

## **End of Term Evaluation Report**

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# **Sierra Leone Eye Care Programme**

### **Specific Projects:**

**Comprehensive Eye Care in Sierra Leone (Seeing is Believing, SiB)  
Project numbers: 57002 (NTDs), 57003 (NECP), 57004, 57005, 57006,  
57009**

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**Submitted by Tropical Health**

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We would like to extend our gratitude to the many individuals who freely shared their valuable time, experience and knowledge with us, therefore making this evaluation rich with insight and experience. We would also like to express our respect for the health workers and partner organisations across the country who have worked hard, with impressive vision and commitment, in delivering eye care to those who most need it and in raising awareness of the importance of eye health. The achievements of this project are testimony to the hard work of everyone who has been involved.

## List of acronyms and abbreviations

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BPEHS	Basic Package of Essential Health Services
CDD	Community directed distributor
CHC	Community Health Centre
CHP	Community Health Post
CHW	Community Health Worker
DHMT	District Health Management Teams
DHS	Demographic Health Survey
DHIS	District Health Information System
EC	European Commission
EPI	Extended Programme for Immunisation
EVD	Ebola Viral Disease
FGD	Focus Group Discussion
FHCI	Free Health Care Initiative
HMIS	Health Management Information System
IAPB	International Agency for the Prevention of Blindness
IEC	Information Education and Communication
INGOs	International Non-Governmental Organisations
KAP	Knowledge Attitudes and Practice
KII	Key Informant Interview
KPI	Key Performance Indicator
LF	Lymphatic filariasis
MCHW	Maternal and child health week
MDA	Mass Drug Administration
MoHS	Ministry of Health and Sanitation
MTR	Mid Term Review
NEHP	National Eye Health Programme
NGO	Non-Governmental Organisation
NTD	Neglected Tropical Disease
OCHO	Ophthalmic Community Health Officer
PEC	Primary Eye Care
PHC	Primary Health Care
PHU	Primary Health Unit
QSAT	Quality Self-Assessment Tool
RAAB	Rapid Assessment of Avoidable Blindness
SiB	Seeing is Believing
SLCO	Sightsavers' Sierra Leone Country Office
TAS	Transmission assessment surveys
ToR	Terms of Reference
VAS	Vitamin A Supplementation

# Executive Summary

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## Background information

The population prevalence of blindness in Sierra Leone is estimated at 0.7% affecting 43,842 people, while the prevalence of blindness in people over 50 years of age is estimated as 5.9%, according to the most recently available national data<sup>1</sup>. More than 90% of all blindness in Sierra Leone is also avoidable, which is significantly higher than the global average of 80%<sup>2</sup>. In 2012, Sightsavers was awarded two complementary five-year grants from the European Commission (EC) and Seeing is Believing (SiB), which together have enabled comprehensive support to the Sierra Leone Eye Care Programme across all four of the country's regions. This evaluation report focuses on the latter of these two grants - Sightsavers Comprehensive Eye Care in Sierra Leone Project.

## Description of project

The project was designed with the aim to contribute to the reduction in avoidable blindness and vision impairment in Sierra Leone through countrywide provision of comprehensive eye care services, targeting over 2,300,000 people over the project duration. The project's objectives include:

- Objective 1: Support the National Eye Health Project (NEHP) to strengthen health systems through improved human resources for eye health, including the training and deployment of required eye care professionals.
- Objective 2: Effectively integrate Primary Eye Care (PEC) services into primary health care through support to peripheral health unit staff.
- Objective 3: Develop and improve community participation in preventive eye health activities, particularly in underserved and marginalised communities.
- Objective 4: Reduce Vitamin A deficiency-associated blindness and mortality by ensuring high and sustained Vitamin A Supplementation (VAS) for children.

The project was implemented in all four regions of Sierra Leone: Eastern Province, Southern Province, Western Area and the Northern Province. Funding was provided by multiple donors with a total budget of \$1,250,172, with the lead donor being the SiB Standard Chartered Bank (SCB). The project began on 1 September 2012 but was interrupted and affected by the Ebola Virus Disease (EVD) outbreak during 2014 – 2015. A midterm review was conducted in late 2015 to assess the project once activities were resumed and a no cost extension was agreed for the project until 31 August 2017<sup>3</sup>.

## Purpose of Evaluation

The aims of the end of term evaluation were to:

- Review and assess the project's achievements against objectives and outputs.
- Assess the long-term effects made by the project on accessibility to eye health services.
- Identify and document the key successes and challenges in the implementation of the projects to inform the future design of Sightsavers' programmes.
- Identify and document specific recommendations for similar, future project designs.

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<sup>1</sup> Limburg, H. *Rapid Assessment of Avoidable Blindness (RAAB) in Sierra Leone (2011)*. Freetown, Sierra Leone: Sightsavers; 2011.

<sup>2</sup> Limburg, H. *Rapid Assessment of Avoidable Blindness (RAAB) in Sierra Leone (2011)*. Freetown, Sierra Leone: Sightsavers; 2011.

<sup>3</sup> Ogundimu, K. Macdonald, D. *Sightsavers Comprehensive Eye Care in Sierra Leone Project – Mid Term Review: April 2016*. Freetown, Sierra Leone: Sightsavers; 2016.

- Identify and document any further cross-cutting or organisational level lessons and recommendations.

The target audience for this report are funders, in-country partners and programme staff, and global programme support teams within Sightsavers.

## Evaluation approach

The evaluation was conducted retrospectively and incorporated a process-impact-outcome approach. It used mixed methods, incorporating both qualitative and quantitative components, which enabled the triangulation of findings during analysis. In order to generate information needed to achieve the evaluation purpose, six evaluation criteria were used, as specified in the evaluation Terms of Reference: relevance, effectiveness, efficiency, impact, sustainability, coordination/coherence. Under each criterion, specific questions guided the overall scope of the evaluation and data to be collected.

A team of two consultants supported by an additional technical expert as well as Tropical Health technical and management teams undertook the evaluation from August to October 2017 in three phases, i.e. inception, data collection and report writing. Evaluation findings were gathered using appropriate tools for each data collection method which were reviewed and approved by Sightsavers as part of the evaluation inception report. In total, 124 documents were reviewed, 57 key informants interviewed, six focus group discussion organized and six primary health units visited. An important amount of the work took place during the in-country work done by the two consultants from 17 to 27 September 2017. Informed consent was obtained from all informants.

Data from all sources was triangulated, through review and comparison of data across all sources, and dialogue within the evaluation team, and presented according to the six evaluation criteria in this Evaluation Report.

This evaluation presents two main limitations. First, due to time limitations and a demanding schedule, the evaluation team were unable to visit very rural locations, which may have provided a broader range of data, particularly as relating to performance and functionality of PHUs, community access to services and health behaviours. Second, there were challenges with the measurement of impact, outcome and outputs of the project. The targets for the measurement of impact were planned to be based on survey data, which in the end was not available. There were also challenges with the measurement of project achievement based on output data in that performance was not routinely tracked against the logframe. Also, there were inconsistencies in the wording of indicators, a lack of indicator definitions, low potential measurability of some indicators, insufficient linkage between indicator and data source, and some gaps in assigning targets. As such, a key limitation for the evaluation is that it over-relies on qualitative data and lacks a very important assessment of performance against agreed logframe indicators and targets.

## Main findings and conclusions

### Relevance

Rating 

There was consensus across all key informants that the project was highly relevant to the needs of Sierra Leone in terms of strengthening and improving eye care service delivery and extending its reach to poor and remote communities, as well as people with disabilities. Its focus on skills development and integration into all levels of the public health system was appropriate and will likely boost efforts for sustainability of impact. The Knowledge Attitudes and Practice study provided valuable contextual insight, used to develop more comprehensive awareness raising strategies around the importance of eye care and accessing services. The project's flexible approach with regards the disability and social inclusion component enabled welcome adjustment and expansion to planned activities, including broadening its collaboration with people with disabilities to include all disabilities, and an evolving advocacy strategy. The post-EVD context actually enhanced the relevance of the project given the large number of survivors with resultant eye complications, as well as ongoing project efforts to strengthen the health system and increase community access to eye care through outreach.

### Effectiveness

Rating 

The project targets, some of which were revised following the Mid Term Review (MTR), were considered realistic, and have mostly been met, and in some cases, have been exceeded. Significant gains have been made, most noteworthy as relating to human resources for health, the introduction of eye health indicators into the Health Management Information System (HMIS) and enhanced access to care and empowerment among people with disabilities, and the high coverage of Vitamin A Supplementation through mass drug administration and recent progress in its integration into the Extended Programme for Immunisation (EPI). Key challenges do remain, such as inequity in the distribution of ophthalmic workers, continued low capacity at the PHU level, the unreliable drugs supply, and ensuring data quality through HMIS, but these reflect the broader challenges of the health system context and the project has made good progress in attempts to address them. Assessment of project effectiveness at the impact level is challenged by a lack of impact and outcome data and the measurement of outputs hampered by the lack of consistent monitoring documentation against the logframe.

### Efficiency

Rating 

In the extreme and unprecedented context of the EVD outbreak, and its implications in terms of the Ministry of Health and Sanitation and its partners having to refocus resources, time and attention away from most other routine project activities for a one-year period, delivery under the project must be considered impressive, given almost all targets were met and some exceeded. The project was appropriately ambitious but despite the fragile context of Sierra Leone, the funds were absorbed effectively. The evaluation considers the financial resources of the project to have been well managed and in line with priorities as stipulated by the project objectives. However, a 'satisfactory' rating has been assigned given the ineffective monitoring and evaluation of the project in line with the logframe, which has implications for the efficiency in reporting, documentation and management.



## Impact

Rating 

Impact under the project has been impressive. Integration of eye care into primary eye care delivery has made important strides and there is increased capacity to deliver quality eye care services across the health system. Access to care appears to have improved for the population at large, including for poor and remote populations. The project is also broadly on track with elimination targets for onchocerciasis and lymphatic filariasis. Further attention must be given to raising the eye care capacity further at the PHU level, including in remote areas, translating outreach output statistics into referral uptake, improving routine monitoring of surgical outcomes and patient follow-up, the collection of patient perception data to inform service provision, boosting spectacles dispensing and glasses wearing in response to need.

