Final Evaluation and Impact Assessment of the Programme

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

Senegal Country Report

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ACRONYMS; *French acronyms/names are in italics*

CAMES	African and Malgasy Council for Higher Education	*PAODES*	*Programme d'Appui à l'Offre et la Demande de Soins*
CFA	Central African Franc	PEC	Primary Eye Care
CHW	Community Health Worker	PHC	Primary Health Care
DHC	District Health Committee	PHFPI	Post Health for Peace Initiative
DHT	District Health Team	PM	Programme Manager
DMO	District Medical Officer/ *Medecin Chef de District*	PMU	Project Management Unit
DPOs	Disabled People's Organisation	*PNPSO*	National Programme for the Promotion of Eye Health
EU	European Union	PO	Project Officer
FGD	Focus Group Discussion	RAAB	Rapid Assessment of Avoidable Blindness
HMIS	Health Management Information System	RHT	Regional Health Team
IEC	Information, Education Communication	RMO	Regional Medical Officer/Medecin chef de Région
IOL	Intraocular Lens	ROM	Results Oriented Monitoring
IOTA	African Institute for Tropical Ophthalmology	*SNIEPS*	National Service for Health Information and Education
MCH	Mother and Child Health	SZRECC	Sheikh Zayed Regional Eye Care Centre
MoH	Ministry of Health and Social Action	TP	Traditional Practitioner
MoU	Memorandum of Understanding	WACS	West Africa College of Surgeons
NTD	Neglected Tropical Disease	WAHO	West Africa Health Organisation
OECD	Organisation for Economic Cooperation and Development	WHO	World Health Organisation
OPD	Outpatient Department		

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Sightsavers

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EXECUTIVE SUMMARY

Programme Description

The Post Health for Peace Initiative (PHFPI) 2009-2013 is a three country project implemented in Senegal, Guinea Bissau and the Gambia, funded by the European Union and Sightsavers with a budget of EUR 1,905,958 for Senegal. It followed on from the successful Health for Peace Initiative 1999-2006 initiated by the Heads of State of Guinea Conakry, Guinea Bissau, the Gambia and Senegal and covering 4 different disease areas. The specific objective of the PHFPI is to establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in the intervention regions and thus contribute to the overall objective of contributing to poverty alleviation through the prevention of avoidable blindness. In Senegal it has been implemented in 10 health districts in border areas, spread across five different health regions.

Purpose of the evaluation

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

Methodology and Analytic Strategy

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

Relevance

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

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

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

Effectiveness

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

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

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

The visibility of eye health and the relevance of secondary and primary eye care services have increased markedly from community up to national level but this is unlikely to translate into increased priority for eye care in relation to other programmes While good progress has been made during the project, more work is now needed for consolidating progress to date, and further developing the provision of comprehensive and quality eye services. There are currently few refractive error and no low vision services, more trained eye health staff are needed together with a focus on eye health

education, rather than awareness-raising. There is a clear need to continue improving the quality of services: the documenting of surgical outcomes and the supervision of the cataract surgeons were found to be inadequate.

Efficiency

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

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

Coordination / coherence

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

At national level, the PNPSO has a clear vision for the directions of eye care but has capacity constraints where the coordination with other MoH services for the integration of eye care into the health system is concerned. This also affects coordination with external agencies: more collaboration needs developing at national level. More staffing is required for PNPSO if it is to fulfil both national coordination role and its support and technical supervision role at regional and district levels. At regional level, high profile Vision 2020 committees were recently formed to promote the coordination of eye care activities amongst a wide range of government and community stakeholders but their effectiveness is not yet evident.

Impact

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

Although there is no recent prevalence data, health system commentators said that the surgery numbers indicate a reduction in blindness levels. With the project only intervening in some but not all districts of each Region, the regional cataract surgical

rates do not directly reflect project surgeries; they show fluctuating CSRs and recent increases in two regions where previously there were no services.

Regional and district authority staff now realise the value and feasibility of offering district and primary level eye care services supported by linkages at community level. Health centre managers commented that the eye services have also contributed to increased patient flow for other services in the health centre. Both health staff and community representatives have clearly understood the link between blindness and poverty and the benefits of sight restoration; the communications messages and inclusion of journalists in the eye health training played a key role in this.
The large majority of service users were happy with the skills and welcome of the eye unit staff and satisfied with the outcomes of their surgery. The survey 'before and after surgery' line of questioning confirmed very noticeable improvements in their quality of life, with no difficulties doing their usual work or outside activities and for many the ability to resume previous activities; for a minority this specifically included improvements in their income level.

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

Sustainability

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

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

Replicability/Scalability

The scale of results achieved by the project in a relatively short time has confirmed the replicability of this approach: regional stakeholders now want to ensure that eye care services are accessible in all districts. However replication initiatives will face ~~the~~ a number of challenges, including understanding the extent to which the eye units are

covering demands from neighbouring districts and, not least, finding external funding for essential components that the Government of Senegal is very unlikely to fund. It will be important for replicability to increase levels of collaboration at national level and to continue improving the integration of eye care into health services, and into new health insurance and financing initiatives.

Implications of the Findings/Conclusions

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

Key Recommendations:

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

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

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

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

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

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

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

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

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

Assessment ratings by evaluators

Relevance	Effective-ness	Efficiency	Coherence	Impact	Sustain-ability	Replication
						

1 INTRODUCTION

1.1 Background

The Post Health for Peace Initiative (HFPI) 2009-2013is a follow-on initiative to the high profile Health for Peace Initiative established by the Heads of State of Senegal, Guinea Bissau, The Gambia and Guinea Conakry; they had recognised that their populations were affected by common health problems and wished to foster peace in the politically volatile border areas. HFPI began 1999 with each country taking responsibility for one of four main disease areas; in 2001 eye care was added with the Gambia as the coordinating country. The programme of eye care activities involved multi-country collaboration on cross-border activities such as high-profile eye camps and the establishment of the Sheikh Zayed Regional Eye Care Centre in the Gambia as a sub-regional training resource.

During HFPI, Senegal first trialled the training and deployment of cataract surgeons and subsequently implemented the Louga Regional Eye Care project 2007-2011; this was a first step in decentralising eye care and bringing service delivery closer to the population. Post HFPI was welcomed by the National Eye Care Programme[1] (PNPSO) as an opportunity to extend the coverage of eye care services to district and community levels and one fully aligned with the vision and directions of PNPSO.

1.2 Purpose of Evaluation

The aim of the final evaluation of PHPFI was to assess the project's achievements and impact in Senegal, the Gambia and Guinea Bissau over the past 5 years. The specific objectives, using the OECD framework of relevance, effectiveness, efficiency, coordination/coherence, sustainability, impact and replicability, were to evaluate:

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

This report focuses on the implementation of PHFPI in Senegal and is one of three country-level reports forming the basis for the overall evaluation synthesis report which contains the full Terms of Reference in Annexe 2 (see main report).

1.3 Programme Description

The PHFPI is a five year programme designed to facilitate implementation of good quality eye care services and also promote eye health in The Gambia, Guinea Bissau and Senegal. This holistic project is one of several components in the overall fight against poverty by improving the lives and social wellbeing of those who are visual impaired, particularly in the porous neighbouring border countries where long term conflicts still exist.

[1] Referred to hereafter for consistency in reporting as the National Programme for the Promotion of Eye Health (PNPSO) – a name change that occurred during the course of PHFPI.

The overall impact-level objective of the PHFPI has been to contribute to poverty alleviation through the prevention of avoidable blindness in Senegal, The Gambia and Guinea-Bissau by the end of 5 years.

The specific objective of the project was to establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in intervention regions in Senegal, The Gambia and Guinea Bissau. In order to achieve this outcome, four main components were outlined:

- Capacity-building through training eye-care providers
- Infrastructure development for delivering comprehensive eye services
- Promoting community awareness
- Partnership-building for adequate coordination.

These were composed of nine key result areas defined for the project activities Cross-border collaboration and learning featured as a cross-cutting theme and an enabler for increased impact.

1.4 Context

The key particularities of the Senegal context, include a decentralised government structure, a larger and more developed institutional and administrative framework that has traditionally viewed eye care as a hospital speciality, more developed human resources, chronic strike action by health sector staff, high level Ministry recognition of PNPSO and the National Coordinator's leadership and intermittent security issues in the Southern Casamance regions of Ziguinchor and Sedhiou.

2 METHODOLOGY

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

2.1 Evaluation Approach

The Senegal field visit involved two team members and visits to four of the ten districts; these were spread across three different Health Regions; Kaffrine and Nioro districts started project activities in 2009 and Fatick and Sokone districts in the last phase 2011/12. Information was gathered via:

- In-depth interviews with a wide range of stakeholders including:
  - National level stakeholders in Dakar x 3
  - Regional health authority staff, health personnel x 8
  - District level health authority staff and health personnel, including secondary and primary levels 14
  - Sightsavers regional and project staff 3
- Focus group discussions with:
  - Community leaders and representatives x 2
  - Primary level health staff and Community-level volunteers (relais) x 5

  - Beneficiaries x 2 and 2 interviews
- A small quantified survey with a random sample of 250 beneficiaries of cataract and trachoma trichiasis surgery from two districts: Nioro in Kaolack Region and Kaffrine in Kaffrine Region. It explored levels of knowledge attitudes and practices towards eye health and the impact of surgery on beneficiaries' quality of life.

A debriefing of initial findings prior to detailed analysis was provided in-country. The itinerary and full list of the people consulted and details of the survey design and execution are in the main Synthesis Report Annexes.

2.2 Limitations

The time allocation for the evaluation led to some methodology limitations, notably just ten days allowed for fieldwork in Senegal: the evaluation team was unable to visit and appreciate variations in the three project districts in the two Southern Regions. It was also not possible to see all the stakeholders on the itinerary due to their other work pressures; in some cases, the post-holders interviewed were recent appointees and did not have an overview of the project period.

3 RESULTS

3.1 Relevance G

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

The Post HPFI project has been highly relevant to the eye health needs in the intervention area: the aims, strategies and activities adopted for improving the availability, accessibility and quality of eye care provided were all highly appropriate and aligned with national and international strategies.

Project design fit with eye care needs

Designed as a follow-on project to HFPI, the project intervention zone in the border areas with Gambia and Guinea Bissau was pre-determined and accepted by the PNPSO. At the outset, the only eye care services available in this zone were at the Regional Hospitals in Kaolack and Ziguinchor; these were inaccessible for many rural communities ~~to access~~ and did not meet international standards for the ratio of eye health personnel to the population.

The PNPSO fully participated in the design process which was informed by blindness prevalence estimates of 1.4% existing at the time. Two RAAB surveys were conducted,[2] in Kaolack and Fatick regions in 2011. These showed a blindness

[2] Appréciation Rapide de la Cécité Evitable dans la région de Fatick au Sénégal, Ministère de la Santé et la Prévention Médicale Sénégal, Sightsavers et International Centre for Eye Health, London School of Hygiene & Tropical Medicine, London, UK ; Dr. Joseph Oye, Formateur ARCE Certifié

prevalence of 7.5% in those aged 50+, extrapolated to an overall prevalence of 0.9%. This is lower than the 1.4% estimate, but it is still considered high in relation to WHO targets. In both regions there was a very high level of 93% of avoidable blindness that could have been either prevented or treated.

