Strategic Evaluation of the Vision Bangladesh Project

6 June 2014
Final Report

Prepared by
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Acknowledgements

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This evaluation was carried out with the assistance of Sightsavers and BRAC staff, who arranged all meetings and field visits. CEPA is grateful for this support received. We are also grateful to all the project staff and other stakeholders who met with us to share their insights and experience regarding the project.

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Acronyms and abbreviations

Acronym	Description
BCO	Bangladesh Country Office
BDT	Bangladeshi Taka
BNSB	Bangladesh National Society for the Blind
CEPA	Cambridge Economic Policy Associates
CFPR	Challenging Frontiers of Poverty Reduction
CSR	Cataract surgery rate
DCR	Dacryocystorhinostomy
DCT	Dacryocystectomy
DGHS	Directorate General of Health Services
GoB, GO	Government of Bangladesh
HNPSP	Health, Nutrition and Population Sector Programme
IAPB	International Agency for the Prevention of Blindness
M&E	Monitoring and evaluation
MoHFW	Ministry of Health and Family Welfare
MO	Medical Officer
MoU	Memorandum of understanding
NEC	National Eye Care
NGO	Non-governmental organisation
OT	Operating theatre
PSP	Patient screening programme
QA	Quality assurance
SACMO	Sub-Assistant Community Medical Officer
SICS	Small incision cataract surgery
ToR	Terms of Reference
VARD	Voluntary Association for Rural Development
WHO	World Health Organization

Executive summary

This report presents Cambridge Economic Policy Associates (CEPA's) findings, conclusions and recommendations from the "Strategic Evaluation of the Vision Bangladesh Project".

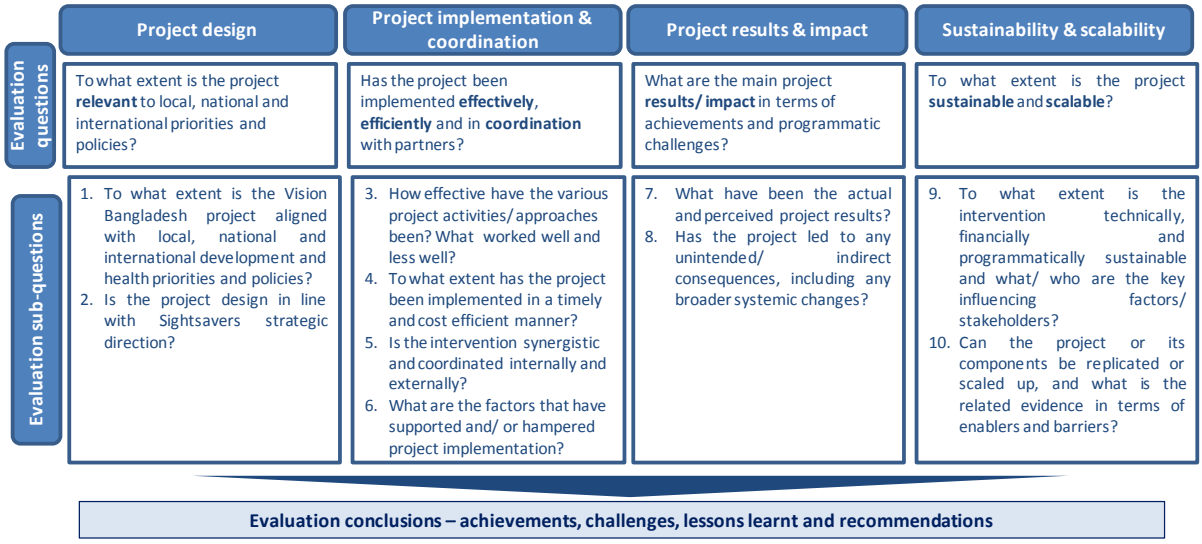
The goal of the Vision Bangladesh project is the "elimination of avoidable blindness from Bangladesh by 2020", and its specific purpose is the "elimination of the backlog of cataract blindness from Sylhet division by the year 2013". The project was a partnership between the Government of Bangladesh (GoB) through the National Eye Care (NEC) under the Director General of Health Services (DGHS) of the Ministry of Health and Family Welfare (MoHFW), BRAC and Sightsavers. BRAC was responsible for demand creation through community mobilisation and case detection at the grassroots level using their trained Shasthya Shebikas (community health volunteers), Shasthya Kormis (community health workers),[1] and GoB's community health workers. Sightsavers was responsible for supporting the supply of quality cataract eye care through partnerships with government and NGO hospitals. The NEC served as the overall coordination, monitoring and quality control agency. This three year project (2011-2013) covered four districts in Sylhet division (total population of over 12m), and had a budget of £2.9m (314m BDT), jointly and equally funded by Sightsavers and BRAC.

The objectives of this evaluation are to: (i) review achievements and challenges of the project to capture lessons and suggest the way forward for Sightsavers, as well as for BRAC and NEC; and (ii) develop strategic and operational recommendations for the project.

Our review framework (presented in Figure 1 below) comprises four inter-related dimensions and questions on project design; project implementation and coordination; project results and impact; and sustainability and replicability. We present our findings on the four dimensions and our conclusions by the Organisation for Economic Cooperation and Development-Development Assistance Committee (OECD-DAC) evaluation criteria of relevance, effectiveness, efficiency, impact, sustainability, scalability/ replication, coordination/ coherence. The evaluation also takes into account the WHO health systems building blocks and cross-cutting issues of gender, equity, service quality and partner capacity.

[1] Shasthya Shebikas are frontline community health volunteers who receive basic training from BRAC to promote a wide variety of healthy behaviours, treat common medical conditions, and refer patients to preventive and curative services according to their need. Shasthya Kormis are frontline community health workers who receive health training from BRAC and supervise the Shasthya Shebikas, for which they receive a monthly stipend.

Figure 1: Evaluation framework



We have adopted a mixed methods approach for this evaluation comprising: desk-based review of documents; stakeholder consultations; focus group discussions; visits to health facilities; and quantitative analysis. These methods have been used for all dimensions of our evaluation framework, with some methods being more relevant for particular evaluation questions.

Summary assessment

Vision Bangladesh is a relevant project aligned with the local and national eye health priorities in the face of high incidence of cataract, as well as the backlog and large treatment gap for cataract in Bangladesh, especially Sylhet. Its objectives and design are aligned with the prioritised action areas under WHO's Universal eye health global action plan and NEC Plan.

The project has largely achieved its objectives of increasing demand for and awareness of eye care services (particularly cataract) in the community as well as access to quality eye care services. The project has also resulted in some positive unintended consequences in terms of supporting improved eye health in Bangladesh (e.g. implementing quality control guidelines, promoting District Vision 2020 committees), and some wider systemic benefits (e.g. systems strengthening in hospitals, facilitating multi-stakeholder collaboration). However, the project faced some challenges around capacity building and training on account of several factors, including inadequate government health workforce at the district and upazila levels, delays in working with the government, and political unrest in the country.

The project successfully implemented a Government-Non Governmental Organisation (GO-NGO) partnership model, and leveraged the skills, expertise and comparative advantages of its implementing partners. The partners worked in close coordination with each other. However, engagement by the government in providing overall strategic guidance/ oversight to the project could have been better.

The project is being taken forward by BRAC and NEC and seeks to replicate and scale-up several elements of the project design such as patient referral mechanism of community mobilisation as well as patient-to-patient mobilisation. Sightsavers are also planning to replicate the approach in three new Divisions. However, the absence of a clearly defined exit/ phase-out strategy in the original project design has led to some key activities being delayed until the continuation of the project by BRAC/ NEC (e.g. incentive payments to Shasthya Shebikas and patient screening programmes (PSPs) at the community level) as well as a decrease in patient inflow for cataract surgeries – challenging the project's sustainability.

We present our main findings on the four review dimensions and our conclusions and recommendations below.

Project design

The Vision Bangladesh project is well aligned with the local and national eye health priorities, especially Sylhet, given that cataract accounts for 80% of avoidable blindness in the country and there exists a large backlog and treatment gap for cataract. The project objectives and design are also aligned with the prioritised areas of action under the NEC Plan and WHO's universal eye health plan. The project seeks to address avoidable blindness by establishing a strong referral system for primary eye care at the community level through strengthening existing health facilities and facilitating partnerships between the government and non-governmental agencies (i.e. GO-NGO approach).

The project is centred around improving access to and delivery of quality eye care services (primarily through cataract surgeries). Although it does not expressly target strengthening health systems (which is prioritised in Sightsavers strategic framework), our assessment is that the project has directly and indirectly supported the health systems building blocks in terms of (i) integrating eye care within the existing health facilities; (ii) strengthening existing facilities through capacity building and Human Resource (HR) training and provision of eye care equipment; (iii) facilitating GO-NGO partnerships; (iv) incorporating standard cataract surgery protocols; (v) increasing reporting and monitoring of eye health; and (vi) developing community awareness on eye health.

While the project's overall design appears appropriate to address eye health (particularly cataract) issues, we have identified a few limitations in its approach, including: (i) phased implementation approach resulted in some eye health delivery issues (including for those unable to afford transport to local health facilities); (ii) use of dated statistics for determining project thresholds which are unlikely to reflect the current cataract backlog in Sylhet; and (iii) criteria for selecting Sylhet for the project was not explicit, given that blindness prevalence in Sylhet was lower than other divisions in the country.

Project implementation and coordination

The three project partners were chosen to leverage their respective areas of expertise and available resources (Sightsaver's eye health expertise, BRAC's wide network of community health workers and NEC's coordination mandate). Further, their roles and responsibilities were clearly defined under the project. The Project Steering Committee (PSC) served as an effective coordinating body which ensured that the partners worked in close collaboration. However the Project Advisory Committee (PAC) was less effective as it did not secure adequate engagement/ participation by the government representative. Quarterly project management meetings at the district level, attended by all the implementing partners, also ensured the project was well-integrated.

The project promoted an effective GO-NGO approach in eye care service delivery in Bangladesh – such a partnership is likely to support greater local ownership and long term sustainability in delivery.

In terms of project implementation, our field visits suggest that the referral mechanism of community mobilisation through the Shasthya Shebikas, Shasthya Kormis and GoB Community Health Assistants has been instrumental in creating awareness of and demand for primary eye care at the community level. Monitoring and supervision under the project has been effective with regular visits by Sightsavers and NEC to the partner hospitals, particularly to ensure compliance with the Standard Cataract Surgical Protocols. Some issues which have detracted from effective implementation include: (i) mixed feedback on adequacy of training; (ii) inconsistent post-operative follow-up; and (iii) sliding scale beneficiary payment structure not working as intended.

The total project budget was £2.9m (314m BDT) for the period January 2011 to December 2013. However, actual project expenditure has been lower at £2.3m (approximately 79% of the total budget). Of total funds expended, the largest proportion was for cataract surgeries (£1.6m against budget of £1.8m). Both BRAC and Sightsavers underspent their respective funds allocated. Mechanisms should therefore have been in place to analyse spending levels between the two funding partners in order to discuss how to reallocate funds. Suggestions on alternate activities to have deployed the under-spent funds include additional PSPs at the community level, a formal equipment maintenance plan (including provision of spare parts), training patient counsellors and introducing task-shifting procedures from ophthalmologists to lower level staff. While the funding approach of Sightsavers UK routing funds to its Bangladesh Country Office (BCO) through BRAC for cataract surgeries appears logical to facilitate quicker clearance from the NGO Affairs Bureau in Bangladesh, we question whether BRAC could have directly transferred funds to hospital partners (subject to approval by Sightsavers BCO to maintain control over partner performance) to save an additional transaction in the routing of funds.

Project impact and results

Vision Bangladesh has exceeded its targets for increasing demand for eye care services (particularly cataract) and increasing accessibility to quality eye care services for the poor. During the project period, a total of 1,010,815 eye patients received eye care services vis-à-vis its target of 1,000,000; and 109,960 cataract surgeries were performed vis-à-vis its target of 100,000. However, the project faced some HR challenges. For example, the number of government staff at the upazila and district level health facilities was inadequate, which had an impact on the quality of services provided. In addition, some consultees questioned the adequacy of training provided, desiring more in-depth as well as periodic refresher training. Other challenges include lack of adequate incentives to retain trained health staff at the district level, delays in establishing eye corners in upazila health complexes, etc.[2]

Lack of a prospectively designed results framework (setting out the desired outputs, outcomes and impact, and related milestones and targets) has constrained our assessment of the project's achievements. In general though, the project was viewed positively by all stakeholders consulted. Key points to note include:

[2] Sightsavers has trained Upazila health complex staff and equipped health complexes with equipment to enable the provision of primary level eye services. A room/ area within the health complex has been identified for this purpose, which is referred to as an "eye corner".

- The project has increased awareness of eye health issues through social mobilisation by BRAC and GoB community health workers; word of mouth by patients; public announcements; imam meetings; folk songs, etc. Several beneficiaries mentioned that they have resumed their daily activities, including employment, after the surgery, resulting in improved livelihoods.
- PSPs organised at the community and upazila level (including the provision of return transport for cataract patients) and eye corners established at the upazila health complexes have resulted in improved access to quality eye care services at the community level.
- The project has provided capacity building training to 8,882 field health workers and 44 technical personnel (ophthalmologists, MOs, nurses, SACMOs) on primary eye care.

The project has also resulted in some positive unintended consequences in terms of supporting improved eye health and wider systemic benefits in Bangladesh – for example, supporting the entry of BRAC in the provision of eye health in the country, implementing guidelines for quality eye care, systems strengthening in partner hospitals, and facilitating multi-stakeholder collaboration for eye health.

Sustainability and replication

The Vision Bangladesh project ended, as planned, in December 2013. BRAC and the NEC have decided to continue implementing the project for a further two years in Sylhet and also launched an urban eye care project named 'Vision Bangladesh Phase II' in 11 city corporations and six Upazilas.[3] Sightsavers are also planning to replicate the Vision Bangladesh approach in three new Divisions.

Overall, there has been mixed experience in terms of sustaining project activities/ benefits beyond its closure. Some aspects of the project design/ benefits are likely to be sustained including: (i) demand and awareness of eye health services created through the patient referral mechanism and patient-to-patient mobilisation; (ii) strengthened institutional capacities to deliver quality services by equipping existing health facilities; (iii) greater ownership by having NEC as a key partner, amongst others; and (iv) leveraging BRAC's field strength to enter into eye health related services.

However, lack of a well-defined exit/ phase-out strategy in the project design meant that stakeholders and beneficiaries were not always well informed of project activities ending. Additionally, some key project activities have been delayed after the project ended in December 2013 until BRAC/ NEC's project continuation (e.g. PSPs at the community level, incentive payments to Shasthya Shebikas). Indeed, since the end of the project, utilisation of cataract services has reduced in Sylhet. For example, the number of cataract surgeries performed in VARD Balaganj hospital decreased from 2,398 in the first quarter of 2013 (83% of which were supported by Vision Bangladesh), to 715 during the first quarter of 2014.[4]

[3] Project details provided by Sightsavers, although we note that BRAC reported the project duration as 2.5 years and operating in 10 out of 11 City Corporations during our in-country consultations.
[4] It should be noted that this period in 2014 also saw political unrest which could further impact this decrease.

The project is generally viewed as having successfully tested new approaches, including creating a GO-NGO partnership and introducing primary eye care services at the community level, which could be scaled up and replicated to eliminate cataract blindness in other areas in the country. Several components of the project are being replicated in BRAC/NEC's continued work in Sylhet and in their wider Phase II project, including: (i) GO-NGO partnership approach to implementation; (ii) social and community mobilisation by BRAC and GoB field level health workers to create demand for and awareness of eye health issues at the community level; (iii) referral system between the communities and health facilities; and (iv) capacity building of eye health care providers; amongst others. Another key success in terms of sustainability is that the NEC is planning to include certain approaches piloted by the project into the NEC Action Plan, currently being drafted.

Cross-cutting issues

Vision Bangladesh has treated almost equal numbers of men and women for cataract surgeries during the three years (52% and 48% respectively). However, there has not been any analysis to ensure that the project design has adequately addressed any gender-specific barriers to access, for example the need for women to be accompanied for treatment and if this might deter access. This is particularly important given that blindness prevalence in Bangladesh is 1.72% in women and 1.06% in men. There is therefore a need for a higher female utilisation rate to redress this.

Financial barriers to access for the poor have been addressed by the project through community-level PSPs, provision of free/ subsidised surgery and coverage of transport costs. However, creating a sustainable mechanism for ensuring the poor have access to eye services will be a real challenge for NEC in the long-term, as such a community focussed project approach is particularly resource-intensive.

A high level of quality of care has been achieved through partnering with high capacity NGO hospitals and suitable quality control procedures (e.g. for post-operative care). In addition, strong monitoring mechanisms were put in place at the district level. However, governance mechanisms at the national level through the PAC have not worked well due to lack of engagement by the government.

Summary conclusions, lessons learned and recommendations

Our summary conclusions and rating (Table 1) are presented by the OECD-DAC evaluation criteria.[5] For each criteria, we also present the key lessons learned/ recommendations.

[5] Criteria are assessed drawing on our evaluation evidence and rated using the Sightsavers "Traffic-light scale", as described in Appendix D.

Table 1: Summary conclusions and lessons learned/ recommendations[6]

OECD-DAC criteria	Our assessment/ rating	Overall assessment	Lessons learned/ recommendations
Relevance	Highly satisfactory G	The overall objectives and design of the Vision Bangladesh project are very relevant for the Bangladesh context, given the high incidence, backlog and treatment gap for cataract.	The mandate and approach (in terms of its focus on the elimination of cataract backlog) of the project worked well and should be continued. A manual or operations research report on the Vision Bangladesh approach should be produced. *Recommendation for:* **all partners**
Effectiveness	Satisfactory G A	The project has been effective in creating awareness of and demand for eye health services and increasing access to quality eye care services. However, factors such as inadequate staff at health facilities and lack of monitoring procedures for post-operative follow-up visits have detracted from effective project implementation.	Staff retention measures should be taken at health facilities to retain trained workforce. Periodic refresher training sessions should be provided. Clearer monitoring protocol on Shasthya Shebika post-operative follow-up visits is required. Provision should be made to ensure regular monitoring visits by NEC for quality assurance and overall monitoring. *Recommendation for:* **Sightsavers & NEC**
Efficiency	Satisfactory G A	79% of the total project budget was utilised, with underspend across expenditure categories. While the rationale for channelling funds through BRAC is understood, it could have been more efficient for BRAC to directly transfer funds to hospital partners.	Financial planning and forecasting should be improved to ensure better utilisation of funds. Funds flow mechanism could be streamlined. *Recommendation for:* **Sightsavers & BRAC**
Impact	Satisfactory G A	Project has exceeded its targets in people receiving eye care services and cataract surgeries performed – creating a positive impact on quality of life for beneficiaries. Additionally, positive unintended consequences include benefits for eye health and some wider systems strengthening.	A results framework should be established, clearly defining the project outputs, outcomes and impact, as well as targets and milestones – related to overall goals/ objectives. *Recommendation for:* **Sightsavers & BRAC**

[6] Table 1 includes a summary of key conclusions and lessons learned/ recommendations. The full list can be found in Section 8.

