Evaluation of Sightsavers' support to the Ministry of Public Health and Sanitation - Eye Care Programme
Executive Summary

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Programme Description: The Kenya Eye Programme 2009–13 is the latest phase of a long established eye health programme that began in the 1990s with the aim of introducing eye health services throughout Kenya. Now focused on 12 districts within Nakuru and Machakos counties, it has aimed to develop capacity to provide quality eye care services in static health facilities through infrastructure development and capacity building. It has also sought to achieve greater sustainability through integrating eye care into primary health care and into health systems and structures.

The primary aim of this evaluation is to assess the progress and impact of the programme. More specifically, the evaluation has sought to determine:

1. The extent to which the project has achieved its stated objectives
2. The facilitating and constraining factors to project implementation
3. How programme implementation strengthened eye health systems in the 12 districts
4. How things could have been done differently to better strengthen district systems and ensure strong impact and sustainability
5. Key lessons in the process of project implementation and any best practices
6. if the programme has potential for scalability and/or replication by government and/or other stakeholders
7. Propose strategic options for Sightsavers going forward.

Methodology and Analytic Strategy: An extensive literature review was undertaken and a work plan documented in an inception report agreed with Sightsavers. A variety of participatory methodologies were used in conducting the evaluation. These included 18 semi-structured interviews with key informants, other meetings, 6 focus group discussions plus a survey of 40 users of the general health and eye health systems in both remote rural and poor urban areas covered by the programme. Field visits were made to four districts by the 2 field evaluators and included 5 hospitals, 7 primary level health facilities and 4 primary schools. Data was inputted into Excel spreadsheets, analysed and graphics created. Stakeholders were interviewed both in the project area and with key national government

and non-government informants.

Implication of Findings: While the programme made progress towards achieving some of its objectives, the evaluation has identified weaknesses in design and implementation, limiting impact. The project was poorly articulated with too many objectives (seven), and too great a focus on service delivery outputs at the expense of strategic outcomes. As such, it is activity focused, with an unclear relationship between strategy, activity and results.

The failure to establish a baseline, calculate unit costs and to establish a clear monitoring framework makes it impossible to demonstrate cost effectiveness and to establish a replicable model for similar interventions. This weakens the evidence base for further advocacy work and hampers arguments for allocating a dedicated element of health budgets for primary eye care provision.

The programme has had some success in integrating eye care services into primary health care and into health systems and structures. There is an opportunity to build on this, both to address identified weaknesses that threaten sustainability and to work with the new county-level health structures as they develop their health strategies.

Relevance:

The programme's objectives clearly identify the desire to demonstrate a sustainable model of eye care provision embedded in the primary health care (PHC) system. It seeks to move away from a reliance on outreach and eye camps to eye care service provision through static facilities.

Stakeholders agree that the programme remains appropriate and relevant to the Vision 20/20 global framework for reducing the incidence of treatable blindness in Kenya. In seeking to strengthen primary eye care services within PHC, the programme also fits well with the national government's promotion of the centrality of PHC systems in Kenya's development and poverty reduction strategies

The programme design is relevant to client needs. It seeks to increase access to and use of eye health services, particularly for rural populations. However, improvement to services may not necessarily, in the Kenya context, result in increased access. The programme did not explore the reasons for non-take up of services, especially in poor rural areas, prior to the design stage. A gap in programme design also led to an absence of sustained eye health outreach work by community units and the absence of an advocacy strategy impacted on the ability of the programme to influence.

Effectiveness:

Overall the programme has taken forward a broad range of work and activity. Many activities have been undertaken effectively despite budget reductions, and clinical

targets, such as for screening, cataract operations and consumable provision, were largely met.

A key component of the programme has been work to strengthen and integrate primary eye care (PEC) into PHC systems. One strategy used to achieve this was to train rural health workers (RHWs) to identify eye conditions, undertake minor treatments and to refer patients to hospitals. In total, 224 RHWs were trained over the project period. However, rather than concentrating these newly trained RHWs in two or three districts, they were deployed over too wide an area. Placing trained RHWs in one small area would have allowed the programme to evidence the advantages of this approach.

Another strategy was to work with the staff on District Health Management Teams (DHMTs) to achieve greater support for eye care inclusion in community health education and outreach. Discussion and interviews with stakeholders suggests that this has resulted in eye care becoming more integrated into PHC.