The generic design set out in the project document was considered broadly appropriate but three key challenges were faced in putting it into operation:

- After the project document was submitted, the budget had to be reduced but this was not accompanied by a review of the activities mentioned.
- A major Sightsavers restructure shortly after the project began led to a loss of continuity; the new staff needed time for fittin the project with the realities faced;
- Enabling strategies and activities implicit in the log frame and the implied theory of change were not fully articulated in the project document or budget.

Having reviewed design gaps, the Sightsavers team invested considerable effort in tailoring the project to the Senegalese working context, introducing a very strong emphasis on communications, resourcing the training of community volunteers (relais), identifying advocacy and decentralisation challenges and obtaining EU approval for a revised budget.

The project adopted a phased approach to implementation, partly reflecting the availability of eye health staff to send for training and partly reacting to the budget structure and constraints at the outset. It adapted well to several other challenges, including a Government restructure of Administrative regions. Many minor adjustments were made in response to the implementation opportunities and challenges encountered: the willingness and flexibility of PNPSO and Sightsavers was a noted feature of the project. However, the selection of only border health districts meant a mismatch with the administrative structures: there is now an unequal distribution of eye care services within the five health regions.

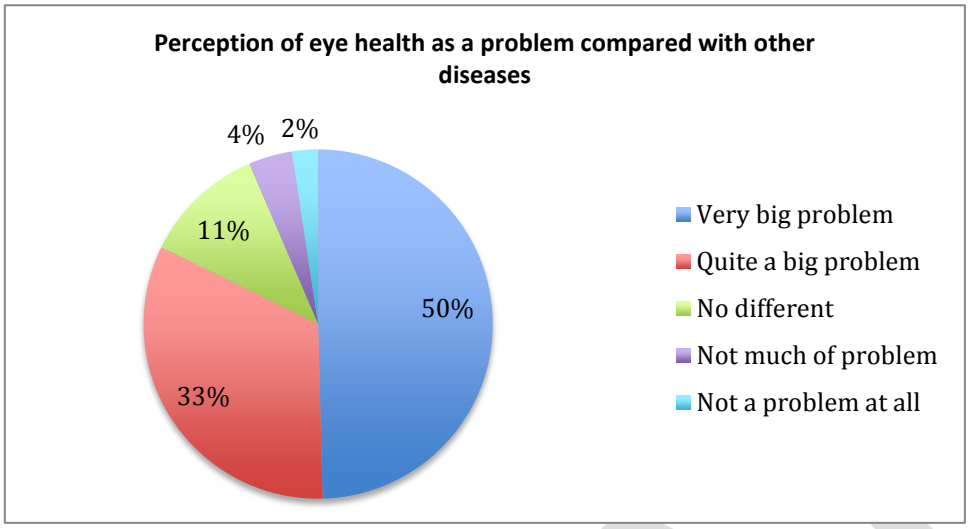
Health system personnel at all levels had previously considered eye care to be a speciality only available at hospitals. All have since recognised the relevance of the provision of eye care services at secondary and primary levels and that they are now able to respond to a previously unmet need.

Reaching the poorest and most marginalised populations

With people in rural communities tending to remain economically active as long as they can, the prevalence of blindness of 8-9% for the 50-59 age group, (and rising to 39% for those aged 80+) indicates a significant number of households likely to be economically affected by blindness and severe visual impairment. Prior to the project, there was little knowledge about eye health and most people were reported to go the Gambia or to consult traditional practitioners (TPs); others accepted traditional beliefs that blindness is part of the aging process and their fate. The project's relevance was confirmed by the perceptions of 50% survey respondents that eye problems are a very big problem compared with other health problems.

Appréciation Rapide de la Cécité Evitable dans la région de Kaolack au Sénégal, Ministère de la Santé et la Prévention Médicale Sénégal, Sightsavers et International Centre for Eye Health, London School of Hygiene & Tropical Medicine, London, UK ; Dr. Joseph Oye, Formateur ARCE Certifié

Chart 1: Importance of eye problems compared with other health problems



The survey team confirmed this with their observations of the enthusiasm of people in the remote areas visited where many people wanting eye care approached them, thus confirming the ongoing needs and continuing relevance of the project.

A range of strategies was adopted to ensure that services reached all communities including the underserved. These included: the training of all nurses in charge of the Health Posts – the main primary healthcare facilities – in the detection, treatment and referral of eye diseases; training of their associated volunteers (CHWs and relais) at community level in eye health education and detection of eye diseases; holding free eye camps for profile raising when inaugurating the eye units; supporting cataract surgeons in outreach and supervision of Health Posts; and promoting eye health communications at all levels.

Alignment with national and international objectives strategies and frameworks

The project and its implementation strategies are very well aligned with national policy and international policy frameworks. Senegal is a member of the Economic Community of West African States (ECOWAS) whose representative institution, the West African Health Organisation, subscribes to the Vision 2020 framework. Since 2006, WAHO has been concerned to address the low rates of cataract surgery across the region. Reflecting these global and sub-regional drives to combat avoidable blindness, in raising the CSR and integrating eye care into primary health care, the PNPSO has evolved from a vertical blindness control programme to the National Programme for the Promotion of Eye Health in 2011.

3.2 Effectiveness GA

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

Specific Objective of Post HFPI

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

Through the focus on PEC at primary level and community linkages, eye care services are now accessible and affordable to at least 60% of the population within the intervention zones. The project did not define how the percentage of the population reached would be measured but a combination of findings indicate that this has been achieved:

- all health posts head nurses in the intervention districts have been trained in PEC and the majority of the population lives within 5-6km of a health post,
- outreach trips were held in a large number of locations in each district;
- the random sample of beneficiaries generated for the evaluation covered a wide variety of remote locations and villages

The cost of eye care has been significantly reduced and is much more affordable: the actual cost of cataract surgery reduced due to cataract kits now being available through the National Pharmacy and the proximity of eye care services obviates the need for travelling long distances and possible accommodation costs. In terms of comprehensive and good quality services, good progress has been made but these are not yet complete and more work remains to be done, especially in terms of the availability of low vision services, supply of low cost spectacles and low vision aids and in the improving the quality of cataract surgery.

Human Resources for Eye Health

The desired result of trained eye care workers present at primary, secondary and tertiary levels of the health system has been achieved in the project intervention zones.

Table 1 Human Resources trained

Cadre of Personnel trained	Level of health service delivery	Target total	Number achieved	Comments on types/ deployment
Cataract surgeon	Secondary level health centre	10	10	2 transferred out of the area
Health Post Head Nurses; including 30 as Lid surgeons	Primary: typically with CHWs	166	284	238 Head Nurses for all Health Posts, 30 as lid surgeons, 26 other doctors, midwives etc, as deemed useful by health centre
Non eye care staff incl. relais	Supporting primary level	432	1,144	includes 416 relais, community leaders, teachers, traditional healers, journalists, RHTs, DHTs, V2020 committees

The training component has been a particular strength of the project in scale and breadth: training in eye health and primary eye care has included all levels of the health system from district management teams, eye unit staff, primary and community levels. The higher number of Health Post Head Nurses trained arises from District concern to train staff at all primary level Health Posts: this reflects the recognised

need for good coverage at community level and has resulted in an equitable distribution at primary and community level.

Sightsavers and PNPSO identified the need for more than just the initial training and showed ingenuity and determination in managing to ensure that all the primary and secondary cadres received one or more rounds of refresher training. Training was also added for the District Management Team and other members of the health system involved in the management and delivery of eye care services: not only the trainees but also their supervisors, administrators and instrument maintenance technicians learned what was required of them and understand its importance. This inclusive training approach played an important role in empowering the health teams.

Cataract surgeons were trained at SZRECC in Gambia since it is not an officially recognised cadre and no training is available in Senegal. Although considered adequate, they reported that the training was affected by management issues and did not provide sufficient practical experience for their hands-on skills; these were principally developed during their internships back in Senegal. The evaluation technical review found that they had good levels of knowledge. For the Head Nurses, a PEC training course from IOTA in Mali was adapted and delivered in Senegal; it was clearly appreciated by trainees.

Despite this investment, current staffing levels of the eye units is an area of risk: there is no career development plan for cataract surgeons who are usually public servants; they can apply for transfer and move within the system and the PNPSO cannot prevent this. With a limited supply of cataract surgeons, it is likely that a departing cataract surgeon will be replaced by an eye care technician without surgical skills; this has already happened at Kaffrine. Only Nioro has two eye care technicians and is thus able to ensure the eye unit remains functional when the cataract surgeon is away on outreach or supervisory activities. While it would be ambitious to aim for the full complement of staff suggested by V2020the eye units should aim to develop the staff team to include an additional eye care technician. The cataract surgeons encountered were all active and motivated; this was frequently remarked on by members of the District Health Teams.

Infrastructure, equipment and consumables

The project sought to rehabilitate or construct 10 secondary eye units, to ensure the availability of basic drugs, consumables and equipment for eye care services allowing a wide range of effective treatments and to improve mobility for the timely delivery of good quality care.

Although 10 functioning eye units now exist and are considered a major achievement, the construction and refurbishment processes proved challenging and have not always achieved the standards desired. Of the four eye units visited, two were constructed and experienced some problems and one, Nioro, has several outstanding structural issues due to poor quality workmanship. The two refurbished units have been adapted from other uses; they are functional but do not have all the facilities for a quality service: Sokone eye unit inhabits a single room with waiting space in a corridor and is at a distance from temporary operating facilities; at Fatick the cataract surgeon managed to obtain additional space as the initial allocation of rooms was too cramped. It is evident that the budget allowed for construction was very limited for the

needs and especially when the costs of compliance with EU and Sightsavers procedures are included.

Each eye unit has received the basic equipment necessary for eye care surgery and OPD consultations; the provision of equipment was globally seen as one of the project's achievements. Considerable attention was paid to training the regional and district equipment maintenance technicians for ensuring the routine maintenance and repair of the equipment. In general the eye units visited had functioning equipment in good condition but it was noted that at Nioro, which opened in 2009, the equipment was already worn and experiencing problems. None of the units were provided with the biometry equipment and associated range of IOLs important for achieving good quality cataract surgery outcomes.

The availability of consumables improved noticeably during the project period as a result of PNPSO collaboration with the National Pharmacy on the production of Cataract Kits and the inclusion of eye care medicines in the Standard List of essential medicines. At the outset, Sightsavers provided the majority of consumables. This was subsequently reduced, together with other supports for the first group of eye units in order to encourage their independence. Most eye units reported being able to get what they needed through the national system although some reported problems with obtaining post-operative medicines, especially when there were stock-outs at the pharmacy depots and/or it was necessary to get them from private pharmacies.

Service delivery

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

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

The project service delivery output indicators show the rapid development of eye care services and the success of strategies used for creating demand and also for empowering the management and coordination of the decentralised health teams.