OECD-DAC criteria	Our assessment/ rating	Overall assessment	Lessons learned/ recommendations
Sustainability	Caution A	The project design did not include an exit strategy or a sustainability plan. Given that this project included introducing new approaches into the health system (e.g. eye corners), discussions as to how these would be carried forward after the project should have been included from the start. That said, some of the project benefits (such as awareness of eye health, equipping of existing facilities) are likely to be sustained.	A clearly defined exit strategy and sustainability plan should be incorporated in the project design. *Recommendation for:* **Sightsavers & BRAC**
Scalability/ Replication	Highly satisfactory G	Several project components are being replicated in the BRAC/NEC continuation of the project in Sylhet and their wider Phase II project, including the GO-NGO partnership approach, community mobilisation by field level workers, and provision of cataract services through partner hospitals. Sightsavers is also planning to replicate the Vision Bangladesh approach.	The project should continue a coordinated partnership approach and draw on partners' respective strengths to achieve its intended objectives. *Recommendation for:* **all partners**
Coordination/ coherence	Highly satisfactory G	Roles and responsibilities of the partners were well defined and strategically leveraged their comparative advantages. The partners also worked in close coordination and in a synergistic manner.	The project should leverage greater engagement from the government in providing strategic guidance/ oversight. *Recommendation for:* **all partners**

1. Introduction

Cambridge Economic Policy Associates (CEPA) has been appointed by Sightsavers to undertake a "Strategic Evaluation of the Vision Bangladesh Project". This is the final report of our evaluation findings, conclusions and recommendations. In this section, we present the background to the project (Section 1.1); objectives and scope of the evaluation (Section 1.2); and the report structure (Section 1.3). The findings and recommendations of this evaluation are intended to be used by Sightsavers (Head Office and Bangladesh Country Office (BCO)), BRAC, project implementing partners and other eye health NGOs to draw lessons for implementation of similar projects in the future in developing country settings.

1.1. Background and context

According to the Bangladesh National Blindness and Low Vision Survey (2003), Bangladesh is estimated to have 750,000 adult blind (with a prevalence rate of 1.53% among people above 30 years and adult population) and 3.3m adults with uncorrected refractive error. Also, the Cataract Surgery Rate (CSR) was notably low at around 1,000 per million population/year covering only one third of the total needs of the country.[7] In particular, Sylhet is a low performing area in terms of health services, education and socio-economic indicators, and has a blindness prevalence of 1.31% of the above 30 population (i.e. 55,295), 75% of which is accounted for by cataract backlog. In addition, Sylhet has approximately 328,000 adults and 120,000 children aged 5-15 years with visual impairment due to uncorrected refractive error, which has resulted in significant visual morbidity in the region.[8]

The Vision Bangladesh project was a partnership between National Eye Care (NEC) under the Director General of Health Services (DGHS) of the Ministry of Health and Family Welfare (MoHFW), BRAC and Sightsavers. BRAC was responsible for demand creation through community mobilisation and case detection at the grassroots level using BRAC-trained Shasthya Shebikas (community health volunteers) and Shasthya Kormis (community health workers)[9] and GoB's community health workers.[10] Sightsavers was responsible for supporting the supply of quality cataract eye care through partnerships with government and NGO hospitals.[11] The NEC served as the overall coordination, monitoring and quality control agency.

The goal of the project is the "elimination of avoidable blindness from Bangladesh by 2020". Its specific purpose is the "elimination of the backlog of cataract blindness from the Sylhet

[7] Sightsavers, National Institute of Ophthalmology, Dhaka, and London School of Hygiene and Tropical Medicine (2005), "Summary Report of the Bangladesh National Blindness and Low Vision Survey".
[8] Huque R (2013), "Mid-Term Evaluation of the Vision Bangladesh Project"
[9] Shasthya Shebika are frontline community health volunteers who receive basic training from BRAC to promote a wide variety of healthy behaviours, to treat common medical conditions, and to refer patients to preventive and curative services according to their need. Shasthya Kormi are frontline community health workers who receive health training from BRAC and supervise the Shasthya Shebika, for which they receive a monthly stipend.
[10] At the community level, BRAC Shasthya Shebikas and GoB's Community Health Assistants conducted social mobilisation for cataract care, outreach and screening for cataract cases.
[11] The project had six selected hospital partners to provide cataract surgery, including five NGO hospitals – Voluntary Association for Rural Development (VARD) in Balaganj and Sunamganj; Bangladesh National Society for the Blind (BNSB) in Moulvibazar; Janashastha Shikkha O Palli Unnayan Sangstha (JASPUS) Habiganj Adunik Eye Hospital; Adhunik Chakshmu (Sylhet); and Shaheed Shamsuddin Ahmod Sadar – a district hospital. An additional three district hospitals were supported with eye corners for the provision of primary eye care.

division by the year 2013".[12] The project covered all four districts of Sylhet division, namely Sunamganj, Habiganj, Sylhet and Moulavibazar with the following objectives:

- Increase demand for eye care services particularly for cataract in the community.
- Increase accessibility to quality eye care services, especially cataract for the poor.
- Deploy/ employ appropriate and competent HR in all eye care facilities in the district and upazila level.
- Manage performance efficiently and effectively.

The project was implemented between January 2011 and December 2013. Prior to this, a six month pilot phase was implemented in four Upazilas to test some of the approaches and as a trust-building phase between the partners. This pilot period informed the design of the Vision Bangladesh proposal, but is not included in this evaluation.

The Vision Bangladesh project budget was £2.9m (314m BDT) jointly and equally funded by Sightsavers and BRAC.[13] The Vision Bangladesh project is being continued by BRAC and NEC in the same four regions of Sylhet for another two years (starting in May 2014) with a total budget of $2.6m. In addition, BRAC has launched an urban eye care project named 'Vision Bangladesh Phase II' in 11 city corporations and six Upazilas. [14]

1.2. Evaluation objectives

In line with the Terms of Reference (ToR), this evaluation seeks to:

- Review the achievements and challenges of the Vision Bangladesh project; capture lessons learned; and suggest the way forward for Sightsavers in the context of relevance, effectiveness, efficiency, impact, sustainability, scalability/ replication and coherence/ coordination. The findings of the evaluation will also be used to draw lessons for BRAC and NEC to be used in the continuation phase of the project, as well as providing valuable lessons learned for other NGOs to build upon.
- Develop recommendations for the project, at both a strategic (e.g. sustainability and scalability of the project) and operational (e.g. improving project effectiveness and stakeholder coordination) level.

1.3. Report structure

The rest of the report is structured as follows:

- Section 2 presents our evaluation design and methodology, including limitations;

[12] The project document states that by increasing the national cataract surgery coverage, the project is expected to bring down the prevalence of blindness in Sylhet from the present (national) prevalence of 1.53% (2003) to 1% at the end of the project.
[13] This is based on the exchange rate of 1GBP = BDT 107.6 in 2011. 61% of the budget was allocated for cataract surgeries; 26% to BRAC for demand creation and community mobilization; and 13% to Sightsavers for capacity building, monitoring and other project activities.
[14] Project details provided by Sightsavers, although we note that BRAC reported the project duration as 2.5 years and operating in 10 out of 11 City Corporations during our in-country consultations.

- Sections 3-6 present the analysis and key findings on the four evaluation dimensions of project design; implementation and coordination; results and impact; and sustainability and replication;
- Section 7 presents our analysis on the cross cutting issues related to gender, equity, quality and partner capacity; and
- Section 8 presents our summary conclusions, lessons learned and recommendations.
- The report is supported by the following appendices: Bibliography (Appendix A); list of consultations (Appendix B); interview guide used for the field visit (Appendix C); evaluation criteria rating description (Appendix D); project key activities and achievements (Appendix E); and Terms of Reference (ToR) for the assignment (Appendix F).

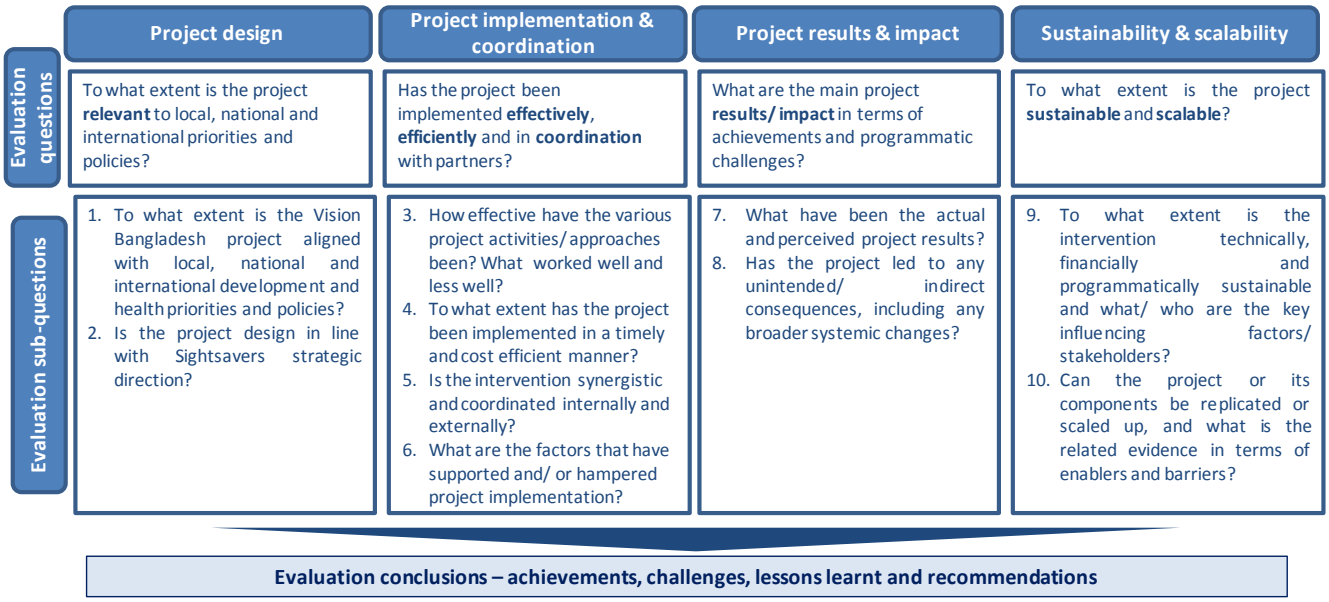
2. Evaluation design and methodology

We present below our evaluation framework (Section 2.1); evaluation methods (Section 2.2); and methodological limitations (Section 2.3).

2.1. Evaluation framework

Our evaluation framework is structured along four inter-related dimensions of project design; project implementation and coordination; project results and impact; and sustainability and replicability. This is in line with the evaluation scope and objectives and covers the OECD-DAC evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability. The evaluation also takes into account relevant global and national policies and development priorities; cross cutting issues of gender, equity, quality, and partner capacity; and WHO's health systems building blocks. Our evidence based findings on the four evaluation dimensions have informed the development of conclusions, lessons learned and recommendations.

Figure 2.1: Evaluation framework



2.2. Evaluation methods

We have employed a mixed methods approach for this evaluation, comprising:

- *Desk based review of documents*. Our starting point has been a detailed review of relevant documents including project documents (e.g. Memorandum of Understanding (MoUs) between the various partners, project descriptions, Sightsavers strategic framework); project progress reports (e.g. interim and annual progress reports, Vision Bangladesh mid-term evaluation report); government plans and policies (e.g. Bangladesh NEC Plan, NEC Operational Plan, National Blindness and Low Vision Survey); and broader literature on eye health and cataract programmes (e.g. Vision 2020 documents; WHO Global Action Plan towards Universal Eye Health).

- *Stakeholder consultations*. Interviews have been a key source of evidence, given the limited availability of quantitative data and the qualitative nature of our evaluation. We conducted structured interviews with a range of stakeholders including Sightsavers Bangladesh Country Office (BCO), BRAC, MoHFW (at the national level through the NEC and at district and upazila level through hospital staff/ doctors and community health workers), patients/ beneficiaries, international NGOs working in eye health in the country (ORBIS, Fred Hollows Foundation, Helen Keller International, CBM). Appendix B provides a list of consultations.
- *Focus group discussions.* We conducted focus group discussions with BRAC health volunteers and community health workers (Shasthya Shebikas and Shasthya Kormis) to understand their role in the project and solicit their views on project effectiveness and impact. In addition, we conducted some focus group discussions with beneficiaries (patients in health facilities and community members, some of whom had had cataract operations) to understand if the project had improved the accessibility and quality of eye care services at health facilities.
- *Visits to health facilities.* We visited five of the six hospital partners of the project which were providing cataract services – Voluntary Association for Rural Development (VARD) in Balaganj and Sunamganj, Sylhet Adhunik Eye Hospital, Bangladesh National Society for the Blind (BNSB) in Moulvibazar, and Shaheed Shamsuddin Ahmod Sadar hospital in Sylhet. We also visited eye corners[15] in government upazila health complexes (Fenchuganj, Balaganj, Sreemongal) and one in Sunamganj District Hospital, as well as some community clinics supported by the project to assess the coverage of services and any related challenges.
- *Quantitative analysis.* We carried out some limited quantitative analysis – primarily examining information on the use of funds (budgeted versus actual) and project indicators provided in the annual progress reports, as well as some analysis of the Output Statistics, the indicators tracked to inform planning meetings and key performance indicators provided by VARD Hospital. This analysis was also used to triangulate information from stakeholder interviews. Data sources are included in Appendix A.

2.3. Methodological limitations and mitigating strategies

The main limitations of our evaluation methods are noted below.

- Given that stakeholder consultations have been a key evidence source for this evaluation, there is scope for bias and subjectivity in feedback. We have attempted to minimise the impact of this by triangulating views across stakeholders and other sources of evidence, to the extent possible. However, given the primarily qualitative nature of evidence, this has been somewhat challenging.
- Some of the methodological limitations faced during the field visit are as follows:

[15] Sightsavers has trained Upazila health complex staff and equipped health complexes with equipment to enable the provision of primary level eye services. A room/ area within the health complex has been identified for this purpose, which is referred to as an “eye corner”.

- There could have been some bias in the selection of health facilities/ eye corners as these were arranged by Sightsavers BCO. However, we have attempted to reduce bias by engaging in a comprehensive discussion with Sightsavers BCO and reviewing available data. In addition, we covered almost all of the hospital partners providing cataract services (five out of six), and met with a selection of poor and high performing health facilities.
- There might also be some bias in the selection of consultees in the districts, as these were again organised by Sightsavers BCO, in consultation with BRAC. This relates mainly to the group discussions with Shasthya Shebikas and Shasthya Kormis in the districts and the beneficiaries in the community. However, this could not have been avoided given the challenges of us contacting these consultees directly/ organising this remotely. Further, some of the standard caveats of group discussions in communities hold – e.g. women speaking up candidly in the presence of elderly men, large groups reducing effectiveness, inhibitions due to lack of familiarity with interviewers, etc.
- While we covered good ground in terms of districts and consultees, our field findings are limited to what we learned and observed in the time available.
- Approximately two thirds of community health workers were the Shasthya Shebikas and Shasthya Kormis recruited and trained by BRAC and the remaining third were GoB's Community Health Assistants. Due to time constraints, we were not able to meet with the latter. This evaluation therefore only covers the activities and results of the BRAC community health workers.
- The presence of BRAC and Sightsavers BCO team members at times during our interviews/ interactions with stakeholders might have biased responses of some beneficiaries as well as the community health workers. It may have been difficult for consultees to be candid with us, in the presence of the project implementing partners.
- Our interaction with the beneficiaries was also constrained due to language barriers, which was further impacted since the BRAC and Sightsavers team members interpreted their responses for us.
- On some salient aspects of the evaluation (e.g. details of BRAC/ NEC's continuation of the project in Sylhet and partner responsibilities for cataract surgery funds), there have been some differences of views between the key implementing partners. We have tried to triangulate these to the extent possible, but where this has not been feasible, we have used the clarifications provided by Sightsavers and footnoted any divergent views.

- Quantitative analysis has been constrained by the limited quantitative data available on project performance. For example, there is no utilisation data for eye corners or data to evaluate the effectiveness of community health volunteer activities. We have used the available data (such as on project finances and some limited project output statistics) as best possible for the evaluation.

3. Project design

We examine the following aspects of project design: the extent to which the Vision Bangladesh project is relevant and aligned with local, national and international development and health priorities and policies (Section 3.1); and if the project design is in line with Sightsavers strategic direction (Section 3.2).

Project design

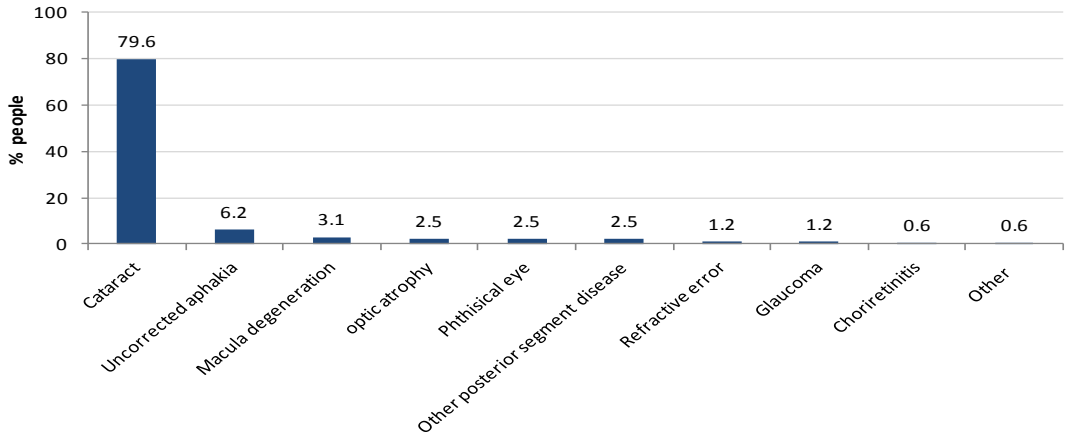
The project is relevant and aligned with local and national eye health priorities, in the context of high incidence of cataract, backlog and large treatment gap for cataract and avoidable blindness in the country, especially Sylhet. The project objectives and design are aligned with the prioritised areas of action under Vision 2020, WHO's universal eye health plan and NEC as it seeks to address avoidable blindness by establishing a strong referral system for primary eye care at the community level, as well as by strengthening existing eye health facilities through partnerships between the government and non-governmental agencies, i.e. GO-NGO approach. The project is also aligned with Sightsavers strategic mandate, albeit with a greater emphasis on providing cataract and eye care services, rather than broader health system strengthening. However, our review also highlighted some design limitations in the project, including delaying some key activities on account of its phased approach; use of dated statistics for determining the performance targets/ indicators; and the criteria used to select the project implementation area.

3.1. Alignment with local, national and international health priorities and policies

Alignment with local and national priorities

The Bangladesh National Blindness and Low Vision Survey (2003) estimated between 586,880 and 784,000 blind adults. Cataract was the predominant cause of avoidable blindness (79.6%), followed by uncorrected aphakia (6.2%) and macular degeneration (3.1%) – refer Figure 3.1.

