined: Capacity-building through training eye-care providers; Infrastructure development for delivering comprehensive eye services; Promoting community awareness; Partnership-building for adequate coordination.

These were composed of nine key result areas defined for the project activities[1]. Cross-border collaboration and learning featured as a crosscutting theme and an enabler for increased impact. Key stakeholders include The Gambia NEHP within the MOHSWSW, Helen Keller International (HKI), and Sightsavers.

1.4 Context

The key particularities of The Gambia context include: a long established and respected eye care programme; strong centralised control, despite the promise of a 2008 decentralisation policy; frequent turnover of senior ministry officials limiting institutional memory and drive; the absence of a functioning National V2020 committee to guide eye health work in country and provide a common reference; limited political ownership and a prevailing expectation that external donors will fund the programme.

2 METHODOLOGY

The overall evaluation team was composed of five members: three with social science and international development backgrounds and two West African ophthalmologists with extensive technical knowledge. After an initial phase of document review and analysis, the approach proposed in the inception report was agreed with Sightsavers and key implementing partners. Field visits were then made to all three countries.

[1] See Annexe for list

2.1 Evaluation Approach

The Gambia field visit involved two team members and visits to two of the eight regions, all of which have an established eye service. Information was gathered via:

- In-depth interviews with a wide range of stakeholders including:
  - National level stakeholders in Dakar x 8
  - Regional health authority staff, health personnel x 6
  - Primary and secondary level staff and health personnel x 8
  - Sightsavers regional and project staff x 5
- Focus group discussions with:
  - Community leaders and representatives x 2
  - Primary level health staff and Community-level volunteers (*relais*) x 2
  - Beneficiaries x 2
  - ROTP students x 1
- A survey conducted over 5 days by 10 trained enumerators of a random sample of 250 beneficiaries of cataract and trachoma trichiasis surgery from the two regions: Upper River Region and Western Region 2. The survey tool was a 42 point questionnaire exploring levels of knowledge, attitudes and practices towards eye health, quality of eye services and the impact of surgery on beneficiaries' quality of life. Data was inputted by two experienced data clerks and then analysed by the evaluators.

A debriefing of initial findings to stakeholders prior to detailed analysis was provided in-country. The itinerary, a full list of the people consulted plus details of the survey design and execution are contained in the Synthesis Report Annexes 9, 7, and 4/5/8 respectively.

2.2 Limitations

There were limitations: a/ the evaluation allowed fourteen total days of fieldwork (10 by lead consultant plus 4 by ophthalmic consultant). This timeframe did not allow for full field visits to more than two of 8 regions b/ data was often not available and 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 NEHP or Sightsavers. This difficulty suggests the need for more rigorous eye health information and monitoring systems c/ the absence of baselines and monitoring systems against key qualitative indicators introduced challenges in assessing change over time – a *before and after* approach was taken to the formulation of some survey questions in order to overcome this limitation.

The evaluation team worked to triangulate data collected by crosschecking information with different groups and staff members at different levels. In spite of the limitations, the evaluators believe that the strategy for choosing the informants, as well as the combination of survey, focus group discussions and key informant interviews with clients, stakeholders and programme staff, and efforts to triangulate collected data, allowed for a thorough understanding of the programme's context, its strategies and activities and to formulate recommendations for ways forward.

3 RESULTS

3.1 Relevance

This section considers the relevance of the project to eye health needs in the project area, the appropriateness of Post HFPI design for meeting these needs and for reaching the poorest and most marginalised people, its alignment with national and international strategies and the extent to which it adapted to reflect learning, challenges and opportunities

Programme design fit with eye care needs and theory of change

The Post HPFI project has been highly relevant to the eye health needs in the intervention area: the aims, strategies and activities adopted for improving the availability, accessibility and quality of eye care provided were all highly appropriate and aligned with national and international strategies. Designed as a follow on project to HFPI the project is considered a relevant response to The Gambian population's need for accessible, good quality eye health services. A draft 2008 RAAB, not endorsed by the government of The Gambia suggested an all age blindness prevalence of 0.6%, with avoidable causes occurring in 81.1% of blindness cases and in 85.2% of severe visual impairment cases.

It is believed by health personnel; across the eye care sector that significant progress has been made in reducing both trachoma incidence and cataract backlogs. Substantial numbers of people with eye disease remain however, with insufficient numbers of trained eye health professionals, especially ophthalmologists and technicians. In aiming to improve accessible eye care and referral services, especially at primary and secondary levels, and to embed primary eye care (PEC) into primary health care (PHC), the project design is clearly relevant to client needs.

The logic applied is that *if eye health units are refurbished, equipped and made operational and, if adequate numbers of eye care and non-eye care personnel are trained to identify, assess and refer clients, then targeted communities, including people with acute and chronic eye conditions, should be able to access local treatment for minor sight problems or be referred following assessment for more complex conditions*. In this way, access to and use of eye health services, particularly for rural populations, is increased. This programme logic and design remains valid in that it aims to promote referral and treatment by strengthening eye health care, user confidence and usage at all levels of the system.

More critically, by focusing on consolidating existing eye care work and completing SZRECC construction, the programme design was insufficiently tailored to context. There was an implicit assumption by Sightsavers that PHFPI would continue the sub-regional aspirations of HFPI, but these were not articulated during programme design and thus were not afforded high priority during implementation. Two experience sharing meetings were organised in 2010 and 2013 plus several meetings between Sightsavers staff and National Coordinators. The failure to develop and implement specific

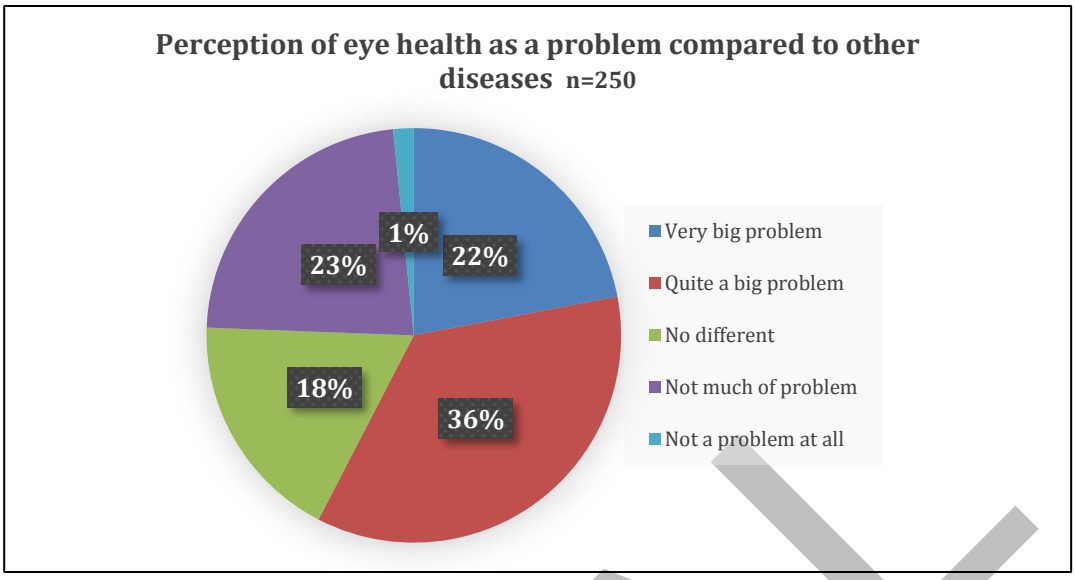
strategies to address long standing SZRECC governance, management and academic issues was a significant oversight that continues to impede international recognition and financial participation by countries of the sub region. It reduces prospects for overall sustainability and is also a missed opportunity.

Reaching poorest and most marginalised populations

The 2013 UNDP Human Development Index (HDI) indicates 35% of The Gambian population living in severe poverty and 33% living below the poverty line. Malnutrition continues to be a major public health problem, with a recent reversal of nutrition trends indicating the proportion of underweight children rising to 18% in 2013 and child stunting to 25% in 2014 (source: Nana 2014 nutrition surveillance).
The relevance of the project was confirmed by 58% of survey respondents indicating that eye problems are a big problem compared to other diseases.

Strategies were adopted to maximise project reach to underserved communities and to overcome people's barriers to accessing treatment: training nyateros ("friends of the eye" - community health volunteers), integrated eye workers (IEWs) and village health workers (VHWs) at primary level in eye health education and detection of eye diseases; supporting cataract surgeons for outreach services bringing services closer to the population and supervision of minor health centres and health posts; promoting radio announcements on local and community radio stations to inform people of outreach clinics and raise awareness. Eye camps did not form part of the PHFPI strategy in The Gambia although other organisations ran eye camps and staff report that people, not only the poor, await the free surgery provided. This impacts on the viability of cost recovery efforts of NEHP eye units.

Chart 1 Perception of eye problems compared to other diseases



Alignment with national/international strategies and frameworks

The project is aligned with national policy and international policy frameworks although The Gambia does not yet have a national eye health policy as it does for other major preventable health issues. The PHFPI project is however consistent with the MOHSW Health Master Plan 2007 to 2020, which includes NEHP in its organogram as well as trachoma control plus training of health cadres for eye disease management. The plan does not specifically mention cataract blindness nor is eye health listed as a basic care package to be delivered through minor and major health centres.

Results areas relating to the development of human resource, infrastructure and equipment are aligned with international targets established by Vision 2020 and endorsed by West African Health Organisation (WAHO), providing a common framework agreed by the International Agency for the Prevention of Blindness (IAPB) and the World Health Organisation (WHO). Indirectly the programme contributes to the United Nations Convention on the Rights of Disabled Persons (UNCRDP) objectives, now ratified by the government of The Gambia if not yet domesticated.

3.2 Effectiveness

This section explores the extent to which the programme objectives in the main result areas have been achieved and how far this has contributed to programme purpose and the strengthening of the health system in The Gambia. It also identifies the extent to which eye care has been integrated into PHC at district level.

A

Specific Objective of Post HFPI
To establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in intervention regions in The Gambia.

Through a focus on primary eye care (PEC) and community linkage as well as strengthening secondary eye care, services are accessible to at least 60% of the population nationally. The project did not define how the percentage of the population would be measured but a combination of findings indicate that this has been achieved: large numbers of community based volunteers have been trained in basic eye health promotion and referral, rural based CONs offer a broad access and the random sample of beneficiaries generated for the evaluation covered a wide variety of remote locations and villages.

The project has done well in taking forward a large body of work providing comprehensive and quality services, although more needs to be done in developing regional refraction services as well as further improving cataract surgery quality. The Gambia has an established and respected eye care programme and the aim of PHFPI in The Gambia, unlike in Guinea Bissau and Senegal, was to consolidate services rather than establish new ones, including infrastructure support to the Sheikh Zayed Regional Eye Care Centre (SZRECC). Activities in The Gambia have been effectively implemented with service delivery targets met or exceeded relating to training, screening, surgeries, consumables and construction. Result areas 3 (empowered regional health teams) and 4 (increased national budgets for eye care) were only partially achieved however, with insufficient emphasis placed on strengthening RHTs, and integrating eye health into national plans and budgetary processes. The failure to adequately address outstanding SZRECC governance, management and training issues potentially compromises overall project sustainability, not just in The Gambia but also in Senegal and Guinea Bissau. Financial unsustainability is a significant risk factor and ROTP needs sub regional government ownership in the form of funding plus visiting lecturers to strengthen its viability and technical quality. The majority of students come from the sub region and of these a large % have been funded by the programme. ROTP has no business plan or marketing strategy in place to address the financial shortfall once these student numbers drop. With sub-regional government support this problem would be in part addressed.