Table 2 Service delivery outputs achieved against targets

	5 year target	Total 2009-2013	Comments
Cataract surgeries	6,860	8,487	Includes Regional Hospital surgeries
Trichiasis surgeries	6,107	8,127	
RE/LV screening	7,500	3,429	Optical workshops not yet launched
Nos people screened	284,547	138,721	Health post information incomplete
Nos treated Azithromycyn	n/a	n/a	
Under 5s receiving Vit A	275,000	309,370	Managed by HKI through nutrition service

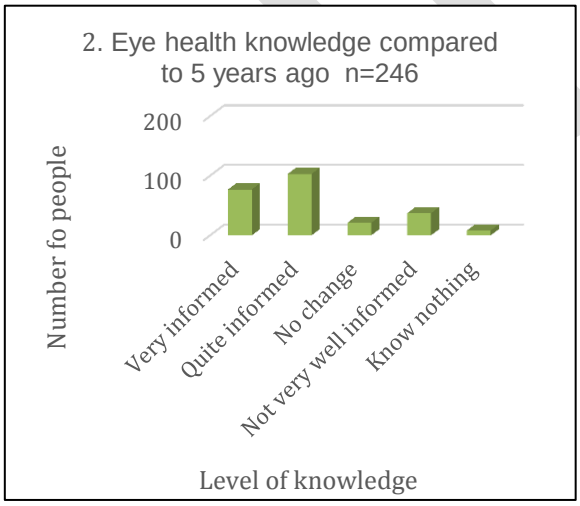
While the cataract surgery targets were met, the detailed figures reveal that only three first phase eye units achieved over 250 routine cataract surgeries in 2013. The others had fewer than 150 routine surgeries, and unless eye camps figures are included,

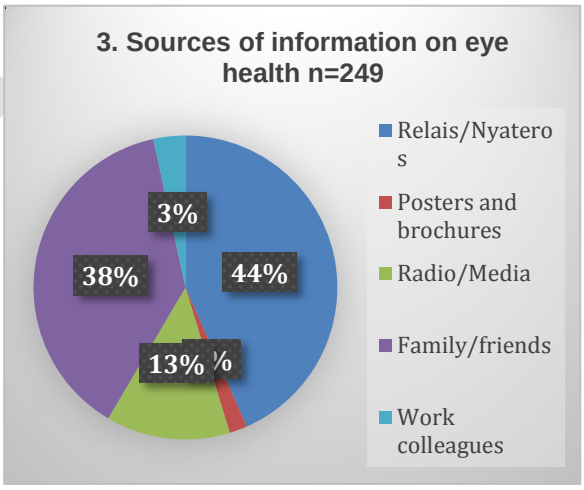
have not yet established the patient flow of 150 surgeries needed for maintaining surgical skills unless eye camps numbers are counted. These figures also show that the full offer of comprehensive eye services was not available when the project ended; whilst some refractions were taking place, the two optical workshops were not operational. In Fatick region, alternative access to optical facilities begun by a small NGO in a nearby district has been organised but there is no provision for the significant number of Low Vision patients.

As a result of the project, district eye care services are not only available from the secondary level eye units but also primary eye care services are being provided at PHC level. The important role played by the Head Nurses of the Health Posts was widely recognised; they now have the knowledge to detect eye problems and are referring or treating simple cases (including trichiasis surgery in some cases); they are working effectively as a team supervising the relais and CHWs in raising awareness of eye health issues and the availability of services. This was confirmed by the survey results where local health staff and the relais were the first people consulted by 62% of respondents, with 26% talking to family and friends in the first instance and only 5% mentioning traditional practitioners. The Head Nurses confirmed that they have now developed the reflex of checking patients who are consulting them about other health issues for eye problems.

Stakeholders at all levels of the health system were clear that community engagement and the work of the relais has been key in increasing the demand for eye care. The beneficiary survey revealed that over 80% considered that eye services had improved during the last 5 years. The levels of interest in receiving eye care information and showed that the relais were the lead source of information used by respondents.

Charts 2 and 3 showing levels and first sources of information on eye health.



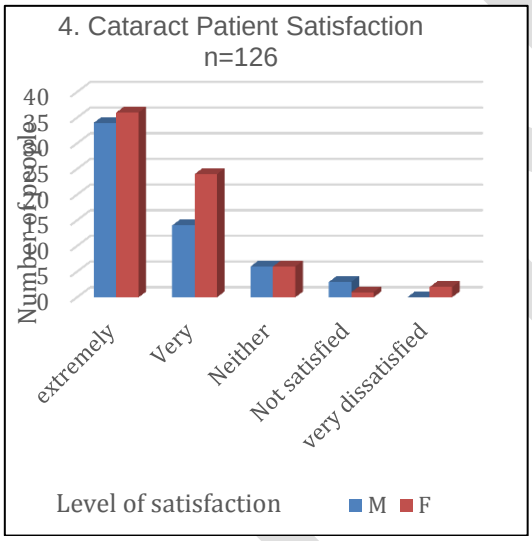


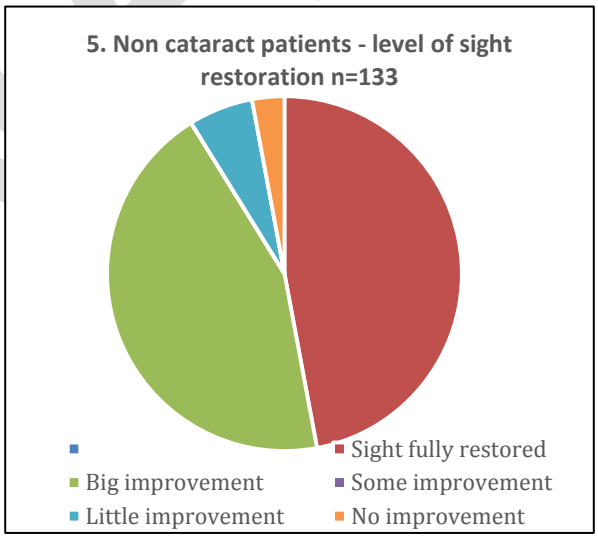
The Senegal HMIS does not track referrals and union action prevented the project from pushing for data to confirm this. The referral system is nonetheless said by health actors to be working well, with cataract surgeons reporting that 10-20 % of their patients are referrals from primary level and that they refer c.5% of their cases onwards. The eye units visited showed a tendency to refer patients directly to Dakar rather than the Regional Hospital indicating a lack of clear system above district level.

The eye units commencing services in 2012 are not yet as well established as those established in 2009 but have been busy, partly due to the heavy schedule of outreach work. This is particularly so with Diouloulou and Thionck Essyl where the approach has been adapted; in the absence of cataract surgeons the Regional Ophthalmologist operates cataract cases identified by eye care technicians. At Kaffrine District, the health centre was unexpectedly designated as a hospital and the district health centre, which is responsible for supervising the health posts, has not yet had the funding necessary for re-establishing itself elsewhere; this is affecting the planning and supervision of primary-level activities and will impact on the sustainability of the eye health services established.

The demand for and supply of services have risen noticeably and during FGDs all the service users expressed their satisfaction with the close proximity of eye care services and the more affordable cost as well as quality of surgery received. This was also confirmed by survey respondents: 90% eye unit users and 92% of eye camp users stated eye health staff have excellent or good skills. However, they also recognised the continuing need for improvement and suggested increases in the numbers and training of eye health staff and in equipping of facilities. These views were corroborated by the high levels of satisfaction of survey beneficiaries with their surgery results (see Charts 4 and 5).

Charts 4 and 5 Patient satisfaction levels





However, despite high quality satisfaction levels, the cataract outcome monitoring tool is not being used despite training and instructions to this effect from PNPSO. Furthermore, the evaluation technical review examined cataract surgery patient records in three of the four units visited revealing the following results:

Table 3: ***Results of technical review of quality of outcomes of cataract surgery with IOL***

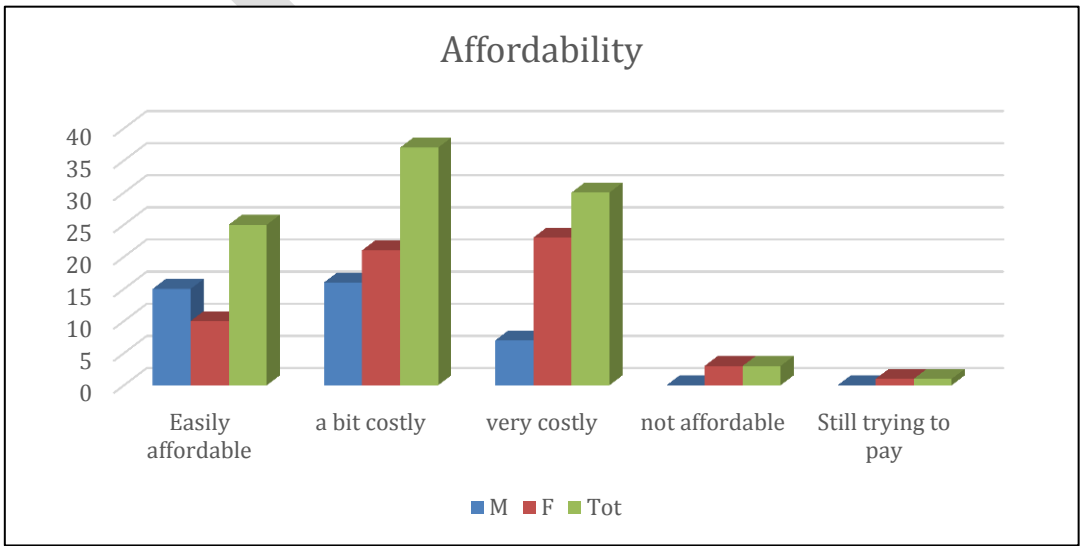
	KAOLACK REGION		FATICK REGION			WHO targets
	2011 RAAB	2014 Kaffrine technical review	2011 RAAB	2014 Sokone technical review	2014 Fatick technical review	
No. records seen :	143	108	67	121	26**	
Results quality						
GOOD	42%	78.7%	55%	3%	N/A	>85%
INTERMEDIATE	22%	16.3%	14%	82.9%	N/A	<10%
POOR	35%	5%	31%	14%	N/A	< 5%

** As only 26 people of the 125 operated for cataract had had at least one visual acuity measurement documented, insufficient numbers for analysis

In Kaffrine, the results show a marked improvement on the quality of cataract outcomes measured in the 2010 RAAB but in Sokone while the % of poor results has decreased, so has the % of good results. While these need improvement to reach the WHO target of 85% good outcomes, it is worth noting that none of the eye units have been provided with the biometry equipment necessary for high quality results. Of more concern is the poor level of documentation noted in Fatick and also at Kaffrine eye unit where only a quarter of the patient files had one visual acuity documented despite several return visits. This indicates a need for review of the supervision arrangements for the cataract surgeons and is an area of current vulnerability for the programme.

Although the eye care services established were considered accessible and affordable, this is clearly a result of intense outreach activity, eye camps and initial free surgery offers. The survey sample and FGDs confirmed that patients are coming from beyond the districts although this aspect has not been measured. Both survey respondents and the interviewers interacting with them confirmed that the reduced cost of surgery is still high for poor communities unless they can access waivers.

Chart 6: Attitudes to cost of surgery



Subsidies or cost reductions and increases in the number of camps were amongst the most common survey suggestions for the improvement of services.