Figure 3.1: Main causes of blindness with visual acuity <3/60 in the better eye



Source: Sightsavers, National Institute of Ophthalmology, Dhaka, and London School of Hygiene and Tropical Medicine (2005), "Summary Report of the Bangladesh National Blindness and Low Vision Survey".

In addition, cataract was identified as the leading cause of childhood blindness, with over 12,000 children suffering from blindness due to un-operated cataract. The current CSR is considerably low vis-a-vis the high incidence of cataract – CSR increased from 957 per million population/ year in 2005 to 1,172 in 2010, but is well below the target of 2,500-3,000 surgeries per million population/ year to bring cataract blindness under control in the country.[16] Sylhet is a low performing area in terms of health and socio-economic indicators. Sylhet Division has the highest proportion of women with no education (35%), the second highest proportion of population in the lowest wealth quintile (24%), the highest fertility rate (3.1 births per woman) and highest mortality rates for all mortality indicators except child mortality.[17] Sylhet is also the division with the lowest proportion of births delivered at a health facility (21%) and the lowest levels of vaccination coverage (80%).[18] The blindness prevalence in Sylhet is 1.31% of the above 30 population (i.e. 55,295), 75% of which accounts for cataract backlog and the annual incidence of blindness is 8,295.[19]

The high incidence, backlog and large treatment gap for cataract and therefore avoidable blindness in Bangladesh, and particularly Sylhet, suggests that the goals and objectives of the Vision Bangladesh project are relevant and aligned with national and local eye health priorities. This view has been strongly echoed by all stakeholders consulted.

Alignment with national and international policies

The GoB ratified the WHO and International Agency for Prevention of Blindness (IAPB's) "Vision 2020: The Right to Sight" Campaign in 2000 as a strategy for strengthening eye care service provision in the country.[20] The NEC Plan was formulated in 2005 to guide the achievement of the Vision 2020 goals for Bangladesh, and was subsequently incorporated into MoHFW's second sector wide plan, known as the Health, Nutrition and Population Sector Programme (HNPSP) for 2003-11.

The NEC Plan emphasises capacity building for eye care at the upazila level; developing primary care at the community level through a referral chain; and the need for partnerships between the government and non-governmental agencies for effective ownership and long term sustainability of improved eye health. The Vision 2020 Action Plan has now been replaced with WHO's universal eye health: A global action plan 2014 – 2019,[21] which promotes universal eye health by seeking to ensure that beneficiaries have access to a network of services covering eye health, prevention of blindness, and provision of clinical services for treating common and blinding eye diseases. The Bangladesh National Blindness and Low Vision survey also recommended organising eye care service delivery, focussing on cataract surgical and refractive error correction services.

[16] Ministry of Health and Family Welfare (2005), "National Eye Care Plan, for Implementation of Vision 2020 in Bangladesh".
[17] National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International (2013). "Bangladesh Demographic and Health Survey 2011" Dhaka, Bangladesh and Calverton, Maryland, USA
[18] Ibid.
[19] Ministry of Health and Family Welfare (2005), "National Eye Care Plan, for Implementation of Vision 2020 in Bangladesh".
[20] "Vision 2020 – Right to Sight" was launched by WHO and International Agency for Prevention of Avoidable Blindness in Beijing in 1999 to eliminate avoidable blindness by 2020.
[21] http://www.who.int/blindness/actionplan/en/

The objectives and design of the project are therefore aligned with the prioritised areas of action under Vision 2020 and WHO's universal eye health plan, as well as the NEC plan. This is evident in the project's focus on establishing a strong referral mechanism for primary eye health, especially cataract surgery, in rural communities through social mobilisation by health workers and strengthening of existing health facilities for primary eye care through partnerships between government and non-governmental (GO-NGO) agencies.

3.2. Alignment with Sightsavers strategic direction

Sightsavers vision and mission (set out in its Strategic framework (2012-18)) provide its raison d'être in the delivery of eye health programmes.

Box 3.2: Sightsavers strategic goals

Vision	*No one is blind from avoidable causes and visually impaired people participate equally in society*
Mission	*To eliminate avoidable blindness and promote equality of opportunity for disabled people.*

Sightsavers strategic framework 2012-18 states that avoidable blindness is best addressed when health systems are aligned with government policies, and health programmes support and strengthen national health systems. In particular, it focuses on demonstrating eye health approaches that are scalable, adaptable, cost effective and can strengthen the overall health systems, to ensure that good quality eye care is universally available to the wider health system.[22]

The Vision Bangladesh project is centred around the delivery of quality eye care services (through cataract surgeries) by designated hospital partners. The project target was for one million people in Sylhet to receive eye care services and 100,000 cataract surgeries to be performed between January 2011 to December 2013.

Our assessment is that the project is broadly in line with Sightsavers strategic mandate. However, we note the project's explicit focus on eye health/ cataract service delivery, rather than strengthening the broader health systems to ensure universal, quality eye care (as per Sightsavers strategic framework).

Nonetheless, the project led to some indirect consequences of health systems strengthening in terms of integrating eye care in the existing health facilities. For example, it helped strengthening existing government facilities through capacity building and HR training (from primary to secondary level) and supplying equipment and instruments to health facilities. The eye corners established at upazila health complexes have also enabled the provision of primary eye care to rural communities; prior to the project, primary level eye care did not exist. Other aspects of health systems strengthening embedded in the project include developing a strong referral mechanism from primary to tertiary level, strengthening GO-NGO partnerships, incorporating standard cataract surgery protocols, increasing reporting and monitoring of eye health, and developing community awareness on eye care. In several ways therefore, while the project did not expressly target strengthening Sylhet's health systems, its

[22] Sightsavers (2010), "Making the Connections, Strategic Framework 2012-18".

delivery of quality eye care services both directly and indirectly augmented the capacities of local health systems.

While the project's overall design appears appropriate to address the eye health problem in Bangladesh, we identify a few limitations in its approach:

- Specific project thresholds for eye service delivery (e.g. number of people receiving eye care services and number of cataract surgeries to be performed to clear the backlog of cataract blindness in Sylhet) were based on the results of the Bangladesh National Blindness and Low Vision survey (2003).[23] Although there has been no similar national survey since 2003, defining performance targets based on such dated statistics is not likely to reflect the current cataract backlog in the region. In all possibility, this backlog would have increased over the years on account of several factors, including low CSR rate, unmet demand for quality eye health services, ageing population, amongst others. This means that it is difficult to accurately evaluate the success and impact of the project, as the current burden of cataract blindness is not known.
- The project was designed to eliminate the backlog of cataract in Sylhet in three phases, covering 12 upazilas in year one (2011); 12 in year two (2012); and 13 in year three (2013), i.e. a total of 37 upazilas supported by the end of 2013. We understand from consultations that the phased approach was based on the capacity of hospitals to manage the increase in patient inflow for cataract surgeries resulting from the project. It was also viewed as a "learning by doing" approach so that appropriate lessons could be learned for implementing the project in upazilas that are phased in later. Our analysis is that this phased approach was more appropriate for the demand side than supply side activities.
    - *Demand side:* PSPs were organised every month at the community level in upazilas covered under the project, making eye health services more accessible for people living in the remote and hard to reach areas, as well as those who could not afford transport to health facilities. At each quarterly management meeting, the numbers of patients attending each PSP was analysed for each upazila, and the actual number of cataract surgeries performed were compared with the estimated surgeries required. Towards the end of each phase, this analysis was used to assess whether the cataract backlog had been adequately addressed and whether PSPs could therefore be held monthly at upazila health complex level (which was seen as a longer-term systems strengthening approach as these are run by upazila health staff). Holding PSPs at community level is resource intensive and the limited project budget meant that this approach could not be sustained. This phased approach therefore seems appropriate for the demand side of the project. However, the use of outdated data to analyse cataract backlog in Sylhet weakened the effectiveness of this approach, making it difficult to accurately assess when the backlog had been reduced. Not conducting PSPs at the community level has

[23] The survey was undertaken in 1999 and the report was published in 2003.

made it more difficult for the poor and marginalised to access eye health services – for example, beneficiaries in Habiganj mentioned that most of them cannot afford to travel to the upazila health complexes. In addition, there were delays in some project activities in the Phase three upazilas (covered in 2013) due to political unrest in the country – which has potentially reduced project impact.

- *Supply side:* The introduction of eye corners at upazila health complexes was also phased, in recognition of the work/ resources involved to establish all of the planned 33 eye corners and train all the relevant staff. However, this meant that some eye corners (e.g. Balaganj and Sreemongal) were only established in the final weeks of the project. Therefore, these newly introduced activities were not monitored and no support was provided for the clinical staff or their supervisors. A phased approach for the supply side interventions needs to be better planned and sequenced to enable sufficient time for key activities such as establishing eye corners, so that they are able to operate and receive adequate supervision visits during the project period.

Project documents and stakeholder consultations report that Sylhet was selected for the project on account of being a low performing division in terms of health services, education and socio economic indicators, as well as having a high backlog of cataract cases. However, the blindness prevalence in Sylhet is lower (1.31%) than other divisions such as Barisal (2.3%), Khulna (1.97%), and Chittagong (1.43%).[24] Whilst data is not readily available on the extent of cataract backlog in other divisions, we question the justification adopted in selecting Sylhet for this project. We do however recognise that the project builds on the extensive experience of both Sightsavers and BRAC in Sylhet. Sightsavers has been working in Sylhet since 1998, including having built relations with two of the four hospital partners (VARD and BNSB).[25] BRAC has worked in Sylhet since 1972 on poverty alleviation work, which has involved training large numbers of Shasthya Shebikas and Shasthya Kormis. Additionally, Sylhet has a large number of high performing NGO eye hospitals, capable of undertaking the large number of cataract operations required for this project. We acknowledge that this combination of needs in Sylhet, local knowledge and prior experience of partners, along with existing surgical capacity are appropriate criteria for a project testing a new approach and partnership. However, in order to suitably assess results and identify criteria for success for any similar future interventions, it is important that the project selection criteria are defined clearly ex-ante. A situational analysis on HR and equipment needs was conducted prior to the project. A comprehensive analysis of the eye care gaps in the country would have better informed project selection criteria and design.

[24] Sightsavers, National Institute of Ophthalmology, Dhaka, and London School of Hygiene and Tropical Medicine (2005), "Summary Report of the Bangladesh National Blindness and Low Vision Survey".
[25] A start-up phase (January to December 2010), was initiated with funding from BRAC and Sightsavers in selected upazilas in Sylhet (Sunamganj and Habiganj) to assess the blindness situation and design a comprehensive project for three years.

4. Project implementation and coordination

The second evaluation dimension covers project implementation and coordination among the various partners. We examine the effectiveness of the project's governance and management arrangements (Section 4.1); coordination/ collaboration among the partners (Section 4.2); factors affecting implementation (Section 4.3); and cost efficiency in terms of the project's actual versus budgeted expenditure and funding approach (Section 4.4).

Project implementation and coordination

The roles and responsibilities of implementing partners were clearly defined and leveraged their respective expertise and available resources. The GO-NGO partnership was viewed positively by all stakeholders and is likely to ensure greater local ownership and long term sustainability of project benefits. The referral mechanism of community mobilisation was instrumental in creating demand and awareness of primary eye care at the community level and monitoring and supervision of partner hospitals worked well. The Project Steering Committee (PSC) met quarterly and was an effective coordination body, but the Project Advisory Committee (PAC) was less effective.

Implementation issues include inadequate number of trained government health staff at health facilities at the district and the upazila levels, mixed feedback on adequacy of training, inconsistent post-operative follow-up, and the sliding scale payment structure not working as intended. There has been an under-spend across budget categories (particularly training and capacity building) which could have been reallocated for other purposes (e.g. organising additional PSPs at the community level), and the flow of project funds and financial reporting mechanisms could have been more streamlined to ensure greater efficiency in the use of project funds.

4.1. Governance and management arrangements

We examine the functioning of the project's main institutional bodies – the Project Advisory Committee (PAC) and the Project Steering Committee (PSC). The PAC was established to discuss the key strategy and policy issues of the project every six months. It comprised of two members each from BRAC and Sightsavers, Line Director - NEC, Hospital Director from DGHS, and selected members of the District V2020 committees. However, only one PAC meeting was organised during the project period. Consultations suggest that this was due to senior DGHS officials not having the time to attend these meetings, which resulted in limited discussions on the strategic aspects of the project (such as on project sustainability or replication).

The PSC was the coordinating body for the project and comprised of two members each from BRAC and Sightsavers. This committee met every three months to review programme and financial performance. Feedback from the implementing partners suggests that the quarterly PSC meetings have served as a useful and effective forum to discuss implementation plans, review progress, and discuss key issues related to the project. We have not specifically had sight of/ reviewed the minutes of these meetings in our scope of work.

In addition, quarterly project management meetings were held in each of the four districts with all implementing partners, including BRAC, Sightsavers, district level MoHFW officials, and NGO partner hospitals. At these meetings, a standard power point presentation was used to analyse the achievements against targets and the planned activities for each upazila. These meetings helped ensure that the project was well integrated and working well.

Sightsavers BCO managed the implementation of their project activities and had been in operation prior to this project. Our evaluation did not suggest any issues with their work.

4.2. Coordination/ collaboration among implementing partners

Roles of and cooperation between partners

The Vision Bangladesh project was an initiative jointly implemented by BRAC and Sightsavers in collaboration with NEC and hospital partners. Partner roles and responsibilities under the project were clearly defined which ensured smooth and effective implementation of project activities. As seen in Figure 4.1 below, Sightsavers supported the supply side through partnerships with selected hospitals for delivery of cataract surgeries; BRAC was responsible for demand creation and social mobilisation; and NEC was responsible for project related health systems strengthening activities. Sightsavers and NEC were jointly responsible for overall monitoring and quality assurance of the project, through regular monitoring visits to the eye health facilities.

Figure 4.1: Roles of implementing partners under the Vision Bangladesh project

Sightsavers	BRAC	Ministry of Health and Family Welfare (NEC-DGHS)
• Active member of PAC and PSC • Financial support for strengthening district hospitals and establishing eye corners at upazila health complexes • Financial support for capacity building of HR (e.g. Ophthalmologists, Medical Officers) • Supply of standard quality lens during the MoU period • Technical support in terms of quality assurance and performance monitoring and reporting • Financial support for cataract surgery	• Active member of PAC and PSC • Social mobilisation throughout the project area • Disseminate eye health messages in the community • Organise patient detection and screening events in the community • Ensure referral of cataract and presbyopia cases • Post operative follow-up and referral to concerned eye hospitals • Involve local government and other stakeholders to raise awareness on eye health • Financial support for social mobilisation	• Member of PAC and PSC , and overall monitoring and quality assurance of the project • Institute mechanisms to retain HR and nominate appropriate HR at Sadar hospitals and upazila health complexes for skills development / training • Provide adequate and appropriate space at Sadar hospitals and upazila health complexes for eye care service delivery • Responsible for repair, maintenance including replacement of equipment and lens after the project period

Source: Memorandum of Understanding (MoU) for Vision Bangladesh Project between the Directorate General of Health Services (DGHS) , Sightsavers and BRAC Health Programme.

The three project partners were chosen to leverage their respective areas of expertise and available resources. For example, the project leveraged BRAC's community mobilisation, outreach and field level capabilities at the household level through their vast existing network of Shasthya Shebikas and Shasthya Kormis to create demand for and awareness of eye health in the community. This was complemented by Sightsavers role in providing financial

and technical support to the hospitals for the delivery of cataract surgeries, and ensuring quality assurance. The hospital partners were chosen based on their capacity to manage surgeries, financial situation, governance and management arrangements, etc. Whilst the selection criteria of hospital partners were not pre-defined, a joint situational analysis was carried out by Sightsavers and NEC, which included standard checklists on equipment and HR availability for each facility. Involvement of MoHFW enabled embedding the eye care services within the existing health systems and priorities. Stakeholder consultations confirm our view that the partners worked in a well-coordinated and synergistic manner.

GO-NGO partnership

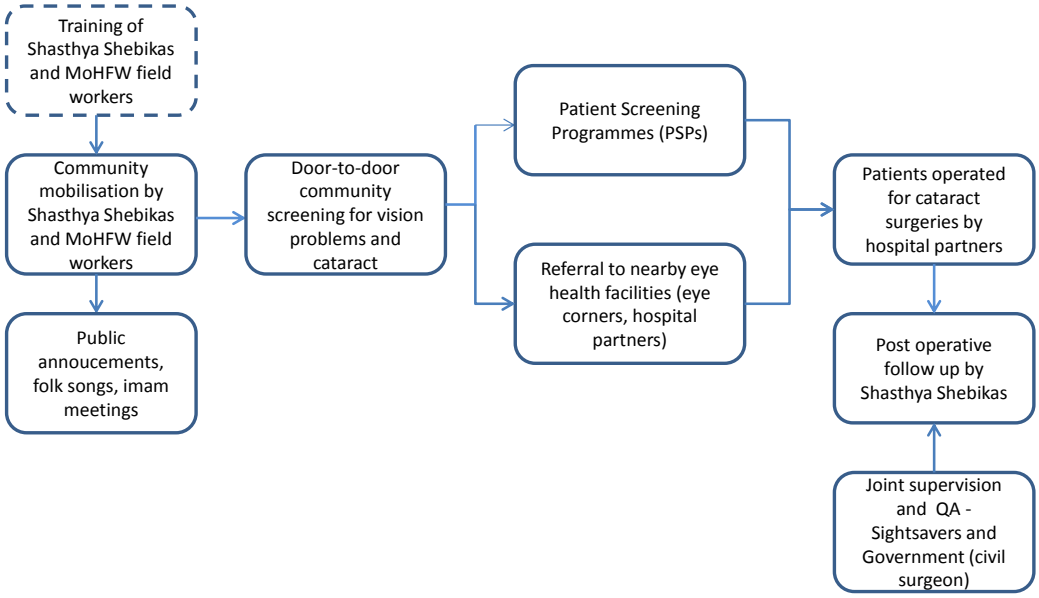
The project has promoted an effective GO-NGO partnership in eye care service delivery in Bangladesh by strengthening the institutional and management capacity of government and non-governmental eye service facilities at the community, upazila, district and division levels. This approach has been viewed positively by all stakeholders, including NEC, and appears to have the potential to be replicated across the country for eliminating avoidable blindness through cataract. Given that the NGO hospitals are important providers of eye care services in Bangladesh,[26] such partnerships can ensure greater local ownership and long term sustainability in the provision of eye health services (as also emphasised in the NEC). This approach is being replicated in BRAC/NEC's ongoing continuation project.

4.3. Implementation

In this section, we have reviewed the key activities and stakeholders involved in project implementation; what has worked well and less well, and the influencing factors.

The project established a referral mechanism through community mobilisation by the BRAC Shasthya Shebikas/ Kormis and GoB's Community Health Assistants (refer Figure 4.2).[27]

Figure 4.2: Schematic of the referral mechanism under the Vision Bangladesh project



Source: CEPA analysis

[26] According to the NEC (2005), in 2003 there were a total of 141 hospitals providing eye care services in the country, of which 71 are government hospitals; 56 are NGOs; and the remaining are by the private sector.
[27] A third were GoB's Community Health Assistants and the remaining were BRAC trained Shasthya Shebikas.