HReH

The project has made a strong contribution to HReH. The target of training and deploying six health cadres was met and there has been a small increase to the number of cataract surgeons.

Sightsavers

Eye care workers trained by the project are present at all levels of the health system (Table 1). The training component has been a strength covering all cadres, except regional health teams. Human resource shortages continue across the health system however representing a challenge to the delivery of eye care services and an area of risk. The problem is compounded by an overall lack of vision for HReH – there is no specific HRD plan and no estimation has been made by NEHP of national needs within each of the professional cadres. It is critical to the sustainability of the eye care service that eye health human resource (HR) shortages are addressed in a planned fashion and that there are accurate projections of the numbers requiring training to meet present and future demand. Without a coherent MOHSW plan, the recruitment and training of eye health staff is likely to remain unsystematic.

Table 1 Human resources trained in The Gambia

Cadre of Personnel trained	Level of health service delivery	Target total	Number achieved	Comment on types/ deployment
Ophthalmologist	Tertiary	1	1	Training ongoing
Non clinical technicians	Tertiary	2	2	LPED technician deployed to Edward Francis hospital; Instrument technician at SZRECC
Cataract surgeon	Secondary level health centres	2	2	2 in training
CONs	Secondary and primary level support	0	4	Still in training – will be deployed to regions
Non eye health personnel	Supporting primary level	140	250	Includes: nyateros, IEWs, teachers, CHWs

Table 2 Eye health human resourcing levels in The Gambia

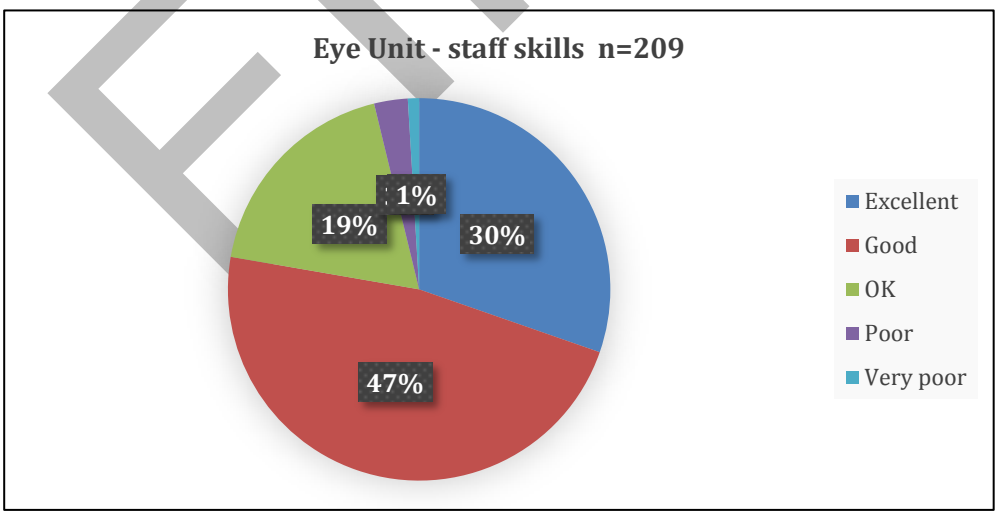
Cadre	Recommended ratio WHO	Number available	Number required	Deficit
Ophthalmologist	1:250,000	2 (2 at SZRECC)	7	5
Cataract surgeon	1:250,000	14 (5 at SZRECC)	7	(+7)
Optometrist	1:100,000	2 (2 at SZRECC)	18	16
Optometric technician	1:100,000	4	18	14
Ophthalmic nurse	1:100,000	19 (10 at SZRECC)	18	(+1)
CON	1:100,000	15	18	3

The Gambia has a small population and the worker-to-population ratios applied to the professional cadre are within WHO limits (Table 2). National statistics, however, mask urban primacy and regional disparities. There is a significant and ongoing deficit of ophthalmologists working in the eye health service.

The attrition of CONs and nyateros continues and 12 CONs left the programme with only three replaced since 2009. Currently there is no government scheme of service offering career advancement or incentives for CONs to remain in the profession. A draft was produced by the MOHSW Human Resources department in early 2013 but not actioned. CONs leave for State Registered Nurse training and the salaries and top ups offered by donor-funded maternal health or HIV/TB programmes. It is unclear how numbers will be maintained in the future. Three successive earlier evaluations of NEHP and predecessors (2004, 2008, 2011) identified the downward trend in capacity through transfers out of eye services.

All eye health staff, other than ophthalmologists and optometrist technicians, were trained at SZRECC ROTP, with supervised internships for cataract surgeons and CONs. Non-eye care staff were trained locally by cataract surgeons , District Ophthalmic Nurses (DONs) or CONs. Senior Ophthalmic Medical Assistants (SOMA – cataract surgeon) confirmed the standard of training to be high. Although there were variations, the skills and knowledge of eye health staff including cataract surgeons, CONs and IEWs were assessed as good by the evaluation team ophthalmologist using a standard checklist. This positive assessment was supported in FGD and SSIs with users and health officials and in the survey: 78% of respondents thought that eye health staff in eye units had excellent or good skills levels (chart 2).

Chart 2 User perceptions of eye health staff skill levels



Tertiary level services at SZRECC are reliant on two ophthalmologists including one national ophthalmologist who is also chief executive officer (CEO). Routine surgery as well as complex cases and private work limit the supervisory time available for cataract surgeons. There are only two people currently in training overseas and it is likely to be years before there is a regionally based professional cadre. Although senior cataract surgeons

currently supervise work there are no regionally based ophthalmologists to technically supervise clinical work performed by cataract surgeons, formally represent eye care agendas in planning and budget setting, and embed eye health into public health activity. This represents a significant gap. It is particularly significant in the context of Senegal, where there is reluctance from health professionals and policy makers to give full recognition and accord status to eye surgeons who are not trained “professional” ophthalmologists. This reduces the credibility of SZRECC as a sub regional centre of excellence and influence.

SZRECC regional ophthalmic training programme (ROTP)

The evaluators visited the SZRECC training centre, meeting with both staff and students. ROTP offers a range of training courses to mid-level cadre across the region with a maximum student capacity of 31. There is a faculty of 22 lecturers of whom only 1 is permanent. Others are part time or visiting lecturers albeit from SZRECC and NEHP. The project supported the training school through completing outstanding construction of the student hostel, staff accommodation and a private block of 10 rooms . Student fees were revised in 2012 and introduced financial self-sufficiency. Fees are broken down and allocated to three main cost centres with a 5-year operational surplus of 1.4 million Dalasi. The system is very dependent on maintaining full student numbers; this in turn is dependent on effective business planning and marketing. To date this has not been adequately addressed by ROTP.

During a FGD students highlighted the following issues: a too brief English language course with some students feeling that they lag in class; students of the advanced diploma in surgical nursing are not taught basic sciences; a series of missed lectures by visiting staff are not rescheduled; a standard text book is not issued to students. The training coordinator also needs to ensure that the 2008 version of the ADSON and DON curricula is used, and not the 2001 version.

There is no business or marketing plan. The visiting lecturers block is mostly empty. SZRECC needs to market itself effectively, both in The Gambia and sub regionally, in order to be financially sustainable. Sightsavers funded a consultant in 2012 to develop a website for the hospital and training centre promoting its services and courses. To date, SZRECC management have not updated the website nor added basic information about courses, dates and application processes. With the end of PHFPI there will be no more student sponsorship from Sightsavers. Over the project period 27% of total student numbers were sponsored by PHFPI (32 of 117) with 58% sponsored by the project in 2013 (14 of 24). Whilst individual Sightsavers’ country offices in Africa may support the training of some candidates in the future this is not a sustainable strategy. The centre faces critical financial and credibility challenges if it does not rapidly produce and implement a viable business plan and market strategy.

Infrastructure, equipment and procurement

Three secondary eye units have been refurbished in Brikama (including a refraction unit), Basse (including a waiting shed) and Essau. The work was completed on time and to a reasonable standard.

Infrastructure work started under HFPI was completed at SZRECC including the construction of a 30 bedroom student hostel, a 10 bed private ward, a twin two bedroom bungalow flat for staff and a four-bedroom block for visiting lecturers. The Gambia programme officer (PO) confirmed a rigorous tendering and selection process for this work, with an external consultant technically supervising the construction process together with monthly site meetings and progress reviews. An evaluation committee, including Sightsavers, NEHP and MOHSW evaluated the bids for the building contract, monitored construction work and made monthly site visits. The buildings were competed on time, despite a 10-week extension in order to modify ventilation arrangements following a mid-term review recommendation, and are to a good standard. Minor defects were addressed although the evaluation team noted flaking paint and sagging ceiling tiles in the private ward.

Apart from the administrative block and student hostel, the new buildings are underutilised. The 10 bed private ward is mostly empty (57 bed nights booked of a possible 3520 bed nights in 2013) and is not bringing in revenue contributing to SZRECC achieving financial self-sufficiency as intended.

Sightsavers assumed responsibility for all programme related procurement including equipment, consumables and vehicles. The Gambia PO managed procurement for the three country programmes using an Excel based procurement plan. In The Gambia there was less equipment involved and processes were straightforward although the laser ordered for SZRECC was not received for 15 months. From 2011 onwards, Sightsavers introduced ProActis, an online ordering system that has worked more effectively and reduced delivery times.

Within the health system, there are frequent stock outs of drugs and spare parts. All facilities visited by the evaluators reported limited supplies of eye drops and basic medicines, with stock outs between 30% and 50% of the time. SOMAs suggest that around 70% of eye medicines are bought by patients themselves at private pharmacies. According to regional health staff, stock levels are determined by central government, with no connection between supplies and the health management information system (HMIS) system that records actual use. The 2012 ROM recommendation regarding stock outs (“*take action on the issue of stock outs at national pharmacies. Support health authorities and advocate for a situation analysis and development of a strategy to solve the problem”*) was discussed at the time with the national eye coordinator but not taken up although the appointment of new leadership in NEHP and MOHSW provides an opportunity for Sightsavers to raise the issue again.

Availability of eye drops was a problem at all eye health facilities visited. Local production of eye drops (LPED) was supported by the programme: the LPED technician was trained in eye drop production and an initial supply of raw materials was provided, including galenicals and bottles. There were quality control challenges, however, and materials were not replaced when stock ran out. Most eye facilities lack antibiotic and steroid eye preparations, so patients purchase from local pharmacies. The establishment of a cost recovery system

and separate accounting would increase the viability of eye drop production and distribution.

Vehicles, motorbikes and replacement equipment were procured and delivered to targeted institutions. None of the units were provided with biometry equipment, important for achieving good quality cataract surgery results; without this, the extent of progress that can be made in improving the quality of surgical outcomes will be limited.

Attention was paid to training the ophthalmic technician based at SZRECC in order to ensure routine maintenance and repair of equipment. The training took place in Nigeria. He maintains equipment from all secondary eye health centres with a turnaround time of one week for minor repairs and one month for major repairs. He reported spare parts challenges and experienced stock outs every six months. The MOHSW has a V2020 link with Swansea hospital in the UK which sends a technical team twice yearly with spare parts.