Empowerment of Regional Health Teams

The project sought to ensure that communities, Regional Health teams and district authorities are empowered and involved in decisions that will ensure the delivery of good quality eye care services.

Senegal has a decentralised health system. As a 'specialty' not previously present at district and community levels, the degree of decentralisation of eye care services and the amount of Regional control was not however automatic. Sightsavers staff drew on experiences from an earlier eye care project in Louga Region, to facilitate this decentralisation process and have supported not only the Regional teams but also devolution to District level where the District health teams own and are taking responsibility for the planning and management of eye health service delivery.

The Health Districts have Management Teams and in each of those visited, the cataract surgeon is a member of this team and thus a part of the decision-making structure and able to integrate eye health into the planning, coordination and supervision of health activities at secondary and primary levels.

While District Health Teams are responsible for Health Centre management, the responsibility for financial management lies with Health Committees whose members are elected by the community. The primary level Health Posts also have management committees that control their funding and are elected by the community. This governance structure ensures accountability through a community voice in eye health decision-making and health authorities taking note of community wishes and needs.

Ensuring that community leaders understand and appreciate the value of available and accessible eye care services is important for ensuring that health facility management committees are willing to provide the funding support necessary for eye care. The project supported extensive communications and awareness-raising activities at community, district and regional level; SNIEPS was brought in to develop eye health messages and IEC materials and a wide range of community members – neighbourhood leaders, women's associations and journalists – were trained and involved, especially in awareness-raising and community mobilisation.

Planning, coordination and expenditure on eye health

At national level, there has been little visible progress towards achieving the desired result of eye care being a priority for governments.

Within the Ministry of Health there have been no formal indicators of an increase in the priority of eye care. The PNPSO does not have a high profile within the Ministry of Health and Social Action and cannot compete with large well-resourced donor programmes addressing issues such as Mother and Child Health MCH and HIV/AIDs. Eye care was not specifically mentioned in the government's strategic Health Development Plan 2007-2017 where the only reference to eye disease is in a paragraph on NTDs. While the Ministry of Health budget has been increasing, the PNPSO budget has fallen from 15 million CFA to 8 million CFA in recent yearsyears.

Despite this, the strong communications component of this project, together with the achievements visible in the project zones, has raised the profile of eye care within the Ministry.

At regional and district level the profile and relevance of eye health as a health issue is now recognised and it is integrated into both planning and coordination mechanisms. Health Districts from the first construction phase provided funding for some recurrent costs; some also contributed towards infrastructure costs, for example the preparation of temporary eye unit accommodation or, in the case of Nioro, Euros 3,710[3] to repairs to the poor quality construction.

The PNPSO has a clear vision and drive to establish primary eye care services at district and community level and is working tirelessly to this end. The challenge is that the Coordinator fulfils multiple roles, not only coordination and planning at national level but also advocacy, policy, research, management and technical supervision of the Regional Ophthalmologists. Because the PNPSO struggled to form a National Vision 2020 committee, bringing together a multi-sectoral range of stakeholders to coordinate and plan strategies related to the prevention of avoidable blindness, it was decided to form Regional Vision 2020 committees. For this to work, it had to have a high-level sponsor and Sightsavers supported the PNPSO with considerable advocacy efforts and succeeded in having Vision 2020 Committees created by Orders of the Governors of the Region (see also Coordination 2.4).

Government funding for primary and secondary level health services is provided via allocations sent directly to Regions and Districts rather than being channelled through the PNPSO. The income of the Health Districts is derived partly from national government allocations and also from the fees paid by patients for consultations and treatments. At the health centres visited, both clinical and administrative members of the Management Team were clearly aware of the revenues generated by the different service units within the health centre; the eye units were ranked between second and fourth place for the income generated. The Health Committees approve and disburse funds in response to Health District requests rather than doing independent planning.

2.3 Efficiency GA

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

Programme management and oversight

Overall, excellent management and oversight of the implementation of project activities were maintained once the current Sightsavers PM and Senegal PO had settled into their roles and established collaborative working relations with PNPSO. However, senior management oversight of progress towards achieving project outcomes and impact and of some technical aspects was less satisfactory.

[3] 2,438,000 CFA @ 1CFA=0.0015Euros; provided by Nioro Health Centre for end of project review

Project set-up was slow and the start of implementation was set back by two initial difficulties. The financial planning and budgeting processes were affected by a delay in receipt of initial funds and by the need to resolve the mismatch between the reduced budget and the submitted project document. The resignation of the programme manager, who was involved in HPFI and had developed the project proposal, during the set up phase, and the time taken to recruit a replacement affected continuity of internal understanding of the project internally and a loss of eye care expertise; it also affected the continuity of relationships with the PNPSO externally that then took time to re-establish.

Once the new PM was established, the PM and PO recognised that a number of adjustments to the activities and budget structure for Senegal were needed to ensure the success of the project; they made considerable efforts to identify more appropriate budget allocations in close collaboration with PNPSO Coordinator and to work with Sightsavers UK to receive European Commission approval.

The Senegal PO maintained a close oversight of project activities and was largely successful in ensuring good coordination of related sets of inputs. The Sightsavers project team put great emphasis on ensuring compliance with EU requirements for financial accountability and programme management, holding a special partner workshop prior to the start of activities and drawing on expertise from Sightsavers UK office for project log-frame revision in compliance with ROM recommendations. The PHFPI Finance Manager worked tirelessly with the project and partner staff ensuring an excellent oversight of project finances through quarterly meetings with Sightsavers colleagues and regular visits to partners to audit and collect receipts.

While Sightsavers has access to construction expertise in UK and eye care expertise regionally, it was not activated for PHFPI implementation. Construction paperwork supplied to UK consultant advisors did not bring any response; the local arrangements made with regional technical experts worked well in 3 districts but failed to prevent poor quality work in three others. The evident need for the PMU to contract independent engineering expertise for Sightsavers was not acted on. Some sample eye unit plans and construction guidelines would be useful for Sightsavers.

The absence of eye care expertise within the Sightsavers Regional Office meant that project technical ophthalmic oversight in Senegal was provided solely by the able and dedicated but very busy PNPSO Coordinator. This in the view of the evaluators was an unsatisfactory situation for a project of this size. It led to perceived inefficiencies with the procurement of eye care equipment (see below) and should have avoided the selection of outcome indicators that were either not clearly defined and/or difficult to measure. Despite Sightsavers UK audits of the PHFPI output data, neither senior Regional Office nor Sightsavers UK office seem to have grasped the issues with the outcome indicators.

There were several implementation delays in the first two years but they were mostly resolved by the last two years of the project. The key ones were due to:

- overfull calendars of activities of both the project, needing to catch up after the slow start, and partners also having to respond to other MoH requirements
- security issues in the two Southern regions that affected the establishment of activities and then subsequently the supply in and demand for services;

- late deployment of some eye care technicians by the Ministry of Health which delayed the launch of eye care activities, especially in the Southern districts
- procurement and receipt of optical equipment in 2011 and 2012 because of a mix of Senegalese administrative procedures and changes in Sightsavers procurement systems; this affected activities in the districts that began in 2011;
- delays in the completion of construction owing to lack of technical expertise in the selection process and/or issues with the quality of contractors work.

Logistics and Distribution

In Senegal, Sightsavers funded the provision of initial consumables for eye units and surgical camps but supplies to the eye units were gradually reduced as they became established. During the course of the project, the PNPSO achieved considerable progress in the supply of consumables with the integration of cataract kits into the standard list of the National Pharmacy. These and the large majority of eye care medicines are therefore available on the Standard List and can be procured from the regional pharmacy depots. The needs of the eye units are integrated into Health Centre purchasing requests submitted to the Health Committees for the release of funds. In Fatick region, some issues with the availability of post-operative eye drops from the government suppliers were mentioned but these are generally available from private pharmacies. Occasional stock outs of eye drops at the regional pharmacy depots were mentioned by some regions; likewise with suppliers of spare parts.

After approval by the PNPSO Coordinator, the procurement of capital items was undertaken by the Sightsavers staff in the Gambia except for vehicles and motorbikes that were procured locally prior to the changes to the procurement system. For eye care equipment the new system proved less user-friendly for the PNPSO and led to timing inefficiencies: the on-line system is in English with no French glossary available and there is no eye care expertise within the procurement chain able to ensure that the order is satisfactory: some major items arrived with missing elements that should have been ordered separately. Furthermore while there were significant cost gains registered from bulk purchases, some of the major pieces of equipment were not found during the evaluation to be of sufficiently robust quality: they have shown signs of wear that should not be expected after only 5 years of use.

Monitoring, Evaluation and Learning

This section focuses principally on the monitoring, evaluation and learning processes of Post HFPI within Senegal.

The Sightsavers PM and PO worked very closely with the PNPSO on the monitoring, evaluation and learning processes; these were very successful in monitoring the progress of activities, ensuring the achievement of outputs and in promoting partner reflection and learning at all levels. Much effort was put into establishing an efficient system for the collection of eye care service delivery indicators and revising the log frame; but these were only partially satisfactory as not all the common outcome indicator data could be collected.

The Senegal PO played a highly significant role in all monitoring processes and ensuring that the PNPSO Coordinator, who has limited capacity for proactively keeping abreast of progress, was alerted to any issues that might require his involvement. Faced with striking health personnel deciding to withhold service

delivery data from the HMIS, the PO managed to persuade health facilities to discreetly release their eye care data to her. Any insistence on the collection of new data wanted by the project risked not only refusal but also compromising the collection of existing data.

Both Sightsavers and PNPSO tried to improve systems for eye care data collection and to ensure the collection of the project indicator data required, but none of these had satisfactory results. The key issue is eye care data collected is sent by the eye units, without any retention or analysis at this level, to the Health Region and to the PNPSO and Sightsavers but it is analysed by PNPSO and is not integrated into the HMIS. At eye unit level, this represents a missed opportunity for instilling the practice of analysis and reflection on their own progress; displaying charts of progress would serve the dual purpose of motivation and awareness-raising amongst eye unit visitors; this is a practice common in the Gambia.

At the outset of the project, the only eye care indicators collected at primary level were conjunctivitis, adult and neo natal. The new PHC register issued in 2013 has reduced this and only contains neonatal conjunctivitis; this conflicts with the range of services now offered at primary level and prevents the standard HMIS system from recording the primary level achievements in detecting cataract and trichiasis and in the provision of TT surgeries.

Good monitoring and learning processes for implementation were built-in to project management processes in Senegal; they were facilitated and encouraged through both project processes and those of the Regional and District health authorities:

- Sightsavers programme and finance staff had quarterly monitoring meetings held with regional and district health teams;
- Project annual review meetings brought participants from all districts together to share progress and learn together.
- District Management Teams deliver reports on progress, with details of outputs and activities, at their monthly meetings. The preparation of detailed narrative reports for feeding into project reporting is not a well-developed practice or skill.

The key weakness has been the failure to agree how the outcome level indicators would be monitored and measured in practice.

Finance and Resource mobilisation

Close financial monitoring by the PHFPI Finance Manager ensured accountability and compliance with Sightsavers and EU systems and formats. Partners clearly appreciated the financial management processes and prompt disbursement of funds but it was remarked that documents in English are not user-friendly.