Our field visit suggests that community mobilisation has been instrumental in creating awareness and demand for primary eye care at the rural community level. Key points to note include:

- BRAC Shasthya Shebikas were oriented/ trained to develop eye health awareness, conduct door to door preliminary vision screening, and refer patients with eye problems to the nearest eye care centre. During their visits, the Shasthya Shebikas screen the community for eye problems (e.g. blurred vision, cloudiness, white spots), and refer patients to the nearest eye care centre (including PSPs, eye corners at upazila health complexes, partner hospitals) and are paid 50 BDT for each referral.[28] Our field visit suggests that the community members generally seem to trust the Shasthya Shebikas and look to them for support in case of any eye related issues.
- Feedback from the beneficiaries suggests that they were informed of the date, time and venue for the PSPs (and other health facilities like eye corners and nearby partner hospitals) through a mix of public announcements in their localities, BRAC project management staff and Shasthya Shebikas.
- Patients are screened by medical teams from partner hospitals at the PSPs. The project provided cataract patients with transport to and from the hospital for surgeries, at no cost to the beneficiary. The Shasthya Shebikas conduct door to door post-operative follow up with cataract surgery patients to check compliance with the recommended hygiene regime, monitor the use of eye drops, amongst others. However, there was no formal monitoring of this check-up system, meaning it is difficult to accurately assess the effectiveness of this approach. Hospital staff did report very low numbers of patients returning with post-operative complications. For example, Sunamgonj hospital reported one post-operative complication for the whole project period.
- *Monitoring and supervision*.
    - *Hospital level:* Our visits to partner hospitals indicated that project monitoring has been effective with regular quarterly visits by Sightsavers and NEC (represented by the civil surgeon), particularly to ensure compliance with the standard surgical protocol.[29] Hospital partners also send monthly reports to the civil surgeon to keep track of the number of cataract surgeries performed. While a comprehensive Management Information System (MIS) software was developed by Sightsavers for the hospital partners to record the number of cataract surgeries performed, this software was not fully functional as this activity only started near the end of the project period. Therefore, the hospital partners were using the previous excel based format for reporting, which had also been developed by Sightsavers.

[28] The Shasthya Shebikas also identify patients suffering from presbyopia and distribute reading glasses under BRAC's "Reading Glasses for Improved Livelihood" project.
[29] A standard surgical protocol was first developed by Sightsavers and endorsed by GoB in 2012. The protocol is now used in all hospitals in the country.

- *Upazila level:* Our visits to some of the upazila health complexes presented mixed views on the effectiveness of monitoring under the project. For example, while Sightsavers and the government visited the eye corner at the Fenchuganj upazila health complex 10-12 times during the project, monitoring visits were not conducted at Sreemongal and Balaganj eye corners, since these have been set up towards project close in December 2013.
- *Community level:* At this level, there was little monitoring of Shasthya Shebika activities in terms of data collection. This meant that the effectiveness of the community health worker referral mechanisms could not be monitored. For example, there was no comparison between the number of referral slips distributed and the attendees at each PSP.

In general, project implementation has been effective, with a few issues being raised as outlined below:

- *Inadequate number of trained government health staff at health facilities.* Our visits to health facilities indicated that the number of government staff was inadequate at the district and upazila levels, which had an impact on the quality of services provided. For example, some upazila health complexes visited should have had 9-11 Medical Officers (MOs), whereas many had only 2-3. At the Balanganj health complex, these 2-3 MOs had to manage 300-400 patients each day. This reflects a wider problem in Bangladesh, where many of the sanctioned positions are vacant - for example in 2012, 22.2% of Sub-Assistant Community Medical Officer (SACMOs) positions were vacant.[30] It has been difficult to retain ophthalmologists and MOs at the district and community level due to several factors including lack of sufficient incentives, frequent transfers, unavailability of quality schooling for their children, amongst others. Further, the eye corner at Balaganj is managed by SACMO since the MO has been transferred to Dhaka. The eye corner at Sunamganj upazila health complex is functional only for a few days every week (subject to staff availability and patient inflow). The need to hire more BRAC Shasthya Shebikas and Sightsavers field workers for implementation and monitoring was also noted in the mid-term evaluation report. We understand that this was not followed up, since there was not enough time to hire more workers before the project ended in December 2013, as well as limited availability of funds. The continuation of the project in Sylhet by BRAC and NEC has fewer workers planned for than Vision Bangladesh, on the basis that the backlog has been reduced and the need is lower than in 2011. The adequacy of this design element is to be seen as the project continues.
- *Mixed feedback on adequacy of training.* MOs and SACMOs were provided a one-month and six-month training respectively in refraction and primary eye care at the Islamia hospital in Dhaka. The BRAC Shasthya Shebikas were also provided a day's training at the beginning of the project on recognition of basic eye health issues, with refresher training every month (with 5-10 minutes spent on eye health issues). Their feedback is that the training has imparted the relevant skills and knowledge. However,

[30] MoHFW (2013), "Health Bulletin 2013" p100.

other consultees (e.g. SACMOs) have questioned the adequacy of training, which covered only basic primary eye care (although this was on account of no government provision for additional eye health service delivery at the upazila and community levels). Also, all the health service providers interviewed stated the need for refresher training to upgrade their skills.

- *Inconsistent post*-operative *follow-up.* Beneficiaries provided mixed views on the efficacy of post-operative follow up for early identification of complications after the surgery. While some beneficiaries voluntarily visited nearby eye hospitals for post-operative care, Shasthya Shebikas made door to door visits in some cases.[31] The project could have developed clearer guidance to conduct this activity in a more consistent and effective manner.

- *Sliding scale payment structure.* The project was based on a sliding scale payment structure whereby poor patients (estimated as 75% of total patients) received cataract surgeries free of cost, while the remaining patients were provided services at a subsidised price (based on their ability to pay). Sightsavers paid a unit cost of 2,200 BDT for each cataract surgery to the hospitals (which included cost of human resources, lens, operating theatre (OT) charges, return transportation from hospitals to PSPs, bed and food charges, amongst others).[32] Eligibility for free/ subsidised rates for cataract surgeries was determined by the Shasthya Shebikas during their visits to the households and by project staff during PSPs, using BRAC's ultra-poor criteria developed on their "Challenging Frontiers of Poverty Reduction" (CFPR) programme.[33] It was estimated that only around 1% of those attending PSPs were evaluated to be able to pay towards the costs of surgery. Project staff felt that those with the ability to pay saw PSPs as a service for the poor and so accessed the eye care services they had been made aware of independently, although there was no data to verify this. Thereby, patients who paid for the surgeries under the project were minimal, despite the intended philosophy of the scaled payment mechanism. The scaled payment mechanism was therefore a less effective project component given these contextual issues and its relevance needs to be assessed for future projects.

4.4. Efficacy and efficiency of funding approach

Review of budget versus expenditure

In this section, we have analysed the project's budgeted versus actual expenditure, the efficacy of its funding approach and the efficiency in its use of funds.

[31] 50 BDT was intended to incentivize Shasthya Shebikas for referral and post-operative follow-up. However, as the latter is more difficult to monitor, incentives were paid on referral, thus reducing the effectiveness of follow-up.

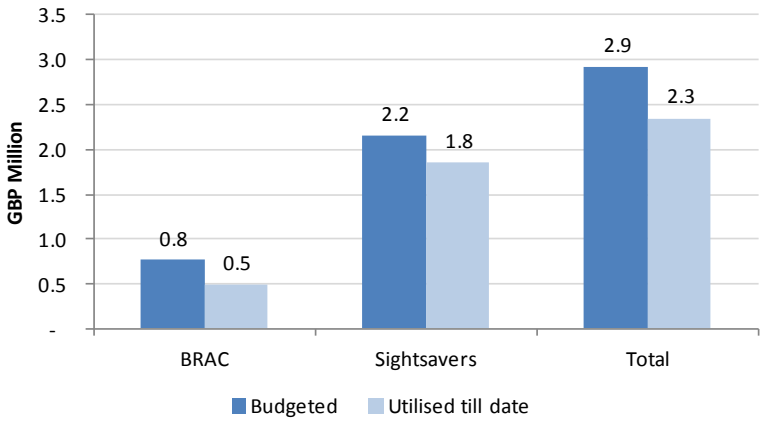
[32] Charges for cataract surgeries for other patients varied in every hospital depending on the quality of lens used, the style of surgery carried out (e.g. small incision cataract surgery (SICS), Phacoemulsification) and the provision of private rooms ranging from 3,000-33,000 BDT. The Vision Bangladesh project provided the most basic package of MSR lens using SICS method.

[33] These criteria include amount of land owned, number of family members regularly earning money, number of productive assets owned by the family, and whether there are school-aged children in the family not attending school due to being involved in income earning activities.

The total project budget was £2.9m (314m BDT) for the period January 2011 to December 2013, jointly and equally funded by Sightsavers and BRAC.[34] The figure below summarises the budget allocation among the partners and actual utilisation to date. Key points to note are as follows:

- Of the total budget of £2.9m, equally contributed by Sightsavers and BRAC (i.e. £1.45m each) 61% was allocated for cataract surgeries (£1.8m), 26% (£0.8m) for demand creation and social mobilisation; and 13% (£0.4m) for capacity building, training and project monitoring.
- Actual project expenditure until December 2013 was £2.3m - approximately 79% of the total budget.[35] We were informed that reasons for under-utilisation of funds included: some capacity development and training activities could not be conducted as originally planned due to inadequate health staff at the government health facilities, frequent transfers of government health staff, lower than planned number of eye corners set up in the upazila health complexes due to delays in signing agreements with the government and political unrest. Also, the project budget was based on cataract surgeries costing 2,500 BDT each. In October 2011, this was reduced to 2,200 BDT due to economies of scale. However, there was no reallocation of these cost savings, which could have been deployed for other priority activities such as organising additional PSPs at community level or more formal equipment maintenance plan (including spare parts).
- Of the total funds spent under the project, the largest proportion was for cataract surgeries (£1.6m against the budgeted amount of £1.8m).
- Both BRAC and Sightsavers underspent their respective funds allocated.

Figure 4.3: Total expenditure under the Vision Bangladesh project (£m)[36]



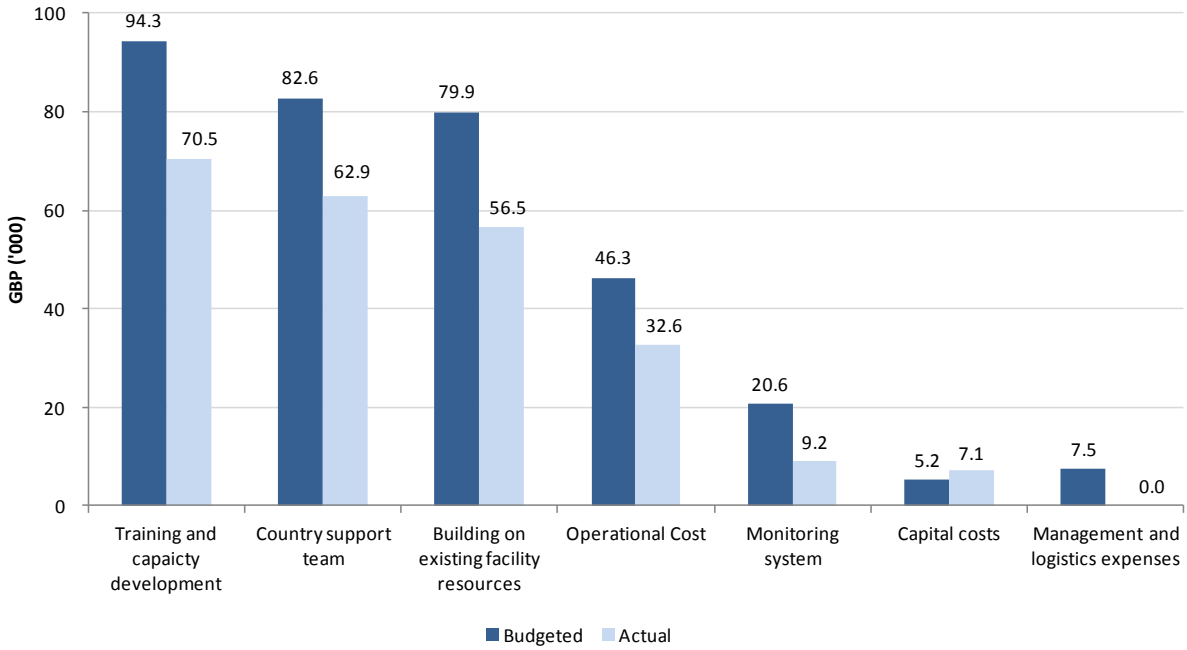
Source: Based on information provided to us by the Sightsavers BCO finance team and BRAC

[34] Based on the exchange rate of 1 GBP = 107.6053 BDT.
[35] We understand the remaining unspent project funds were not disbursed by Sightsavers UK or BRAC.
[36] The budgeted amount is calculated based on the exchange rate of 1 GBP = 107.6053 BDT. The actual amount spent is calculated based on the exchange rate of 1 GBP = 121.96 for BRAC and cataract surgeries and 1GBP=119 for Sightsavers. BRAC and Sightsavers have used a different exchange rate since BRAC received funds from UK and the converted to BDT. While the total project budget was £2.9m, equally contributed by BRAC and Sightsavers, Sightsavers was responsible for utilising £2.2m (for cataract surgeries and capacity building) and BRAC was responsible for utilising £0.8m (for social mobilisation).

Overall, Sightsavers utilised 82% of its total budget (including for cataract surgeries), i.e. £1.8m was spent of its budget of £2.2m and BRAC utilised 63%, i.e. £0.5m was spent of its £0.8m budget.[37]

The figure below presents the total budget and expenses of Sightsavers for project activities other than surgeries.[38] There has been a fair degree of variance between actual and budgeted amounts across most cost categories. In particular, we were informed that the amount spent on training and capacity building was lower than budgeted, due to inadequate manpower at the health facilities and delays in working with the government.[39]

Figure 4.4: Summary of budgeted and actual expenses by Sightsavers (Jan 2011-Dec 2013) (£ '000)



Source: Based on information provided to us by the Sightsavers BCO finance team.

Funding approach and management

We understand that Sightsavers UK remitted project funds for cataract surgeries to BRAC; and for capacity building, project monitoring and training to Sightsavers BCO. Funds for demand creation were contributed by BRAC.

Project funds for cataract surgeries were routed through BRAC to facilitate quicker approval and clearance from the NGO Affairs Bureau in Bangladesh, since BRAC is a local NGO. These funds were then transferred by BRAC to Sightsavers BCO, who paid the partner hospitals on a quarterly basis in advance on the basis of reports submitted by them. The amount collected by hospitals in the previous quarter for subsidised surgeries was deducted by Sightsavers BCO before disbursing funds.[40] We question whether BRAC could have

[37] These figures are based on the assumption that Sightsavers was responsible for all cataract surgery funds, as per the project's overarching roles and responsibilities.
[38] This level of budget detail was not available from BRAC, so a similar budget analysis was not possible.
[39] For example, nothing was spent on ophthalmologists training and counselor training; and workshop for management staff.
[40] We understand that very few patients paid around 500-1,000 BDT for the cataract surgeries.

directly transferred funds to the hospital partners for cataract surgeries (subject to approval of the hospital report and amount requested by Sightsavers BCO), to save an additional transaction in the routing of funds.

Whilst BRAC and Sightsavers were committed to funding the project equally, ensuring this 50:50 split in practice proved challenging. At the end of each quarter, BRAC submitted a report to Sightsavers UK with the amount they had expensed for Sightsavers to transfer funds for the next quarter. However, toward the end of the project, the exact division of funding between both organisations was not fully clear, which was partly due to exchange rate differences and an under-spend on most activities. Our view is that the financial management and reporting on the project could have been more streamlined.

Efficiency in the use of funds

A number of organisations which focus on eliminating avoidable blindness adhere to the principles of providing large volume, high quality and affordable services in a financially sustainable manner both for the patients as well as for themselves to minimise costs and achieve results more efficiently. Some of the strategies which have been used by organisations to deliver this have included:[41]

- *Building patient volumes by reaching out to the community* through active partnerships with social organisations, local philanthropists, volunteers, school systems and key industries in the community. Outreach screening camps are organised to enhance the local population's awareness of eye care and improve health seeking behaviour, thereby growing the customer base in the hospitals.
- *Reducing the cost to patients,* such as by making eye care locally available through outreach and vision centres; making all investigations in a single visit; offering patients a surgery slot immediately if surgery is required; ensuring availability of prescribed medicines or spectacles locally and at a fair price; offering free transportation to patients identified during the outreach as needing surgery, amongst others.
- *Reducing the provider costs* by shifting the routine tasks of ophthalmologists (e.g. measuring intraocular pressure and assessing refractive error) to mid-level ophthalmic personnel and so improving the productivity of ophthalmologists.
- *Empowering patients for better compliance* by developing a cadre of staff called patient counsellors whose main task is to make sure that the patient fully understands the importance of what is prescribed – surgery, medication, follow-up, spectacles, etc.

Some of the above activities/ strategies have been pursued in this project with a view to utilise the project funds efficiently. For example, carrying out a larger number of surgeries per day reduces the fixed cost drastically. We noted that such a strategy was used at the VARD Balaganj hospital, where we saw that there were two operating tables in one room so the surgeon could operate on one patient, swing the microscope across to the next table and then start surgery on another patient. Using such an approach, it was possible for the

[41] Sources: (i) Ravilla T & Ramasamy D (2014), "Efficient High Volume Cataract Services: the Aravind Model" *Community Eye Health Journal 27:85;* (ii) Thulasiraj R D (2007), "Delivering Efficient Eye Care" *Cataract & Refractive Surgery Today*

surgeon to carry out a large number of procedures, thus increasing the volume of cataract surgeries. Other such efficient strategies include building patient volumes through effective community demand creation and organising PSPs at the community level; reducing cost (travel and associated costs) to the patients by making eye care locally available through eye corners and providing free transportation from the PSP to the hospitals, amongst others.

However, in our view, the project could have more efficiently used funds by investing in areas of capacity building and training. For example, through developing patient counsellors who could have played an important role in ensuring that the patients follow-up regularly and comply with what has been prescribed to them. In addition, funds could have been used for reducing the provider costs by shifting the routine tasks of ophthalmologists to a lower level trained personnel, which could have also helped in improving the productivity of ophthalmologists. Although we acknowledge that mid-level ophthalmic personnel are not included in the NEC's Operational Plan, Vision Bangladesh could have been used to pilot and provide evidence for such a task-shifting approach in Bangladesh.

5. Project results and impact

We assess the following aspects of the project's results: (i) reported performance against planned targets (Section 5.1); (ii) overall findings on results from the field visit (Section 5.2); and (iii) unintended and indirect consequences of the project, including broader systemic changes (Section 5.3).