Supplies of consumables, notably intra ocular lenses (IOLs) have not been reported by SOMAs to be problematic. The project provided some consumables in The Gambia; historically they have been purchased by NEHP and sold at a subsidised price to eye units, with patient fees accruing in what became a diminishing revolving fund. A new partnership established in 2013 between NEHP and a French INGO, will sell 3,000 cataract kits at cost price to hospitals and health centres with built in cost recovery through the 800 Dalasi surgery fee, aimed very much at financial sustainability.

Service delivery

The eye care programme in The Gambia started from a stronger base than Senegal and Guinea Bissau and has been able to build on support from Sightsavers accrued over a 25 year period. Over 500,000 people accessed eye care services delivered by trained and competent eye health cadres working in conjunction with significant numbers of community volunteers. These services span sensitisation to screening and referral, basic treatment to surgery and refraction, operating from community to tertiary levels. While there are significant challenges and some gaps, the eye health service being delivered is nonetheless an achievement.

The project service delivery output indicators illustrate the development of eye care services and success of strategies used to create demand, significantly exceeding targets in all instances, especially for cataract surgery and treatment for refractive error. Tables 3 and 4 summarise the outputs.

Table 3 Numbers reached with comprehensive eye services (data for non blinding diseases not provided)

Indicator	Target	Achieved
Treated for Cataract	12,500	16, 903
Treated for Trichiasis	1000	1398
Treated for Refractive error/Low Vision	4000	11767
Screened	400,000	474,529
Under 5 Vit A distribution	227000	365,763
Total	**644,500**	**870,381**

Sightsavers

Table 4 Patients seen at all eye centres disaggregated

Year	Adult males	Adult females	Children (both sexes)	Total
2009	23,115	26,756	33,680	83,551
2010	21,679	29,220	28,938	79,837
2011	21,802	24,880	23,382	70,064
2012	35,749	39,407	26,241	101,397
2013	39,798	46,297	36,951	123,046
5 year total	**142,143**	**166,560**	**149,192**	**457,895**

A total of 457,895 people were seen at eye clinics over the five-year period; 31% males, 36% females and 33% children. Cadres of eye health workers, especially cataract surgeons reach remote and poor communities in order to maximise access to eye services. This is achieved through outreach services in minor health centres and village health posts and through bi-weekly or weekly surgeries at the secondary level eye units. SOMAs estimate that 30-40% of surgeries are conducted through outreach, accessed by people who say they would not otherwise attend the main clinic, for cost and other reasons. The end of outreach funding is thus likely to impact on future cataract surgery levels. Eye camps did not form part of the PHFPI strategy in The Gambia although it is thought by health staff that numbers of people in remote communities still wait for eye camps funded by other non-state actors or private sector.

Some services are vulnerable as government budgets still do not include a direct provision for eye health services. The national health budget has a general provision for salaries, building maintenance and utilities, and some drugs, but it does not fund fuel, consumables and top ups for outreach services. Neither does it replace broken equipment or refurbish eye units to any degree. There is little evidence of project engagement with disabled people's organisations (DPOs) to develop influencing strategies targeting GoTG decision makers to integrate eye health care into the national health budget. This should have been an approach included at the design stage. It would also have ensured the participation of a broad network of civil society eye health and disability actors from the outset, enhancing the legitimacy and ownership of the programme by a broader range of stakeholders.

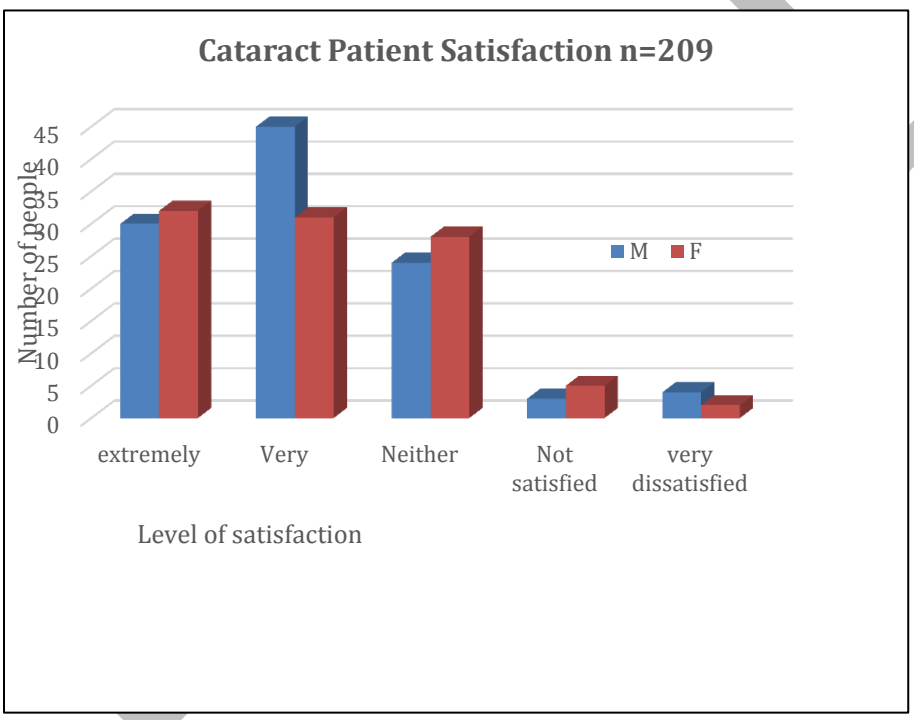
Surgical outcome

Surgical outcome quality has not been monitored by eye health staff to any meaningful degree. Previous reviews have raised this issue, including the 2012 ROM, and the strategy adopted by the project was to operationalise the WHO cataract audit tool in each secondary eye unit. All cataract surgeons have received training in the tool but none are generating surgical outcome data, citing time limitations and the failure of many people to return for follow up appointments. Most forms are incomplete and none have been analysed. Given that surgical outcome is a key success indicator for cataract support it is surprising that no other strategies have been explored to encourage eye units to engage. Although not statistically significant, the evaluation technical review examined a sample of 132 completed audit forms and calculated a good outcome rate of 74% (VA 6/6-6/18) with 25% borderline (VA 6/24-6/60) compared to a WHO target of 85% good outcome. The 2008 RAAB indicated

28% poor outcome. Although by no means definitive, both survey results (71% of respondents reporting good or very good vision) and the examination of completed forms suggest a marked improvement to surgical outcome.

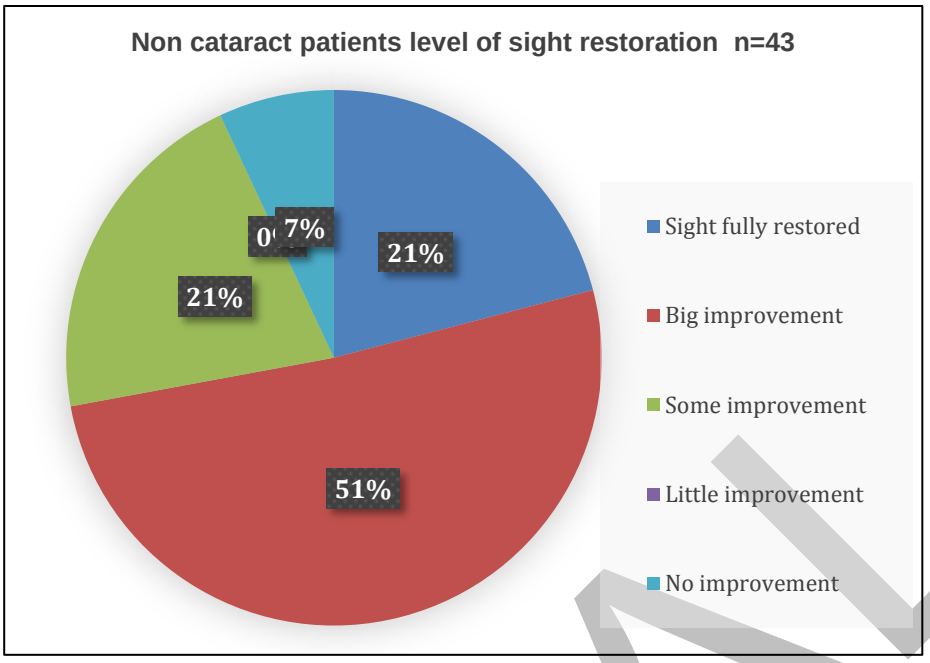
Biometry is not applied to assess IOL strength. In practise, standard lenses are fitted to all patients. While IOL selection without biometry was considered acceptable in 19972 biometry is increasingly used to ensure adequate and consistent outcomes for patients. At the tertiary level facility in Banjul it is especially surprising that biometry and use of the full range of IOL lens strengths is not standard practice. The SZRECC director confirmed that biometry is under consideration acknowledging that the provision of biometry, training in its use and the selection of patient specific IOLs will improve surgical visual acuity.

Chart 3 Cataract patient satisfaction



[2] Cataract Surgery with IOL Implantation. WHO Workshop Lilongwe. June 1997 http://whqlibdoc.who.int/hq/1998/WHO_PBL_98.70.pdf

Chart 4 Non cataract patient satisfaction



Vit A distribution

Vitamin A deficiency is widespread and The Gambia is a regional leader in integrating vitamin supplementation into national immunisation programmes. Helen Keller International (HKI) is the Sightsavers' partner on Vitamin A working with the national nutrition programme to distribute UNICEF supplied Vit A tablets twice annually. The National Nutrition Agency (NaNA) achieved 101% coverage in 2013 from its bi-annual national campaigns with an increased consolidated coverage of 80%. The 2014 surveillance identified Vit A deficiency of 0.6% (low) in children and 1.3% (moderate) in adults. In SSIs both NaNA management and HKI confirmed that project support has led to better data management, improved monitoring and raised public awareness on prevention.

Referral and screening

Some 160 school teachers and 416 community volunteers (nyateros) were trained in order to increase screening levels in communities and schools. The aim was to identify people with basic eye conditions so that they could be referred to other levels of the health service. Over the five year period, 534,443 people were screened nationally against a target of 400,000.

Awareness Raising

Volunteers are widely used in public awareness campaigns. Discussions with CONs, CHWs, health professionals and nyateros confirmed that community attitudes are changing, with less fear and greater confidence in eye health services. This has translated to increased numbers presenting at eye health facilities. People are better informed, with 61% of survey respondents indicating that they feel very or quite informed about eye health issues compared to 2009 (chart 5). Nonetheless, 41% of respondents indicated a need for more public information on eye health. Given the long duration of the NEHP in The Gambia one might reasonably expect overall knowledge levels to be higher. The evaluators noted a dearth of IEC materials in eye units and

village health posts. Survey respondents identified media and family/friends as their main sources of eye information and not, as one might have expected, the nyateros - 24% cited (chart 6). Given other demands on nyateros' time this suggests that the overall level of interaction between them and the public may not be as high as previously thought.

Nyateros are supervised by CONs in monthly meetings but now the programme has ended the loss of the monthly fuel allowance will impact on the ability of CONs to visit the field. In districts such as Brikama up to one third of nyateros have left the programme because of better inducements elsewhere although in more rural regions the nyateros tend to stay; Some nyateros say they feel underused and would like to be more involved in radio sensitisations, be given more IEC materials and engaged in more innovative ways of raising public awareness.