The Finance Manager's frequent monitoring visits to partners ensured that financial and programme management were closely linked, but the financial monitoring system was not so user-friendly or empowering for the Sightsavers PO when trying to monitor expenditure against budget lines. Nevertheless extremely efficient use was made of available resources with foresight and ingenuity used for making minor additions and adjustments while remaining within the EU guidelines.

Analysis of annual expenditure against budget for Senegal reflects some of the difficulties encountered during the first couple of years and shows how, after the revised budget and activities were approved in 2011, activities intensified with the commencement in the final 4 districts and the work with relais at community level.

Table 4: Annual expenditure rates of budget

SENEGAL PROGRAMME	2009	2010	2011	2012	2013	TOTAL
Budget in Euros	537,897	537,879	527,697	359,024	579,432	**1,905,957**
Expenditure in Euros	362,249	262,884	322,690	370,110	742,861	**2,060,794**
% of budget spent	**67%**	**49%**	**61%**	**103%**	**128%**	**108%**

Discussion of analysis details did not prove possible within the timeframe of the evaluation fieldwork but points worth noting are:

- considerable price savings made on some eye equipment from bulk purchases;
- the relatively small budget allowed for the costs of experience sharing meetings
- low use of translation line despite partner difficulties with documents in English.

There has been little or no mobilisation of additional resources from outside sources by the regions or districts for eye care activities. The District Health Teams (DHT) are used to involving civil society in awareness-raising for events but the concept of partnering with them, and/or their donors, for mobilising additional resources appeared to be a new but potentially useful idea. Some DHTs have other funders: World Vision, Plan International and the Red Cross were mentioned.

The District Health Committees (DHCs) manage the receipts derived from service delivery and the funds received from the Health Ministry. Only one eye unit reported repeated difficulties with unblocking funding from the DHC and this was for outreach activities off-site. Several DHCs had contributed to the costs of temporary accommodation for eye units while refurbishments and construction took place, and Nioro in particular has funded repair work, but none had as yet been tested by the need for capital expenditure on replacement equipment.

Cost recovery, unit cost and cost effectiveness

A major achievement during the project has been the reduction in the cost of cataract surgery to a standard rate of 25,000 CFA (Euros 38) due to the availability of cataract kits on the standard list. Cataract surgery fees reported by beneficiaries varied widely as the charges in hospital settings are higher; Kaolack Regional Hospital charges 55,000CFA (Euros 84). Cataract surgery can now be more affordable at the secondary eye units although it was reported that not all District Health Authorities have reduced the price of surgery, as this enables a greater contribution to be made to their running costs. This will not necessarily exclude access by poorer patients as 10% of health centre income has to be paid into a social fund for meeting health costs of those who cannot pay them. One eye care technician was regularly using this to ensure his patients could access surgery.

The eye care units were recognised to be a good source of income and were usually among the best performing services, ranked between second and fourth place, in their

ability to generate income for the health centres However, when issues of unit cost and cost effectiveness were explored it was commented that these calculations are not undertaken as they are “pure” accountancy requiring a management accountant.

The project financial monitoring system was established to track budgets and expenditure at regional level as this was the level at which bank accounts were established for the transfer of project funds for onward disbursement to the districts. There was no specific analysis on an eye unit basis and no routine collection of information on funds contributed by DHCs to the eye units in cash or kind; it was reported that partners do not maintain these records.

2.4 Coordination and Coherence GA

This section considers the coherence and coordination of the programme at country level and coordination between the three country programmes at regional level.

The project is directly aligned with the overall aim of the PNPSO to reduce the prevalence of blindness below 1% and its main strategic objectives. It was very clear that national, regional, and district stakeholders, including a range of community representatives, had been consulted and were involved in monitoring progress. The project document and budget details were shared with RHTs and often featured in their progress reports. Communications, coordination and stakeholder participation were one of the key strengths of project implementation and stakeholders agreed that there were exceptionally good communications at all levels.

Coordination within MoH system

The decentralised structure and management mechanisms of the Regional Health Authorities for planning and coordinating implementation by the District Health Authorities are well established and work efficiently. The inclusion of the cataract surgeons onto the DHTs has ensured that eye health services are integrated into routine management and coordination processes. Regional and district authorities reported good communications with PNPSO; even so it was clear that Sightsavers PO played a key role in informally facilitating communications and ensuring that the PNPSO was alerted to any potential problems or actions required on its part.

The PNPSO is responsible for national-level coordination with other MoH services relevant to eye care, but has capacity constraints for monitoring and following up specific issues. For maintaining the current programme achievements, a good flow of communications is clearly essential with associated services: HMIS, the National Pharmacy, SNIEPS and training institutions for optimising the integration of eye care when they revise the Standard lists, data collection tools and curricula. This is done at regular intervals and without PNPSO ground work, attendance at key meetings and advocacy, there is a risk that the interests of eye health will be ignored.

Sightsavers Coordination Mechanisms

The coordination mechanisms established and implemented by the Sightsavers PO worked extremely well and ensured excellent communications with partners. Partners commented that the PO was the face of Sightsavers and their lack of a clear sense of the PMU as a structure was not an issue. As well as quarterly visits to partners, involving a wide range of stakeholders, the PO kept close telephone contact with

partners at all levels. Annual reviews brought partners together for planning purposes and promoted learning between partners in different districts.

Internally, there was good coordination with the PM through proximity in the office and with the Finance Manager through quarterly meetings and regular phone calls. The PMU coordination meetings took place every 4-5 months to review progress.

External linkages with other eye service providers, rehabilitation organisations, BPO/DPOs, INGOs, donors

A wide range of community representatives participated in project activities but as participants on committees and in eye health awareness-raising rather than as independent organisations working in partnership. DPOs are on the Vision 2020 Committee statute and were consulted, but have not been actively involved.

Regional Vision 2020 committees were formed to facilitate linkages and collaboration with different external stakeholders. Their creation by Governorial decree is an achievement and ensures a high profile and good meeting attendance. However, the future effectiveness of the committees is uncertain: most have main role of 'developing strategies' for promoting eye health and four of the five were formally created in the final year and two in the last 3 months; they do not have track records of meetings or activities beyond those supported by the project.

At national level attempts to form the Vision 2020 committee were stalled by difficulties in organising and motivating that the PNPSO does not have the capacity to address without funding. While not affecting PHFPI directly, for sustainability and the future of the eye care programme as a whole, more collaboration needs developing at national level.

PNPSO has made contact with PAODES, a Belgian cooperation programme, in districts where it overlaps with PHFPI. It shares the same aims of improving health system management and improving the demand and the quality of services. Several of the health authorities have funding partners for other programmes but there was very limited evidence of collaboration or of exploring possibilities for joint working. The relais' education sessions and home visits are programme specific but could potentially cover multiple topics: this was not explored by PHFPI.

Linkages were made with schools and the service for school health for enabling school screening but these do not appear strong. The distribution of Vitamin A was organised by HKI through the nutrition service; the main linkage with the eye services was the involvement of the eye unit staff in the distribution campaigns.

Coordination measures between the 3 country programmes to learn and share experience and good practice

During the planning phase, the project name and involvement of the three countries involved in the initial HFPI appeared logical and was not queried. For PNPSO there were two key aspects of interest in this collaboration:

- Improving the governance of SZRECC and the status of its training courses
- Frank, in-depth discussion of shared experience, challenges and problems

Unfortunately, these expectations were not met and the key benefit of the 3 country structure was the training of the cataract surgeons and optometrists; this would have been more difficult without the framework of the project MoU. The quality of the discussions was disappointing and attributed to the capacity of the participants. The Senegal eye health personnel learnt mainly about the Gambia system through training at SZRECC but they also found the experience sharing meetings valuable for the insights it gave into other people's working conditions and challenges.

Partners were not consulted about other possible experience sharing and coordination activities and did not suggest them either. Visits by district level personnel to other eye health programmes to learn about how they coordinated and implemented their activities within a different health system would have increased two way learning at the operational level. A notable missed opportunity for sharing of learning relates to health facility M&E as it is the norm in the Gambia for health centres to analyse and display charts of their progress for all to see.

The multi-country meeting organised to try and resolve the SZRECC issues with WAHO participation only took place in the closing months of the project. It did not achieve any real progress and highlighted this issue left unresolved by the project.

2.5 Impact 

The evaluation sought to assess the impact of the programme with respect to two key question areas: the key changes to target groups and tangible outcomes achieved; and the extent to which the programme fostered and developed cross regional relationships and agendas.

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

Key Pathways in Theory of Change

The PHFPI theory of change suggests that achieving the outputs and outcomes against 4 key result areas will directly lead to the overall programme goal and purpose thus by establishing comprehensive, quality and affordable eye care services it will contribute to poverty alleviation and the prevention of avoidable blindness. This is based on internationally accepted studies establishing a close relationship between poverty and blindness and demonstrating that addressing blindness will contribute to improved livelihoods and reduced household poverty levels. The result areas spanned eye cadre training; strengthening infrastructures and procurement systems; empowering regional teams for greater decision making; and improved health planning and coordination and increased government budgetary commitment to eye care.

The issue is therefore whether planned results and outcomes have a/ been realised and b/ led to the desired impact. The output data and interviews with a wide range of eye health and health actors at different levels confirm that services are functioning at primary and secondary level. Although not yet mature and stable in all the project

districts, the demand has been created at community level and the health structures are able to maintain the services even if not at the same intensity. These are considerable achievements in the short space of time elapsed.

From the Senegal perspective there are a number of omissions from the Theory of Change and process-related adjustments that it would be useful to make explicit so that they are taken into account when preparing project plans and budgets:

- The time frame: this level of change is likely to take longer than five years
- The importance of advocacy and communications components
- Community level eye health promotion component

The evaluation team assessed progress against key impact indicators identified at overall objective and specific objective level using monitoring data collected by the programme as well as information from interviews with health service personnel. The team also assessed changes to the lives of targeted service users through FGDs plus a survey of 250 people exploring service satisfaction levels, quality of life changes, and eye heath knowledge, attitudes and practices. With no baselines for qualitative indicators such as quality of life, the survey design deliberately employed a *before and after* questioning line. RAABs conducted in 2010 provide a baseline for blindness prevalence and surgical coverage rates but will not be repeated for several years so change can be deduced but it cannot be evidenced. Progress against overall and specific objective indicators is listed in Table 5.