Project results and impact

The Vision Bangladesh project has largely achieved its objectives of increasing awareness of and demand for eye care services (particularly cataract for the poor) at the community level and ensured greater accessibility to quality eye health services for the poor in Sylhet. In general, all stakeholders viewed the project very positively, with beneficiaries reporting increased quality of life and health care providers reporting increased confidence and ability to perform a larger number of cataract surgeries.

The project has also resulted in some unintended positive consequences in terms of benefits for eye health (e.g. supporting the entry of BRAC into eye health in Bangladesh, promoting the District Vision 2020 committees, implementing guidelines for quality eye care), and wider systemic benefits (e.g. systems strengthening in hospitals, facilitating multi-stakeholder collaboration), amongst others. However, the project did face issues in capacity building, training and effective management. Additionally, the absence of a results framework has constrained our assessment of the project's progress and achievements.

5.1. Performance against planned targets

As a first step to reviewing the project's performance, we have considered its M&E framework, including objectives and milestones. We highlight two main issues which made it difficult for us to assess the project's achievements in a consistent and useful manner:

1. *Absence of a logical framework of results*. The project lacked a prospectively designed results framework, setting out the desired outputs, outcomes and impact, and related targets and milestones.[42] We provide an illustrative results framework for this project in Section 8.
2. *Need to define SMART indicators*.[43] Currently, the performance indicators (refer Table 5.1 below) are defined for the four project objectives, and the Annual Progress reports provide details on the progress against these. However, these indicators are a combination of process and results related metrics, partly in reflection of the framing of the four objectives (e.g. number of HR trained, and number of folk songs organised are more process oriented outputs; whereas number of people receiving eye care services and cataract surgeries may be deemed to be project outcomes). In addition, it would be useful to include some equity related indicators such as access to the poor, gender balance in cataract surgeries performed. etc.

[42] Sightsavers project development is now overseen by the Strategic Programme Innovations, Development, Evidence and Research Directorate, who would ensure projects include a logframe and exit strategy. However, this process was not in place at the time of developing Vision Bangladesh.
[43] Specific, measureable, attainable, relevant and time bound (SMART).

Planned versus actual results

We present the key achievements of the project in Table 5.1 below. The project has exceeded its targets for increasing demand for eye care services (particularly cataract) and improving accessibility to quality eye care services for the poor. Consultations with the hospital partners highlight that the project has improved eye health in Sylhet, with more patients coming to hospitals for cataract surgeries. For example, the number of cataract surgeries performed at the VARD hospital in Balanganj increased on average from 10,000-12,000 surgeries per annum previously to 28,000 surgeries in 2013; number of surgeries performed in Adhunik Eye Hospital in Sylhet also increased from 480-600 per annum to around 4,200 per annum due to the project. However, the project faced some HR challenges in terms of inadequate hospital staff, issues in training and capacity building, lack of adequate incentives to retain health staff at the district level, etc. There were also delays in setting up eye corners in the upazila health complexes due to delays in working with the government, and political unrest in the last quarter of 2013.

Table 5.1: Summary of progress against objectives

Objective	Indicator	Progress
Objective 1: To increase demand for eye care services particularly for cataract in the community	1,000,000 people receive eye care services during January 2011-December 2013	A total of 1,010,815 eye patients received eye care services during this period[44]
Objective 2: To increase accessibility to quality eye care services especially cataract particularly for the poor	Perform 100,000 cataract surgeries during January 2011-December 2013	A total of 109,960 cataract surgeries have been performed
Objective 3: To deploy/ employ appropriate and competent HR in all eye care facilities in district and upazila level as per V2020 standard	• Strengthen 4 district hospitals and establish 33 corners at 33 upazila health complexes for eye care services. • 82 technical staff and 10,000 government/ NGOs field workers/ volunteers receive skills development for eye care services.	• 1 district hospital has been equipped for eye care service delivery including surgery. • 3 eye corners developed at 3 district Sadar hospitals • 22 eye corners established at upazila health complexes for eye treatment, refraction, follow up. • 8,882 field health workers oriented on primary eye care, identification and referral of eye patients. • 44 technical personnel (ophthalmologists, MOs, nurses, SACMOs) trained.
Objective 4: To manage programme efficiently and effectively	Form and make function 1 PAC; 1 PSC and 4 District V2020 Committees	• 1 PAC meeting organised • Quarterly PSC meetings held • 4 District V2020 committees formed at Habiganj, Moulvibazar, Sylhet and Sunamganj.

Source: Sightsavers (2013), "Annual Project Report"

[44] The specific activities covered by this indicator are not defined in the project documents.

5.2. Field findings on project results

This section assesses the extent to which the project has achieved its intended results (i.e. increased demand for and improved accessibility to quality eye care services, particularly for cataract and for the poor), based on implementation experience and stakeholder feedback in the focus districts in Sylhet.

In general, all stakeholders viewed the project very positively in that it has increased awareness of eye health issues and strengthened the provision of primary eye care at the community level. Several beneficiaries mentioned that they have resumed their daily activities, including employment, unaided after the surgery, resulting in an improvement in their livelihood.

Box 5.2: Project impact on beneficiary quality of life

> *"Vision Bangladesh changed our lives, before I couldn't walk without someone accompanying me"*
>
> *"If this project wasn't running, I would not have been able to get treatment [for cataracts]"*
>
> *"I'm a teacher and would have had to resign from my job had I not received this operation. Now I am able to continue working and teaching"*
>
> Quotes by beneficiaries interviewed during the evaluation

Increased awareness of and demand for eye health at the community level

In our view, a key achievement of the project has been creating demand for and increasing awareness of eye health issues at the community level. The project introduced a strong patient referral mechanism through social mobilisation by both BRAC and GoB community health workers for identification of eye problems and referral of patients to PSPs, eye corners and nearby health facilities, which we understand did not exist earlier. In addition, our field visit suggests that public announcements (commonly referred to as "miking"), folk songs, imam meetings etc. have been effective in creating awareness among community members on primary eye care. Beneficiaries corroborated this benefit that they were made aware of the PSPs (including the date, time and venue), eye corners and nearby eye health facilities through a mix of BRAC Shasthya Shebikas, GoB field staff and public announcements. Patient-to-patient mobilisation through positive word of mouth has also been effective in raising awareness, particularly for eye surgery – where there had earlier been high resistance among the population due to apprehensions and lack of understanding of the issue.

Greater accessibility to quality eye health services for the poor

The project has also resulted in improved access to quality eye health services at the community level. For example, PSPs organised at the community and upazila level served as useful outreach programmes to provide primary eye care treatment, screen and transport patients requiring secondary eye care (particularly cataract surgeries) to partner hospitals. The provision of free return transport for cataract patients at the PSPs was viewed as very

beneficial by all stakeholders consulted, given that distance to hospitals and lack of transport are large barriers to accessing eye health services in the region. Many beneficiaries said that they could not have afforded these services in the absence of such a provision.

In addition, eye corners established at the upazila health complexes have resulted in the provision of primary eye care at the community level – which did not exist previously (in terms of eye care equipment and trained staff). Under the Vision Bangladesh project, these eye corners have been equipped with a slit lamp, ophthalmoscope, retinoscope, trial lens, etc. which allow for more effective diagnosis and treatment.

Indeed, a recent study on barriers to cataract surgery in Bangladesh reported the lack of awareness of cataract and cost of surgeries as the main barriers to accessing health services; both of which have been addressed by this project in Sylhet.[45]

Vision Bangladesh exceeded its target of number of cataract surgeries, with a total of 109,960 surgeries performed. These surgeries were distributed equally across the three years, with 48% of female patients and 52% male. In 2010, the overall CSR for Bangladesh was 1,172 per million population/ year.[46] In 2013, the project performed 36,256 cataract surgeries, which gives a project CSR for Sylhet division of 3,006 per million population/year.[47] This is not only above the national average, but also shows that with a targeted approach, it is possible to reach the Vision 2020 CSR goal of 3,000 per million population/year.

In March 2014, BRAC's M&E team carried out a cataract blindness survey to assess the current level of backlog, with a sample size of 77,000 from four districts. The results from this survey are expected by end of May 2014 and assuming a robust survey approach has been used, will provide valuable information on the overall achievements of the Vision Bangladesh project.

5.3. Unintended consequences

In assessing the results of the project, we identified a few unintended positive consequences. We classify these in terms of benefits for eye health and wider systemic benefits.

Benefits for eye health

- *Developing a key partner in the provision of eye care in Bangladesh*. Both Sightsavers and BRAC acknowledged that the Vision Bangladesh project has been instrumental in strengthening BRAC's foray into eye health services in Bangladesh, including training of its field force for eye care in Sylhet. BRAC was previously involved in a broad range of other healthcare activities in the country, including nutrition, maternal and child health, water and sanitation, amongst others.[48] This project has helped in developing a strong institutional partner in eye health, whose vast resources and outreach/ field presence could sustain the provision of such services across the country. That BRAC

[45] Syed, A et al (2013), "Predictors of attendance and barriers to cataract surgery in Kenya, Bangladesh and the Philippines" *Disability and Rehabilitation,* 35(19): 1660-1667
[46] Ministry of Health and Family Welfare (2005), "National Eye Care Plan, for Implementation of Vision 2020 in Bangladesh".
[47] Sylhet's population is assumed to be 12,060,000, as cited in project documents.
[48] Prior to Vision Bangladesh, BRAC had one eye health programme in the country called "Reading Glasses for Improved Livelihood Project".

(in partnership with NEC) are continuing the project in Sylhet for two years, and have launched "Vision Bangladesh Phase II" in 11 city corporations and six Upazillas is viewed as a positive achievement.[49]

- *Promoting District Vision 2020 committees*. The NEC Operational Plan (2011-2016) defines the need for District Vision 2020 committees to be formed in order to ensure smooth implementation of the NEC plan, identify district eye care plans and implementation strategies; periodically review progress and challenges; and support resource mobilisation through increased allocation of funds, amongst others. The committee comprises representatives from the government, national and international NGOs, partner hospitals, and other stakeholders.[50] The Vision Bangladesh Project improved the effectiveness of these existing committees in terms of ensuring regular meetings and making them functional at the district level in Sylhet.[51]

- *Implementing guidelines for quality care*. We understand that Sightsavers developed a "Standard Cataract Surgical Protocol" for cataract surgeries which was endorsed by the GoB in 2012, and is now adopted by all hospitals in the country.[52] Regular monitoring visits by Sightsavers and NEC ensured compliance with the protocol by all hospital partners, including district Sadar hospitals where this was previously not rigorously followed.

- *Influencing other projects*. Vision Bangladesh has influenced other Sightsavers projects in Bangladesh, in terms of supporting primary eye care. Previously, Sightsavers had been focused only on secondary eye care. The project also influenced other partners, for example, VARD hospital now implements the PSP demand creation approach at other hospitals outside of Sylhet.

Wider systemic benefits

- *Wider systems strengthening in the NGO hospitals*. The project led to some wider systemic changes in partner hospitals to accommodate the increase in patient inflow for cataract surgeries resulting from the project (e.g. purchasing more equipment, expanding infrastructure, etc). In addition, more efficient surgical procedures were introduced under the project, having two patients in the operating room at a time with a separate nursing team for each to eliminate bottlenecks and make most effective use of the surgeon's time.[53] Hospitals were also able to reduce the length of stay for patients from two nights to one. This was achieved through hospitals being aware of when PSPs would take place. Surgeries would be scheduled for that same day and post-operative check-ups the following day. Despite surgical numbers having reduced since the end of the project, these more efficient processes still appear to be followed.

[49] However, we were informed that BRAC has not yet integrated eye health in their overall health programmes. For example, the Shasthya Shebikas are only trained for presbyopia, and not other eye health issues.
[50] Terms of Reference (TOR) of "District Vision 2020 Committee"
[51] While some District Vision 2020 committees were formed prior to the project, most of these were not functional with very few meetings being held.
[52] This is a technical protocol or guideline where technical issues have been described in four chapters: pre-operative; per-operative; post-operative; and sterilizations.
[53] This follows a similar practice pioneered by the Aravind Eye Hospitals in India.

These changes provide an opportunity for operational research on efficient/ more productive eye surgery procedures.

- *Facilitating multi-stakeholder collaboration*. The project has facilitated greater collaboration and coordination among the government and NGOs, and successfully demonstrated a that a GO-NGO model can be effective in eliminating avoidable blindness in the country.
- *Health systems strengthening*. Whist the main focus of the project was on service delivery, it resulted in wider health systems strengthening for eye care in Sylhet. Unlike previous vertical interventions in eye health, this project adopted a more integrated approach to eye care, especially cataract, delivery. In terms of WHO's six health system building blocks,[54] the project resulted in (a) a sound patient referral mechanism leading to increased demand for and awareness of primary eye care at the community level; (b) strengthening existing health facilities by supplying appropriate eye care equipment and infrastructure required for effective diagnosis and treatment; (c) better information systems and reporting of eye care data than in the past, including monitoring visits, use of protocols/ QA procedures; and (d) GO-NGO partnership, although leadership/ engagement by NEC could have been better. Whilst the project helped in training field health workers and health facility staff, capacity building/ HR issues need to be addressed further. Also, the project could have been an advocate for including eye medicines in the country's essential/ priority drug list.

There was unanimous feedback from all stakeholders, including surgeons, that the project has provided them the confidence and ability to perform a larger number of surgeries to eliminate the backlog of cataract. The large number of cataract surgeries performed over the project span of three years demonstrates that such an approach can be effective in eliminating avoidable blindness in the country and achieving the goals of Vision 2020.

[54] These are service delivery, health workforce, information, medical products, financing, and leadership/ governance

6. Sustainability and replication

The last dimension of our evaluation framework assesses the extent to which the project is technically, programmatically and financially sustainable (Section 6.1); and the extent to which it can be scaled up or replicated (Section 6.2).

Although the concepts of sustainability, scalability and replicability are inter-related, we distinguish between them as follows:

- *Sustainability* refers to the continued funding of an activity from any source (financial sustainability), and when the approaches/ interventions introduced can be continued (technical sustainability), and where the resulting benefits can be maintained (programmatic sustainability) after the project ends.
- *Replicability* refers to an approach/ intervention being copied or reproduced in a different region or country. In this case, differences between contexts need to be considered.
- *Scalability* refers to a situation where an approach/ intervention is increased in size or coverage.

Sustainability and replication

There has been mixed experience in terms of sustaining the project activities and benefits beyond its closure. BRAC and the NEC have decided to continue implementing the project for a further two years in Sylhet and also launched an urban eye care project named 'Vision Bangladesh Phase II' in 11 city corporations and six Upazilas. Several core elements of the Vision Bangladesh project design are therefore likely to be sustained in BRAC's continuation of the project, including demand and awareness of eye health in communities through the patient referral mechanism of community mobilisation as well as patient-to-patient mobilisation; and support from NEC as a key partner, amongst others. The continuation of the project does not however support the provision of primary eye care in Upazila health complexes through eye corners, or capacity building/ health systems strengthening activities. Additionally, Sightsavers are planning to replicate the Vision Bangladesh approach in three new Divisions.

Lack of a clearly defined exit strategy has led to some project activities being delayed after December 2013 (e.g. incentives to Shasthya Shebikas have not been paid in recent months although we understand that BRAC will fund this as the project continues, PSPs at the community level have also not been conducted), and there has also been a decrease in patient inflow for cataract surgeries, partly due to patients not being able to afford services or transport.

Overall, Vision Bangladesh has successfully tested new approaches to delivering cataract eye care at primary level, including creating a GO-NGO partnership and introducing primary eye care services at community level, which could be scaled up and replicated in other areas in Bangladesh.

6.1. Sustainability

The Vision Bangladesh project was phased out in December 2013 and BRAC and NEC are jointly continuing the project for a further two years.[55] Sightsavers are also planning to replicate the Vision Bangladesh approach in three new Divisions.

It was originally envisaged that the project would leave behind eye care infrastructure and efficient HR by improving the provision of eye care services with a continuous focus on quality and strengthening eye care facilities and human resources. In particular, the project emphasised strengthening the existing eye healthcare workforce (including ophthalmologists, mid-level eye care professionals, etc.) to ensure that the services continue even after project completion. It was believed that the cost of services (especially for cataract surgery) would be significantly reduced through the sheer volume of services, and thus people would be able to access quality eye care services even after the project phased out.[56]

The following strategies were proposed to ensure project sustainability: increase hospitals' quality of care and income (e.g. utilising revenue generated from eye health services to expand and increase range of services, regular outcome monitoring of surgeries, developing sustainability plan and business plan by each partner, increasing volume of surgeries); and decrease their expenditure (e.g. reduce unit cost, standardise practices and procedures, optimum use of staff and reduce wastages, retain skilled staff, etc).[57]

Overall, there has been mixed experience in terms of sustaining project activities/ benefits beyond its closure. Our field visits suggest that some elements of the project design/ benefits are likely to be sustained. For example, the patient referral mechanism of community mobilisation by field level health workers and patient-to-patient mobilisation are likely to sustain demand for and awareness of eye health in the communities;[58] and providing existing health facilities with appropriate equipment have strengthened institutional capacities to deliver quality services more effectively. In addition, support from NEC as a key partner is likely to ensure greater ownership and long-term sustainability (as evidenced by their partnership with BRAC for the continuation of the project). A key success in terms of sustainability, is that the NEC are planning to include certain approaches tested by Vision Bangladesh into the NEC Action Plan, currently being drafted. It is likely that the provision of primary level eye services through eye corners at Upazila level will be included into the NEC. The inclusion of eye corners is in line with the V2020's recommendation of including mid-level refractionists (who are not currently part of the Bangladesh health system) in the formal health workforce, should GoB decide to do so.

However, we understand from consultations that the project design did not incorporate an "exit" or "phase out" strategy, and there was limited discussion and strategic planning on the sustainability of the project.[59] In fact, despite formal letters of the project's closure in

[55] Our understanding from Sightsavers is that they decided not to support the continuation of the project due to resources being allocated to other strategic priorities/ projects.
[56] Sightsavers and BRAC (2010), "Project Description: Vision Bangladesh Project (VBP)"
[57] Ibid
[58] Although demand may be sustained, ensuring access to services is more challenging, as discussed later.
[59] Sightsavers project development is now overseen by the Strategic Programme Innovations, Development, Evidence and Research Directorate, who would ensure projects include a logframe and exit strategy. However, this process was not in place at the time of developing the Vision Bangladesh project.

December 2013 having been sent to District level officials, this message had not been clearly received by all stakeholders, with our evaluation finding both senior health officials and community members unaware of this. Given the project staff presence on the ground, this information could have been disseminated better. This also highlights the need for a well-planned phase-out strategy, which would have included these activities in the workplan. Discussions between BRAC and Sightsavers about the potential continuation of the project only started in the last quarter of 2013, as also negotiations with NEC and partner hospitals. This resulted in a few months gap in the project activities being continued/ funded by BRAC. For example:

- BRAC Shasthya Shebika's incentive payments for referring patients to PSPs were not made since December 2013 and until BRAC/ NEC's continuation of the project started (although we understand that some of them have continued to refer patients, due to trust and confidence developed with local populations over time).
- PSPs are no longer conducted at the community level, which might make it difficult for the poor people in remote areas to access eye health services.[60]
- Consultations with the hospital partners suggest that there was a decrease in patient inflow for cataract surgeries since December 2013 (including due to PSPs not being organised at the upazila levels thus making it more difficult for people to access eye care services at the community level). For example, the number of cataract surgeries performed in VARD Balaganj hospital decreased from 2,398 in the first quarter of 2013 (83% of which were supported by Vision Bangladesh), to 715 during the first quarter of 2014.[61] We were informed that some of the NGO hospitals were continuing to organise PSPs to ensure that the patients continue to access these services. Although the project design expects a decrease in surgical numbers as the cataract backlog is reduced as a result of Vision Bangladesh, beneficiaries suggested that some eye care needs were not being met due to access difficulties.
- Monitoring visits by NEC have been discontinued at some of the eye corners in the upazila health complexes due to resource constraints. We are not aware of any plan to sustain the monitoring visits by NEC as the project continues.