## Sustainability

Rating 

Project emphasis has been on the integration of eye care into government health systems, development of government human resource capacity, awareness raising around the importance of eye care, and the strengthening of a strong eye care partner network across the country which are important foundations for sustainability. However, the demand created for eye care needs to be sustained through feasible access to PHUs and through overcoming financial constraints because large outreach spend is not sustainable in the long term. Eye care is far from being cost recoverable given the biggest need is among the poorest people. That eye care service delivery is almost entirely dependent on external funding is of concern. Training achievement needs to be maintained by intensified support supervision, and further skills gaps need to be filled. There is a real need to recognise the importance of the next phase given the recent gains that need to be sustained and built upon.

## Coherence/coordination

Rating 

A key factor in the project's success has also been the extensive and much appreciated collaboration and co-ordination with all the relevant stakeholders, including government departments and clinics, private not for profit hospitals, non-governmental organisations (NGOs) and civil society partners and community leadership at the national, sub-regional and community levels. There are coherent links between the project rationale, objectives and implementation approach.

## Recommendations

Some recommendations are made for the immediate next phase of activity to support eye care in Sierra Leone, based on the findings of this evaluation, as included in the table below. It is noted that the next phase of Sightsavers' implementation activity is currently funded by SiB and Irish Aid. Nevertheless, these recommendations could also inform the design of further projects to be implemented by Sightsavers or other eye health and disability partners in Sierra Leone, as well as a direct relevant government public service activity, as highlighted in the table.

Recommendation	Responsibility	Level of priority
<i>Human resources for eye health</i>		
1. Prioritise PHU essential training on the diagnosis and management of eye conditions/ infections through the	NEHP	H

Recommendation	Responsibility	Level of priority
District Health Management Teams (DHMTs) as per planned curriculum, and ensure follow-up practical support supervision, peer support, refresher training plans are in place and implemented.		
2. Support the development of Key Performance Indicators (KPIs) for in-service training as part of training cascades to encourage any PHU or district level health worker staff to give deliberate effort to passing on comprehensive training to other clinic staff members; this should be followed up and monitored by DHMTs.	NEHP	H
3. Advocate at the central level to address a) challenges in locating health workers to remote PHUs given the lack of available incentives, allowances, accommodation or requirement post-training and b) gender imbalances in health worker training so as to boost the further recruitment and training of female health workers across the health system	NEHP, Sightsavers' Sierra Leone Country Office (SLCO) and other partners	M
<i>Outreach</i>		
4. Develop criteria for the prioritisation of ongoing eye care outreach activities, such as a minimum of e.g. 5km from a PHU, with the aim of phasing out of universal outreach activities given efforts to raise capacity of PHUs and the introduction of a comprehensive network of Community Health Workers.	NEHP	M
<i>Eye care promotion</i>		
5. Continue to promote the importance of eye care and appropriate health seeking behaviour, including for the EPI, through Information Education and Communication (IEC) activities as funds allow and as recommended for the context based on likely effectiveness, such as community dialogues in collaboration with district leadership. Men should also be targeted given the influential role they have in deciding whether women should access certain interventions.	NEHP, SLCO and other partners	M
6. Give more focus to refractive error testing and glasses wearing in IEC activities in communities, PHUs and schools, and explore ways of reducing prohibitive costs to accessing spectacles, including collaboration with other programmes or insightful formative research on barriers to glasses wearing	NEHP, SLCO and other partners	M
<i>Data analysis and use</i>		
7. Support in-country effort as required for HMIS/District Health Information System 2 (DHIS2) training, and ensure a comprehensive focus on eye health indicators is included in district level support supervision on an ongoing basis.	NEHP	H

Recommendation	Responsibility	Level of priority
8. Conduct targeted data quality assurance checks for eye health indicators data three-six months post introduction to inform further support needs	NEHP, SLCO	M
9. Consider conducting a case study on the range of eye health cases presenting, managed and referred at different levels of the health system in one ideally typical district based predominantly on outpatient registers over a period of around three months. This will give more detailed insight into the extent of case filtering at lower levels, within-district referral and a more accurate prevalence of eye conditions, beyond which the HMIS/ DHIS2 data may be able to provide, particularly as the new monitoring system is being rolled out.	NEHP, SLCO	L
<i>Supply chain</i>		
10. Enhance technical or logistical support or collaboration at the central level with the specific aim of addressing eye health drug shortages, as dependent on specific bottlenecks. For example, support to the analysis of stock data and quantification to enable a more responsive pull system (will be particularly important once DHIS2 is up and running) or support to specific procurement planning efforts.	NEHP, SLCO and other partners	H
<i>Health financing</i>		
12. Advocate where possible for government to allocate funding to eye care service delivery through a phased and targeted approach, e.g. training activities and equipment maintenance.	NEHP, SLCO and other partners	H
<i>NEHP coordination and management</i>		
13. Support the recruitment of an assistant manager to the NEHP, preferably a person with some management/finance skills, to assist the NEHP Coordinator in the management and coordination of the programme.	NEHP	H
<i>Project management</i>		
14. Ensure any project monitoring and evaluation plans are based on realistic yearly targets, with measurable, defined output, outcome and impact indicators linked to specific and available data sources. Achievements against targets should be monitored and analysed on defined periodic basis and all project monitoring and quantitative reporting should be linked to the monitoring plan (logframe).	SLCO/M&E teams	H

# 1. Introduction and background

## 1.1. Background

The population prevalence of blindness in Sierra Leone is estimated at 0.7% affecting 43,842 people, while the prevalence of blindness in people over 50 years of age is estimated as 5.9%, according to the most recently available national data<sup>4</sup>. More than 90% of all blindness in Sierra Leone is also avoidable, which is significantly higher than the global average of 80%<sup>5</sup>. In recent years, the number of people accessing eye care services in Sierra Leone has increased through a combination of enhanced awareness, improved service provision and reduced financial barriers through the Free Healthcare Initiative<sup>6</sup>. But weaknesses in eye health service delivery in Sierra Leone have remained and were further compounded by the Ebola Viral Disease (EVD) outbreak including insufficient coordination and monitoring of health-related interventions, low government support to eye health and insufficient staff numbers and capacity<sup>7,8</sup>.

In 2012, Sightsavers was awarded two complementary five-year grants from the European Commission (EC) and Seeing is Believing (SiB), which together have enabled comprehensive support to the Sierra Leone Eye Care Programme across all four of the country's regions. This evaluation report focuses on the latter of these two grants - Sightsavers Comprehensive Eye Care in Sierra Leone Project.

## 1.2. Purpose of evaluation

As indicated in the Terms of Reference (ToR, Appendix 1), the overall purpose of this end of term evaluation was to review the achievements of the project against objectives and outputs as detailed in the project documents, as well as assess the long-term effects made by the project on accessibility to eye health services by people with disabilities in the regions.

The specific aims of the end of term evaluation were to:

- Review and assess the projects' achievements against objectives and outputs.
- Assess the long-term effects made by the project on accessibility to eye health services.
- Identify and document the key successes and challenges in the implementation of the projects to inform the future design of Sightsavers' programmes.
- Identify and document specific recommendations for similar, future project designs.
- Identify and document any further cross-cutting or organisational level lessons and recommendations.

The target audience for this report are funders, in-country partners and programme staff, and global programme support teams within Sightsavers.

<sup>4</sup> Limburg, H. *Rapid Assessment of Avoidable Blindness (RAAB) in Sierra Leone (2011)*. Freetown, Sierra Leone: Sightsavers; 2011.

<sup>5</sup> Limburg, H. *Rapid Assessment of Avoidable Blindness (RAAB) in Sierra Leone (2011)*. Freetown, Sierra Leone: Sightsavers; 2011.

<sup>6</sup> Eye care services are included in the Basic Package of Essential Health Services for Sierra Leone, which was initiated in 2010, and which enables free delivery of key components of primary health care to pregnant and lactating women, and children under five.

<sup>7</sup> Potter, A.L., Vandy, M., Smart, N., Blanchet, K.I. *Eye Health Systems Assessment (EHSA): Sierra Leone Country Report*, Freetown: Ministry of Health and Sanitation, International Centre for Eye Health, Sightsavers; 2013.

<sup>8</sup> Sightsavers. *Situational Analysis to critically assess the impact of the Ebola outbreak on our programmes in Sierra Leone (May 2015)*. Freetown: Sightsavers Sierra Leone Country Office; 2015.

## 1.3. Project description

The project was designed with the aim to contribute to the reduction in avoidable blindness and vision impairment in Sierra Leone through countrywide provision of comprehensive eye care services, targeting over 2,300,000 people over the project duration. The project's objectives include:

- Objective 1: Support the National Eye Health Programme (NEHP) to strengthen health systems through improved human resources for eye health, including the training and deployment of required eye care professionals.
- Objective 2: Effectively integrate Primary Eye Care (PEC) services into primary health care through support to peripheral health unit staff.
- Objective 3: Develop and improve community participation in preventive eye health activities, particularly in underserved and marginalised communities.
- Objective 4: Reduce Vitamin A deficiency-associated blindness and mortality by ensuring high and sustained Vitamin A Supplementation (VAS) for children.

The project was implemented in all four regions of Sierra Leone: Eastern Province, Southern Province, Western Area and the Northern Province. Funding was provided by multiple donors with a total budget of \$1,250,172. The lead donor was the SiB Standard Chartered Bank (SCB) (\$1,000,138), followed by Sightsavers (\$138,863), Christoffel Blinden Mission (\$77,703) and Helen Keller International (\$33,469). The project began on 1 September 2012 but was interrupted and affected by the EVD outbreak during 2014 – 2015. A midterm review was conducted in late 2015 to assess the project once activities were resumed and a no cost extension was agreed for the project until 31 August 2017<sup>9</sup>.

## 1.4. Methodology and ethical considerations

### 1.4.1. Evaluation approach

The evaluation was conducted retrospectively and incorporated a process-impact-outcome approach. It used mixed methods, incorporating both qualitative and quantitative components, which enabled the triangulation of findings during analysis. In order to generate information needed to achieve the evaluation purpose, six evaluation criteria were used, as specified in the ToR: relevance, effectiveness, efficiency, impact, sustainability, coherence/coordination. Under each criterion, the ToR provided a series of specific questions to guide the overall scope of the evaluation and data to be collected. These questions and related data collection methods are included in the Evaluation Matrix presented Appendix 2.

### 1.4.2. Evaluation design

The review was completed by a team of two consultants<sup>10</sup>, supported by initial and final inputs to reports from a third consultant<sup>11</sup> and by the technical and management teams at Tropical Health. It was carried-out in three phases, as detailed below; Appendix 3 presents the workplan for each evaluation phase.