Chart 5 Level of eye knowledge compared to five years ago

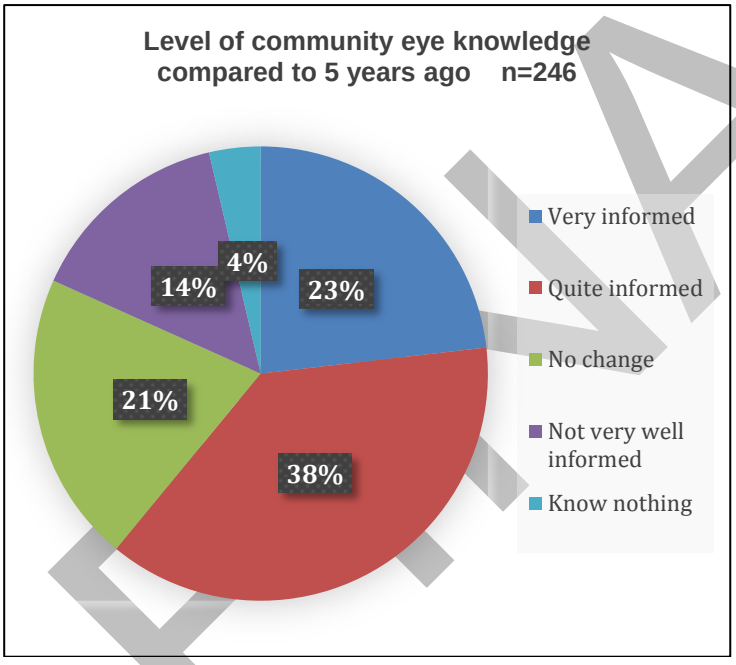
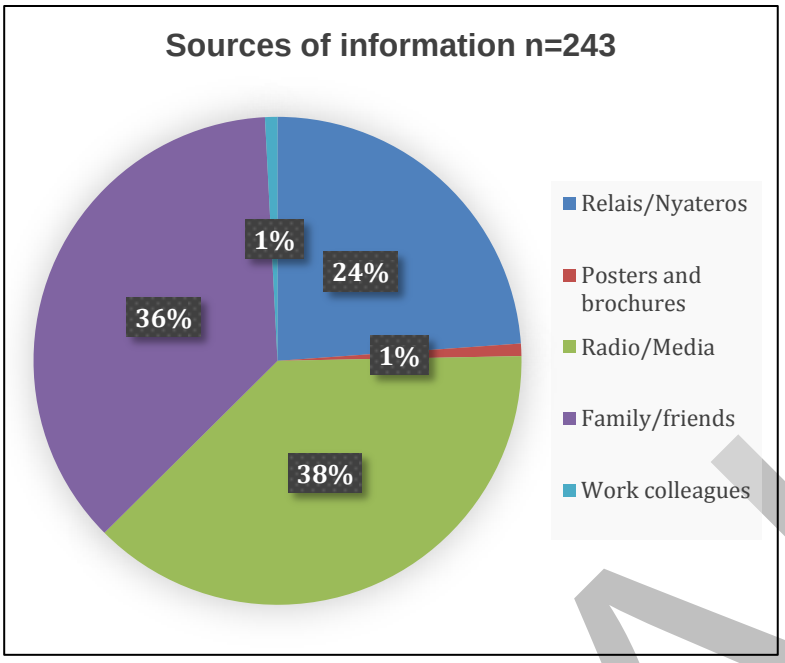


Chart 6 Sources of information



School screening is an integral part of the strategy to increase eye health knowledge and establish referral of treatable eye conditions. Some 160 teachers from 80 schools received a two-day training course on basic eye care screening. The evaluators saw variations in approach but in general it included some classroom screening conducted alone by trained teachers along with occasional joint screening with health centre staff. In some instances the school works closely with itinerant teachers who visit regularly. Whatever the approach, children with eye problems are referred to the local eye clinic.

Teachers also promote basic hygiene and general eye health messages. During school visits it was clear that school children's basic knowledge of eye hygiene was adequate at both primary and secondary levels. Asked what they knew about keeping eyes healthy, several groups of children aged 9–14 had basic knowledge about using clean water, preventing dust getting in eyes, hand washing, avoiding rubbing eyes and keeping a clean environment. However, motivation and engagement of teaching staff varied widely. In one school, staff had placed plastic basins and jugs in each classroom with soap for washing; in another, neither screening nor health education talks had taken place despite 10 teachers being trained. Some teachers wanted more training, all require more charts and IEC materials, not evident in most schools visited.

A booklet for schools was developed containing standard eye health messages: 300 copies were printed in 2012 and distributed to all regional health teams (RHTs) and eye units. Over 100 radio programmes were funded by the programme and many free slots were also provided. Overall, however, it was felt by programme as well as eye health staff that Sightsavers could have considered a broader communications approach; one that included

media work, artists for mural and posters, community theatre, peer approaches and establishing school eye health clubs.

Empowerment of regional health teams

RHTs were involved in PHFPI design and are supportive of the project. However, they have not been involved in routine planning and management and their participation has been limited to PO monitoring visits, annual review and planning meetings, and attendance at the two experience sharing meetings.

It had been hoped to strengthen RHT management capacity to better engage with eventual decentralisation and devolution of budgets. That this did not happen in The Gambia suggests again that key context issues were not considered at design stage.

Planning, coordination and expenditure on eye health

Integration of eye care is important for sustainability and for cost sharing and yet it is not yet fully embedded into the PHC work of the hospital or RHTs. Health officials confirmed that cataract surgeons attend monthly RHT meetings and hospital management meetings but they are invited rather than full RHT members. Increased coordination is also reported between departments (inter department referrals, inclusion in outreach) in the facilities visited in Western Region 2 and Upper River Region but this is not institutionalised. Inclusion of eye health messages in public health education campaigns or the provision of additional fuel for planned SOMA outreach is common, but not formalised. Sightsavers programme staff recognise the potential to achieve better integration of eye care into health programming by involving eye care staff in multipurpose outreach work and by institutionalising relationships but even so, given the longevity and profile of The Gambian eye programme, it is surprising that these issues remain largely un-addressed.

Despite a decentralisation policy, budgetary processes in The Gambia remain centralised. Regional directorates confirmed little power or input into annual budget setting processes. RHT priorities are set by central government and their work doesn't necessarily reflect their annual plan – a list of prioritised activities submitted to MOHSW, negotiated and agreed without a budgetary attachment. Those RHTs interviewed had not seen the annual MOHSW budget and erratic disbursement from the centre often delays implementation.

The regional planning process does not include eye health and, in this respect, eye health may be still considered a vertical programme. Regional eye care staff prepare an annual plan, but it is submitted separately.

6% of the national budget was allocated to health in 2014. This represents a reduction from the 2013 health allocation of 10.5%. Within this it is not possible to state the proportion allocated to eye health. The evaluation team was unable, despite considerable effort, to obtain basic eye health budget information from MOHSW relating to staff salaries, drugs and basic operating costs. In a context therefore where budgets and budgetary processes are un-transparent, the PHFPI programme indicators (a/ increased expenditure on eye care and b/ the % of committed expenditure to eye care) may be

unrealistic. In reality, sustained advocacy is needed in a strategy involving other sectoral actors to influence the MOHSW. The capacity of The Gambia civil society networks and policy institutes to engage in budget transparency and accountability work is not yet developed.

3.3 Efficiency

This section examines the efficiency of implementation and through assessing the management and administration of the project and how well resource inputs were converted to the desired outputs.

A

Programme management and oversight

Strong management and oversight of implementation were maintained once the current Sightsavers programme manager and The Gambia PO had settled into their roles. The reconfiguring of the programme management unit took time to achieve and although it introduced committed programme staff, there was a loss of eye care expertise to the programme after the early departure of the programme manager (The Gambia country director).

The Gambia PHFPI project was not complex; The Gambia PO maintained a close oversight of project activities and was largely successful in ensuring good coordination of inputs. The Sightsavers project team placed considerable emphasis on ensuring compliance with EU requirements for financial accountability and programme management, holding a partner workshop prior to commencement of activities and drawing on Sightsavers UK office for revision of the project log frame in compliance with the ROM recommendations.

Mechanisms for country level review and programme oversight were satisfactory and included quarterly monitoring visits by NEHP and Sightsavers, and an annual joint review and planning meeting attended by Sightsavers, NEHP, RHTs and cataract surgeons to review progress and plan for the forthcoming year. Annual in-country reviews were mainly concerned with capturing results from the current year and not with the larger goals of the five-year programme.

Annual reports were compiled by the Sightsavers PO from quarterly reports submitted to Sightsavers by NEHP. Narrative reporting at all levels reflects the service delivery focus of the programme document, with under reporting on outcomes and progress made towards achieving objectives.

A summary tool developed by the PMU in 2012 prior to the ROM was adjusted to include subsequent log frame revisions and thereafter updated quarterly by the PO. The tool allowed programme staff to systematically view progress against output targets by country as well as for the sub-region. While this is clearly very useful there could have been greater emphasis on reinforcing the connection between activities implemented and desired change outcomes.

Logistics and distribution

In The Gambia, some consumables and other medical items including eye drugs are purchased by central government annually and distributed through the central pharmacy. Regular stock outs of drugs and eye drops were reported by all health facilities although most medications are available from local private pharmacies. In the facility pharmacies visited by the evaluators, especially at minor health centres, there were minimal quantities of drugs and consumables other than those relating to global funded malaria and TB programmes.

Project clinical equipment and vehicles were purchased directly by Sightsavers. In procuring through an international non-governmental organisation (INGO) the project was able to take advantage of duty free concessions, introducing financial efficiencies into the procurement process.

Monitoring, evaluation and learning

Oversight of progress towards achieving project outcomes and impact was less than satisfactory. The limited emphasis on monitoring, evaluation and learning (MEL) is a challenge to the ability of Sightsavers and NEHP to learn lessons, make informed management decisions and to document and measure change and impact.

Sightsavers and NEHP successfully collated and reported service delivery data and thus it is possible to say that output level targets have been largely achieved. The integration of eye care data was also integrated into the national HMIS system during the lifetime of the project, a considerable achievement. NEHP quarterly reports contain details of outputs and activities but nonetheless the PO had to expend significant amounts of time completing data gaps.

The key weakness has been a failure to agree how outcome level indicators would be monitored and measured in practice. This remained unresolved. It is therefore more difficult to comment on the impact of activities on people's lives and people's access to, attitude towards and use of eye services. Current outcome monitoring gaps include surgical outcome, cataract surgical coverage, blindness prevalence rates, impact on user lives including quality of life and satisfaction levels, community eye health attitude and knowledge levels, budget allocations to eye health.

The PHFPI log frame was revised on two occasions, the second being after the 2012 ROM, in which the Sightsavers Monitoring and Learning team introduced a more measurable qualitative focus including a quality of life indicator. However, baselines were not put in place against key qualitative change indicators and they were not monitored. There is thus little hard data available to evidence improvement at outcome level and changes to the lives of users or to health systems resulting from the project's work tend not to have been systematically captured.

Capturing output data is more straightforward, but it needs to be analysed if it is to inform management decision-making and this was not always the case. For example, although the CSR indicator was introduced in 2012, data was

available for the programme period back to 2009. If annual calculations had been made, then a trend of declining CSR levels at regional level may have prompted discussion between NEHP and Sightsavers on causal factors together with remedial planning.