Large amounts of technical equipment were provided through this project. However, the project did not provide any assistance for the NEC or partner hospitals to establish plans as to how this equipment would be maintained and replaced after the end of the project. Partner hospitals were paid a set amount per surgery conducted. These payments had been calculated to include a small amount per surgery to cover replacement surgical equipment, which can be particularly expensive for eye care. However, none of the hospitals interviewed had set up any savings mechanisms to use funding in a more sustainable way. Vision Bangladesh did not provide any financial advice to assist hospitals with longer-term budgeting and equipment maintenance plans. Lessons from other Sightsavers projects that have developed 5-year business plans with private partners may have been useful here.

[60] In some cases, the hospital partners have continued to organise their own PSPs (but not at the community level). We also understand that BRAC may fund some PSPs as the project continues.
[61] It should be noted that this period in 2014 also saw political unrest which could further impact this decrease.

The project has not achieved its intended targets of developing an appropriate and trained eye health workforce. For example, Small Incision Cataract Surgery (SICS) training to ophthalmologists could not be provided due to unavailability of eye consultants at the district hospitals; and counselling training for nurses could not be provided due to political unrest in the country.[62] These detract from sustaining improvements to health systems by the project.

6.2. Project replication and scale-up

We understand that the continuation of the project by BRAC/ NEC fundamentally draws on the model developed in and learnings derived from the Vision Bangladesh design. However, certain aspects have not been included, such as support for primary eye care through eye corners and capacity building/ systems strengthening activities. This project continuation has a total budget of US$2.6m, and is aligned with NEC's goal of eliminating avoidable blindness, and aims to eliminate the backlog of cataract by 2015. Further, BRAC has launched an urban eye care project named 'Vision Bangladesh Phase II' in 11 city corporations and six upazilas. Sightsavers are also planning to replicate the Vision Bangladesh approach in three new Divisions.

The Vision Bangladesh project components that are being continued/ replicated by BRAC/ NEC include: (i) GO-NGO partnership approach of project implementation; (ii) social and community mobilisation by BRAC's Shasthya Shebikas/ Shasthya Kormis and GoB's community health care assistants to create demand for and awareness of eye health issues at the community level; and (iii) referral system between the communities and health facilities; amongst others. Moreover, we understand that VARD has replicated the PSP approach of the project at some of their eye hospitals in Dhaka.

Our interaction with NEC officials suggests that they view Vision Bangladesh as a unique project which should be scaled up and replicated to eliminate cataract blindness in other areas of Bangladesh (after accounting for geographical and socio-economic contexts).

In terms of programme replication in other settings, certain key project elements should be noted as being unique:

- Vision Bangladesh's achievements would not have been possible without BRAC's community mobilisation experience and coverage at the community level. It may be difficult to replicate this in other country settings, where several local community mobilisation partners/ strategies may be needed.
- Large numbers of cataract surgeries were possible in Sylhet in a short period due to the high calibre of existing NGO eye hospitals, which needed limited support to cope with the increased patient numbers. If Vision Bangladesh were to be replicated through less capable/ resourced hospitals, a longer timeframe and additional systems strengthening resources would be required.
- Bangladesh has a high population density, making an approach of taking services into the community feasible, thereby ensuring access for the poorest. In a less densely populated country enabling access to services for far-flung populations would be more challenging and require a different approach, most likely needing increased resources.

[62] Sightsavers (2013), "Annual Project report".

7. Cross cutting issues

Following our findings on the four evaluation dimensions, this section analyses the cross-cutting issues of gender, equity, quality of governance and services provided, and partner capacity in turn.

Cross cutting issues

Whilst Vision Bangladesh has treated almost equal numbers of men and women during the three years, there has not been any analysis on whether the project adequately addressed any gender-specific barriers to access. This is particularly important given the disproportionate burden of blindness amongst women and therefore the need for a higher CSR among females to redress this.

Financial barriers to access have been addressed during the project through community-level PSPs, and provision of free/ subsidised surgery and transport services. However, creating a sustainable mechanism for ensuring the poor have continued access to quality eye services will be a real challenge. A high level of quality of care has been achieved through partnering with high capacity NGO hospitals. In addition, strong monitoring mechanisms were put in place at the district level. However, governance mechanisms at the national level through the PAC have not worked well due to lack of engagement by the NEC.

7.1. Gender

Studies globally have shown the disproportionate burden of blindness faced by women and the need for interventions to plan accordingly to address this.[63] This is the case in Bangladesh as well, with a blindness prevalence of 1.72% in women and 1.06% in men.[64] Additionally, the NEC Plan reports that women do not equally receive services.

Our discussions with community members in Sylhet included a mix of men and women, which made women less vocal, making it difficult to assess how barriers to access may have affected them differently. Quantitative analysis shows that both cataract surgeries and eye care services were availed almost equally by men and women (52% and 48% for cataract surgeries and 49% and 51% for eye care services respectively). However, in order to address the relatively higher burden of blindness in women, there would have needed to be a higher female utilisation rate. A possible analysis on whether there are gender-specific barriers to access is examining any demographic differences between those referred for services and those accessing them. A recent study on barriers to access in Bangladesh showed the odds of attending cataract surgery were 2.9 times higher for men than women even when no treatment costs were incurred (1.6 – 5.2, 95%CI).[65]

[63] Abou-Gareeb, I et al (2001) "Gender and blindness: a meta-analysis of population-based prevalence surveys". *Ophthalmic Epidemiology* 2001 8(1) pp39-56
[64] Ministry of Health and Family Welfare (2005) "National Eye Care Plan: For Implementation of VISION2020 in Bangladesh"
[65] Syed, A et al (2013), "Predictors of attendance and barriers to cataract surgery in Kenya, Bangladesh and the Philippines" *Disability and Rehabilitation,* 35(19): 1660-1667

The Vision Bangladesh project used an all-female cohort of Shasthya Shebikas and Shasthya Kormis, who also came from the village in which they worked and so were known by the population. There was a high degree of confidence amongst implementing stakeholders that this approach would help reach all community members, including women. The project design did not as such account for any potential specific needs of women – for example, for them to be accompanied for treatment and if this might deter access. Moreover, the data analysed during the quarterly planning meetings on whether the PSPs were meeting patient targets was not disaggregated by gender, even though this information could have been collected and tracked.

7.2. Equity

The project used the ultra-poor criteria developed by BRAC's "Challenging Frontiers of Poverty Reduction" (CFPR) programme, which includes amount of land owned, whether any member of the household has a regular income, whether the family depends on the woman's earnings rather than the man's, and whether there are children who do not attend school due to working. These criteria were used to assess whether or not a patient was able to pay for services. This provision of transport and treatment costs for the ultra-poor, alongside the use of local Shasthya Shebikas who know their community well to ensure coverage of all, sought to ensure equity of access.

During the initial intense phase of PSP provision at the community level, when transport as well as treatment costs are covered, the project adequately ensures access for the poorest. However, once the phased approach assesses that the backlog of cataract blindness has been addressed in that community, PSPs are then only provided at the upazila level. This is then a challenge to continue ensuring access for the ultra-poor. One Shasthya Shebika estimated that out of the 250 households they covered, at least 10-15 would not be able to afford transport to the upazila level. Another Shasthya Shebika cited five people needing cataract surgery having gone on their own to the hospital since the end of the project, but having to return as they were unable to pay the treatment fees. Financial barriers are therefore a key issue which were addressed during the project, but creating a sustainable mechanism for ensuring the poor have continued access to eye services is a challenge.

7.3. Quality of services and Partner capacity

Based on our visits to five of the partner hospitals and stakeholder consultations, there appeared to be strong capability for the hospitals to deliver quality services. They were able to cope with the large increase in patient numbers created by the project. A limited analysis of procedures such as sterilisation methods, quality of equipment and techniques used, analysing pre- and post-operative visual acuity records, types of counselling provided, post-operative check-up procedures, as well as satisfaction levels of beneficiaries, showed that high quality care was being delivered. Most clinical providers we interviewed reported to understand and use the Standard Cataract Surgery Protocols.

Through Sightsavers technical support, the project seems to have improved quality of care. For example, NGO hospitals now collect data to monitor quality by analysing the percentage of people with improved post-surgery visual acuity. They send this data on a monthly basis to the district level, which is then sent on to the central level as well as to Sightsavers.

Sightsavers provides quarterly feedback on these indicators. NGO hospitals also hold monthly meetings to discuss and analyse these data.

Further, the project had instituted some quality control mechanisms – for example, one hospital had to suspend cataract surgeries due to high post-operative infections. As a result, post-operative follow-up procedures were implemented under the project, with community health workers being required to carry out five follow-up visits (rather than three previously) to the beneficiary homes. However, these follow-up visits were not monitored and formal procedures/ documentation were not adopted to guide and record these visits.

Governance arrangements to ensure quality were implemented well at the district level, with quarterly management meetings to discuss project progress and identify solutions to challenges. All implementing partners, including NEC and NGO hospitals engaged in these. Regular monitoring visits to hospitals/ eye corners also took place. Although NEC were highly engaged in this activity, this has stopped since the end of the project due to a lack of central funds. The project could have provided for advocacy with the government to address this issue.

Governance in terms of NEC engagement in the PAC worked less well with the committee meeting only once during the entire project. BRAC plans to address this during the continuation of the project through clearly defining the role of this committee in the overarching MoU. It is important to adequately engage NEC in these activities.

8. Summary conclusions, lessons learned and recommendations

In this section, we present our overall conclusions on the strategic evaluation of the Vision Bangladesh project by the OECD-DAC evaluation criteria (relevance, efficiency, effectiveness, impact, sustainability, scalability/ replication, coordination/ coherence). These criteria are assessed drawing on our evaluation evidence and rated using Sightsavers "Traffic-light scale". (Appendix D describes this scale). The evaluation conclusions are followed by key lessons learned and recommendations to improve the performance and effectiveness of the Vision Bangladesh project approach for future use and draw on the evaluation findings and our judgement.

Relevance	**Assessment: Highly satisfactory**	G

We have examined the relevance of the project in terms of the extent to which the project objectives, design and approach are consistent with the country and local needs/ gaps, priorities and policies. The project's focus on eliminating the backlog of cataract blindness in the face of the high incidence, backlog of, and large treatment gap for, cataract and thereby avoidable blindness, is very relevant for Bangladesh, particularly Sylhet. In addition, the project objectives and design of strengthening the provision of primary eye care at the community level through establishing a strong patient referral mechanism (from primary to tertiary level) and GO-NGO partnerships are well-aligned with the prioritised areas of action under the Vision 2020, WHO's universal eye health plan and the needs/ gaps highlighted in the NEC.

However, the relevance of the project may be questioned on some counts, such as the use of dated statistics for determining performance targets/ indicators for eliminating cataract backlog in Sylhet, and its phasing of key project activities towards the close of the project.

Lessons learned/ recommendations:

1. **The mandate and approach of the project work well and should be promoted in Bangladesh.** Our review has confirmed the need and relevance of the project, given the context in which it operates. However, several stakeholders have raised whether the project could expand its remit beyond cataract to other associated eye diseases (e.g. dacryocystorhinostomy (DCR) and dacryocystectomy (DCT)), and provide a more comprehensive package of eye health services at the community level. However, our view is that the Vision Bangladesh project should continue to primarily focus on eliminating cataract (as opposed to other eye diseases), given that it accounts for 80% of avoidable blindness in the country.[66] Our rationale is that from a programmatic point of view, addressing cataract is a cost effective and relatively simple intervention and has the potential to be replicated in other areas in Bangladesh (in terms of ease of diagnosis and operation, duration of stay at the health facilities, availability/ training of appropriate HR to perform cataract surgeries, amongst others). We do not make specific recommendations on the geographic remit of replicating project activities in Bangladesh, which is beyond the scope of this evaluation.
2. **Create a "Vision Bangladesh: How To" guide**. Other eye NGOs were keen to use the Vision Bangladesh model, having heard of the positive results, and requested further details on the

[66] Sightsavers (2003), "The Summary Report of the Bangladesh National Blindness and Low Vision Survey".

project activities and results. A manual or an operations research report on the Vision Bangladesh approach would be helpful in enabling the scaling up and replication of the project by other agencies, and also for advocating its benefits to GoB. Sightsavers could support the creation of this guide, potentially using some of the unspent project funds and/ or assisting BRAC/ NEC in preparing it.

3. **Use of current and relevant data for project design.** The project should ideally be designed using the latest data on eye health needs. If recent data does not exist, the possibility of funding a new survey should be explored or conducting a comprehensive baseline situation analysis. If these are not feasible, sensible assumptions should be made to project eye care needs for the present from the previous surveyed data.

Effectiveness	**Assessment: Satisfactory**	

We have examined effectiveness in terms of whether the project's design and processes have contributed positively or negatively to the attainment of its objectives. Our assessment is that the project - in terms of what it aimed to do, how it positioned itself in the Bangladesh context, and its approach of working with the government and NGOs - has helped meet its objectives of increasing demand for eye care services (particularly cataract) and accessibility to quality eye care services at the community level. In particular, the referral mechanism established through community mobilisation by the BRAC Shasthya Shebikas and GoB's Community Health Assistants has been instrumental in creating awareness of and demand for primary eye care at the community level. However, several factors have detracted from the effective implementation of the project, including inadequate number of trained GoB staff at health facilities (e.g. ophthalmologists and MOs) at the district and community level due to lack of sufficient incentives, frequent transfers, etc; insufficient training provided to MOs and SACMOs mainly due to their inability to leave their duty station for longer periods of time; delay of project activities in later phases/ after project closure; inconsistent post-operative follow-up; and sliding scale payment structure, amongst others.

Lessons learned/ recommendations:

4. **Staff retention measures at GoB health facilities**. Retaining trained staff at district and community health facilities was a key factor affecting project implementation. The project could institute various monetary and non-monetary measures to retain hospital staff such as provision of suitable remuneration/ incentives, recognition of good work, periodic job satisfaction surveys, rotation of roles (if sensible) etc. Although this is outside the project's control, the partnership with NEC provides a unique opportunity to influence policy.
5. **Training of Shasthya Shebikas.** Given BRAC's extensive experience of training community health volunteers, the basic eye health training developed for Shasthya Shebikas as part of this project could be used by Sightsavers and BRAC on future projects and also shared with other implementing partners.
6. **Periodic refresher training**. Regular refresher training sessions should be provided to BRAC Shasthya Shebikas and all eye health service providers including MOs, SACMOs, ophthalmologists to upgrade their skills on eye care on an ongoing basis. In addition, any continuation of the project should include training on counselling of nurses, including counselling for post-operative follow-up.

7. **Strengthen monitoring and supervision**. The design of any continuation should ensure regular monitoring visits to the health facilities by NEC for quality assurance and overall monitoring of progress of the project. The MIS developed by Sightsavers, if found to be fit-for-purpose, may be followed by the hospital partners and integrated with the GoB MIS to the extent possible to allow for more effective monitoring. An additional monitoring mechanism would be a clearer protocol on Shasthya Shebika post-operative follow-up visits and how these will be monitored.

Efficiency	**Assessment: Satisfactory**	

Efficiency is an economic term that relates to the ability to deliver desired outputs at the lowest possible cost (cost effectiveness) for a given quality. For this project, efficiency relates to how well it has performed in terms of its funding design/ approach as well as utilisation of funds.

Despite having a relatively small budget as compared to the community needs/ backlog, 79% of the total budget has been utilized, with an under spend vis-à-vis budget across the expenditure categories. A significant proportion of the total funds under the project was spent on cataract surgeries – which was the main aim of the project. However, utilisation of funds by both Sightsavers and BRAC on other project components has been lower than budgeted, particularly for capacity building and training of HR, monitoring systems, and demand creation. Funds for cataract surgeries were channeled to Sightsavers BCO through BRAC to facilitate quicker clearance from the NGO Affairs Bureau – but this resulted in additional steps/ transactions in the funds flow.

Lessons learned/ recommendations:

8. **Procedures to analyse spending levels should be developed.** Given the significant underspend on this project, mechanisms should have been in place to analyse spending levels between the two funding partners in order to discuss how to reallocate funds. Suggestions on alternate activities to have deployed the under-spent funds include additional PSPs at the community level, a formal equipment maintenance plan (including provision of spare parts), training patient counsellors and introducing task-shifting procedures from ophthalmologists to lower level staff.
9. **Fund flows could be streamlined.** Given the clearances required from the NGO Affairs Bureau in Bangladesh, the channeling of cataract surgery related project funds through BRAC appears to be efficient and we are not aware of any management fee levied by BRAC for this. However, we question whether it may have been more effective for BRAC to disburse cataract surgery related funds directly to the hospital partners (subject to approval by Sightsavers BCO to maintain performance control of partners), to save an additional step in the routing of funds. Alternatively, Sightsavers could have secured the requisite local approvals to remit funds directly to BCO, thereby streamlining fund management.