<sup>9</sup> Ogundimu, K. Macdonald, D. *Sightsavers Comprehensive Eye Care in Sierra Leone Project – Mid Term Review: April 2016*. Freetown, Sierra Leone: Sightsavers; 2016.

<sup>10</sup> Clare Strachan - Team Leader; Martin Long - Social Inclusion and Disability Specialist

<sup>11</sup> Lynne Elliott – Technical Resource Person, Health Systems Specialist



- During the **inception phase**, the evaluation team reviewed project background documentation, as provided by Sightsavers (see Documents list in Appendix 4), so as to inform contextual insights and the refinement of the evaluation questions and methodology. Two kick-off meetings with Sightsavers took place<sup>12</sup> which enabled a detailed briefing on the two projects, clarifications on evaluation purpose, scope and technical focus, discussion about evaluation methodology and data available, and logistical planning for the fieldwork.
- The **data collection phase** involved the collection of all primary data required for the evaluation, as well as the continuation of the documentation review and collation of relevant secondary data. Two consultants visited Sierra Leone for a combined number of 16 days. During this time, they met with a range of stakeholders with varying experiences and scope of involvement with the project at the national, sub-regional and community levels across all four regions of the country, in line with the data collection schedule agreed with Sightsavers (Appendix 5). Primary data was acquired from key informant interviews (KIIs), focus group discussions (FGDs) and visits to Primary Health Units (PHUs) from which case studies were developed (see Appendices 6, 7 and 8 for respective data collection tools). At the end of the field work<sup>13</sup>, a de-briefing meeting took place to share, discuss and validate the preliminary findings. This meeting was attended by Sightsavers' Sierra Leone in-country team, key national level implementing partners and disability partners, and representatives from the NEHP and province-level Eye Care Programmes.
- The **data analysis and report writing phase** involved the compilation and analysis of all primary data collected, the review of secondary data (documentation and quantitative output data) and overall synthesis of information so as to produce key findings and recommendations to be documented in the evaluation report.

### 1.4.3. Ethical considerations

Informed consent was obtained from all informants, guided by the Information Sheet and Consent Form (Appendix 9). This consent included taking photographic evidence. Additional considerations were made for interviewing potentially vulnerable persons, including using a private and accessible venues. All identifiable data, including recordings and photographs, are stored in secure locations and only those directly involved with the research have access to them. Data was also de-identified at the analysis stage, through the use of codes as relating to key informant category. Responsibility for feeding back evaluation findings to the participants, as possible and considered appropriate, lies with the Sierra Leone Country Office (SLCO). In-country ethical approval of the evaluation protocol was not required. All consultants complied with Sightsavers ethics requirements<sup>14</sup>.

### 1.4.4. Limitations of the evaluation

Due to time limitations and a demanding schedule, the evaluation team were unable to visit very rural locations, which may have provided a broader range of data, particularly as relating to performance and functionality of PHUs, community access to services and health behaviours. It is also possible that people with disabilities might have faced greater mobility challenges in remote areas, thereby potentially limiting their access to health care and participation in Disability Persons' Organisation (DPO) activities. However, the particular effect of the rural context was discussed with a range of stakeholders at different levels, and some beneficiaries were sampled in the community. Some gender imbalance was also seen in FGD representation among DPO partners; gender specific FGDs may have enabled more insight into disability issues discussed from the female perspective.

<sup>12</sup> The kick-off meetings took place on the 24<sup>th</sup> July and 22<sup>nd</sup> August 2017.

<sup>13</sup> The de-briefing meeting took place on the 27<sup>th</sup> September 2017

<sup>14</sup> Completing UNICEF's 'Ethics in Evidence Generation' or equivalent course

However, this was not considered to affect the findings to a notable extent, in large part because the evaluation achieved a good gender balance in terms of stakeholders interviewed overall.

In addition, there were challenges with the measurement of impact, outcome and outputs of the project. The targets for the measurement of impact were planned to be based on survey data, which in the end was not available. There were also challenges with the measurement of project achievement based on output data in that performance was not routinely tracked against the logframe. Also, there were inconsistencies in the wording of indicators, a lack of indicator definitions, low potential measurability of some indicators, insufficient linkage between indicator and data source, and some gaps in assigning targets. This all resulted in considerable time spent in unsuccessfully collating and reviewing the data. Summaries of output data relating to key project activity areas were in the end received and have been included in this report, though a key limitation for the evaluation is that it lacks a very important comprehensive assessment of performance against agreed logframe indicators and targets.

### 1.4.5. Data collection methods

The review was both quantitative and qualitative in nature. Quantitative assessment focused on ascertaining the programme's achievements against logframe targets, whilst qualitative enquiry enabled further exploration and insight of the 'how' and 'why' of progress to date as well as probing sustainability issues. Four complementary data collection methods were used as presented in Table 1 below.

**Table 1: Data collection methods**

Data collection method	Type of data collected	Rationale
Documentation review	Quantitative and qualitative information as reported by the programme or evidenced in national and sub-national documents.	<ul style="list-style-type: none"> <li>To inform evaluation methodology</li> <li>To better understand the scope and process of implementation, covering all aspects of the evaluation</li> <li>To evidence evaluation results</li> </ul>
KIIs	Qualitative information as reported by key programme stakeholders at national and sub-national levels	<ul style="list-style-type: none"> <li>To elicit perceptions of stakeholders on success factors, challenges, sustainability issues and other lessons learned</li> <li>To triangulate findings gathered through other methods</li> </ul>
FGDs	Qualitative information as reported by key programme stakeholders at community level	<ul style="list-style-type: none"> <li>To elicit perceptions of communities/beneficiaries mainly but not limited to the relevance, effect and sustainability of specific project support</li> <li>To triangulate findings gathered through other methods</li> </ul>
PHU visits	Qualitative information as observed in health facilities supported by the programme	<ul style="list-style-type: none"> <li>To illustrate in case studies<sup>15</sup> the process and effect of the programme at lower level as it concerns integrating eye care into primary health care delivery.</li> </ul>

<sup>15</sup> Case studies also drew on KIIs with PHU Eye Focal Persons and service users where possible.

Photographic evidence was acquired during the KIIs, FGDs or PHU visits where permission was granted, feasible, relevant and ethical. This was used to add substance and context to the other data collected.

## Data collection methods:

### *Documentation review:*

Appendix 4 presents the list of documents reviewed, including documents provided and prioritized by Sightsavers, as well as additional documents gathered through the consultants' own research. The documents included organisational and internal project documentation, mid-term evaluation reports, periodic reviews, monitoring/outcome data, available secondary data, and technical reference material. In total, 124 documents were reviewed. The documentation review was iterative, with documents revisited and additional information reviewed throughout the evaluation to cross-reference findings.

### *KIIs and FGDs:*

A purposive sampling approach was used to select the key informants, in consultation with the SLCO. Criteria used were level of involvement in the projects (national, sub-national and community levels), informant availability and access by the evaluation team. The full list of KIIs and FGDs conducted, and participants interviewed (by informant category), is presented in Appendix 10. Table 2 below presents a summary of the targeted and actual number of KIIs and FGDs conducted by data collection level.

**Table 2: KIIs and FGDs targeted and actually conducted**

Data collection level	KIIs		FGDs	
	Target	Actual	Target	Actual (inc. number of participants)
National level	16	19	0	2 (12 participants)
Sub-regional level	15	22	0	4 (24 participants)
Community level	0	16	11	0
<b>TOTAL</b>	<b>31</b>	<b>57</b>	<b>11</b>	<b>6 (36 participants)</b>

Where relevant, informants were grouped together (into FGDs) where considered practical or likely to enhance the quality of opinion provided, whilst not adversely influencing informant candour. The initial interview target had been 31 KIIs and 11 FGDs, which overall was far exceeded (57 KIIs and six FGDs with a total of 36 participants). Fewer FGDs were conducted than anticipated because beneficiaries tended to be found on an individual basis and, on further consideration, it was considered more appropriate to interview them in isolation to enable a more comfortable environment to discuss personal issues. Both KIIs and FGDs followed semi-structured topic guides (Appendices 6 and 7), ensuring a focus was retained on enabling the evaluation objectives to be met but also new and potentially unexpected perspectives to be raised. Most interviews were recorded electronically with back-up to notes written, whilst for some, detailed notes were taken. Key points raised and quotes were documented in an Excel file according to sub-themes arising from the data (this is available on request).

### *PHU visits:*

In the inception phase, it was agreed to visit three PHUs for the generation of case studies, each in different provinces to enable a geographic range. A further three were added during the course of field work to enable a wider range of PHUs to be included. All PHUs were selected in coordination



with the SLCO and included a range in terms of level of PHU<sup>16</sup>, size of catchment population, strong/less strong performance and rural/urban location. A summary of the location and level of PHUs visited is provided in Table 3 below.

**Table 3: PHU visits conducted**

Province	PHU – Community Health Centre	PHU – Community Health Post	PHU – Maternal and Child Health Post
Eastern province	1	1	0
Southern province	1	0	1
Northern province	1	1	0
<b>TOTAL</b>	<b>3</b>	<b>2</b>	<b>1</b>

During the visits, a guide (Appendix 8) was used to elicit data from observations, informal discussions with health workers and review of data. The guide covered six areas, including human resources, general functionality and supplies, quality of care, integration of eye care into primary health care services, disability and gender, sustainability and data for decision-making.

#### 1.4.6. Data analysis, synthesis and production of evaluation report

- Data on outputs and outcomes against logframe targets were collated and analysed to calculate measures of performance using specifically developed tools (Appendix 10).
- Thematic analysis of KII and FGD data was informed by the ‘framework’ approach<sup>17</sup>, which involved the analysis of data according to the most salient themes.
- Findings from the PHU visits were documented in Word and synthesised into summaries. This information was triangulated with data from KIIs with the in-charge (or their delegate) and service users where possible at each PHU visited. Three case studies, as originally planned, are included in the Results section of this report to illustrate the reality of eye care service delivery at the PHU level, and to help illustrate some of the key findings of the evaluation.
- Project financial information was analysed to assess progress against budgets and workplans.
- Data from all sources was triangulated, through review and comparison of data across all sources, and dialogue within the evaluation team, and presented according to the six evaluation criteria in this Evaluation Report.