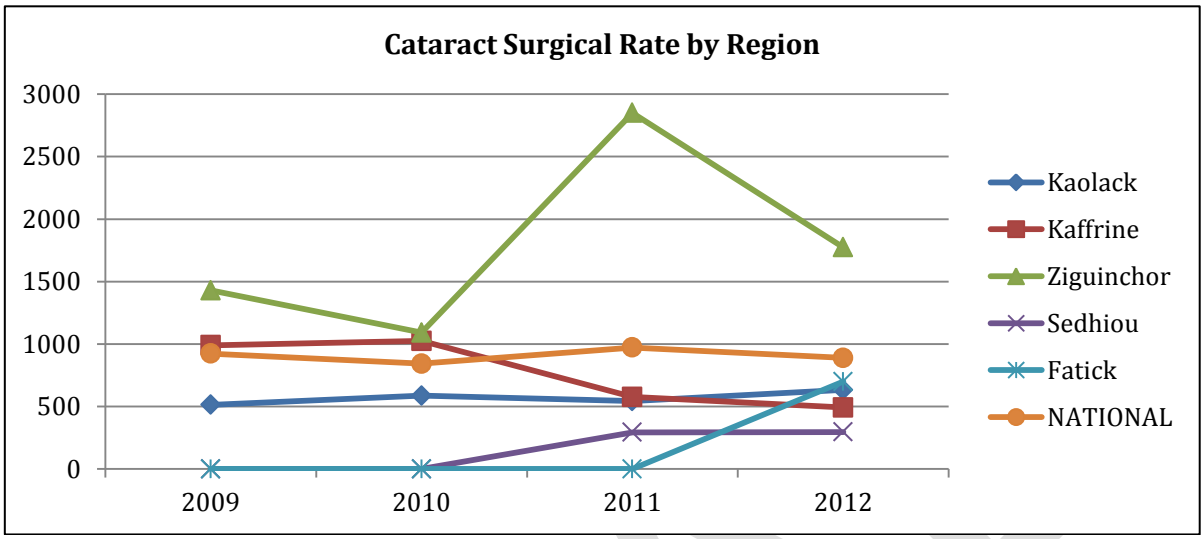
Table 5: Results against outcome indicators for overall and specific objectives

Indicator	Result
CSR	CSRs for five regions show rises and falls 2009-2012, figures for 2013 are incomplete and not available. See table below.
Blindness prevalence	RAAB Baseline in 2010 showed prevalence rate of 7.5% for over 50s. All ages is 0.9%. 2014 is too soon for follow on RAAB survey
Quality of Life	Survey of 250 people suggests significant impact on lives
% referrals from TPs	Not monitored by MOH. No statistics available
Surgical coverage	2010 RAABs established baselines of 60% and 62% cataract surgical coverage. No follow on surveys organised.
% positive surgical outcome	Audit tool not used in many cases and not analysed. A random examination of a sample forms in two districts showed a fall in bad surgical outcomes in two districts but also serious gaps in documentation; one district had an increase to 78% good outcomes but the other a drop to only 3%.
Number cataract surgeries with IOL	95% +
% facilities with stock outs	Very few at 4 eye units visited: essentials including cataract kits available through regional pharmacy depots
No patients presenting receiving eye care service	All 4 eye units visited said that 100% patients presenting are seen and get treated even if sometimes first line treatment then referral
% committed expenditure on eye care met	Eye care does not have specific budgets; full data on district expenditure not collected; fall in PNPSO budget.

Cataract surgical rates are calculated for health regions and the project was not implemented in all the districts of each region, the project has contributed to the effects below. The advent of new services beginning with free eye camps in 4 districts of Fatick, Sedhiou and Ziguinchor are clearly visible; the decline in Kaffrine CSR may relate partly to a fall after the initial camp and to the administrative restructuring. The Zuiginchor Region CSR is influenced by the presence of a well known eye clinic in one

of its other districts, outside the PHFPI project area, that attracts many patients able to travel from a distance. [4]

Chart 7 CSR in Senegal Regions 2009-2012



Interviews with health system actors revealed that the PHFPI has contributed more generally to other significant impacts:

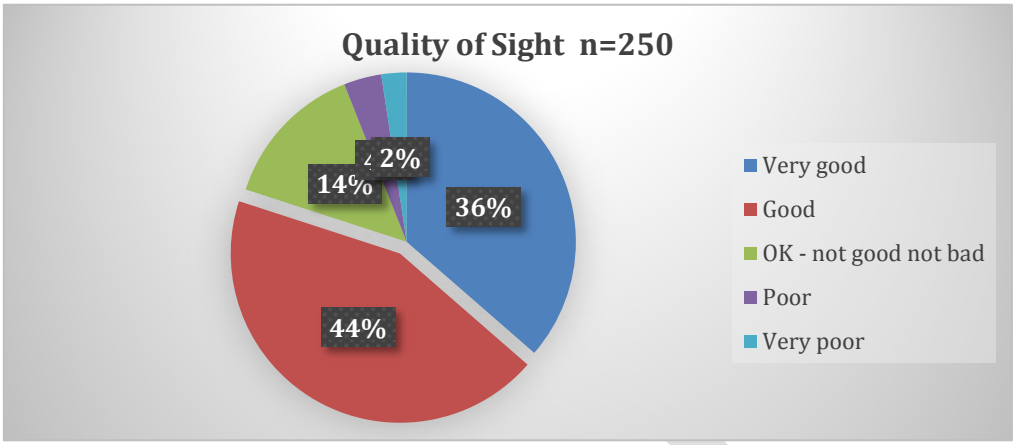
- Health authority leaders unfamiliar with the concept of district level eye care services reaching community level are now convinced of its relevance and feasibility and no longer see it as a specialty service only for hospital settings;
- The link between blindness and poverty is more widely understood;
- The eye units have contributed to raising the profile of the health centres with new users and increased traffic to other services as well.

The MoH does not collect referral information in the HMIS but there is a paper trail of referrals and counter-referrals. With no formal record of referrals, it was reported that within the districts the referrals are flowing from community level to the eye units: the relais are effective at increasing the flow of people to the Health Posts where the nurses are referring patients to the eye units. From the eye units, the referral system seems unclear with patients being referred both to the Regional Hospital and directly to ophthalmologists in Dakar.

Because of the supply of consumables provided by the programme and the absence of biometry equipment, standard strength IOLs were used. Despite the issues with recording surgical outcome and the need for quality to be improved, referred to in Effectiveness 2.3, beneficiaries in FGDs were all very pleased with their surgical outcomes, even where these were only rated as 'intermediate' in quality. This was confirmed through survey where 85% of respondents reported that they were very or extremely pleased with surgery outcome. It should be noted however that ROM recommendation for cataract surgeons to consistently use and monitor surgical outcome using the WHO audit tool has not been implemented and this issue remains a problem within the eye health service.

[4] The effects of services getting underway in Guinea Bissau in 2012 may have affected the fall in Ziguinchor in 2012.

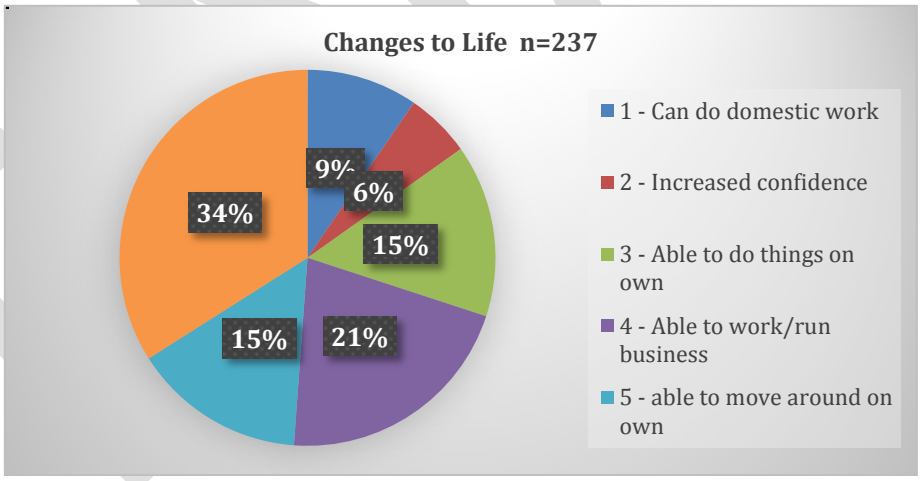
Chart 8: Cataract patients perceptions of quality of their surgical outcome/vision



Quality of Life

Both survey results and FGDs confirm the significant impact of restoration of sight on the quality of life of eye health service users confirming changes to quality of vision, confidence and self-esteem, ease with engaging with outside activity, usual work and work related activity as well as other changes. Respondents also reported a reduction in their sense of burden to others since receiving treatment.

Chart 9: Changes to life since eye treatment

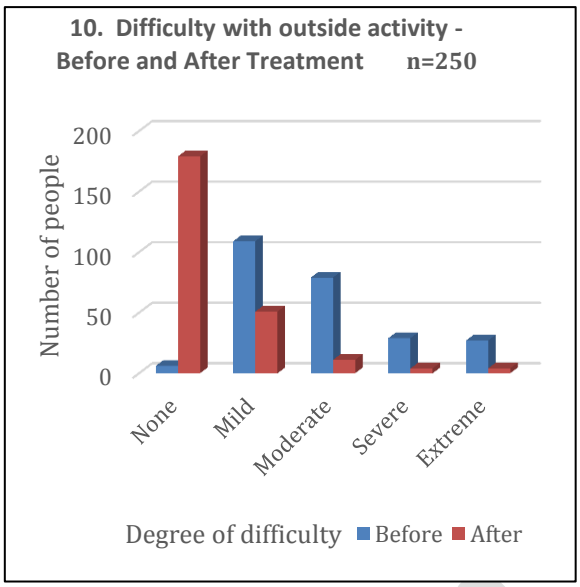


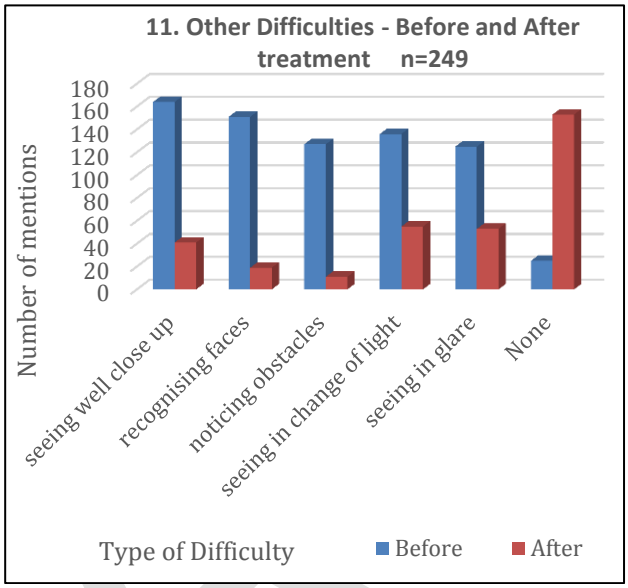
Critically, cataract patients in FGDs reported greater levels of independence, ability to undertake domestic duties and to resume a wide range of different occupations: neighbourhood leaders, lorry-drivers, Qur'an teachers, farmers, lorry drivers, market traders etc. These findings were reflected to a lesser extent in the survey where 5% respondents confirmed that their household wealth had improved a lot and 31% that it had improved a little following eye surgery.