Finance and resource mobilisation

The project was allocated 12% of the total PHFPI budget with the majority earmarked for training, salary top ups and equipment. The burn rate in The Gambia varied annually, achieving 99% expenditure against budget across the 5 years (Table 5). What is clear is that there was significant rear loading of the budget with 37% received in the final year. This was mostly allocated to capital items, some of which were not handed over to MOHSW until early 2014.

The PHFPI finance manager worked with the project and partner staff ensuring strong oversight of project finances through quarterly meetings with Sightsavers colleagues and regular visits to partner administrations to audit, collect receipts and ensure monthly returns were submitted on time. Close financial monitoring also ensured compliance with Sightsavers and EU systems and adherence to their correct formats. Partners expressed their appreciation of financial management processes and of the learning opportunities presented through close and regular engagement with the finance manager, although late financial reporting would delay Sightsavers fund disbursement.

Partners also mentioned the problem of monthly disbursement – Sightsavers, despite the MTR recommendation, did not introduce quarterly transfers in The Gambia and it was commented that delays impacted on implementation. The lead time for Sightsavers financial reporting and transfers was 15–20 days: a two-to-three week period from partner transfer to cash in account.

Table 5 The Gambia annual expenditure analysis

Programme	2009	2010	2011	2012	2013	Total
Budget EUR	67,134	47,945	215,516	174,169	258,100	699,426
Expend EUR	72,869	81,840	151,948	119,394	247,064	673,115
% Spent	133%	122%	78%	62%	96%	99%
% The Gambia budget	10%	12%	22%	17%	37%	

There were budget revisions in August 2009 and September 2011 and the year one programme of work and budget was revised to accommodate delays to the start of implementation caused by phasing across countries and regions plus financial limitations. As a result, the eye health programme didn't commence in The Gambia until year 3, excepting ophthalmologist training and SZRECC construction. In year 3 the budget was revised again in order to align activities in the work plan.

Cost recovery, unit costs and cost effectiveness

The programme did not directly address cost recovery issues although these are critical to financial sustainability from programme outset. This is an

unusual omission given Sightsavers strategic aim to build capacity and institutionalise eye services.

Charges are fixed by central government and designed to recoup the cost of treatment. Waivers are available for the poorest on making a presentation to the officer in charge (OIC). On average, about 15% of patients in those facilities visited for the study were exempted from fees. Waivers are funded by cross subsidising user fees. The average cost of a cataract operation was kept relatively low, although it rose from 350 Dalasi to 800 Dalasi in 2013. Fees are kept by the hospital or health centre in a revolving fund although officers in charge (OICs) were unclear on the percentages retained by the health facility and the percentage ploughed back to the eye unit in order to purchase more consumables and drugs.

All eye care managers acknowledged the importance of finding a balance between affordability for the poor and ensuring a high take up of services. Too few operations reduces the turnover on which the hospital or health centre depends to support overhead and other running costs of the eye unit.

The PHFPI project did not calculate cost per activity against beneficiary numbers. It is not therefore possible to analyse costs comparatively across the programme. Staff did not receive training or directions from Sightsavers in calculating unit cost and cost effectiveness to any meaningful extent. Nor were staff required to provide this data and analysis.

3.4 Coordination and Coherence

The evaluation sought to assess the coherence and coordination of the programme: at country level it explored the complementarity of programme objectives, approaches and design; the inclusiveness and representativeness in design and operational coordinating structures; information flow; and the degree of coordination with the MOHSW and other organisations working on eye health issues. At regional level, it explored coordination between the three country programmes.

AR

Coordination within MOHSW

Health care in The Gambia is not decentralised, a significant limiting factor in realising the integrative aims of the PHFPI project with respect to planning and coordination at regional level. Even so, whilst not yet fully institutionalised, cataract surgeons are included in RHT meetings in the majority of regions and this ensures that eye health services are integrated to some degree into routine management and coordination processes. This represents an improvement from 2009 when eye care was not recognised by many health facilities. The national ophthalmologist commented that the NEHP now works more closely with RHTs. This includes informing them of plans and sending directions for SOMAs via the regional authority. Eye surgeons are now required to report both to NEHP and to RHTs.

Although there is certainly scope for greater integration, eye health is aligned with the health systems in The Gambia and the programme is broadly consistent with the objectives of The Gambia health strategy. However, there

is no overarching national eye care vision within which to locate the work of the programme, address key issues such as staff retention, engage with other sectoral actors such as DPOs, or promote influencing agendas.

The programme was implemented by the MOHSW and coordinated by NEHP at national level. There has been a high degree of ownership and involvement by NEHP and some senior MOHSW officials in review, planning and monitoring. At regional level however, the work of the programme has been impacted at times by a challenging relationship with the NEHP. In hindsight, Sightsavers programme staff acknowledge that a broader range of mitigation strategies could have been developed in order to identify solutions and circumvent obstacles.

Sightsavers coordination mechanisms

Programme coordination mechanisms put in place by Sightsavers have largely worked well. Externally, quarterly reporting deadlines ensured a regular flow of information on progress from RHTs to the national coordinator to the PMU. Scheduled quarterly planning and review meetings between the PMU, the NEHP coordinator and RHTs took place less often than planned as did quarterly monitoring and supervision visits to field facilities. The Gambia PO was accompanied by the national coordinator with detailed PO visit reports shared widely.

Annual country review and planning workshops were attended by Sightsavers programme staff, NEHP and RHTs as planned. The two sub regional experience sharing meetings were also used as an opportunity for progress review and planning across the programme, with the April 2013 forum held in Dakar considering disengagement plans.

Internally, there was good coordination with the Finance Manager through close proximity in the Banjul office and with the PM in Dakar through quarterly meetings and regular phone calls. The quarterly PMU coordination meeting took place every 4 – 5 months to review progress and share experiences but overall there is not a strong sense of programme teamwork across countries.

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

Sightsavers programme staff acknowledge that opportunities to collaborate with broader civil society, especially DPOs, were not fully pursued. This could have added significant value to the programme through more inclusive planning and review mechanisms and in forwarding influencing agendas.

The V2020 committee has been dormant in The Gambia for some years, possibly since The Gambia country director left post. Sightsavers regional staff from Dakar attended meetings with donors and government when visiting The Gambia to discuss strategic issues relating to PHFPI. It is surprising therefore that the Sightsavers country team in The Gambia had such minimal links with WHO and other UN agencies with a health mandate and that it did not use the programme to launch greater engagement with V2020. Whilst not affecting PHFPI directly, for sustainability and the future of eye care

programming as a whole, more collaboration needs to be developed at national level.

There is evidence of collaboration with other agencies during the project period. One Sight, an INGO in global strategic partnership with Sightsavers also works in The Gambia to coordinate resources so that refractive error services are supported as widely as possible. Not all eye units have optical units and One Sight equipment and training is seen by NEHP and Sightsavers as making an important contribution to the overall programme. It also supports business planning and cost recovery systems. More widely however there is limited evidence of collaboration with others.

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 funded through HKI but implemented through NaNA; the main linkage with eye services has been the involvement of eye unit staff in distribution campaigns

Coordination measures between the three country programmes

Following on from HFPI, from Sightsavers perspective there were 3 key aspects of interest in the 3 country collaboration: improving the governance of SZRECC and the status of its training courses; frank and detailed discussion of shared challenges and problems; supporting sub regional sharing and learning mechanisms.

The first two areas of interest were not resolved and the key benefit derived from the 3 country structure and coordination measures was the training of 18 mid-level eye health cadre from Senegal and Guinea Bissau and 14 from The Gambia. The disappointing quality of discussions was largely attributed by participants to stakeholder intractability on outstanding governance and financing issues. The multi country meeting organised to try and resolve the SZRECC issues with WAHO participation did not take place until the closing month of the programme, without much progress being made.

The sub regional mechanism put in place for learning and sharing amongst programme partners and stakeholders were two experience sharing meetings organised by Sightsavers in 2010 and 2013. The Gambian attendance at the larger 2013 meeting was limited by the NEHP national coordinator and clinical staff therefore did not attend. This limited the scope for sharing best practise from The Gambia programme at a key time in the PHFPI programme. The focus was largely on replicating best practise but a considerable utility was attached by Sightsavers to exploring monitoring issues and reviewing performance against targets in 2013.
The 2013 meeting also spent time developing country level disengagement strategies, to be further developed and actioned by participants upon their return. It is not evident from reports or interviews that the forum explored influencing agendas or the collective development of a common platform around regional support for eye services. Generally, this remained as a gap in the programme. Influencing initiatives did not emerge from any country level programme to be developed and promoted sub regionally.

There was little further contact between eye care programmes outside of the sharing meetings and it is broadly recognised that the potential for programme exchange was limited by language challenges. Had a budget been available then Sightsavers could have done more to widen the range of opportunities and to foster a culture of sharing.

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 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.*

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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 health systems 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. Certainly much has been achieved in 2 of the 4 result components in meeting overall service delivery targets. In The Gambia context the evidence from output data and interviews with eye health and other health actors suggests that services are well established and that, although staffing levels remain challenging, a comprehensive range of eye health services are being provided. The linkage to One Sight in particular introduces significant value addition to comprehensive service delivery through the phased development of regional refraction and optical units.

From The Gambia perspective there are a number of omissions from the theory of change and process related adjustments that it would be useful to make explicit so that they are taken into account in the future: a/ time frame – given the Sightsavers 25 year experience of support to eye services in The Gambia it was perhaps unrealistic to assume that empowered regional authorities could be achieved within a 5 year period without specific project inputs; b/ the importance of creating focused advocacy and communications

components with clear change agendas; c/ the impact of centralised services on planning and delivery at regional level and on the integration prospects of eye services d/ sub regional aspirations needed to be explicit both in design and implementation with less attention to service delivery and more to strategic challenges including policy frameworks and SZRECC governance and management, impacting on longer term sustainability.

The evaluation team assessed progress against impact indicators at overall objective and specific objective level using monitoring data collected by the programme as well as information from SSIs. Results are presented in Table 6 below. The team also assessed changes to the lives of targeted service users through FGDs and through a survey of 250 people exploring service satisfaction levels, quality of life changes, and eye heath knowledge, attitudes and practices. Baselines had not been established for qualitative indicators and therefore the survey design deliberately employed a *before and after* questioning line in order to assess change over time. There are no recent statistics officially available for The Gambia that would establish a baseline on blindness prevalence and surgical coverage rates. While it is possible to infer change, it is not possible to definitively evidence this change.

PHFPI has made a positive contribution to maintaining comprehensive eye services in The Gambia and also boosted the ability of SZRECC to provide quality training to eye health students from The Gambia and across the sub region. The actual impact of this support is harder to assess. Statistical data suggests a decline in services and coverage in The Gambia, with falling CSR levels (i.e. cataract surgeries), screening figures, and percentage of people presenting that are treated.