#### 1.4.7. Report structure

The Evaluation Report contains three substantive sections: i) **Introduction and background** which provides key background information to the project, a brief project description, project purpose, evaluation design and methods, ethical considerations and evaluation limitations; ii) **Results** section which details the main findings of, and lessons learned from, the evaluation against the six evaluation criteria and their associated lines of enquiry. Appendix 11 demonstrates which parts of the results section addresses each of the evaluation criteria and questions; iii) **Conclusion and Recommendations** which discusses the key overall findings of the evaluation and sets out clear and actionable recommendations. An Executive Summary, found at the top of this report, summarises the key points from each of these sections.

<sup>16</sup> There are an estimated 1,238 PHUs in Sierra Leone and this number continues to rise, in part due to considerable external funding under the Ebola Response Consortium. Three levels exist: PHU – Community Health Centres (CHCs) serve about 10,000 people, PHU – Community Health Posts (CHPs) – serve about 5,000 – 10,000 people and PHU – Maternal and Child Health Posts (serve around 1,000 – 5,000 people).

<sup>17</sup> Pope C, Ziebland S, Mays N. Qualitative research in health care. Analysing qualitative data. BMJ. 2000;320(7227):114-6.

## 2. Results

### 2.1. Relevance

**Rating: Excellent**



There was consensus across all key informants that the project was highly relevant to the needs of Sierra Leone in terms of strengthening and improving eye care service delivery and extending its reach to poor and remote communities, as well as people with disabilities. Its focus on skills development and integration into all levels of the public health system was appropriate and will likely boost efforts for sustainability of impact. The Knowledge Attitudes and Practice (KAP) study provided valuable contextual insight, used to develop more comprehensive awareness raising strategies around the importance eye care and accessing services. The project's flexible approach with regards the disability and social inclusion component enabled welcome adjustment and expansion to planned activities, including broadening its collaboration with people with disabilities to include all disabilities, and an evolving advocacy strategy. The post-EVD context actually enhanced the relevance of the project given the large number of survivors with resultant eye complications, as well as ongoing project efforts to strengthen the health system and increase community access to eye care through outreach.

#### 2.1.1. Overall relevance of the project

The project's focus on health systems strengthening, in particular to improve human resources for eye health and to effectively integrate PEC services into primary health care, was considered highly relevant to the needs of the Sierra Leonean population, according to informants at the national, sub-regional and community levels. The Rapid Assessment of Avoidable Blindness (RAAB) survey<sup>18</sup>, carried out in 2011, indicated a strong need to strengthen eye health services in the country so as to address the burden of a range of eye infections and conditions; the prevalence of blindness was reported as 5.9% of the population and of all blindness in Sierra Leone, 91.5% was reported as avoidable and 58.2%, treatable. At the onset of the project, eye care remained a neglected area within government, and clinical eye care specialists were not found below district level, nor were they available in each district. There was a considerable need to extend eye care services to a population which is predominantly rural and under-served in terms of general health services, and which in large part cannot afford access to basic primary health care. The 2013 Demographic Health Survey (DHS) reported that routine eye care screening was uncommon to the extent that 80% of respondents had never had their eyes examined by a health care provider and with reasons for not seeking eye care services included no felt need (84.5%), distance to facility (38.5%), and lack of money (5%)<sup>19</sup>. Eye health knowledge was also relatively low at the start of the project; according to the KAP study, just 49% of respondents were aware cataract could be treated by surgery, only 5% of respondents had heard of glaucoma, 54% had heard of refractive error problems and just one in five respondents

<sup>18</sup> Limburg, H. *Rapid Assessment of Avoidable Blindness (RAAB) in Sierra Leone (2011)*. Freetown, Sierra Leone: Sightsavers; 2011.

<sup>19</sup> Statistics Sierra Leone (SSL) and ICF International. *Sierra Leone Demographic and Health Survey 2013*. Freetown, Sierra Leone and Rockville, Maryland, USA: SSL and ICF International; 2014.

mentioned blindness as a possible manifestation of onchocerciasis<sup>20</sup>. The DHS also highlighted the challenges in reaching the majority of the population with health messages; 56% of women and 43 % of men were reported not to have weekly access to newspapers, television, or a radio<sup>21</sup>.

In response, a number of appropriate intervention areas were prioritised through the project, namely the strengthening in human resources of eye health, with the intention of bringing ophthalmic specialists to all levels of the health system and ensuring their equitable distribution at the primary level for the delivery of community eye care services. The strengthening of eye care services was only possible through the integration of eye health into government health systems, with a stated emphasis on primary health care delivery and outreach services to raise awareness of the importance of eye care and the availability of services, and to refer patients into the government health system. The inclusion of an advocacy component to encourage appropriate levels of funding for eye health within national budgets and district health care plans was greatly needed given the high reliance on external donor funding for eye care. The effective collaboration of both the SiB and EC projects also meant a geographic spanning of the entire country.

*"At that time, the central government had not designed an eye care programme - it was started here with this programme." (Sub-regional government partner)*

*"The programme has achieved many things - in the case of extension of services to places where there were previously not available i.e. Makeni there is an ophthalmologist now and some ophthalmic nurses and places far in the east and even close to Guinea. The number of eye care doctors and nurses has increased tremendously. Also, some improvements in equipment and drugs which have made the work easier. So [the project] was very much relevant." (National government partner)*

The project's focus on improving community participation in preventive eye health activities, particularly in underserved and marginalised communities, resulted in a focus on Information Education and Communication (IEC) activities and community dialogues, and comprehensive outreach screening services at both schools and in communities. The outreach aimed to raise awareness of the importance of eye health, the need for screening and the enhanced capacity of the PHUs in managing a range of eye conditions. It was highly relevant and critically important to do so as to detect a range of eye conditions requiring referral to the PHUs whilst eye care was being integrated into PHC, however, the focus now needs to be on enabling and sustaining the demand for primary eye care, which will be discussed in the Sustainability section.

The mass drug administration (MDA) programme (*ivermectin, albendazole*) for all people at risk from onchocerciasis and lymphatic filariasis (LF) was highly relevant to the Ministry of Health and Sanitation's (MoHS) agenda to continue efforts towards elimination of both diseases by 2020-2025 through the maintenance of high therapeutic coverage in districts with continued prevalence and where acceptability of the intervention is already high. The project's support to VAS for children under five, first through MDA to maintain high coverage levels, and later through its phased re-integration into the Extended Programme for Immunisation (EPI), was closely in line with the government's aim to reduce Vitamin A deficiency-associated blindness and mortality, as well as its efforts to increase EPI attendance at health facilities.

<sup>20</sup> Yumkella F, Engels T, Kamara D, Smart N, Vandy M. *Knowledge, attitude and practice (KAP) study with regard to eye health and disability in Sierra Leone: Final report*. Freetown, Sierra Leone: Ministry of Health and Sanitation, Sightsavers and Dalan Development Consultants.

<sup>21</sup> Statistics Sierra Leone (SSL) and ICF International. *Sierra Leone Demographic and Health Survey 2013*. Freetown, Sierra Leone and Rockville, Maryland, USA: SSL and ICF International; 2014.

Overall, Sightsavers' long history of working in Sierra Leone and its strong collaborations with the MoHS and other in-country partners also appeared to be influential in enabling a relevant and appropriate project design – this point was raised by a number of national level partners. The project appears to be embedded within MoHS in that its objectives are aligned with that of the government and it operates fully through the NEHP, the District Health Management Teams (DHMTs), as well as DPO networks.

*"One of Sightsavers' strengths is proactive intervention in terms of needs assessment - they are somehow focused on the main issues and can tailor that on the specific needs of the people. They need to continue that." (Donor)*

### 2.1.2. Value of the Knowledge, Attitudes and Practice (KAP) study

The KAP with regard to eye health and disability in Sierra Leone study<sup>22</sup>, was particularly useful in shaping project activities in the second half of the project. The MTR noted that as a result of the KAP study, the project will have a greater ability to understand the heterogeneity of needs within the population and more effectively focus information and awareness raising materials to encourage and support greater access to services needed<sup>23</sup>. This seemed to have been the case as the KAP study led to a broadening in project scope to include a more comprehensive focus on eye care awareness. While informants found it hard to highlight specific examples as to how particular KAP study findings fed into the development of specific approaches or tools, it appeared that the findings were used generally to develop IEC materials and activities, in that posters, radio sensitisation programmes and outreach messages highlighted the need for eye screening or testing and raised awareness of a range of eye conditions.

It was suggested by some national level informants that the KAP study, with its quality report highlighting interesting findings in a previously under-researched area, helped raise the profile of eye care in Sierra Leone and the work in general being done under the project. A follow-up KAP study is now planned in 2020, funded by Irish Aid<sup>24</sup>.

### 2.1.3. Post-Ebola context

The evaluation aimed to explore whether any changes in the context of the project, and specifically the post EVD outbreak in 2014, impacted upon the relevance of the project, and if so what measures were put in place to mitigate this. The EVD epidemic weakened the already fragile health system in the country and depleted human resources<sup>25</sup>, and had a significant impact on project implementation and achievements of targets during the main contagion period (May 2014 to August 2015) with all 14 districts in the country affected by the EVD. The MoHS was diverted to managing the crisis and the ban on public activities directly limited school screening and outreaches from August 2014 until September 2015 when they were resumed effectively. All training of healthcare workers and teachers was halted and general demand for health care services was considerably reduced as a result of fear of EVD contagion<sup>26</sup>.

<sup>22</sup> Survey data was collected in December 2013 and the report finalised in November 2015 once the EVD epidemic had passed

<sup>23</sup> Ogundimu, K. Macdonald, D. *Sightsavers Comprehensive Eye Care in Sierra Leone Project – Mid Term Review: April 2016*. Freetown, Sierra Leone: Sightsavers; 2016.

<sup>24</sup> The "Towards Universal Eye Health Services in Sierra Leone" project, implemented by Sierra Leone Sightsavers country office, spans five years from January 2015.

<sup>25</sup> Sightsavers. *Sightsavers Sierra Leone Country Office: Ebola Viral Disease Update, July 2015*. Freetown, Sierra Leone: Sightsavers; 2015.

<sup>26</sup> Ogundimu, K. Macdonald, D. *Sightsavers Comprehensive Eye Care in Sierra Leone Project – Mid Term Review: April 2016*. Freetown, Sierra Leone: Sightsavers; 2016.