For trachomatous trichiasis surgery patients, the physical relief gained was also considerable: pain and crying eyes had often rendered them completely inactive. Women's groups explained the stigma attached to trachoma and how people may refuse to eat food prepared by a woman with crying eyes. The survey results that

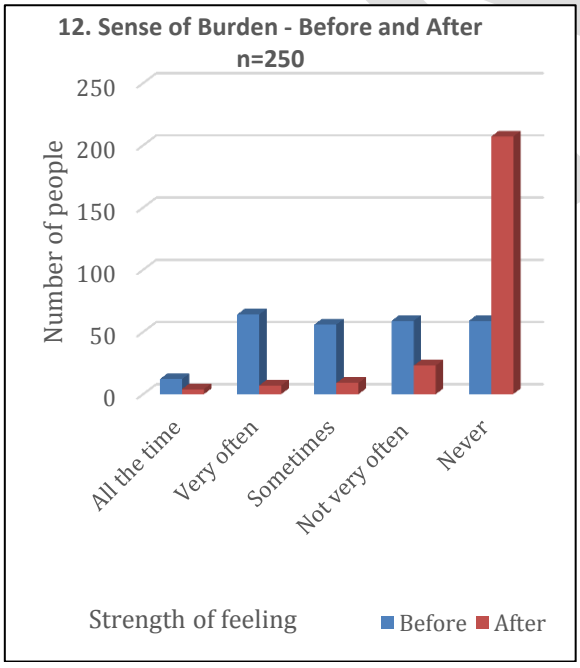
highlight the changes to people's quality of life since treatment which strongly suggest significant impact by the programme on quality of life for eye care patients:

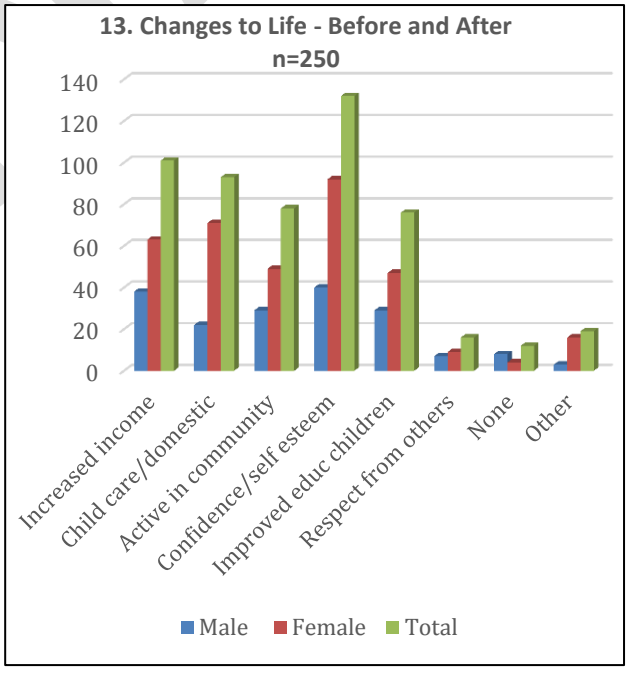
Charts 10 and 11 Difficulties with outside activity and other difficulties.



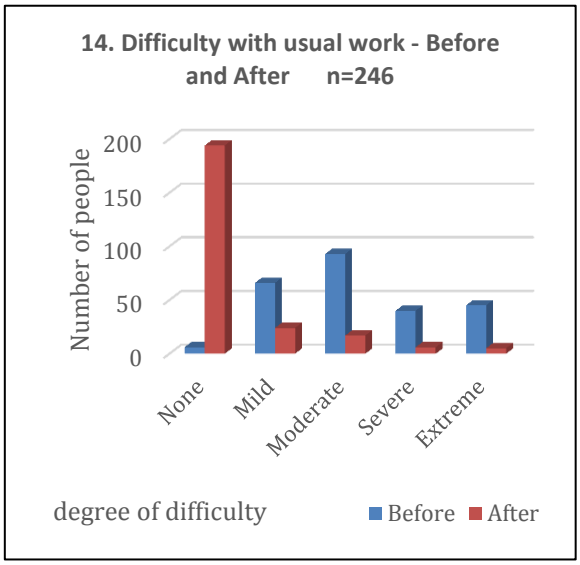


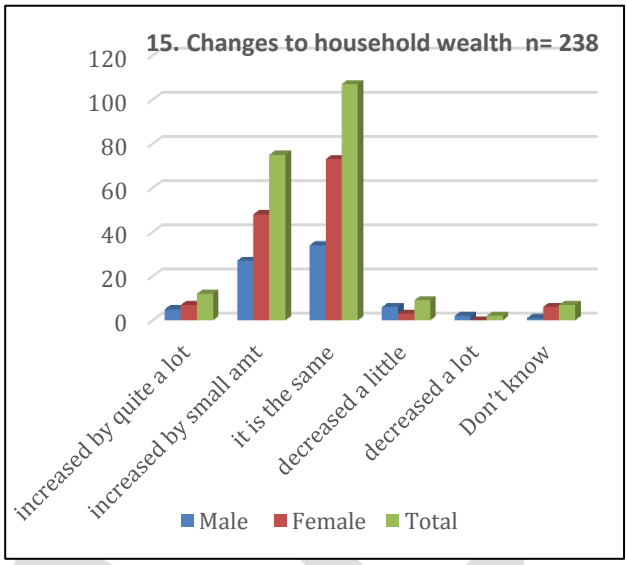
Charts 12 and 13: Sense of burden and main changes to life- before and after





Charts 14 and 15: Difficulties with usual work and changes to household wealth



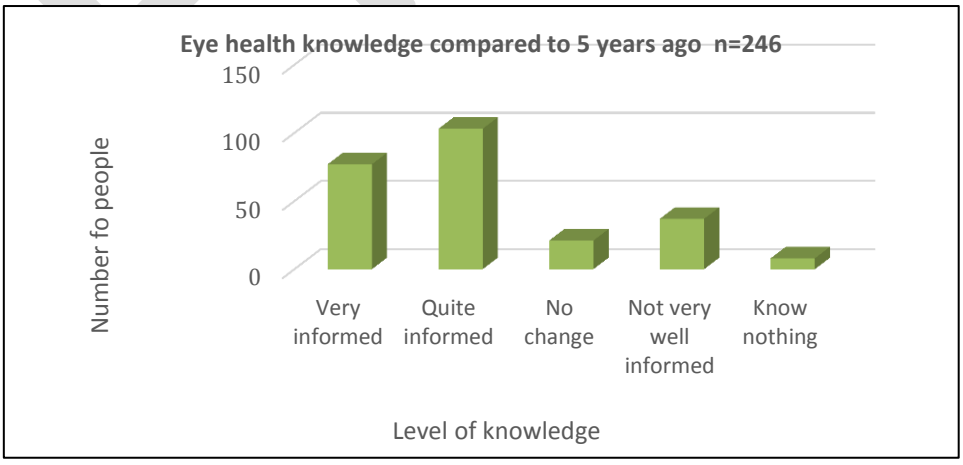


The poverty alleviating effect of sight restoration was commented on directly by some community leaders, beneficiaries and health authority officials. This confirms wider recognition of the impact achieved and is a testimony to the effectiveness of project communications strategies in Senegal.

Knowledge and attitudes

The survey explored changes to community eye health knowledge compared to 5 years ago and although only 23% considered themselves well informed, with 77% wanting more information on eye health, communities were thought by 73% to be quite or very informed about eye health compared to 5 years ago. Furthermore, 69% of respondents indicated that they had made one or more changes to their habits relating to eye health. A very supportive community attitude to people with visual impairment was reported by 64% of respondents.

Chart 16 Perceptions of changes in community knowledge



Budget allocations

The Ministry of Health began providing a budget allocation to PNPSO as a result of the increase in profile from the initial HFPI project. The PNPSO allocation from the Ministry of Health is for coordination activities; funding allocations for health services

are sent directly to the regional and district structures. While the Ministry of Health budget is reported to have been rising, the funding allocated to PNPSO has reduced in recent years from 15million CFA to 8million CFA.

When managing funds received from national level and managing health facility receipts, the DHCs consider and respond to requests made to them by the health teams for funding – whether infrastructure, equipment and salaries. There were no reports of specific budget allocations being fixed by them.

Multi-country collaboration

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

Multi-country collaboration was the key feature of the first Health for Peace Initiative 2001-2006 which enabled the participating countries to learn about the eye health conditions in the other countries, their models of service delivery and the level of service delivery development.

The Post HFPI project document reflects the spirit of HFPI but the three specific strategies mentioned for continued collaboration were not translated into explicit activities or targets in country plans or budgets. The reawakening of sub-regional interest in the HFPI initiated Sheikh Zaid Regional Eye Care Centre (SZRECC) in the Gambia was a key implicit aim. Some units had not been completed and there was a clear risk that it would not develop its intended sub-regional status role.

Overall, PHFPI provided an international framework and structure that facilitated the training of Senegalese eye health staff in the Gambia but the activities were limited to four meetings[5], two specifically for experience sharing and these were not considered to have had added value at national level. There were no cross-border programmes or synchronised activities as envisaged in the initial proposal.

The possibility that multi-country partnership would, with the aid of WAHO, resolve both governance and management issues at SZRECC was of key interest to PNPSO in Senegal. The academic and institutional frameworks in Senegal are more highly developed than in the Gambia and do not recognise the SZRECC diplomas because of SZRECCs lack of formal international academic status and of formal supervision by a more senior academic institution. Formal legal status as an international institution and validation of the training courses by a recognised institution such as CAMES or WACS are required for resolving this issue and for the Government of Senegal to consider participation in its governance or funding.

Unfortunately, efforts made by a range of Sightsavers staff to further the resolution of SZRECC issues only resulted in the key meeting being held in the last month of the project. This highlighted the issues involved to senior Senegal attendees but the discussions did not result in any obvious progress. In practice, the key value for Senegal at national level came from:

[5] : the initial briefing on project administration in the Gambia, the two experience sharing meetings and a final WAHO sponsored meeting on SZRECC.

- the international framework it provided for collaboration; this facilitated the administrative measures necessary for sending trainees to SZRECC;
- the stimulating effect of RHT staff visiting the Gambia at the outset: the Gambia is less developed, so they felt that 'if they can do it then we must be able to'.

The transfer of Gambian experience in community level work was outlined in an initial planning meeting, when a guided tour was organised to visit SZRECC, but it was not supported by detailed exposure or exchange visits for health system personnel at regional or district level who might have benefitted.

The possibility of cross-border or joint planning was not raised or explored. Synchronised campaigns have been organised for some vertical programmes in Senegal, notably vaccinations, and it would have been relevant to at least discuss this for MDA of Azithromycin, even if it was then decided to be no longer appropriate. The Senegal regional health staff were clear that any such cross-border collaboration would need to be initiated centrally by PNPSO.

Changes in the patterns of population movements in search of eye care – formerly from Guinea Bissau to Senegal and, during the project, from Senegal to Guinea Bissau – were cited as an impact indicator for the success of the project but strangely given the interest in cross-border collaboration there has been no attempt to measure these patient flows. While the porous borders and treatment of nationals from neighbouring countries may be accepted as the norm, any significant shifts in these flows may affect the validity of national and project CSR indicators and estimates of how far the services are meeting needs in Senegal.

3.6 Sustainability A

The evaluation sought to assess programme sustainability, reviewing the extent to which the programme is likely to sustain its gains in providing accessible and affordable eye health services, especially for the poorest; the inclusion and recognition of the programme in health and development plans; the level of cost sharing with government; and exit strategies.