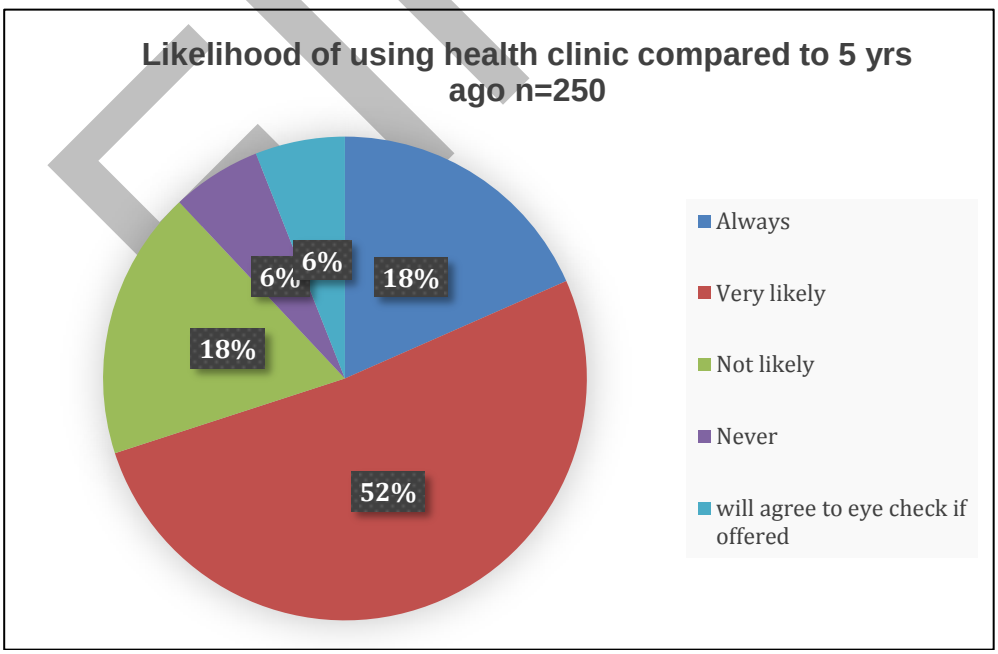
Chart 7 indicates 70% of respondents more likely to use an eye health facility than 5 years ago but in the context of such a long standing programme should this figure have been higher? Focus groups and user surveys however suggest public perceptions of improving services and greater confidence in eye health services with increased quality of life resulting from available treatment/surgery. These contradictions require further exploration by NEHP and MOHSW.

Table 6 Result against output indicators at overall and specific objectives level

Indicator	Result
CSR	2,151 in 2009 to 1,760 in 2013. The trend is downwards and the figure below the West Africa V2020 of 2000 needed to address ongoing incidence.
Blindness prevalence	Epidemiological study in 1996 indicated prevalence rate of 0.4%. This has not been updated. The 2008 RAAB finding of 0.6% was disputed by The Gambian government and not endorsed.
Quality of life	Not monitored. Survey of 250 people plus FGDs suggests significant impact on lives. No baseline in place.

Percentage of referrals from traditional practitioners	0.2% referrals from TPs (955 of 523,443)) in 2013. No baseline figure in place
Surgical coverage	No prevalence survey undertaken since 1996. Current surgical coverage unknown requiring a country wide study.
Percentage of positive surgical outcome	Audit tool inconsistently used in most instances and not analysed. A random examination of a sample of 125 forms indicated good surgical outcome of 74%. WHO standard is 85%.
Number of cataract surgeries with IOL	100%. No biometry. Standard lens strength used of 20 and 21 dioptres.
Percentage of facilities with stock outs	80% facilities experience regular stock outs of eye drugs and eye drops linked to limited national health budget and to inefficiencies in central procurement and distribution system
Patients presenting receiving eye care service	Number of presenting eye care patients that are treated falling annually from 96,146 (66% of total) in 2009 to 58,720 in 2013 (48% of total).
Percentage of committed expenditure on eye care met	Salaries, maintenance and utility costs covered within MOHSW national budget plus drugs. No specific eye budget. Health budget fell to 6% in 2014.

Chart 7 Likelihood of using eye health services compared to 5 years ago



The national 2013 CSR figure of 1,760 (including the tertiary centre) represents an overall drop of 18% since 2009. Whilst there are annual fluctuations, the regional average CSR in 2013 was 1,625 with reductions of between 18% and 58% in five of seven regions over the project period. The

tertiary hospital, SZRECC maintained a CSR level of 2,261. In 2009, five regions attained the West Africa CSR threshold of 2,000 required to address current cataract blindness incidence rates, but only two regions attained that level in 2013 (Table 7). This suggests that the programme is unlikely to have had an impact on prevalence rates and that, while eye health services are well established in The Gambia, central government budget limitations plus other challenges relating to policy, human resourcing and systems inefficiencies are negatively impacting on service delivery at regional level to largely rural populations. These changes require exploration, especially the very marked falls in cataract surgery in North Bank Region west, North Bank Region East and Central River Region.

Table 7 Change to regional CSR figures 2009 to 2013

Region	CSR 2009	CSR 2013	Percentage change
Western Region 1	1782	1741	=
Western Region 2	1709	2127	+57
Upper River Region	2203	1815	-18
Lower River Region	2499	1808	-28
Central River Region	2985	1549	-48
North Bank Region – E	4260	2112	-50
North Bank region – W	1928	825	-57
Kanifeng (SZRECC)	2226	2261	=
National average	2151	1760	–18

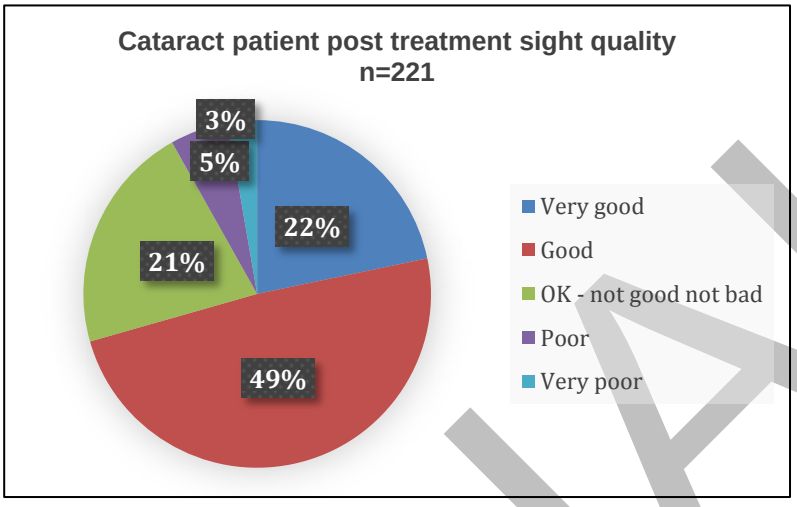
This overall picture is reinforced by statistics indicating that the number of eye patients presenting at eye units whom are treated is falling (Table 8). Other MOHSW statistics suggest that community screening numbers have dropped by 75% over the period and that school screening numbers have fallen by 59%. Early detection and referral through screening is vital to the community-based approach promoted in The Gambia and the reasons for these declines again should be urgently explored by NEHP.

Table 8 Numbers presenting being treated

	2009	2010	2011	2012	2013
No treated	96,146	74,228	71,121	59,645	58,720
No presenting	145,072	132,406	939,946	113,513	123,046
% treated	66	56	76	53	48

Surgical outcome is an important indicator of surgical quality. The WHO audit tool is not being used consistently within the eye health service and there are no statistics collected nationally on surgical outcome. In the beneficiary survey 68% of respondents reported that they were very or extremely pleased with surgery outcome with 25% recording a neutral response. The WHO recommended level for good surgical outcome is 85%. User focus groups confirmed high levels of satisfaction with surgical outcome.

Chart 8 Cataract patient sight quality

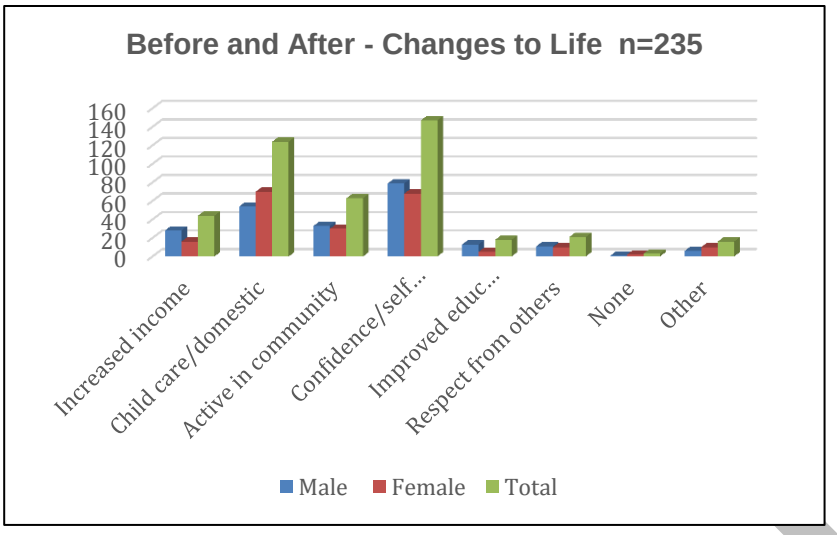


Quality of life

Although the project did not baseline or monitor quality of life, both survey results and FGDs confirm the significant impact that restoration of sight has on the quality of life of eye health users. They report changes to quality of vision, confidence and self-esteem, and ease with engaging with outside activity, usual work and work related activity. Respondents also reported a reduction in their sense of being a burden to others since receiving treatment. Charts 9 to 14 below illustrate some of the positive changes experienced by project users.

In the survey (Chart 12) 57% of respondents reported no difficulty with engaging in outside activity after treatment compared to just 8% before treatment; 24% had reported moderate or severe difficulty before treatment compared to 7% after treatment. After treatment, (chart 10) 54% of respondents reported that they feel that they are never a burden to their families compared to 18% beforehand.

Chart 9 Changes to life since treatment



In SSIs, OICs, women's groups, Village Development Committees (VDCs) and Village Health Workers (VHWs), confirmed increased community confidence in the quality of eye health services being provided locally and reduced hesitation to use these services. All knew of people and family members who have received treatment and are pleased with the results. In FGDs, cataract patients reported greater independence and reduced sense of burden, ability to assist with domestic duties, look after children and care for themselves. Many are able to do farm work again.