While the EVD clearly and understandably slowed project progress and achievement for around one year, there was a general consensus that the post-EVD context actually made the project more relevant. This was largely due to the large number of EVD survivors suffering from visual complications, in particularly uveitis<sup>27</sup> which anecdotally is estimated to affect up to 60% of survivors, and (to a lesser extent) hearing impairments<sup>28</sup>. While project funds could not be reallocated due to existing commitments, Sightsavers used unrestricted funds to expand the outreach services to enable specific targeting of EVD survivors to enable referral as needed to clinics for assessment and care, and for health worker training, including at the PHU level, in the diagnosis and management of uveitis, a previously rarer condition in Sierra Leone.

*“Eye care was generally swept aside by the more immediate needs of Ebola because Ebola was something that was alien and people had to deal with it. But during the recovery stage, eye care was prioritised because a lot of people had ocular implications. So it was a priority and there was a lot of pressure on us to act, and that’s when we really saw the usefulness of partnership and coordination.” (SLCO)*

At the national level, the EVD outbreak laid bare the weaknesses of the health system and this has led to institutional and system improvements, such as laboratory preparedness, and strengthened surveillance and health worker safety, which Sightsavers has been able to support as a key partner. Some informants also commented that the EVD led to an enhanced general focus on community engagement in Sierra Leone, which has also had an effect on strengthening the community engagement component of this project. The project IEC materials were also first distributed at a time when there remained a lot of sensitisation around the EVD epidemic which not only meant that there were various EVD discussion platforms into which eye care could be integrated, particularly relevant for EVD survivors (given some were developing related eye complications), but that people were also at that time generally receptive to health-related messages.

*“After Ebola, this community engagement has been intensified - previously it was more of hospital-based, now we talk of community health workers, patient safety and the communities themselves. For me, I’m happy because I have been telling them - it doesn’t matter how much you put there, because if the community doesn’t know about it, they are not going to use it. We have structures in the community - if we can go to these leaders and can convince them and be on our side, so when we are not there, they can speak to these people. But we need to go there sometimes. We need to get these leaders to talk technical.” (National government partner)*

*“The IEC posters were finalised when there was still lots of sensitization about Ebola so we would also bring eye health into that and use it as an opportunity to sensitise. People were listening well to health problems at that time after Ebola, so if we discussed problems with eyes, they were like, ‘wow’. So people thought, before I get problems, let me come forward. After Ebola, everyone wanted to hear about health issues.” (SLCO)*

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<sup>27</sup> Uveitis is the inflammation of the uvea, the pigmented layer that lies between the inner retina and the outer fibrous layer composed of the sclera and cornea. The condition is generally considered to be an ophthalmic emergency and requires a thorough examination by an optometrist or ophthalmologist and urgent treatment to control the inflammation.

<sup>28</sup> SLCO Ebola Viral Disease Update, July 2015. Other complications experienced by as part of ‘post-Ebola syndrome’ include physical weakness, joint pains and mental health issues.



## 2.2. Effectiveness

**Rating: Satisfactory** 

The project targets, some of which were revised following the MTR, were considered realistic, and have mostly been met, and in some cases, have been exceeded. Significant gains have been made, most noteworthy as relating to human resources for health, the introduction of eye health indicators into the Health Management Information System (HMIS) and enhanced access to care and empowerment among people with disabilities, and the high coverage of Vitamin A Supplementation through MDA and recent progress in its integration into EPI. Key challenges do remain, such as inequity in the distribution of ophthalmic workers, continued low capacity at the PHU level, the unreliable drugs supply, and ensuring data quality through HMIS, but these reflect the broader challenges of the health system context and the project has made good progress in attempts to address them. Assessment of project effectiveness at the impact level is challenged by a lack of impact and outcome data and the measurement of outputs hampered by the lack of consistent monitoring documentation against the logframe.

### 2.2.1. Project achievements

#### *Impact*

According to the logframe, assessment of overall impact was planned to be measured in terms of prevalence of avoidable blindness (targeting 3% prevalence among 50+ age group), government spend on eye health (targeting 5% additional spend by Government on eye health) and access to quality eye health services (targeting 2.3 million people). However, survey data, on which the measurement of impact was due to be based, was not collected (and a follow-up RAAB study is not yet planned) so this effect must be considered based on output data (see below) and from the qualitative data collected as part of this evaluation (and discussed in detail in the Impact section). While no data was available to formally assess change in government spend on eye health, anecdotally it appears that over the course of the project, the government has not increased its financial contribution, with all public eye care services continuing to be fully funded by external donors, beyond the salaries of public health care workers which are government-funded. This will be discussed more in the Sustainability section. Access to quality eye health services is also not defined in the logframe, and the data source, listed only as NEHP reports, is unspecific. 'Access' refers both to quality of eye health services available and feasibility of access. The project appears to have had a significant impact in terms of improving the quality of eye health services given the range of health workers trained and deployed at different levels in the 14 districts across the country, including at the PHU level, which improves community accessibility. The extensive conduct of outreaches and school screening have also supported access at all levels, and patient care costs especially for women and the elderly have been funded under the project. Whilst not without challenges, there has also been an improvement in availability of simple drugs and consumables for simple eye diseases. All these aspects of project will be discussed separately in the sections below.

## *Outcomes and outputs*

Inherent challenges with the project logframe meant that, performance was not routinely tracked against the logframe. This created a challenge with the quantitative measurement of effectiveness. Inherent problems included inconsistencies in wording of indicators, lack of indicator definitions, low potential measurability of some indicators, insufficient linkage between indicator and data source, and some gaps in assigning targets. The actual wording of indicators and level of data aggregation/disaggregation used across the logframe narrative reports and MTR also varied, making assessment of project effectiveness difficult (e.g. “staff trained” without specific cadres specified, and in another document, individual cadres were specified without being linked specifically to the aggregate of “staff”). A large number of data sources was also specified which may have complicated and overwhelmed data collection activities and it is not clear whether there were specific efforts to collect, aggregate and review data from some specified sources such as health facility records and government reports.

While comprehensive quantitative assessment against the logframe was challenging, monitoring efforts have concentrated on all key service related activities, including surgeries and medical interventions conducted, screening and outreach activities, health education activities and health workers trained. Table 4 provides a summary of achievements against these key output areas (progress against specific outputs has not been reported here due to space limitations, though are available from the SLCO). As can be seen from the table, most of the output areas exceeded targets. For example, medical interventions notably exceeded their targets. This could have been a consequence of targets being set too low due to the lack of HMIS data to inform them during the planning stages and, being a broad indicator, it may have included a larger range of interventions than had previously been anticipated. Nevertheless, the conduct of a larger number of medical interventions than targeted implies an increase in access and uptake of eye care services across the health system over the course of the project. Also, the number of children benefiting from VAS surpassed targets considerably, particularly important given its integration into EPI over the course of the project (to be discussed in more detail in the VAS section). Where outputs did not quite meet targets, as relating to surgical interventions and health worker training, the variance was marginal and achievement still impressive.

Gender analysis of the targets broadly suggests that it was expected that men would outnumber women considerably in terms of reach across most output areas. In fact, either the gap between men and women reached was less than expected or women outnumbered men, which was the case for medical interventions, screening and refraction, health education and indirect beneficiaries and VAS, suggests higher gender equity in access than anticipated. While there is more gender imbalance with regards to health worker training, with considerably more men than women being trained across the health system, the gap was less than anticipated.

**Table 4: Project achievements against key output areas**

Performance scale  
 0-49%  
 50-79%  
 80-100%



Output areas (totals)	Including	Cumulative planned outputs 2012-2017			Cumulative actual outputs 2012-2017			Performance (% of planned outputs met)			% Beneficiaries	
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
Surgeries	Cataract surgeries and other surgical interventions, surgery follow-ups all for adults and children	7,861	6,646	14,507	7,127	6,708	13,835	✓ 91%	✓ 101%	✓ 95%	52%	48%
Medical interventions	At all levels of the health system for adults and children	93,256	86,582	179,837	394,750	407,891	802,641	✓ 423%	✓ 471%	✓ 446%	49%	51%
Screening	School-based, refractive error screening, general for range of eye conditions	242,031	547,942	789,973	443,993	449,925	893,918	✓ 183%	✓ 82%	✓ 113%	50%	50%
Refraction	Refractions and prescriptions, spectacles supplied/ dispensed, low vision devices provided, all for adults and children	28,356	24,817	53,173	29,081	29,708	58,789	✓ 103%	✓ 120%	✓ 111%	49%	51%
Health education and indirect beneficiaries	Direct one to one counselling, people reached through targeted health education (i.e. community meetings, schools, clinics), estimated to be reached through mass media	1,740,910	1,739,438	3,480,348	1,428,442	6,270,202	7,698,644	✓ 82%	✓ 360%	✓ 221%	19%	81%
Health worker training	Ophthalmologists, optometrist assistants, ophthalmic equipment technicians, OCHOs, ONs, low vision staff, PHC cadres, CHWs, teachers	95,807	8,992	104,555	69,735	23,607	93,342	○ 73%	✓ 263%	✓ 89%	75%	25%
Vitamin A supplementation	All children having received	212,000	212,000	424,000	825,949	848,530	1,674,479	✓ 390%	✓ 400%	✓ 395%	49%	51%
Average								192%	257%	210%	49%	51%

### Key areas of achievement

Key project achievements will be briefly discussed here in terms of their connection to the overall project objectives, though discussion will continue in further detail in sub-sections below.

The focus on building human resources for eye health appeared to result in significant gains in terms of the quality, scale and equity of eye care service delivery. Prior to the project, clinical eye care was largely limited to the towns and big hospitals, whereas each district now has at least one ophthalmic specialist (ophthalmologist, cataract surgeon or Ophthalmic Community Health Officer [OCHO]), with most districts having cataract surgery capacity, and all PHU staff have been trained in basic diagnosis and management of common eye conditions, according to project reports and discussions with key informants, - although refresher training is now needed. More clinical workers have been encouraged to specialise in eye care/ophthalmology and a steep rise in numbers trained has been seen. There is more to do in this area, and the gains need to be sustained, but the progress made under this project has been significant and this was recognised across all key informants.

Eye health in general appears to have been well integrated into the government health system at the national, district, primary health care, and to some extent community, levels. An Eye Health Policy and a national human resourcing plan which incorporate eye health now exist, both of which were spearheaded and developed with support from the project. There is an eye health focal person in each DHMT, introduced under the project, who leads and promotes the active engagement of the DHMT in all eye care activities across the district. PHU capacity has been raised across the country and eye care is being integrated into the new Community Health Worker (CHW) curricula which has begun to be rolled out; Sightsavers under this project have played an active role in developing the eye care component in coordination with the NEHP and other partners in line with expected capacity of CHWs and support available from the PHU level. After considerable lobbying and planning efforts under the project, four overall eye health indicators will now be integrated into the new HMIS which will enable the planning and review of services based on actual eye care data from the primary level upwards (expected by December 2017).