The integration of eye care services into health systems and structures at all levels is critical for ensuring the future sustainability of the programme. Many health service stakeholders reported significant progress in eye health recognition at primary and secondary levels, by hospitals and by DHMTs. This represents a substantial change over four years. However, these gains are fragile and have not been formalised. Much of the improvement is reliant on good will and personal relations. The more challenging aims of ensuring formal integration of eye health into annual operational plans and of obtaining dedicated budgets for eye care service has not been achieved.

Another important component of the programme was to improve cataract surgical rates (CSR). Significant activity was undertaken, with 173 RHWs (against a target of 200) trained to identify eye conditions including cataracts, and 24,186 surgeries undertaken, of which 7,977 were cataract operations (target 9,000). Capacity has been increased but productivity remained a challenge. Only Kabarnet achieved the productivity target but the overall median output of 124 cataract surgeries per surgeon was substantially below the target figure of 250. CSRs improved in four districts, declined in four districts and remained the same in four districts. Overall the programme has not built on the levels achieved at the end of the previous phase.

Although the results of the small-scale survey showed broad patient satisfaction with services, surgical outcomes were not monitored or reported. The strategy of providing hospitals with the Department of Ophthalmic Services (DOS) audit tool has not worked. No hospital is currently generating surgical outcome data, citing giving the complexity of the format and time limitations as reasons. The programme also sought to integrate eye health data into main health information system. Budget restrictions delayed this part of the programme, but a pilot in Machakos, Nakuru and Mbagathi and Kajaido district hospitals

was initiated in 2013. At the time of the evaluation, none of the installations were generating data.

Overall, while some evaluation evidence suggests that programme inputs have led to an improvement to the quality of hospital eye care services over the period, the 2007 RAAB is not due to be repeated until 2017 and therefore there is no recent data to assess whether the incidence of eye disease is declining in the two zones.

Efficiency:

The evaluation team observed a disconnect between the many activities and outputs highlighted in the reporting format and actual results and achievements. Narrative reporting quality is generally weak, with gaps in information and significant under reporting on activities, outcomes and progress towards achieving objectives.

Limited emphasis on monitoring, evaluation and learning is a critical challenge. It is important to measure impact, but a paucity of project baselines and log frame absence have limited the development of a comprehensive monitoring framework. Changes to the lives of users or to health systems resulting from the project's work have thus not been captured.

The programme had annual (and unplanned) budget cuts with the planned budget reduced by 27% over the period. By choosing to cut back on some areas severely, the programme was largely able to maintain RHW and DHMT training schedules and cataract support. In retrospect, the policy of cutting outreach in all 12 districts was un-strategic and perhaps not the best use of resources.

Neither unit cost analysis nor cost effectiveness analysis have been attempted at project level either by Sightsavers or by hospital authorities. Without such information Sightsavers is challenged to deliver cost effective and replicable programmes.

Impact:

The evaluation sought to assess what tangible outcomes have been achieved in the programme period. As no baseline or monitoring was undertaken on prevalence rates, no data exists to indicate overall impact or if prevalence has decreased as a result of programme activity. What can be said is that, within the budget constraints, the programme was effective in delivering eye health care services, including screening, referral and treatment with evidence indicating reasonable levels of user satisfaction.

With respect to national cataract surgical output, DOS statistics suggest that the programme has made little progress, with the contribution to national cataract output falling from a 12% average in the previous phase to a 7.25% average in 2009–12. The reduction in output may also be a reflection of the change in approach by Sightsavers over the past 4 years – from service delivery to health systems strengthening and integration for sustainability.

There is clearly a lot more to do in building public confidence in primary eye care services, especially promoting access by hard to reach communities. There are still large numbers of outpatients at hospital clinics with minor eye conditions that could have been treated locally. There are also large numbers of self-referrals, people who bypass the level 2/3 PEC system.

Progress has been made towards integrating eye health into health systems and structures, but it is not yet achieved. Where there is representation, then eye care has greater recognition in hospital systems and in the DHMT, but there have been no increases to budgets and not all DHMTs and health management teams (HMTs) have eye representatives. Sightsavers needs to develop strategies to meet this challenge.

