Final Evaluation and Impact Assessment of the Programme: Reducing Poverty through Improved Eye Health in the "Post Health for Peace Initiative" in The Gambia, Senegal and Guinea Bissau 2009-13

Executive Summary

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Programme Description

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

Purpose of evaluation:

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

Methodology and Analytic Strategy:

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

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

Overall findings

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

Investment in the Sheik Zayed Regional Eye Care Centre (SZRECC) enabled the eye health personnel to be trained for the national programmes. Though the sub regional role of SZRECC was not identified specifically at the design stage the potential for SZRECC to act as a catalyst and focal point for the sharing of experience of best practice was recognised as the programme progressed. Therefore continuous facilitation, including exchanges with national coordinators, review of HFPI protocols, mediation and organisation of technical meetings took place. Despite this effort a SZRECC role in the development of sub region wide strategies and policies was not achieved due to a lack of agreement on its ownership and governance.

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

Findings by criteria

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

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

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

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

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

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

Efficiency: Output tracking and activity oversight were effective though the analysis of data collected was often inadequate or not available in accessible forms. Decentralisation in Senegal greatly facilitated efficient programme management, enabling effective integration of eye health services into the locally managed health systems structures. The vertical and more centrally controlled systems elsewhere in the sub region made management and oversight more challenging and dependent on the professional relations built by eye health staff with regional health managers and others, rather than on the formal inclusion of eye health into planning systems.

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

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

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

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

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

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

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

governance issues.

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

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

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

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

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

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

Although the range of strategies varied across the programme, overall there has been considerable impact on knowledge and awareness levels of communities in eye health care

and the availability of services. Those surveyed expressed the perception that knowledge levels have improved. Seventy nine percent of respondents indicated that they had made one or more changes to their habits relating to eye health. The project did not baseline or monitor quality of life but both survey results and FGDs across the sub region confirm the significant impact that restoration of sight has had on the quality of life of eye health users. Impact on livelihood is not evidenced but inferred through international studies.

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

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

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

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

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

Ratings against criteria:

Relevance	Effective-ness	Efficiency	Coherence	Impact	Sustain-ability	Replic-ation
						

Key recommendations

For post PHFPI in the sub region[i]

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

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

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