The level of integration of eye care into the health services is recognised as a determining factor for their sustainability. There is currently a good level of integration in Senegal but there are still gaps where components are not integrated and others where the level of integration are at risk.

Table 6 Integration of eye care components into health care services

Fully integrated	Partially integrated	Not integrated
Planning processes at district and regional levels Representation in district management team Supervision of primary level by district level Multi-disciplinary outreaches Consumables – cataract kits Essential medicines	Cataract surgeons (cadre and supervision) Equipment – purchase and inventory Inclusion in performance /results based financing and health insurance pilots	Eye care data in HMIS, absence at primary level Regional coverage PEC in basic primary health care training Eye health Education at all levels incl. community – on programme by programme basis

The absence of any eye care indicators from the primary level register pages submitted to HMIS is the most serious integration issue identified and one with potential repercussions for sustainability. If eye care activities are not recorded, this aspect of Health Post work will not be monitored or adequately recognised and valued at district and regional levels. This may undermine the motivation levels of staff, while at national level there will be no formal evidence of demand or the achievements of health facilities to support planning, policy and advocacy activities. The leadership and capacity of the PNPSO to address these will be key in determining the sustainability of the programme.

Despite considerable efforts during the final year to ensure reflection, planning and the identification of strategies for maintaining project achievements – there is some uncertainty as to the degree of programme sustainability. The evaluation identified the following factors likely to promote and likely to hinder sustainability:

Table 7 Factors promoting and hindering sustainability

PROMOTING SUSTAINABILITY	HINDERING SUSTAINABILITY

• Strong desire and interest of all stakeholders for sustaining services
• Regional and District Health Authorities now convinced of value and feasibility of providing district and community-level eye health services and empowered to achieve this
• Sensitisation of wide range of community leaders and stakeholders represented in health committees.
• Infrastructure, equipment, trained personnel and consumables all in place
• Training provided in project and management skills to administrators
• Recognised benefits to health system:
  ○ Increased patient traffic for health centres
  ○ Eye units generate good income
  ○ Status and recognition for those delivering services
	• Health system leaders have many demands on their time: national and donor-funded programmes likely to take priority
	• Insufficient human resources nationally and minimum staffing at eye units
	• Difficulty in training more cataract surgeons
	• Difficulty and risks of not ensuring adequate supervision of cataract surgeons
	• Lack of buy-in of some ophthalmologists and other doctors
	• Funding over for relais activities and camps and reduced for outreach visits
	• End of facilitation, support and close coordination of activities within Regions and with PNPSO by Sightsavers PO: issues will not be picked up so promptly
	• Range and level of communications will reduce at all levels;
	• Poverty and perceptions of price barrier will limit demand

• Level of integration into health system • Trained personnel at community level will continue to detect and refer eye cases to eye units • Demand created at community level as result of visible activities and results: outreach activities, successful eye treatments, offer of services at Health Posts and awareness raising by relais. • Presence of social fund at health centres for poor patients and Senegal moves towards universal health insurance should improve affordability • Cost recovery mechanisms enable some motivation of eye health staff	• The use of outreach, cataract camps and some free surgeries has created hopes of more free services • Limited capacity of PNPSO to provide necessary policy and advocacy support • Lack of integration of eye care into HMIS at primary level: work at health posts is not properly recognised/valued • National capacity for advocacy and timely coordination with other health actors • Cost of replacing expensive equipment and/or spare parts. • Perceived need for replacement partners to continue to provide funding • End of salary top ups for cataract surgeons

Two factors were identified with the potential to both help and hinder sustainability:

- the presence of districts without eye care service provision in each health region: this could serve as the rationale for either expanding to the other districts or, if this is not possible, not maintaining the service in just some districts
- the start of a trachoma project in some, but not all, of the PHFPI districts: where Sightsavers is present for the trachoma project, there will be the opportunity to informally mentor and encourage the sustainability of this project. However, there were also indications that while Sightsavers is still present, the health authorities may continue to hope for practical support if problems arise with the services established by this project.

Once the project ends, two components key to its success in developing the demand for services are less likely to continue: the extensive communications activities at all levels and the community-level work undertaken by the relais. Visibility levels are likely to drop and an emphasis on eye care treatment looks more likely to be sustained than on the prevention and promotion components, which actually need more attention. Walk-in attendance and routine surgeries are less well-established at the eye clinics where activities only began in 2012; memories of camps are still fresh and patterns of eye health seeking behaviour, patient flows and eye unit income are still developing. With cataract surgery prices still perceived as high for poor patients, it will be important that patients who cannot afford fees are made aware of Health District social funds and how to access them.

Continued investment in improving in the quality of cataract surgeries will be vital for promoting the sustainability of the programme: if any serious issues were to emerge, these could be used to undermine the current acceptance of the cataract surgeon category. This risk should not be underestimated and must be mitigated.

Overall there was a strong sense of ownership among health system stakeholders – health authorities, health committees and service delivery personnel – and expressions of determination to maintain the results achieved. However, it was evident that many of the districts are assuming that they will need to find other sources of external funding, probably a partner organisation, to continue providing support after the project ends but there has been little action on this so far. Training in

resource mobilisation was not provided by the project and would undoubtedly have been beneficial.

3.7 Scalability and Replicability GA

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

The results achieved by the project in a relatively short time have confirmed the replicability of this approach in providing eye care services and cataract surgery at district level linked to strong primary health care and community level participation. Learning from the earlier Sightsavers supported regional eye care project in Louga has been used and shown the benefits of increasing the involvement of community leaders, a strong communications component and the level of decentralisation.

The PNPSO and regional stakeholders are now convinced that eye care, including cataract surgery, can be offered at district level and believe that it should be accessible to all districts. The PNPSO has increased experience in implementing this model but replication initiatives will face the following key challenges :

- The cataract surgeon cadre is not officially recognised in Senegal so it is highly unlikely that the MoH will fund the training of additional cataract surgeons in the Gambia even though it accepts them in practice.
- The difficulty in ensuring adequate professional supervision of the cataract surgeons who are not meant to work without this; this is a particular challenge in Senegal because the PNPSO has difficulty retaining ophthalmologists at regional level and because there is still resistance to the idea of cataract surgeons from many ophthalmologists in Senegal;
- Assessing the catchment area of existing eye units and how far they are serving neighbouring districts and how practical this is in the longer term;
- The high initial investment costs for the whole process of establishing eye units.

At national level, it will be important for replicability to continue improving the integration of eye care into the health system (HMIS etc) and in particular to facilitate the integration of eye care into pilot health insurance and performance-based financing initiatives. The coverage of the project in 10 districts across 5 regions should, in itself, increase the likelihood of it being replicated: health authority staff are routinely transferred and will take these experiences with them. A chance meeting with a cataract surgeon who has transferred to an underserved Dakar suburb revealed just such a scenario: the incoming DMO has apparently identified the lack of eye care services as a key gap in the health centre's services and already convinced the DHC to invest in ordering equipment with advice from the PNPSO.

4 CONCLUSIONS & RECOMMENDATIONS

The project was highly relevant to the unmet eye care needs in the intervention districts and fits well with the overall programme for delivering the PNPSO strategic vision. Overall it has been very effective and has achieved excellent levels of results

in a short space of time even if the indicators for measuring these are insufficient; it is estimated that these results would have taken 2-3 times as long for the national programme to achieve alone. Nevertheless, more still remains to be done in consolidating the achievements to date as the services established are not yet mature and some of the gains achieved are still vulnerable. In supporting the development of HREH, Sightsavers has identified a real need and registered some clear achievements but this task is not yet done.

Project implementation proved effective in Senegal despite the early setbacks caused by the delay in receipt of funds and the change in key project personnel shortly after it began. The time taken by the Senegal team to understand the generic project design, to identify how it could best be operationalised and to align the reduced budget with the outcomes was well invested. However, this process should ideally have taken place after funding was granted in order to realign the activities with the cuts made to the budget before implementation began.

The adoption of a phased approach to implementation clearly disadvantaged the four districts where eye care activities only began in 2011/12 as they had less time to establish routine eye-health seeking behaviour and develop an appropriate volume of surgeries at the eye unit prior to support being withdrawn. Ideally all eye units should be supported for a minimum of 5 years after their inauguration.

Acceptance by the health teams of the importance of health messaging and the involvement of journalists as stakeholders enabled not only the creation of understanding of the need for eye services and its demand from a wide range of community leaders but also recognition that district health facilities can successfully respond to this demand. Without the critical additions of a strong focus on communications and eye health messaging at all levels and of a greater emphasis on the relais and their activities at community level, the project would not have had such successful results.

The very intensive programme of activities has enabled all the project output targets to be met and some to be exceeded; however the eye health programmes are still developing and activities, especially those at community level will inevitably slow following the end of project funding. Even in the districts where activities began in 2009, the eye units and their functioning are vulnerable to the transfer of scarce eye health human resources, to some key gaps in the integration of eye care into health systems and to the capacities of regional and national level to maintain the support and supervision needed for ensuring quality services. While PNPSO affirms that the quantity and quality of cataract surgery achieved by cataract surgeons is higher than that of ophthalmologists, the circumstances of the context mean that this is nevertheless an area of vulnerability and a risk that requires mitigating strategies.

Overall, the project has been efficiently managed and benefitted from excellent coordination and communications between all the key stakeholders. The Sightsavers management team made good use of their skills and experience and drew on central organisational resources to ensure their compliance with EU and Sightsavers procedures; however the Sightsavers UK technical expertise proved somewhat removed from the operational realities and did not always translate into efficient results.

The project has raised the profile of eye health and understanding of its importance as a health issue but nevertheless, eye health is unlikely to ever compete with the profile of the well-resourced programmes tackling health issues affecting mortality. Its impact has been observed at multiple levels:

- convincing health authority leaders that the delivery of eye care services at district and community level does work and challenging the perceptions of many health system actors that eye care is a specialist service that needs to be delivered by specialist doctors in a hospital setting
- strengthening the health system at district and primary levels
- changing community levels of awareness and take-up of eye services
- in the lives of the those who have had surgery and their households

While the selection of districts bordering national frontiers did not fit with the Regional administrative structures, this can arguably now be said to be creating a dynamic for replication. Some of the Regions visited find it difficult to explain why not all of their districts can respond to the evident demand for eye care services; this has prompted the Health Authorities to wish to replicate it in other districts. Replication will, however, face several challenges, notably being dependent on external inputs for the training of cataract surgeons as these are likely to remain an unofficial cadre.

Planning and exit strategies should ideally have begun earlier and been integrated from the outset. While the impetus behind eye care activities will now undoubtedly slow there is a widespread sense that the investment of all concerned and the gains achieved are such that it is now impossible to go backwards. Arguably, much will depend on the motivation level of key decision-makers, notably the RMOs and DMOs who have the potential to play a decisive role, and the ability of the higher levels of the eye care pyramid to provide the necessary supervision and support.

Recommendations:

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

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

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

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

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

5. Undertake a detailed assessment of how current initiatives developing health insurance coverage and results-based financing are being designed and

implemented with a view to optimising the integration and provision of eye care services at secondary, primary and community levels (MoH).

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

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

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