Impact	Assessment: Satisfactory	

Impact refers to the long-term consequences of an intervention. We consider project impact in terms of whether the project has met its intended results of increasing demand for and awareness of eye care services in the community (particularly for cataract) and increasing accessibility to quality eye health services for the poor. Notwithstanding the absence of a well-defined results framework, our assessment is that the project has performed well on the following:

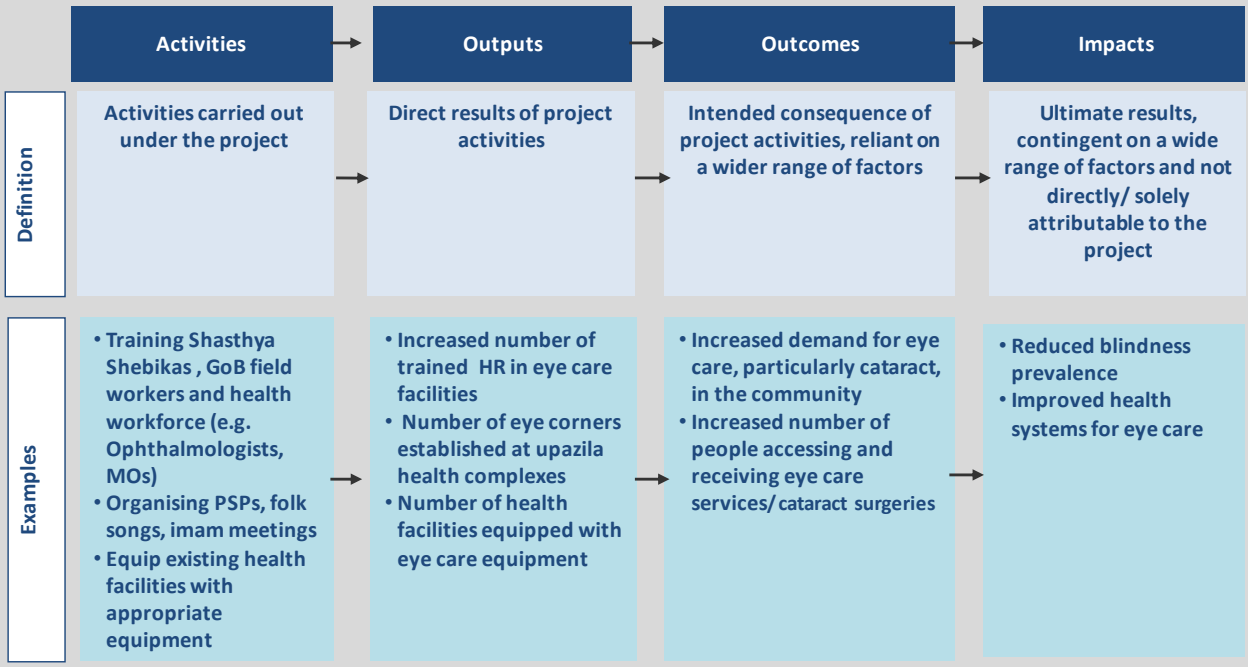
- The project exceeded its targets of increasing demand for eye care services (particularly cataract) and increasing accessibility to quality eye care services for the poor. During the project period, 1,010,815 people received eye care services vis-a-vis the target of 1,000,000 and 109,960 cataract surgeries were performed vis-a-vis the target of 100,000.
- The project has helped beneficiaries resume their daily activities and employment resulting in an improvement of their livelihood. (Box 5.2 provides some examples of this impact).
- The project introduced a strong patient referral mechanism through social mobilisation by both BRAC and GoB community health workers for identification of eye problems and referral of patients to PSPs, eye corners and nearby health facilities, which did not exist earlier. The evaluation indicated that these referral mechanisms were still functioning several months after the end of the project.
- PSPs organised at the community and upazila level, and eye corners established at the upazila health complexes have resulted in the provision of primary eye care at the community level.

The project has also resulted in some positive unintended consequences in supporting improved eye health in Bangladesh (e.g. supporting the entry of BRAC in the provision of eye health in the country, promoting the District Vision 2020 committees, implementing guidelines for quality eye care) and some system-wide benefits (e.g. systems strengthening in partner hospitals, facilitating multi-stakeholder collaboration between the government and NGOs).

Lessons learned/ recommendations:

10. **The project should establish a results framework, clearly defining its overall goal and objectives as well as outputs, outcomes and impacts.** It is good practice for any intervention to establish a results framework or theory of change upfront. This should clearly define the project goals and objectives; the progression of how its activities/ processes will lead to certain outputs and contribute to specific outcomes and impacts (theory of change); as well as planned targets and milestones for these performance indicators. It is also important to develop a pre-agreed and standardised format for partner reporting on results (including capturing results on the cross-cutting issues of gender, equity, quality and sustainability). We provide an illustrative framework that may be followed by Vision Bangladesh.

Figure 6.1: Illustrative logframe for Vision Bangladesh



Sustainability	**Assessment: Caution**	A
Scalability/ Replication	**Assessment: Highly satisfactory**	G

Sustainability of an intervention refers to the extent to which the project activities are likely to be continued after donor funding. For this project, we consider the extent to which the project activities and benefits are likely to be sustained as well as their potential to be scaled-up or replicated. The project lacked a clearly defined exit/ phase out strategy which has resulted in delay of certain activities after the project's closure, until BRAC/NEC's continuation of the project. For example, PSPs are no longer organised at the community level, BRAC Shasthya Shebikas are no longer paid incentives for patient referrals, there is no allocation for upkeep and replacement of new cataract equipment installed, amongst others.

However, some elements of the project design/ benefits are likely to be sustained going forward, including demand for and awareness of eye health at the community level through social mobilisation by Shasthya Shebikas and patient to patient mobilisation, and equipping existing health facilities with appropriate eye equipment. Several components of the project are being continued by BRAC, including its GO-NGO partnership approach, social and community mobilisation by field level workers and provision of cataract operations through partner hospitals.

Lessons learned/ recommendations:

11. **Need for a clearly defined exit strategy and sustainability plan in project design**. The plan to ensure sustainability both for project and partner level activities needs to be developed and agreed in the inception phase of the project in order to avoid any negative impact of services being withdrawn once funding ends. This would ensure that the required processes, capacities and institutions are developed with a view to create sustained demand for eye health services and accessibility of eye care delivery, especially for cataract, at the community level. We understand that some other eye-NGOs have developed exit strategies for their projects. These could be consulted for future projects and effective strategies/ lessons learnt from across projects discussed at the eye-NGO forum meetings.
12. **Need for contextual analysis if replicating the Vision Bangladesh approach.** In terms of replicating the project approach in other settings, certain project elements should be noted as being unique, notably BRAC's wide community mobilisation coverage, the high calibre of partner hospitals and Bangladesh's high population density.

Coordination/ coherence	**Assessment: Highly Satisfactory**	G

Roles and responsibilities of the implementing partners were clearly defined under the project, and leveraged their comparative expertise and available resources. The partners have worked in a well-coordinated and synergistic manner, facilitating smooth implementation of project activities. The project has also facilitated and strengthened partnerships between the government and NGOs in eye care service delivery. The PSC served as a useful forum for reviewing project progress and planning future activities, however the PAC has not engaged adequately, particularly with regards to the strategic and planning decisions on the project.

Lessons learned/ recommendations:

13. **The project should continue a coordinated partnership approach.** For a project of this nature, it is important to leverage the skills and expertise of each of the implementing partners for the project to achieve its intended objectives. Thus, it is important to identify and draw on the comparative advantages of Sightsavers (in terms of eye health expertise through clinical quality assurance and clinician training); BRAC (in terms of demand creation and community awareness through its field level capabilities); NEC (for overall monitoring and quality assurance); and the hospital partners (government and NGOs). The NEC in particular is keen for this GO-NGO approach to be replicated in the future and other NGOs have also expressed interest in this model.
14. **Leverage greater engagement from the government.** There has been limited engagement of the government in providing strategic direction/ oversight support to the project. The government needs to be encouraged to engage more with the partners and provide strategic leadership and guidance on various issues (e.g. health systems strengthening, sustainability, scalability/ replication across the country). The creation of a clearer ToR for the PAC in a continuation project, in discussion with and buy-in from NEC, may be a step towards addressing this issue.

Appendix A: Bibliography

This appendix presents a list of key documents and datasets used for the assignment.

Documents

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Datasets

- BRAC (2014), "Vision Bangladesh Project, Financial Report – Receipts and Payment Statement for Cataract Surgery".
- Sightsavers financial reports, including detailed budget versus actual
- Sightsavers planning meeting data (indicators collected to assess frequency requirements of holding PSPs)
- Sightsavers Output Statistics
- VARD Eye Hospital, Key performance indicators

Appendix B: List of Consultations

Table B.1 lists the consultations carried out as part of this evaluation. We consulted with beneficiaries, Shasthya Shebikas and Shasthya Kormis at the health facilities and communities, but were unable to understand/ record all their names.

Table B.1: Consultation list[67]

Stakeholder	Position/ organisation
Sightsavers - Bangladesh Country office (BCO)	Country Director
	Senior Programme Officer
	Programme Development Advisor
	Finance & Support Services Manager
	Programme Manager
Sightsavers , UK	Strategic Evaluations Advisor
BRAC , Dhaka	Associate Director, Health Nutrition and Population Programme
	Senior Program Manager, Health, Nutrition and Population Programme
BRAC District Offices	BRAC Upazila Manager
	BRAC District Manager
Ministry of Health and Family Welfare (MoHFW), National Eye Care (NEC)	National Eye Care Programme Paediatric Ophthalmologist, National Institute of Ophthalmology, Dhaka
District and Block level representatives	Civil Surgeon, Sylhet
	Retired Consultant, Sadar Hospital, Sylhet
	Adhunik Chakshmu hospital, Sylhet
	Chairman of Local Government Union, Sylhet
	Civil Surgeon, Sunamganj District
	RMO Sunamganj District Hospital
	Medical Office, Sunamganj District Hospital
	General Secretary, Bangladesh National Society for the Blind (BNSB), Moulvibazar
	Hospital Manager and Consultant of Eye Health, BNSB, Moulvibazar
	Sub-Assistant Community Medical Officer (SACMO), Balanganj Upazila Health Complex
	Upazila Health and Family Planning Officer, Balanganj
	Family Welfare Assistant, Community Clinic, Balaganj
	Community Health Care Provider, Community Clinic, Balaganj
	Assistant Director, Voluntary Association for Rural Development (VARD), Balaganj
	Hospital Manager, VARD, Balaganj
	Ophthalmologist, Balaganj

[67] Where names were not provided, job titles and organisation have been noted

Stakeholder	Position/ organisation
	Eye Surgeon, VARD, Balaganj
	SACMO, Sreemongal Upazilla Health Complex
	Upazila Health and Family Planning Officer
	Medical Officer, Fenchuganj
	Community health care provider,
	Health management committee treasurer, Fenchuganj
ORBIS	Program Manager, Bangladesh Country Office
	Director of Programs
Fred Hollows Foundation	Program Manager
	Program Coordinator
Helen Keller International	Country Director
CBM	Country Coordinator

Appendix C: Interview guide

This annex presents the interview guide used for consultations with stakeholders during our field visit to Dhaka, Sylhet and supported health facilities in districts.

We present below the types of questions discussed with: (i) government officials at the state and district level; (ii) implementing partners (Sightsavers, BRAC and hospital partners); (iii) health service providers (e.g. civil surgeons, ophthalmologists, etc); (iv) community health workers (BRAC Shasthya Shebikas and Shasthya Kormis); (v) beneficiaries; and (vi) other eye health NGOs in Bangladesh.

The guide was developed for Sightsavers and CEPA's reference and was not shared with the consultees. The questions were tailored and structured appropriately (e.g. avoidance of use of jargon and complex terms, administered in local language) when directed at consultees. In general, our approach to interviews has been to avoid any leading questions and provide required background where needed in support of our questions.

Interview questions

Section 1: General questions for discussion

We will discuss the following questions with all stakeholders, focusing on those questions where the stakeholders might have detailed knowledge.

1. What are the key issues and needs relating to eye health in your area and how has the Vision Bangladesh project addressed these?
2. What aspects of the project approach/ activities have worked well and not so well? Have the project activities been implemented in an efficient manner, and what factors have affected project implementation?
3. Has the project been successful in facilitating and strengthening effective collaboration and coordination among the various stakeholders (e.g. MoHFW, BRAC, Sightsavers, NGOs, health facilities), and have partner capacities been built as a result of the project? Please explain with examples.
4. What are your views on the emerging results/ impact of the project – both proximate outcomes such as increased demand for eye care, and improved accessibility and quality of eye health services; and any unintended consequences/ broader systemic changes within the country health systems?
5. What is the potential for sustainability (programmatic, technical and financial) of the project post funding from Sightsavers/ BRAC? What are the key factors that may affect/ improve sustainability?
6. Can the project or its components be replicated in other parts of Bangladesh or in other similar contexts? Are there any aspects of the project which would need to be modified in order to be relevant for other areas?
7. Do you have any recommendations to improve a similar project in terms of its design and implementation, including partner coordination mechanisms? What are the lessons learned from this project?

8. Does the project take account of/ address socio-economic factors like gender and equity related disparities in Sylhet? Please provide examples.

Section 2: Sub-questions per stakeholder group

In addition to the above general questions, we will seek to explore the following questions with each stakeholder group.

Government officials at the state and district level

The focus of these interviews will be to understand the country specific context and relevance/ alignment of the Vision Bangladesh Project with the national policies and priorities, as well as the results and potential for sustainability/ replication of the project. We will aim to meet the officials in MoHFW as well as district officials in Sylhet as feasible and the specific questions may differ accordingly.

1. Could you comment on the strengths and weaknesses of the country health systems/ infrastructure in eye health?
2. Is the Vision Bangladesh project aligned with the local and national health priorities and policies (e.g. Bangladesh National Eye Care plan, National Eye Care Operational Plan)? In this context, what has been the added value of the project?
3. What role, if any, did you have in designing, implementing and/or monitoring the Vision Bangladesh project? What has been your involvement in the project after funding from Sightsavers has been withdrawn?
4. Have human resource capacities and retention of government and partner hospitals improved due to this project? Do you have any recommendations to improve this issue and are there any particular challenges in developing and retaining eye care staff than other health staff?
5. To what extent has the project integrated with and improved the public sector eye health delivery systems (at all levels)? Has the project approach helped promote any sustainable public private partnerships in eye care services?

Implementing partners (e.g. Sightsavers, BRAC and VARD project staff)

The focus of these questions will be to understand how effectively and efficiently the project has been implemented, as well as the extent of coordination among partners. Given the different remits/ activities of each implementing partner, the focus of questions is likely to differ accordingly.

1. What has been your role in the Vision Bangladesh Project? Have the roles and responsibilities of the various implementing partners involved been defined clearly and executed as planned?
2. Please comment on your interaction with other partners under the project? What coordination and governance mechanisms were in place to ensure effective coordination/ communication?
3. How have your institutional and management capacities in eye care services, especially cataract, been improved due to the project? Have any aspects of the eye health systems in the country been strengthened as a result?
4. To what extent is the project design aligned with Sightsavers strategic objectives?

Health service providers (e.g. Civil surgeon, ophthalmologists, ophthalmic nurses, optometrists)

The focus of these consultations will be to understand the experiences of health providers at district and upazila level under the Vision Bangladesh project and what added value the project has provided them, as well as their perceptions of project success.

- What has been the impact of the project on the demand for eye care and your ability to provide more accessible and quality services?
- Has the project improved coverage of and access to quality eye care services for women, the poor, aged, marginalised and rural populations? Please explain with examples.
- Has the project resulted in any changes/ improvements in the systems, processes and human resource capacity in the eye health facilities?
- Which aspects of the project were most responsible for any changes/ improvements in (a) eye care demand, and (b) the quality and equity of services?
- What reporting requirements do you have, both for MoHFW and Vision Bangladesh? Have you received monitoring visits from either Sightsavers, BRAC or MoHFW staff?
- Did you receive any training under this project, and how useful was it? Do you feel there were other training needs that were not addressed?
- What are your suggestions to further improve eye care demand and provision of high-quality and equitable eye care services in Bangladesh?

Community Health workers (BRAC Shasthya Shebikas and Shasthya Kormi)

- What is your role in the Vision Bangladesh project in terms of mobilising the community on eye health services and increasing demand for eye care, especially for cataract? Has this role changed since the project ended in December 2013?
- Have you been provided with adequate training and support under the project?
- What has the impact and value add of the project in terms of increasing demand and quality of eye health services? Are there any ways in which the design and implementation of this project have been different (in terms of strengths and weaknesses) than previous projects in eye health in the country?
- How could you ensure that everyone was aware of and able to access eye care services, including the poor, aged, women, marginalised and rural communities?

Beneficiaries

The focus of these questions would be to understand the experience of beneficiaries of the Vision Bangladesh Project (e.g. in terms of accessibility, quality and equity of eye health services). We would aim to interview beneficiaries on an individual and group basis, as feasible.

- Are you aware of the Vision Bangladesh project and its benefits, and how were you made aware of this project? Did you spread the word regarding the project to others in your community?

- Have you faced any issues or challenges with regards to accessing eye health services in your area? Did you have to pay for these services, if so, were these affordable?
- Could you comment on the quality of care and efficiency of service delivery at the health facilities/ eye care centres and has this improved with the introduction of the project?
- Are you satisfied with the services provided to you by the community health workers and at the eye care centres? Do you have any recommendations on how to improve these services?
- Did the project result in any wider benefits or changes in your community (besides eye health services)?

Other eye health NGOs in Bangladesh

The objective of these interviews would be to understand activities of other NGOs in the area of eye health in Bangladesh and solicit any views they may have on the Vision Bangladesh project in terms of the project design, potential for sustainability/ scalability, value add of the project and lessons learned.

1. Could you provide us with a background of your organisations' activities in the area of eye health in Bangladesh? Are these in any way aligned with/ complementary to the Vision Bangladesh project?
2. Are there any lessons to be learned from your activities in eye health care in Bangladesh for Sightsavers – both in terms of challenges/ barriers to demand creation and service delivery as well as achievements?
3. Do you have any views on whether the design of the Vision Bangladesh project is aligned with the national and local eye health priorities and policies in Bangladesh?
4. What are your views on the value add of the Vision Bangladesh project? What lessons can be drawn from the project in terms of its design, implementation and partner collaboration for future programming of eye health projects?
5. Do you think such projects are generally sustainable (financially and programmatically) post funding (from Sightsavers)? Can the project be replicated/ scaled up in other parts of Bangladesh, and if so, please provide suggestions on how this can be achieved.

Appendix D: Evaluation criteria rating

Table D.1 presents the rationale used to rate the extent to which each of the evaluation criteria have been met, as per the evaluation guidelines provided by Sightsavers.

Table D.1: Evaluation criteria rating

G	Highly Satisfactory	There is strong evidence that the evaluated initiative ***fully meets all or almost all*** aspects of the evaluation criterion under consideration. The findings indicate a highly satisfactory, largely above average achievement/progress/attainment and potentially a reference for effective practice.
GA	Satisfactory	There is strong evidence that the evaluated initiative ***mostly meets*** the aspects of the evaluation criterion under consideration. The situation is considered satisfactory, but there is room for improvements. Achievement/progress/attainment under this criterion is potentially a reference for effective practice. There is need for a management response to address the issues which are not met.
A	Caution	There is strong evidence that the evaluated initiative ***partially meets*** some aspects of the evaluation criterion under consideration. There are issues which need to be addressed and improvements are necessary under this criterion. There is need for a strong and clear management response to address these issues. Evaluation findings are potentially a reference for learning from failure.
AR	Problematic	There is strong evidence that the evaluated initiative is ***borderline in terms of meeting*** the aspects of the evaluation criterion under review. There are several issues which need to be addressed. Evaluation findings are potentially a reference for learning from failure. There is need for a strong and clear management response to address these issues.
R	Serious Deficiencies	There is strong evidence that the evaluated initiative ***does not meet key*** aspects of the evaluation criterion under consideration and is performing poorly. There are serious deficiencies in the evaluated initiative. There is need for a strong and clear management response to address these issues. Evaluation findings are potentially a reference for learning from failure
NE	Not Sufficient Evidence	There is **not sufficient evidence** to rate the evaluated initiative against the criterion under review. The programme needs to seriously address lack of evidence in their initiative.

Appendix E: Summary of progress against key activities/ milestones

Table E.1 below presents a summary of the key activities and achievements of the Vision Bangladesh project on its four objectives, as of December 2013.