There is little evidence of advocacy being adopted as a strategy in the programme in order to influence power holders for greater voice and leverage.

Sustainability:

Eye care in Kenya remains very much dependent on the presence of INGOs and their supply of materials. Integration of eye services into the broad health care systems is the only way to ensure programme sustainability and Sightsavers' strategy is entirely appropriate although challenging given the long history of service delivery support.

There is little evidence that sliding fee scales can generate sufficient funding in the short term to cover the cost of outreach or medical consumables. Cataract operations are heavily subsidised through the free provision of consumables by Sightsavers. In the event of an exit, user fees would need to substantially increase.

There is an opportunity to help reshape the PHC system in the decentralised political structures by building strong relationships with power holders, including at governor level. There is urgency to this; as counties put in place structures and policies they are open to influence and the time to advocate for eye service delivery is now.

It is also critical that Sightsavers Kenya develops a monitoring framework that captures results and provides evidence of sustainable gains as well as value for money in order to convince health authorities at national and county levels that the eye care model Sightsavers promotes should be adopted and funded by the MOH.

Coherence and Coordination:

The programme is coherent and fully consistent with the objectives and key indicators of the Kenya Eye Health Strategy developed by DOS. This is a great strength. The programme is implemented by the MOH and coordinated by DOS. It is thus fully embedded in the health system and there are strong relations between the programme and health department.

Stronger coordination and collaboration is evident at technical level, both within the hospital and at DHMT. This is largely due to the attendance of Ophthalmic Clinical Officers (OCO) and Zonal Eye Surgeons (ZES) at DHMT and HMT meetings. Many districts report that eye care is increasingly taken account of in planning and coordinating routine hospital and public health work.

More broadly though, the programme is missing opportunities to add value by associating with other programmes and sharing experience. The eye sector has been quite fragmented in the past, limiting opportunities to coordinate work, and to share lessons and successes and to influence and advocate for investment.

Replication and Scalability:

The three main components of the programme are service delivery including outreach, integration of PEC into PHC and embedding eye care into health systems. Although not designed with scalability/replicability in mind, elements of the programme do show strong potential for scalability in the future especially the integration of eye health planning into county implementation plans and the integration of PEC into PHC including adding eye health skills to RHWs through training.

There is great potential for the approach exemplified by the programme to improve primary services, impacting both on user confidence as well as increasing the number of people accessing eye health at primary level. Unfortunately, during the current phase, resources were thinly spread and programme implementation was not sufficiently guided, monitored or documented.

Eye health service delivery work at secondary level is still dependent on Sightsavers funding and until greater headway is made in embedding eye care into health planning and budgetary systems it is likely to remain so. This is not therefore currently a sustainable or replicable part of the programme.

Main Recommendations

Programme Design: Sightsavers should apply its SIM and theory of change analysis to redesign a model pilot programme operating from community through to national levels. It should focus resources on this small geographically focused pilot so that it is better able to prove the replicability of the model through demonstrating and evidencing impact and value for money. It should aim to build on the gains from RHW and DHMT training and also strengthen its focus on community units, which are key to mobilising people to access local eye health services. Sightsavers should seek to increase synergy with other eye health deliverers and in the context of decentralisation and changes to the DOS mandate engage more on advocacy, both at county and at national levels to embed eye care in health planning documents with a dedicated budget. In these ways the programme would become more aligned to the Sightsaver SIM and with country and global strategy.

Monitoring and Evaluation: Design a comprehensive monitoring framework: Sightsavers to make a concentrated effort to address the weaknesses to the monitoring framework to produce a comprehensive baseline, log frame and reporting formats, and also develop a series of lesson questions linked to the programme log frame. Sightsavers should undertake KAP surveys and prevalence studies as a starting point in establishing a comprehensive baseline and in monitoring changing attitudes to eye care services, especially at difficult to reach rural level. These changes will enable the programme team to develop a timetable for M&E activities, to identify tools, and to link monitoring to their regular review sessions.

Advocacy and influencing: Through development of a successful model in a further phase of the programme as described in this report, Sightsavers and its partners to use the evidence derived to help convince power holders at all levels on best practice and the social and economic benefits of investing and supporting inclusive eye health (and other) services to the broad population of Kenya.