The output data and discussions with key informants suggest that there has been a steep rise in the number of eye conditions detected and being managed and treated at levels of the public health system over the course of the project. This is also supported by a review of outpatient registers at the national referral hospital and at eye clinics at the regional and district hospitals visited (this was harder to explore at the PHU level given the fewer number of cases and the lack of eye health indicators). Prior to the project, outreach was minimal but community mobilisation has received considerable investment under the project which has raised awareness of the importance of eye health, screening and common eye conditions. The CHW network is well placed to continue this effort, though challenges remain in enabling access into the health system for people in poor and rural communities.

*"Before people would just come and do what they want to do. Now there are policies, procedures and expected ways of doing things." (National government partner)*

*"Eye care is now a force" (Sub-regional government partner)*

## 2.2.2. Factors driving project success

This section discusses some key factors that appear to have contributed towards project success. Factors that led to lack of project success, particularly challenges to implementation or to sustaining outcomes are discussed in specific sections as relevant in this Results chapter.

First, Sightsavers' reputation in Sierra Leone is very high, built up over many years of engagement and hard work, and buttressed by skilled, committed staff. Sightsavers is widely respected and regarded within the MoHS. Some of that can be attributed to their longevity; unlike some International Non-Governmental Organisations (INGOs), they have been around for decades, they are extremely well integrated and understand systems and realities well. In many ways, they are seen as part of the fabric, and this brings two challenges. It risks dependency being developed, albeit inadvertently (Sightsavers' office move out of Connaught Hospital has helped in that regard, even though it was for reasons of staff safety during the EVD outbreak); and it can mean that for beneficiaries commenting on a specific project is difficult as from their perspective Sightsavers' work is simply part of the landscape. However, it does mean they are included and involved in ways not always achieved by INGOs. Their participation in task forces, working groups and the like, with different branches of government as well as local and international civil society is not just welcomed but actively sought out, one result of this being that project design is from a position of deep strength of understanding.

Second, these good relations and the respect in which Sightsavers is held enables them to develop programme plans and projects in collaboration with and alongside government and other NGOs, including the identification of priority areas for project focus, rather than in isolation. Such a position does not guarantee success, but it does increase the likelihood that any design will have been built around a deep knowledge of the situation and where the potential for collaboration exists, with each stakeholder playing to its strengths and contributing the different skills and experience, thereby creating opportunities for synergy.

Third, the approach taken of seeking to integrate eye care into the wider health system has started at least to mainstream it, even within the human resourcing plan, and has brought both greater efficiency and better use of resources, such as attaching eye health to an existing DHMT focal person, incorporating eye health into district level support supervision, and the sharing of vehicles provided under the project for integrated support supervision activity. Additionally, this approach has expanded the availability of eye health care to a wider population.

## 2.2.3. Application of learning from monitoring and evaluation activities

### *Project monitoring*

Monitoring data was used to develop ad hoc presentations for partner audiences at national level with the aim of sharing and discussing project progress. It has also been used to develop other proposals, such as the successful Irish Aid proposal, as well as to reflect on lessons learned. While the project did not consistently and systematically monitor data as it relates to the logframe, and there is no evidence that an alternative formal internal monitoring system existed, SLCO's in-depth knowledge of project progress suggests that they have been tracking project performance in some way, at least sufficiently to enable reporting to the donor to a standard which was deemed to be satisfactory by Sightsavers and the donor.

### *MTR*

The Mid-Term Review<sup>29</sup>, conducted by an internal Sightsavers team and submitted in April 2016, reviewed and assessed the effects and impact of the EVD outbreak on project progress and implications for resumed project activities, and made recommendations on adjustments and adaptations to activities and targets for the remainder of the project period. The MTR was slightly delayed due to the EVD outbreak and as such, the project just had one year to implement its recommendations, all of which were accepted by the Sightsavers management team. Broadly, progress made against the MTR recommendations, as summarised in Table 5, has been very good with action plans mostly completed against all recommendations, an exception being for an assistant manager to join the NEHP to provide administrative support to the programme and enable the Programme Manager to dedicate more time to specialist clinical work: this did not happen. A number of informants agreed that the MTR provided an important opportunity to collaborate and reflect with partners over the progress so far and remaining work to be done and required strategies.

According to a SLCO representative:

*"The MTR was very useful. [It] came at a useful and opportune time, just after Ebola. It was a way to sit and reflect what can be done and how can we salvage the project after Ebola. At that time, we were about 45% success rate so we needed to do so many things. So the recommendations were very relevant - more money, a focus on outreach. There was a lot of need to bring people into services."*

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<sup>29</sup> Ogundimu, K. Macdonald, D. *Sightsavers Comprehensive Eye Care in Sierra Leone Project – Mid Term Review: April 2016*. Freetown, Sierra Leone: Sightsavers; 2016.

**Table 5: Progress against MTR recommendations**

#	MTR Recommendation (April 2016) <sup>30</sup>	SLCO Management response (October 2015 action plans)	Evaluator's assessment of progress by end of project
1	It is recommended that an assistant manager, preferably a person with some management/finance skills joins the NEHP Coordinator to form a management team to support the programme	<ul style="list-style-type: none"> <li>Advocate with the Chief Medical Officer &amp; Director of Primary Health Care to make the NEHP a full programme and allocate appropriate staff to provide support</li> </ul>	This has not happened.
2	In order to strengthen human resources for health, the MTR recommends that the national human resourcing plan for eye health be reviewed by partners and placed within the human resources for health plans with a road map for the next 10 years aimed at achieving geographic coverage, meet the needs of the eye health facilities and at least minimum recommended ratio's and equitable distribution	<ul style="list-style-type: none"> <li>Advocate for the review of the HREH plan and support its development</li> <li>Work on the existing document to capture issues in the recommendations</li> <li>10-year plan finalised</li> </ul>	This has happened, with eye health included in a wider human resourcing plan approved and since launched by the MoHS, as evidenced by the Human Resources for Health Strategy 2017-2021 and the Human Resources for Health Policy 2017-2021.
3	Progress towards implementing the recommendations from the Connaught Hospital QSAT should be done and outstanding recommendations implemented by partners with support from the Country Office. Similar principles should be applied where relevant in other eye health facilities as well.	<ul style="list-style-type: none"> <li>Work with Western Area Eye Care Project to finalise recommendation in QSAT report</li> <li>Conduct QSAT for at least two Eye Departments</li> </ul>	The Connaught Hospital QSAT has been closely followed up and all recommendations achieved, including a refurbishment of the theatre (funded by the Latter-Day Saints).
4	Greater attention must be paid to thorough maintenance of all clinical equipment, and ensuring adequate numbers of well-trained technicians are in place by partner facilities.	<ul style="list-style-type: none"> <li>Three relevant eye care staff should be trained on maintenance of equipment where there is no Maintenance Officer (two-three to be identified and trained where funds are available)</li> </ul>	The evaluation team have not seen any evidence to indicate that this training has taken place.

<sup>30</sup> Level of priority, responsibilities and timelines associated with each of the MTR recommendations have been removed here for space reasons but can be found in the MTR reports.

#	MTR Recommendation (April 2016) <sup>30</sup>	SLCO Management response (October 2015 action plans)	Evaluator's assessment of progress by end of project
5	A full listing and review of existing and faulty equipment should be carried out collaboratively across all provinces by hospital partners to identify gaps and needs, especially regarding cataract sets.	<ul style="list-style-type: none"> <li>A review of the inventory will be done to ascertain the usefulness of the equipment</li> <li>Orders have been put in and funded by Sight savers for some equipment for the NEHP (Government supported eye care projects)</li> </ul>	This list was done and re-ordering is underway, with some equipment having already arrived.
6	Where not in place already, hospital partners should establish a sound procurement planning and inventory system which includes a strategy for budgeting and resourcing.	<ul style="list-style-type: none"> <li>Advocate with MOHS to include orders for essential equipment in its procurement</li> <li>Provide Eye Care Managers with MOHS procurement guideline</li> </ul>	Procurement is done nationally for government hospitals. Eye care drugs are included in the essential drugs list.
7	For improved integration of eye health into existing PHC systems, recording of eye health patients and treatments must be systematically incorporated into monitoring systems and checklists at the earliest opportunity	<ul style="list-style-type: none"> <li>Advocate with the Director of primary health care and planning for the inclusion of eye health indicators into MOHS reporting forms</li> <li>NEHP to provide MOHS directorates with Indicators</li> <li>Prepare the forms and train PHC staff to include and collect data on additional indicators and monitor its collection and documentation.</li> </ul>	Four overall indicators have been agreed and approved for inclusion in the HMIS. These are focused on cataract, glaucoma, low vision and refractive error (see section below for specific details). The eye infection indicator will also remain – this was the only eye health indicator in the patient register at PHU level. The NEHP has developed a reporting form for the community level which includes these indicators and will be adapted for use in the revised HMIS forms which will be rolled out from PHU level upwards. Training on the of the new HMIS and related forms, which will link to the new electronic District Health and Information System 2 (DHIS2) has been initiated but is not yet completed. It is hoped that this may be operational by the end of this year. An additional two-day training is planned for PHU staff to (refresh) train them on the diagnosis and management of eye infections/ conditions.
8	In the longer term to strengthen integration, PHU staff require longer and more systematic training with strong supervision to ensure skills and competencies are embedded in daily practice. It is likely that this will need to be done beyond the project life time	<ul style="list-style-type: none"> <li>NEHP &amp; Sightsavers to develop a strategy on taking this forward in the next phase of the eye health project implementation</li> <li>Implement strategy and monitor its implementation</li> </ul>	Training is now better structured according to the level of the health worker. The importance of continued training for PHU staff is recognised. A two-day (refresher) training on the diagnosis and management of eye infections/ conditions is being planned.