Chart 10 Before and after treatment - difficulty with outside activity

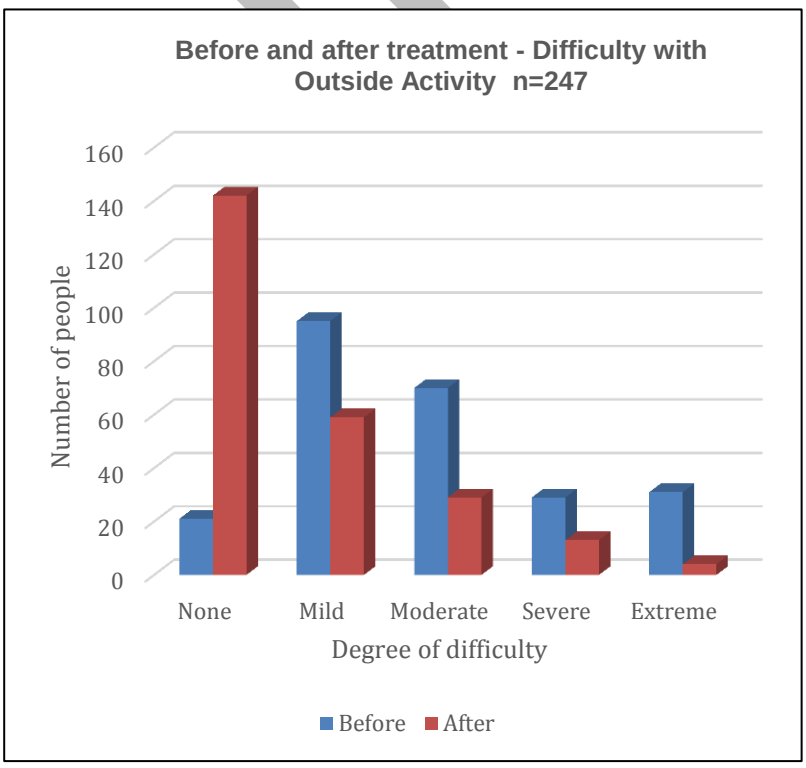


Chart 11 Before and after treatment - other difficulties

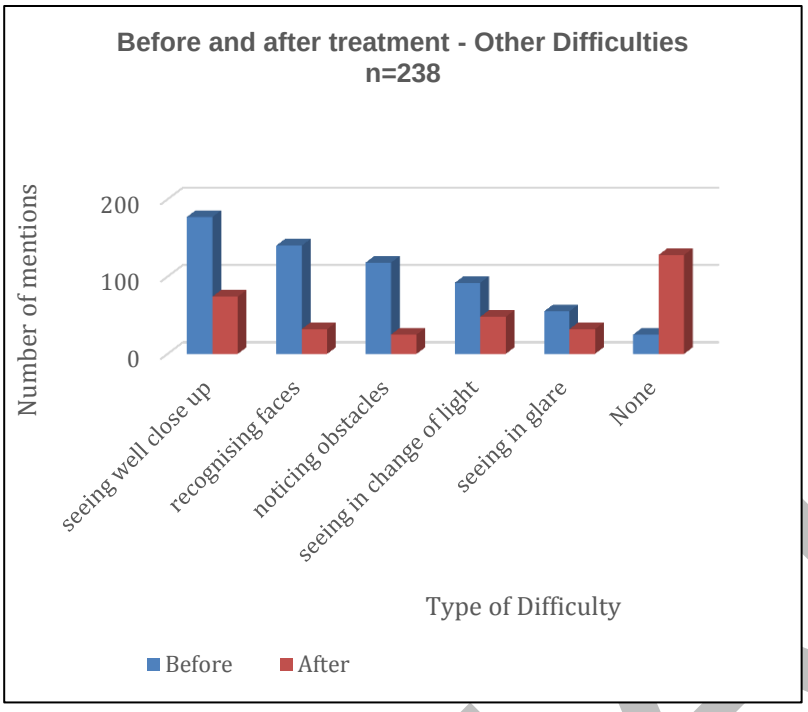


Chart 12 Before and after treatment - sense of burden

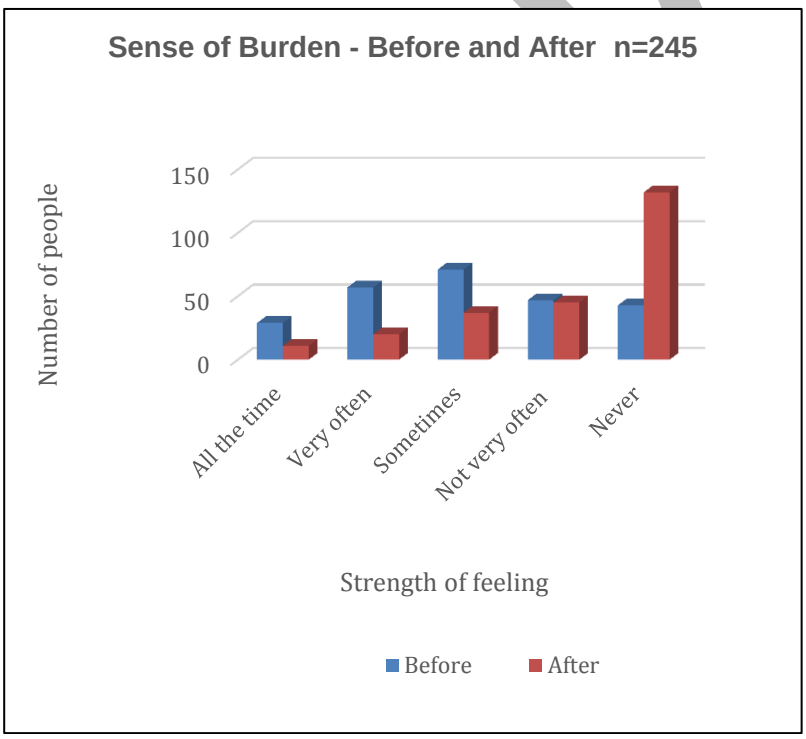


Chart 13 Before and after treatment - difficulty with usual work

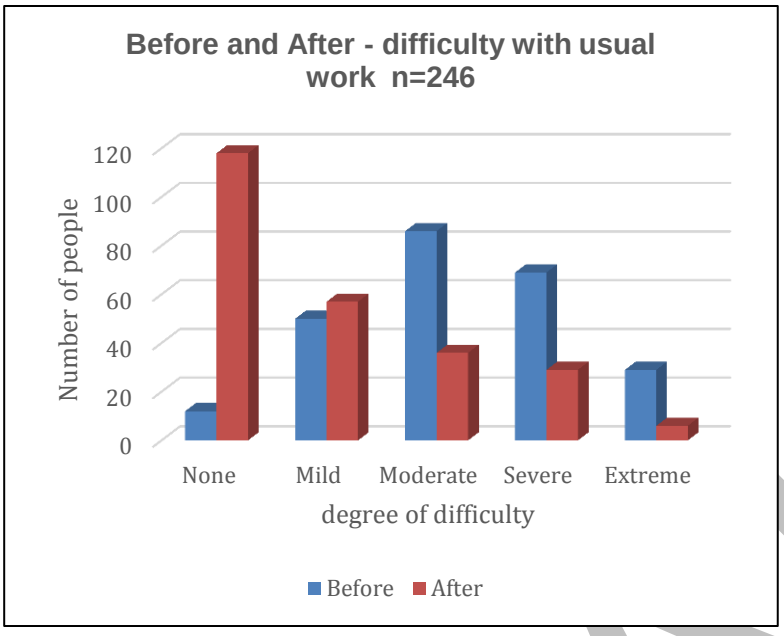
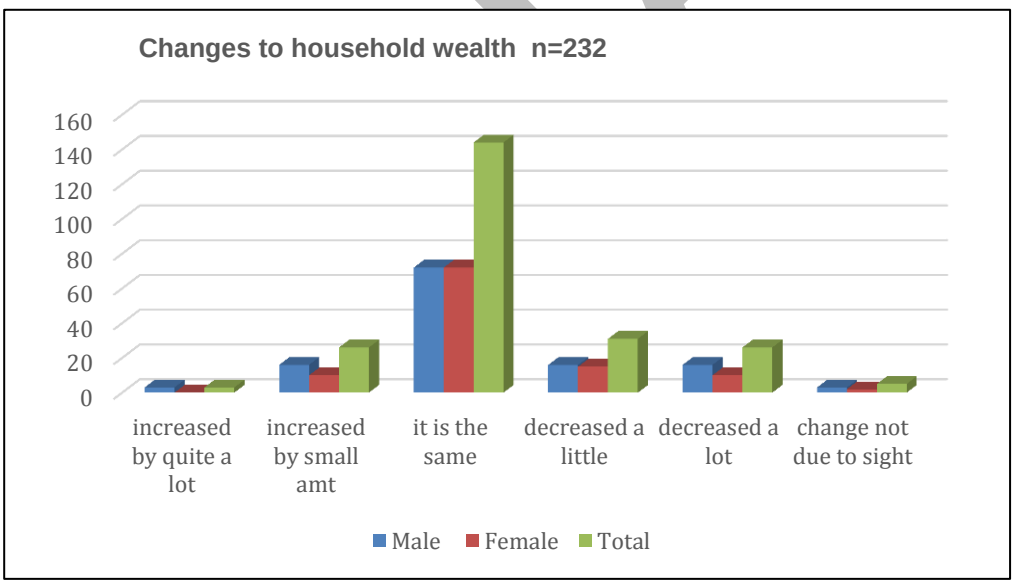


Chart 14 Changes to household wealth



Knowledge and attitudes

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 long term work of community-based nyateros. In the survey, 61% 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 59% of respondents reporting quite or very supportive attitudes to people with visual impairment and 88% stating that they have made changes to their daily habits in order to maintain healthy eyes.

The data suggests that there is more to do in developing and promoting effective communication strategies. Trachoma has almost been eliminated in The Gambia after successive campaigns and treatment of trichiasis within the PHFPI programme is low, with both surgeons and CONs reporting very few cases. Yet, 55 % of survey respondents reported that they did not know the main causes of trachoma.

Budget allocations

Government funds many aspects of eye health service delivery including salaries, drugs, basic utility and some fuel costs. IOLs are provided by another agency and sustained through a cost recovery system. However, there is no specific eye health budget, a key indicator against the specific objective. The project did not develop 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.

Sightsavers priority has been to ensure effective service delivery and, although regional Sightsavers managers have discussed these broader agendas at ministry level during periodic visits to The Gambia, there is little to suggest a comprehensive influencing strategy being systematically pursued at country level by Sightsavers. Since 2010 there has not been a country director in The Gambia to promote the Sightsavers brand or to strategically network. This role was undertaken by a regional operations manager based in Dakar who visited The Gambia two to three times a year.

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, rotating the board chair position plus sub regional recruitment of the SZRECC Director position. This in turn would promote greater engagement 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 project as well as undermining the sustainability of all three country projects. It is also surprising that Sightsavers commenced PHFPI without a clear MOU and timetable in place with GoTG on addressing these issues.

The outstanding SZRECC issues have not been resolved. Discussions commenced again at a December 2013 sub-regional meeting hosted by WAHO in The Gambia and funded by Sightsavers. This key meeting highlighted the issues to senior MOHSW 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 provided an international framework and structure that facilitated sub regional training but actual activities were limited to two meetings 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 The Gambian stakeholders as a benefit or perceived weakness of the programme. When probed, most health 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.

3.6 Sustainability

The level of integration of eye care into the health services is recognised as a determining factor for their sustainability. There is some integration in The Gambia but the limited decentralisation together with un-transparent budget processes pose a considerable challenge to further embedding eye care into national and regional planning and coordination mechanisms.

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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?

Eye care services and structures in The Gambia are well established and will continue beyond the life of the programme. In that sense, the service is embedded although still quite dependent on the presence of Sightsavers for

human resource development, infrastructure development and supplies of some materials and equipment. Some disappointment was expressed by NEHP managers that Sightsavers country support may be ending.

Eye services are located within the general health system, but there are some integration issues undermining sustainability that have not been addressed. A key challenge, according to all health professionals is the limited MOHSW resourcing although the percentage of national budget allocated to health care rose from 9.1 to 10.5% by 2013. Funding for eye health services is not specifically identified within general health budgets however and it proved impossible for the MOHSW planning unit in Banjul to determine actual levels of eye financing by the government. At present, the MOHSW meets the costs of staff salaries and pays for basic drugs and eye drops. There is no reason to believe that staff salaries may be at risk but salary top ups of 10% provided by the project to cataract surgeons, CONs and others to increase motivation ended in December 2013 and will not be picked up by MOHSW.

Medical professionals including cataract surgeons expressed doubts about whether fee levels can generate sufficient funding in the short term to cover the cost of outreach and top up. Fees recently increased to 800 Dalasi and may create barriers to access by poor people, reducing demand and over time undermining the financial viability of the eye units. This is a significant risk. An MOU with The Gambian government highlighting roles and responsibilities after the end of the funding period on costs such as fuel for outreach, top up salaries or training may have increased the chances of achieving sustainability after PHFPI support.