Table E.1: Summary of progress against key activities/ milestones[68]

Objective one: Increase demand for eye care services particularly for cataract in the community		
Indicators / *Activities*	**Target**	**Achievement**
Provision of eye care services	1,000,000	1,010,815
Organise folksongs	140	207
Organise advocacy meetings with city corporation	1	1
Organise meetings with municipality bodies	6	5
Organise patient screening programmes (PSP)	525	903
Organise six-monthly district coordination meetings with government officials	8	7
Organise six-monthly meetings with government officials at upazila level	74	60
Organise meetings with local government representatives at union level	140	143
Organise meetings with religious leaders	150	148
Organise meetings with primary school teachers	192	250
Observe annual World Sight Days at district level	9	9
Objective two: Increase accessibility to quality eye care services especially cataract particularly for the poor		
Indicators / *Activities*	**Target**	**Achievement**
Number of cataract surgeries performed	100,000	109,960
Implement guidelines for cataract surgery	Standard operating protocols are being used in all partner hospitals	
Develop MIS software	Work is still outstanding for partner hospitals to use this software, as previous versions are currently being used	

[68] Sightsavers (2013), "Annual Progress Report".

Objective three: Deploy/ employ appropriate and competent HR in all eye care facilities in the district and upazila level		
Indicators / *Activities*	**Target**	**Achievement**
Strengthen district hospitals to provide cataract surgeries	4	1 hospital equipped for surgery and eye corners established in 3 others
Establish eye corners at upazila health complexes / district hospitals	33	25 (22 at upazila and 3 at hospital level)
Train government/NGO field workers/volunteers on eye care services	10,000	8,862 (6,394 NGO & 2,468 MoHFW)
Train government technical staff (Ophthalmologists, Medical Officers, Nurses, & Sub Assistant Community Medical Officers)	82	44
Objective four: Manage performance efficiently and effectively		
Indicators / *Activities*	**Target**	**Achievement**
Form and make functional Project Advisory Committee (PAC)	1	Only 1 meeting held during project
Form and make functional Project Steering Committee (PSC)	1	PSC functional throughout project
Form and make functional District V2020 Committees	4	Committees created but not all still functional after project end

Appendix F: Terms of Reference (ToR)

Strategic Evaluation of Vision Bangladesh Project

1. Background

Sightsavers is an international development organisation and its overall goal is to contribute to the achievement of the MDGs by eliminating avoidable blindness, and promoting equality of opportunity for disabled people. Currently, Sightsavers is supporting projects in 30 countries across Africa, Asia and the Caribbean.

1.1 **Project name:**
Vision Bangladesh - Elimination of Cataract Backlog in Sylhet Division

1.2 **Project duration:**
01 January 2011 – 31 December 2013

1.3 **Project budget:**
BDT 313,793,073

1.4 **Project Partners include:**
National Eye Care under the Director General of Health Services of Ministry of Health & Family Welfare, BRAC and Sightsavers. Hospital partners are Voluntary Association for Rural Development (VARD), Bangladesh National Society for the Blind (BNSB) Moulvibazar, NAYAN and JASPUS.

1.5 **Key Stakeholders:**
Under the Director General of Health Services (DGHS) of Ministry of Health & Family Welfare (MoH&FW) include the National Eye Care (NEC), Civil Surgeons of Sylhet, Habiganj, Sunamganj and Moulvibazar districts, Members of the District Vision 2020 Committee that comprises of a cross-section of people, District Hospital's Ophthalmologists and Nurses, Upazila Health & Family Planning Officers, Medical Officers and Sub Assistant Community Medical Officers at upazila health complexes, government field level health workers, community health clinic workers & beneficiaries, school authorities, teachers and district/sub-district education officers, Directorate of Primary Education, local government authoritiesunion parishad representatives, i.e. chair & members, elected union parishad officials, family members of service recipients, service recipients (provided services free or at subsidized rate or on full payment), hospital service providers, BRAC shebikas and representatives, religious leaders and students.

1.6 **General information of the project area:**
The project area: Sylhet is a low performing area in terms of health service, education and socio-economic indicators for various socio-economic and geographic factors.

Total population of Sylhet division is 12,060,000 According to the National Blindness Survey, the prevalence of blindness is 1.31% of the above 30 population (i.e. 55,295) and 41,471

(75% of prevalence) is cataract backlog and annual incidence of cataract is 8,294 (20% of backlog). Sylhet has approximately 328,000 adults and 120,000 children aged 5-15 years with visual impairment due to uncorrected refractive error, which has resulted in significant visual morbidity. Studies done in different countries indicate that 'blindness and poor vision having tremendous impact on quality of life; and that ninety % of blind individuals have difficulties accessing work; and it is also related to the achievement of the millennium development goals (MDGs). Recognising the inter-relationship between poverty and blindness , the Vision Bangladesh, a joint-venture project was designed to be implemented in a phase by phase manner starting with Sylhet division (2011-2013).

A study conducted under Vision Bangladesh Project records the following number of people with blind/visual impairment in Sylhet division at a given time:

- 59,605 people are blind
- 75% are blinded by cataracts
- Around 9,000 new cases of cataract blindness occur every year
- 350,000 adults and 130,000 children suffer from severe visual impairment which could be easily corrected with glasses.

As elsewhere population above the age of 40 years in the country suffer from blurred vision, a condition clinically known as presbyopia. This affects the productivity and quality of life during the productive years of the populations bearing significant socio-economic implications.

1.7 The Vision Bangladesh Project:

The 'Vision Bangladesh Project' is a joint venture of BRAC, Sightsavers and Government of Bangladesh designed to eliminate cataract blindness from Sylhet by 2013; while establishing/strengthening collaboration and coordination between a range of stakeholders.

A start-up phase (Jan. 2010 to Dec. 2010) for Vision Bangladesh Project was initiated with sole funding from Sightsavers in selected sub-districts (upazila) in Sylhet, Sunamganj & Habiganj districts to assess the situation and design a comprehensive project for the next 3 years (2011 – 2013) to be implemented with BRAC and National Eye Care with the purpose of elimination of the backlog of cataract blindness from Sylhet division by the year 2013. The start-up phase has also given the opportunity to Sightsavers to orient 715 BRAC Shyasthya Shebika (SS), Shyasthya Kormi (SK) and others. The project also builds upon Sightsavers previous experiences of working in Sylhet, Sunamganj, Habiganj and Moulbhibazar districts since '90s with VARD and BNSB Moulbhibazar, two of the 4 hospital partners operating under the Vision Bangladesh project in Sylhet Division.

The design and implementation of the Vision Bangladesh project (2011 – 2013) was done in accordance with the National Eye Care Plan 2005 as well as specific areas of WHO Health System Building Blocks for implementation and achievement of the Vision 2020 goal in Bangladesh. Attempts have been made to integrate Eye Health Care with the existing health care facilities & providers (in the public sector at various tiers within a district) creating easily

accessible comprehensive eye care services for those who need it and develop an approach involving public-private partnership.

Vision Bangladesh is a good example of GO-NGO collaboration with the joint leadership of National Eye Care of the Government, BRAC, and Sightsavers. At the local level the project has been able to showcase high volume of service deliveries involving several stakeholders within a short period, build close relationships and coordination between the districts based health administration led by the civil surgeons and NGO stakeholders in particular.

The total project budget from Sightsavers and BRAC for Vision Bangladesh to operate in Sylhet division was Taka (Bangladesh currency) 313,793,073 (in word Three Hundred and Thirteen Million, Seven Hundred & Ninety-three thousand, Seventy-three only, for three years (Jan. 2011 till Dec. 2013); apart from this the project continued to utilize government facilities, human resources and services in kind, where possible.

Overall strategy of the programme is based on: (1) Increased demand for eye care services particularly for cataract in the community (2) Increased accessibility to quality eye care services particularly for the poor and, especially for cataract (3) Capacity building of human resources of government and partner hospitals within the Division and (4) Developing institutional and management capacities of the partners.

The specific purpose of this project is “Elimination of the backlog of cataract blindness from Sylhet Division by the year 2013”

The specific objectives of the project are:

1. To increase demand for eye care services particularly for cataract in the community.
2. To increase accessibility to quality eye care services especially cataract particularly for the poor.
3. To deploy/employ appropriate and competent HR in all eye care facilities in district and upazila level.
4. To manage programme efficiently and effectively.

A Mid-term review conducted in 2012, has the following key findings:

- The project has increased awareness, demand and access to eye care services
- At the local level the project has been able to build close relationship andcoordination among the GO-NGO partners.
- The project faces a number challenges including inadequate number of health care providers retention of trained staff, inadequate supply of medicine, centralised decision making process at public facilities etc.

As of September 2013, the project has reached over

- 934,000 persons seeking general eye examination (with a ratio of 49:50.93 of men and women, 51.62:48.38 ratio of boys and girls)

- Performed 104,505 cataract surgeries (with 52.41: 47.59 ratio of men and women and 74.51: 25.49 ratio of boys and girls)
- Refracted 208,105 cases with an overall ratio of 47:53 for men and women
- Dispensed spectacles to 85,138 persons (includes 51.26% women)
- Established 26 eye corners at public facilities
- Trained over 7000 health workers (till July 2013)

2. Purpose of Evaluation

The purpose of the evaluation is to assess the projects' achievements, challenges, capture the lessons learned and way forward for Sightsavers and partners in context of relevance, effectiveness, efficiency, impact, sustainability, scalability/replication, and coherence/coordination.

Thus, the evaluation will review the achievement of the project against objectives and outputs as detailed out in the project document, as well as assess the long-term effects made by the project on eye health. The key issues to be addressed are service delivery, institutional and overall programmatic development at the partners' level, contribution to health system strengthening and contribution made at the beneficiary level as well as financial management of the project.

2.1. Evaluation criteria

Relevance: Assess the appropriateness of the application of the project design

1. How aligned is the project to local, national and international development priorities and policies?
2. What specific health development policies and priorities is the project aligned to and how?
3. How aligned is the project to Sightsavers strategic direction?
4. To what extent are Sightsavers, BRAC and the Government through this project responding to the needs and priorities of the constituencies they work in?

Effectiveness: Assess the effectiveness of interventions across all the objectives i.e. demand generation, improving access and capacity development:

1. How effectively are trained staff organising individual functions and competently supporting cases?
2. How effectively are hospitals managing high volume of patients referred for services?
3. How has the project delivered against the planned targets and what factors (if any) have contributed/hampered this?
4. What were the various approaches tried? Which ones did not work? Why? What was the learning?
5. How/ what active efforts were made to bring about a joint understanding between diverse partners?

Efficiency/Cost-effectiveness:

1. How well has the project been implemented?

2. Have resources been allocated in a way that maximises their use?
3. Was the intervention cost-effective? Compared to different approaches.
4. How effective was the coordination between partners? How this has increased the service delivery efficiency? What was the effect of the partnerships on the cost effectiveness?
5. How efficient is the referral chain at different levels? What interventions were undertaken to contribute to improve the referral chain by the project? What are the gaps?

Impact/Results

1. Has the delivery of project outputs and activities led to the desired outcomes and impact? Have there been any unintended/additional outcomes?
2. What are the broader systemic changes brought about by the intervention, directly or indirectly that will lead to improvement of the overall Health systems?
3. What changes (if any) are evident in the capacity of the partner hospitals? Will they be able to continue the same beyond the project duration and geography?
4. What is the perception of the beneficiaries/key stakeholders/partners of the project and its impact?

Sustainability:

1. What are the key lasting changes achieved by this intervention as an overall programme in relations to the Vision 2020 milestones and health systems strengthening agenda?
2. To what extent is the project intervention likely to be technically, financially and programmatically sustainable?
3. What partnership strategies were employed and which ones have been successful? Why? How will these influence sustainability?
4. What are the key factors that ensures (or will ensure) sustainability of the programme beyond BRAC and Sightsavers support? Who will be responsible for this?

Scalability/Replication:

1. Is any aspect of the programme or its components likely to be scaled or replicated by participating partners, other agencies or government? How likely is this to occur or what conditions need to exist for this to happen? What factors or constraints might inhibit this process?
2. What evidence has been generated by the project to support scalability efforts by interested parties? How has the project packaged and shared this evidence to date?
3. In the event of a scale-up, what lessons learnt from the implementation process in this context need to be taken into account?

Coherence/Coordination:

1. To what extent has the intervention systemically created synergies with other institutions, towards achieving the defined objectives and goals over time?
2. Are there specific mutually reinforcing policies that have been promoted by the project over time to create these synergies?
3. How have the project activities been coordinated in light of similar or other sectoral interventions/approaches in the region?

4. To what extent did the programme objectives, approaches and design complement and/or contradict each other?
5. How did the project engage the community in its intervention? Is there a system developed to maintain such engagement beyond the project period? What else could be done to improve coordination and how?

3. Review Team

The evaluation shall be conducted by an external evaluator, or evaluation team, which will be selected through competitive proposal submission. The evaluator/evaluation team will have demonstrated competence in having undertaken similar work before, including experience in programme design and management, planning, monitoring and evaluation.

The lead evaluator will have as a minimum the following core competencies; public health specialist experience, possess projects/program analysis, comprehensive understanding of public health policy (national and global) and demonstrate sound skills in health systems strengthening and financing in developing countries. S/he should have extensive experience in conducting medium scale evaluations.

The evaluator/evaluation team will work closely with an evaluation working group. The role of this group (or their representatives) will include validation of strategic information, issuing of relevant directives or endorsement of necessary proposals during the course of the exercise and coordination of local logistics. The evaluation working group will consist of:

- A technical expert from National Eye Care
- Sightsavers Programme Development Advisor Eye Health & Health Systems Strengthening (Asia)
- Sightsavers Institutional Funding Manager South Asia**,** Sightsavers
- One representative from BRAC research cell

4. Methodology

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

The evaluator/evaluation team is responsible for developing the evaluation framework and methodology that addresses the key evaluation questions. The evaluator/evaluation team will define an appropriate sample size and specify to Sightsavers what mechanisms will be adopted to avoid selection bias. The evaluation should meet the principles of participation involving both male and female beneficiaries.

As a minimum, the evaluation will include the following key steps:

- **Review** relevant secondary document (including project and organizational documents
- Consultants will take part in a **briefing** with Sightsavers Bangladesh Country Office (BCO), BRAC, National Eye Care (NEC) and Hospital partners in Dhaka
- Development and application of **appropriate data collection tools** (e.g. questionnaire schedules and tools, interview checklists and focus group templates) for interviews and

discussions with stakeholders including the project implementers, donors, service recipients and other actors in the eye care delivery system.

- **Visit** NGO hospital partners, Divisional Director, Civil Surgeons, UH&FPOs, Upazila health complexes, District sadar hospital, Eye corners, Community Clinics, BRAC community health workers/volunteers and staff/patient screening programmes (PSP) and meet beneficiaries.
- **Interviews/focus groups** with project implementers, partners, donors, other relevant actors in the sector and service recipients/beneficiaries. The evaluation should seek a representative sample of service recipients from relevant groups, e.g. women, elderly, marginalised group etc.
- The team leader will hold **debriefing session** for partners and stakeholders of Vision Bangladesh Project at the end of the field work period.
- **Analysis** and **report writing**.

5. Reference Material

- Project document
- MoU with partners
- Project reports
- Vision 2020 document
- National Eye Care Plan 2005
- Draft National Eye Health Plan 2014 - 2020
- Mid-term evaluation report of Vision Bangladesh Project
- Health system strengthening framework
- Summary Report of the National Blindness & Low Vision Survey 2000
- Sightsavers strategic plan (2009 – 2018)
- Primary Eye Care Training Manual
- Standard Cataract Surgical Protocol
- Vision 2020 document
- WHO six building blocks
- Sightsavers Strategy Implementation Card (SIM) Card and the Change Themes
- Bangladesh National Eye Care Plan-2005
- Summary Report of the National Blindness & Low Vision Survey 2000
- Beneficiary Case Studies
- Training curriculum for Medical Officers and Sub-Assistant Community Medical Officer (SACMO).
- Report on improving the QoL of people with cataract: an evaluation of the Vision Bangladesh pilot project in Sylhet Division
- Other relevant documents

6. Timeframes

The duration of the assignment will be approximately 20 working days and the evaluation team will be expected to demonstrate through their expression of interest indicative timeframes for undertaking the key activities. The start date of the evaluation is no later than February 2014.

The evaluation will follow the key phases:

Phase I - Desk study: Review of documentation and elaboration of field study [5 days]

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

Phase II: Field Data Collection [8 days]
This phase of the evaluation will seek to collect primary data on the key evaluation questions explained under evaluation criteria. The evaluator/s will use the agreed plan, methodology and sampling strategy from phase 1 to conduct the field work.

Phase III – Data analysis and production of evaluation report [7 days]
The team will draw out key issues in relation to evaluation questions and produce a comprehensive report. This analysis should draw on the wider issues in the development sector and to what extent the use of funding represents value for money.

6.1 Maximum number of days inputs by evaluator/evaluation team

Phase	Activity	No of Days
Phase I – Desk study: Review of documentation and elaboration of field Study	Desk research /literature Review	2 days
	Inception Report	2 days
	Revision of collection methods and tools based on inception report comments	1 days
Phase II: Field Data Collection	Field Visits & Data-collection	8 days
Phase III – Analysis and production of evaluation report	Debriefing (In-country)	2 days
	Data analysis and preparation of draft report	2 days
	Review of draft report from feedback.	2 days
	Submission of final report	1 day
Total		**20 days**

7. Outputs/ Deliverables

7.1 Inception report

The purpose of this report is to ensure that the evaluator/s covers the most crucial elements of the exercise including the appropriateness and robust methodology to be employed. The inception report provides the organisation and the evaluator/s with an opportunity to verify that they share the same understanding about the evaluation and clarify any misunderstanding at the outset. The report should reflect the team's review of literature and the gaps that the field work will fill.

Field work will only commence once this inception report has been reviewed and agreed with the designated representatives[69] (consortium) of the stakeholders.

7.2 Draft Report

A draft report (not more than 40 pages including executive summary and excluding annexes) should be submitted to Sightsavers within five working days after completion of the field activities. The report should provide an inventory of equipment, tools and HR training (if any) provided and lessons learned. Sightsavers will provide feedback on the draft version to the evaluation team within 3 weeks after receiving the draft report.

7.3 Final Report

The Final Report will be submitted to Sightsavers within 5 working days after receiving the feedback of Sightsavers on the draft report. Findings and recommendations from the Final Report will be used to inform future decisions.

7.4 Data Sets

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

7.5 Summary findings

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

8. Reporting Format

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

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

Administrative/Logistical support

9. Budget

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

- Economy class airfares and visas. (where applicable)

[69] *National Eye Care, BRAC and Sightsavers*

- In-country transportation
- Hotel accommodation (bed, breakfast and even meals taken at the place of accommodation)
- Stationery and supplies
- Meeting venue hire and associated equipment eg projectors

Sightsavers usually cover the above costs, unless otherwise stated.

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

10. SCHEDULE OF PAYMENT

The following payment schedule will be adhered to:

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

11. MODE OF PAYMENT

As agreed by Sightsavers and the consultant.