#	MTR Recommendation (April 2016) <sup>30</sup>	SLCO Management response (October 2015 action plans)	Evaluator's assessment of progress by end of project
9	Targets and strategies for cataract are agreed as soon as possible, and any necessary funding required allocated. Strategies such as outreaches to capture those with cataracts for free surgeries for the most vulnerable particularly women, children and the elderly will be explored	<ul style="list-style-type: none"> <li>• Targets have been agreed</li> <li>• Eye care partners to step up screening and outreaches</li> <li>• Increase sensitization and awareness raising campaigns</li> <li>• Additional funding provided for screening and outreaches</li> <li>• Develop and implement strategies on free cataract surgeries for the most vulnerable</li> </ul>	The 'Patient Care' fund covers some of the costs for operations for those who cannot pay and are not covered under the Free Health Care Initiative (FHCI), though how this budget line is used varies by hospital/ clinic. Some hospitals/ clinics adopt a 'pay as much as you can afford' approach, with the understanding that they don't want to turn any patients away who cannot afford treatment. Intensified outreach has led to higher numbers of cataract surgeries though many people still face access challenges, due to poverty and their remote location.
10	A review of the challenges to providing refractive error services within the project is undertaken by partners and project staff in order to develop an action plan for addressing overall low outputs across the project period to date.	<ul style="list-style-type: none"> <li>• Organise a meeting to look into this challenge</li> <li>• Develop a plan to address the way forward including options of reducing the target or additional funding for meeting the target</li> </ul>	Data is collected on the number of people screened and tested for refractive error, but follow up referral uptake and therefore spectacles dispensing has remained low as the costs remain prohibitively high for most people. A plan to address this challenge is still needed.
11	That the target for dispensing of LV devices is adjusted downwards to reflect the feasibility of what may be able to be achieved in the remainder of the project term.	<ul style="list-style-type: none"> <li>• Targets have been reduced by half to reflect what the team might be able to deliver by the end of the project.</li> </ul>	Target reduced.
12	In the light of the learning about new strategies for types and targeting of IEC materials, as a result of the KAP study, the current associated outputs may need to be reviewed and any relevant adjustments made on how this area of work will be measured as these plans move forwards	<ul style="list-style-type: none"> <li>• IEC materials are being developed. Pretesting of these materials is in progress. Based on outcomes of the pre-testing more printing of IEC materials will be done.</li> <li>• PHU staff have been trained to use these materials and to note any learning coming from their use.</li> </ul>	IEC materials were produced and distributed, with support from a communications agency. The SLCO staffs' perspective, based on their own insight, appears to be that the IEC materials, specifically posters, have been effective in raising awareness of the importance of eye health, when to seek eye care and in the need for social inclusion of people with disabilities. According to SLCO staff, the KAP findings were especially useful in shaping messaging and image decisions for the posters. No evidence was available to suggest further use of KAP findings as relating to broader communication approaches, though there may have been other cases where KAP findings were applied. A review of the effectiveness of any specific communications activity is beyond the scope of this evaluation. Neither a project specific or SLCO programme wide communications strategy was seen.



#	MTR Recommendation (April 2016) <sup>30</sup>	SLCO Management response (October 2015 action plans)	Evaluator's assessment of progress by end of project
13	The project logframe should be reviewed by project staff, with support of Sightsavers global staff, at the earliest opportunity to identify clearer indicator definitions and in some cases alternative means of indicator verification, especially at impact and outcome levels where current means of verification may no longer be available/possible to collect.	<ul style="list-style-type: none"> <li>A thorough review of the logframe will be carried out to assess the practicalities of measuring some of the indicators earlier proposed.</li> <li>This will be followed by identification of clearer and more realistic indicators at outcome level</li> </ul>	The logframe was reviewed following the MTR, with a focus on the revision of targets downwards against some specific outputs. There are still limited options in terms of indicator verification at the impact and outcome levels however, and indicator definitions are not always clear. The logframe would have benefited from a more thorough review so as to facilitate more efficient monitoring against the logframe.

## 2.2.4. District level advocacy

The project aimed to develop joint district level advocacy plans by all project partners, to influence integration of primary eye care in the Basic Package of Essential Health Services (BPEHS). However, no internal or external advocacy plans were available for review, making assessment of progress against plans challenging. Rather, the integration of primary eye care into the BPEHS seemed to be an overall project objective, reflected in a range of project documentation.

## 2.2.5. Human resources for eye health

As already highlighted, a key project achievement is undoubtedly its contribution to the strengthening of the national health system through the training and deployment of eye health professionals at all levels of the health system, despite the break in health worker training due to the EVD outbreak. Specific outputs against targets as relating to health worker training across the health system have already been discussed in the outcomes/outputs section above.

Tables 6 and 7 look beyond specific project outputs to summarise overall achievements, gaps and targets for ophthalmic orientated health workers in Sierra Leone more broadly, based on review of reports, discussions with key informants and plans as outlined in the National Eye Policy<sup>31</sup>. The vast majority of ophthalmic workers, as listed below in Table 6, have been trained under the project over the last five years.

<sup>31</sup> Ministry of Health and Sanitation (MoHS). *National Eye Health Policy Sierra Leone: Towards Attaining the Highest Standard of Eye Health for All People in Sierra Leone*, June 2017. Freetown, Sierra Leone: MoHS, Government of Sierra Leone; 2017.

**Table 6: Human resources for eye health: project targets and achievements**

Performance scale

0-49%

50-79%

80-100%

Outputs	Cumulative planned outputs			Cumulative actual outputs			Performance (% of planned outputs met)			% Beneficiaries	
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
PHU staff	1,948	2,380	4,328	1,776	2,282	4,058	✓ 91%	✓ 96%	✓ 94%	44%	56%
Ophthalmologists trained	1	0	1	1	0	1	✓ 100%	N/A	✓ 100%	100%	0%
Ophthalmic Community Health Officers trained	6	6	12	16	2	18	✓ 267%	✗ 33%	✓ 150%	89%	11%
Ophthalmic Nurses trained	6	6	12	10	13	23	✓ 167%	✓ 217%	✓ 192%	43%	57%
Community Health Workers (teachers, Vaccinators CDDs, etc.)	93600	6600	100200	67920	21306	89226	⚠ 73%	✓ 323%	✓ 89%	76%	24%
Optometrists/optometrist assistants	0	0	0	0	1	1	N/A	N/A	N/A	0%	100%
Low vision staff	1	0	1	11	3	14	✓ 1100%	N/A	✓ 1400%	79%	21%
Eye care equipment technicians trained	1	0	1	1	0	1	✓ 100%	N/A	✓ 100%	100%	0%
<b>Average</b>							<b>271%</b>	<b>167%</b>	<b>303%</b>	<b>66%</b>	<b>34%</b>

**Table 7: Human resources for eye health achievements, gaps and targets – selected cadres for which data is available**

Health worker cadre	Key competencies	Vision 2020 ratio target	Equity in distribution	Number needed for Sierra Leone*	Number now	Gap remaining
Ophthalmologist	Leadership, range of surgery	1/1 million (or 500,000)	At least 2 in each regional hospital (or 1 ophthalmologist and 1 cataract surgeon), with 6 at national referral hospital, of whom 3 are sub-specialised	7 (or 14)	4 (+1 in training)	3 (or 10)
Cataract surgeon	Cataract surgery	1/250,000	1 per district	28	9	19
Ophthalmic Community Health Officer	Diagnosis, treatment and referral	1/100,000 / 250,000?	2/3 per district	28	18 (+ 6 in training)	4
Ophthalmic nurse	Diagnosis, treatment and referral	1/100,000	2 per district	70	56 (7 in training)	14

\*based on seven million population.

As is clear from Tables 6 and 7, despite considerable gains and overall impressive achievement against project targets, the Vision 2020 targets for human resource per million populations are still some way from being met. There is more to do to improve the number and skills mix of eye health workers and from discussions with key informants and general review of literature, including the MTR report and project reports, their distribution remains somewhat skewed to urban centres (mostly provincial capitals) affecting rural service delivery. While integration of eye care into primary health care has been a big focus of the project, and according to project reports, all PHU staff were trained in eye care at the start of the project, the quality in service delivery at this level remains hampered by irregular availability of drugs and supplies, challenges in locating staff in remote PHUs (given the lack of available incentives, allowances or accommodation), and a lack of regular intensive follow-up on trainings through supervision for PHU staff, according to both PHU based health workers and DHMT members. It is likely that these supply side factors continue to affect general patient flow to health facilities (though demand side factors are significant as already discussed in section 2.1.1), as well as the filtering of cases at the primary level so to avoid simple cases dominating specialists' time at the secondary and tertiary levels – though it is recognised that this will take time to impact.

*"At the referral hospitals, you get patients with a simple headache or red eye, so many of them - we even have to turn some patients away. We need to build up the lower levels to enable treatment and management at the appropriate levels. As soon as you put an announcement on the radio then the number coming also rises exponentially. Also outreach increases the number of patients coming." (Health worker)*

*"When you see them trained, that is one thing, all of them in chorus. Then when you go to the facility, you see something different. The project did not capture enough follow-up, mentorship - that is what we are realising. If you are just training and stop, then you stop there. You need to make sure that if you want them to implement it, then you need to make sure there is follow up and that people have really grasped it." (Sub-regional government partner)*

For those who have been trained, there is a considerable resource need for ongoing effective support supervision, mentorship, refresher training, as well as replacements as staff approach retirement age. As deduced from a number of discussions with health workers, DHMT members and SLCO staff, the level of support supervision at different levels of the health system varies according to district capacity and mobility opportunity. At the PHU level, support supervision can take place from every ten days to every two months and from the national level to regional and district levels, approximately every quarter, if funds are available. While no documentation was available to explain more comprehensively the scope of support supervision activity, it seems that the focus tends to be on review of registers and drug stocks and general functionality of the facility, rather than observation of staff management of patient cases, though understandable given time constraints and the integrated nature of the support supervision. The person in-charge from each PHU also reportedly visits a district level meeting each month to discuss performance issues and any relevant updates to health service delivery – this seems to be useful for motivating performance in a peer review/competitive context. There was no discussion or report of formal refresher training activities or any mentorship activities which would be useful, and information cascade is seemingly down to individual inclination. However, a two-day PHU level training curricula on the diagnosis and management of common eye conditions is currently being adjusted by the NEHP from the initial PHU level training conducted under the project, with the aim of rolling it out across all PHUs<sup>32</sup> by the end of the year.

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<sup>32</sup> Funded by the Irish Aid project.



Management and coordination demands on both ophthalmologists and cataract surgeons continues to present a challenge in terms of time available for specialist clinical eye work, with two ophthalmologists (national level and Northern province) and three cataract surgeons (Southern and Eastern provinces and Western Area) also operating as eye care programme managers at the provincial or national level. As mentioned above, the MTR recommended an assistant manager join the NEHP to alleviate this burden, but this has so far not happened.