Non-retention of trained eye care staff, especially at CON and nyatero level, probably represents the greatest threat to the sustainability of the programme in the longer term. These challenges are already highlighted in the Effectiveness section of the report but progress depends on the long awaited National Eye Care policy, which has still not been developed. MOHSW transfer policy exacerbates the situation by transferring CONs out of region or to other nursing duties.

Decentralisation of decision-making and devolution of funding to regional health teams has not yet taken place, despite the promise in the 2008 policy initiative. Since 2011 NEHP communications to SOMAs have been directed through the RHT but even so, eye health care in The Gambia continues to be centrally managed with little decision-making input by RHTs. At regional level, eye health services are integrated with respect to space, utilities and HR, but this is not the case in terms of planning, decision-making, supervision and funding. Eye health staff and OICs at facility level suggest that progress has been made in the level of interaction with other health programmes and SOMAs also confirm the referral of eye patients to other departments, including HIV and diabetes units, when they see symptoms. These arrangements are not yet institutionalised.

It is important that eye care at national level is identified as a separate health issue in national health plans and has its own budget. Sightsavers did not develop influencing strategies during PHFPI aiming to ensure a dedicated

budget for health, nor did it develop baselines and monitoring frameworks capable of measuring programme impact. Robust evidence of sustainable gains and value for money might help convince health authorities at national level to fund the eye care approaches promoted by Sightsavers. However, the regular turnaround of senior ministry officials tends to undermine both institutional memory and relationship building. In this context taking forward change agendas or even exploring issues of concern becomes problematic, as experienced by Sightsavers with respect to the SZRECC regional governance issue.

How effective are the systems developed by the programme to sustain project achievements to target communities at the expiry of the programme funding?

The risk to long standing non state supporters such as Sightsavers is that the MOHSW comes to regard them as the main service provider. This makes it difficult to convince the authorities that they need to plan and budget eye health within the overall health system. There are limited resources across the health sector and although eye care is recognised by senior health officials, it is not considered the highest priority when allocating limited resources.

Outreach activity is considered essential by many eye health workers in accessing hard-to-reach groups and maintaining surgery numbers, as many people are not able to attend secondary health centres. According to programme staff and health officials, top ups and per diems do not necessarily promote right motivation to make an eye health difference. However, without funding for fuel, outreach cannot happen. Health staff predict that cataract surgery numbers will drop in 2014 as outreach comes to an end and services become more unaffordable due to the increase in fees.

Awareness raising is a key strategy for encouraging service take up. Programme staff acknowledge that Sightsavers should have embraced a broader and more inclusive range of communication and awareness raising strategies and allocated more funding to this activity area. At the least, volunteer peer mechanisms would be more likely to continue after programme end. IEC materials were limited in scope and were seen in very few of the health facilities, schools and communities visited by the evaluation team.

Exit strategies

Currently there is no overarching exit strategy in place for the sub regional programme although draft disengagement strategies were developed by each country team in April 2013. The Gambia disengagement strategy was agreed in December 2013 with NEHP, after the end of the programme, although it is unclear to what extent this has been fully shared with stakeholders, actioned or funded. Overall, insufficient attention was given by Sightsavers and NEHP to developing and communicating a clear exit strategy including post-project sustainability and business planning. What is clear at local level is that committed and highly motivated eye health and medical staff will ensure that eye care is integrated as much as possible into other outreach and public health education programmes. Nyateros and volunteer community health workers are also likely to continue to include eye health talks as part of their role.

3.7 Scalability and Replicability

On the basis of evidence the evaluation sought to assess and identify the potential of the PHFPI programme to be scaled up and/or replicated by other sector actors and government health ministries.

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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. The Gambia eye health programme is well established and its approaches well known. These include linking community to region via rural services that include volunteer nyateros and the rural deployment of a CON cadre; increased community eye care education and screening; stronger primary and secondary level units able to manage basic treatment with informed referral to regional eye units and hospitals; collaboration between public health actors and eye care workers on outreach and eye health education.

With adaptation, some approaches have been replicated. The *relais* in Senegal, perform the same role as nyateros. Eye workers from Guinea Bissau have reported that information and sharing on the way eye screening has developed in The Gambia has been valuable as they develop a similar service.

The model is not underpinned by robust data on its impact. 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 MOHSW 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.

Until greater progress is made in embedding eye care into health planning and budgetary systems, both at national and regional levels, NEHP is likely to remain dependent on donor funding, thus undermining both the sustainability and the scalability of programme achievements. A revised MOU with the MOHSW and NEHP, more clearly highlighting responsibilities, expectations and resourcing commitments after programme end, is important in supporting sustainability and scalability.

Ideally outreach and screening work should be maintained by health authorities linked to V2020. This however requires political will on the part of national authorities both to establish a national eye care plan linked to V2020 and to provide funding for these core activities. The Vision 2020 committee has not met for 3 years although it has a critical role to play in establishing strong frameworks for the future development of eye care services in The Gambia.

4 CONCLUSIONS & RECOMMENDATIONS

PHFPI in The Gambia has supported the further development and delivery of accessible eye health services in all regions of the country reaching over 60% of the population and making a significant contribution to the achievement of the programme goal.

The programme has made a strong positive impact through a large body of work to achieve output targets against four key result areas: increasing HR capacity; service delivery; infrastructure and equipment; and coordination. Clinical targets in particular have been exceeded. There has been reported but un-quantified progress against purpose and goal level indicators including impact on sight quality and quality of life of eye health users. Impact on livelihood is inferred rather than proven.

Higher numbers of potential users are being reached with increasing demand for services. NEHP remains dependent on donor funding however to maintain the service including infrastructure quality, ophthalmic equipment replacement and undertaking outreach work. This limits sustainability but will remain the case until there is greater political ownership and commitment to developing an overarching eye health framework.

Overall performance and delivery by cadres of motivated eye health professionals is impressive, all the more so in a context of vertical planning and limitations on human resource and budget levels. Human resource challenges include high CON and nyatero attrition rates and a continued shortfall of national ophthalmologists able to clinically supervise cataract surgeons and contribute to regional eye care planning. In the longer term, non-replacement of key staff will weaken service delivery and make it difficult to sustain eye health awareness and referral levels. Developing and implementing an HRD policy that includes career progression and a scheme of service for eye health workers is therefore critical.

Eye care statistics were integrated into HMIS in 2013, a major achievement by Sightsavers The Gambia country team. However, more attention should be given to qualitative monitoring and data analysis with comprehensive MEL systems established at programme outset. Inconsistent qualitative monitoring potentially undermines learning and management decision-making. There remains limited data on prevalence, surgical outcome and budget allocations, with no quality of life or KAP baseline or data set and no tracking of MOHSW allocations to eye health services.

The evaluation team analysed eye health data. The national 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 are declining in rural areas of The Gambia, reinforcing a disputed 2008 RAAB portrayal of increasing blindness prevalence.

An important element of the community based health care approach is awareness raising and CONs, nyateros and the radio media have played an

important role although survey results suggest that more work is needed . A broader basket of communications strategies may have also included media work, artists, community theatre and peer work in schools and communities. IEC materials were developed by the programme, but they were noticeably absent from the majority of health centres and schools visited by the evaluation team.

In general, well executed PHFPI service delivery has been achieved at the expense of addressing strategic challenges that inhibit impact and sustainability. These include the absence of influencing strategies with respect to the re-establishment of a V2020 committee in The Gambia, developing a national eye care policy, strengthening regional health bodies in preparation for eventual devolution, and the integration of eye care into health care plans and budgets. These could have been given greater consideration at PHFPI design stage with the participation of a broad range of civil society actors, thus enhancing legitimacy and overall ownership of the programme. Sustainability is undermined at SZRECC through the lack of a business plan and marketing strategy that can achieve financial self-sufficiency.

The sub regional agenda has been largely subsumed and represents a major omission at design and planning stage. Other countries will not commit resources until SZRECC governance issues are addressed and limited progress has been made. Unless management is re-energised the training school also faces critical challenges over coming years to maintain quality, numbers and relevance. Similarly, the opportunity presented by the project for cross border collaboration and sharing was not fully exploited. These issues represent missed opportunities undermining overall impact and sustainability.

The PHFPI experience has generated some general sustainability and impact lessons for Sightsavers. Key lessons include having the following in place at the outset of the programme: a MEL system focused on tracking and documentation qualitative indicators of change; an MOU with government on exit strategies and respective role and responsibilities after the end of the programme funding period; cost recovery and business plans from programme inception for improved financial sustainability; funded advocacy plans with a broad network of stakeholders aimed at strategic influencing around key policy issues; and, more broadly, actioning the truism that the power to negotiate over financial and policy matters is stronger at programme beginning than at programme end.

Recommendations:
In addition to more detailed suggestions contained in the text, the evaluation identifies the following key recommendations in the context of a Sightsavers country exit strategy:

1. **Integration of eye care**: NEHP should seek to increase the integration of eye health services into Regional Health Teams through including eye unit operational matters and outreach activity in ongoing planning and management. The NEHP would retain strategic management responsibility with technical guidance and support provided by Regional Ophthalmologists (where in place) or NEHP. This would reduce the burden on NEHP created by

its current responsibility for all aspects of eye unit functioning including technical supervision. Sightsavers should consider supporting a programme of RHT capacity strengthening and improved governance over a two-to-three year period in preparation for the eventual devolution of the planning and funding responsibility to regional level. In addition it should engage in a network of CSOs to advocate with government for enactment of the 2008 decentralisation policy.

2. **Future sustainability**: Sightsavers should consider putting the following in place *before* the start of any programme: an effective MEL system for capturing change; Mousy with GOTG that include roles and responsibilities including financial ownership at programme end; cost recovery and business plans for greater sustainability; advocacy and influencing agendas with other stakeholders on strategic issues

3. **Advocacy**: Engage WHO on the lack of progress in developing a national eye care strategy with a broad coalition of civil society actors. Such a policy to include eye health HRD and the integration of eye care into health budgets and plans.

4. **Exit strategies:** a/ Ensure The Gambia PHFPI disengagement strategy is funded and actioned in order to maximize the programme investment and gains made to data 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.

5. **V2020:** The protracted dormancy of the V2020 committee is a matter of concern needing urgent attention. Progress requires the elaboration of a strategic approach and action plan with key partners including MOHSW, DPOs, WAHO, WHO.

6. **SZRECC:** a/ Support SZRECC to develop and action a business plan and full marketing strategy in order to maximize its potential for financial sustainability. Without these in place the considerable investment made into ROTP is likely to be undermined. b/ Support deficiencies identified in the training programme c/ Sightsavers with WAHO to urgently support and facilitate resolving the outstanding governance issues inhibiting the ability of SZRECC to assume its full sub regional mantle. An MOU with GoTG should be agreed establishing actions and timeframes.

7. **MEL**: The current blindness prevalence rate in The Gambia should urgently be established as a baseline for NEHP future work. Recruit MEL officers during inception of major programmes to lead on data analysis plus the extraction and documentation of key lessons and best practice for experience sharing.

8. **Consolidation**: develop and implement strategies for improving the quality of services offered at regional level eye units, in particular the supervision arrangements for cataract surgeons and provision of biometry equipment for cataract surgery. This is important for protecting and consolidating the progress achieved.