The project has facilitated the introduction of the OCHO cadre at the primary care level, who are selected Community Health Officers (CHOs) who receive an additional eighteen months of ophthalmic training (in comparison to the 15 weeks received as part of CHO training), which is based on one year of teaching and six months of supervised vocational training back in your district. Twenty-three have been trained since 2013/14 under the project; individuals are selected by DHMTs based on having worked for two years post CHO training, the location and size of the catchment population of their PHU, as well as the performance of their PHU and individually. While the deployment of this mid-level cadre has helped to enhance eye care within primary health delivery and to bring cases into the system, the cadre remains limited (far below the initial three OCHOs per district target) and unevenly distributed (some districts have one OCHO, some have three, according to SLCO staff). In fact, rather than prioritising the remoter areas, it is considered that taking one of the CHOs out of service for training from a PHU in a hard to reach area would be too detrimental to ongoing service delivery where staffing limitations already exist.

*"Some districts have a constraint - they have a lot of health centres where they don't even have CHOs to take care so they have nurses and other cadres. These are in hard to reach areas - and so the DHOs don't want to lose them. So these ones need to be targeted instead with the usual training cascade." (Health worker trainer)*

While the intention with the OCHO cadre was that they would go on to train and support other staff in their PHUs in eye care, how much this has happened has seemed to depend on the individual, time and patient flow, as well as support and encouragement from the DHMT. The changed status of the OCHO can also be a challenging challenge in that in some cases, they expect to return at an elevated level to a CHO and not do the full range of work they used to do; this can also be demotivating for the CHOs. The MTR raised uncertainty around the effectiveness and cost effectiveness of this approach as distinct from the approach of training all CHOs to provide integrated eye health care<sup>33</sup>; while this discussion has not yet been resolved, with the closure of this project, the availability of donor funding to continue training OCHOs in any case does not exist. While OCHO training will remain feasible if the individual has the funds or scholarship support, the current plan is to integrate ophthalmology into the three-year BSc Community Health programme. This is seemingly welcomed from the perspective of integrating ophthalmology training with other specialities, but there are concerns as to how much this will translate into raised skills in eye care operating out of PHUs, and how many graduates will actually go on to specialise in eye care when they haven't been targeted specifically for ophthalmology training.

The challenge in attracting health workers to ophthalmology as compared with other sectors, such as obstetrics and gynaecology where there are opportunities for comparatively more financial reward, is ongoing though has been specifically targeted under the project through awareness raising efforts, such as in schools and training institutes and existing ophthalmologists have been encouraged to give guest lectures in universities. According to SLCO and NEHP staff, this has had some positive effect in that recruitment into ophthalmic nursing and ophthalmology specific courses has increased

<sup>33</sup> Ogundimu, K. Macdonald, D. *Sightsavers Comprehensive Eye Care in Sierra Leone Project – Mid Term Review: April 2016*. Freetown, Sierra Leone: Sightsavers; 2016.

over the project. As more ophthalmic specialists are deployed throughout the health system, this will offer further opportunities to observe, learn and be mentored which may continue to stimulate recruitment. Training capacity is also set to increase with Connaught Hospital now being upgraded to a teaching hospital through a collaboration with six hospitals in Freetown and affiliated hospitals in the regions, including Njala University in Bo which is set to become a medical university with an ophthalmology department. While this is not the result of any specific initiative under the project, it is no doubt that it is only possible as a result of the project's emphasis on human resource development for eye health and the prominence eye health has been given through the project.

*"Before this project, you would find few doctors and nurses interested in going into ophthalmology- but there was a specific aim in project to raise this awareness. We targeted science based secondary schools - seven or eight of them - and talked to them about the opportunity of doing other things outside the usual clinical stuff and ophthalmology. I am pretty sure we have more and more ophthalmic nurses going into the programme now." (Health worker)*

*"We need to attract more people to ophthalmology. We don't really have a vehicle full time [for eye care at this hospital]. Students will say ah, but there is no money in ophthalmology - obs/ gyn, those places are where you can make money. There is no money in eyes because of what we are dealing with. So you need to attract students in other ways - they need to at least see life is at least comfortable." (Health worker)*

Politics around task-shifting, however, continue to exist, which may affect other proposed adjustments to introduce additional tasks to certain cadres as eye care continues to be integrated across the health system and service capacity boosted. This challenge is conveyed well by a government partner representative:

*"The IAPB suggests that we need to train nurses to do cataract surgery. But in eastern Africa, they are not training them, they are training clinical officers to become ophthalmic clinical officers and then they can learn the cataract surgery. But we did not have many clinical officers in Sierra Leone, so we decided to train the nurses, but there has been resistance here - people have been saying that nurses are not allowed to do surgery. That we need to train more ophthalmic clinical officers in cataract surgery – we have trained 18 of them but now we don't have enough - and the fight about nurses carries on. We don't have the human resource as a small country, so we have to train other people like nurses - task shifting. I am not sure when we will get a breakthrough." (National government partner)*

PHU Case Study 1 highlights that while inequity in the distribution of eye care personnel continues to be a challenge, where specific PHUs have been targeted for capacity building, this can really boost the quality of eye care services offered at this level, though health system challenges persist.

#### **PHU Case Study 1: PHU – Community Health Centre (CHC), Kailahun district, Eastern region**

This PHU is one of five in the chiefdom with a more urban location and was newly built with donor funds following the EVD outbreak. Access for people with disabilities is good. Its catchment population is estimated at 10,034 people residing across 27 villages. The PHU is clean and organised and a neatly hand-drawn map of the catchment area including rivers, roads and forest areas, as well as graphs of recent disease incidence such as malaria and malnutrition numbers, are displayed on the wall.

While all eye cases are recorded as 'eye infection' in the outpatient register, anecdotally, the OCHO reports that the most common cases he sees are conjunctivitis, bacterial conjunctivitis and trauma, but that he also sees some cataract and uveitis among survivors. One of its CHOs was trained in 2013/14 to become an OCHO. He did his follow up training at the regional Kenema Eye Hospital, about an hour and a half away, so the District could monitor his performance. In terms of other staff, the PHU has one CHO, one midwife, three SECHNs, two MCH aides, one laboratory technician and one laboratory assistant. He believes that, *"eye care level integration into the primary care level is very much necessary. Before this point, we have had a problem with eye care, at the primary level – our nurses and midwives, they don't know about eyes."* With his training, he says he can now treat the simple cases locally: *"I treat those small infections here and the others, cataract and foreign bodies, I refer them to Kenema Eye Hospital. I tend to know when they go as the patients come back to me afterwards."* He feels his training has boosted the number of patients coming to the clinics with eye problems: *"People around here know I am trained in eye care... and they have seen me treating eye infection effectively – they go back to the community and they talk. They know they have someone here now for eyes."*



*Patients waiting to be seen at the PHU CHC (Photo credit: Clare Strachan)*

He believes equity in eye care staff distribution to be a challenge. *"While being based in the town is good because I can manage more here rather than refer them all up, this is where most of the OCHOs are - these more populated areas – there are still no eye specialists in those more rural areas."* Though he believes the CHWs will serve as a good tool for raising eye care awareness and boosting their outreach activities which is constrained by staff and mobility limitations, and is confident the CHWs will refer to the PHU rather than bypass, he has some concerns in that *"the CHWs will be able to treat similar cases because they should also have tetracycline – we will both be referring many of them."*

There are a range of posters on the walls, highlighting how to prevent blindness and the importance of eye testing, which have been donated by Sightsavers. No other clinical guidance is available, though the OCHO bought a book himself on primary eye care which he uses regularly. At the end of the training he was given a pen torch but it has since been lost and he has not been able to get a

replacement. There is no ophthalmoscope. At the time of the visit, drugs were not available –regular drugs consignments arrive but tetracycline has not been included for six months, which means he has recently been sending patients to pharmacies to buy the drug themselves.

## 2.2.6. Gender responsiveness

The project made various efforts to identify and respond to the different needs of women and men, even if those efforts were not always visible to external stakeholders. For instance, awareness of gender issues was evidenced in project activities such as the monitoring and evaluation protocols, output targets which were disaggregated by sex, the KAP and the MTR, and the IEC materials were designed explicitly with gender issues in mind, and women were specifically encouraged to come forward for patient care. The ‘patient care line’ of the project has also enabled direct clinical care costs, especially for women and the elderly, to be covered which has likely considerably boosted the number of women able to access care. As one member of staff put it:

*“We have encouraged more women to come (for) patient care. Also, we encourage women who have been through a cataract operation to speak to other women about it and encourage them by saying that if you don’t have it done, the man will leave you for another wife and why it will be beneficial for them. There is a lot of counselling going on (and) in community sensitizations, we will use them as role models.”*

Such encouragement is necessary given it is widely recognised that women’s health needs are often – even by themselves – not be regarded as a high priority. Instead, their health needs may be overridden by the demands on their time in and around the home, or their perception about what is ‘right and proper’, about what is acceptable for women to ask for or demand. If and when women attend health care facilities it is often, except when they are pregnant, for their children rather than themselves. There also appears to be a gender imbalance in terms of glasses wearing, with both women and men often considering glasses as a “*man’s thing*” and not necessary for women given the domestic focus of their usual responsibilities (this is discussed more in section 2.4.2). One area where this might not apply is in that of cataracts, where because of women’s productive roles they are prioritised so as not to limit their capacity to work - “*when she is better she comes to take care of me,*” as one husband said of his wife. Given the influential role men have in deciding whether women should access certain interventions, as mentioned elsewhere (see section 2.2.8 for example), it is important that men are also targeted by IEC activities promoting access and demand for care among women.

As already noted, while targets suggest that it was expected that men would outnumber women considerably in terms of health service access, in fact the gap between men and women reached was less than expected or women outnumbered men for medical interventions, screening and refraction, health education and indirect beneficiaries and VAS, suggesting higher gender equity in access than anticipated. There has been more gender imbalance with regards to health worker training though, with considerably more men than women being trained across the health system, as already reported.

## 2.2.7. Recording of eye health data

A key aim of the project, in particular since this was specified as a recommendation in the MTR, has been to facilitate the introduction of key eye health indicators into HMIS to be applied from the primary



health level upwards. Earlier this year, four overall eye health indicators which relate to the most common eye infections/conditions currently in Sierra Leone were approved (Table 8), which represents a significant achievement under the project. The new data collection system against the revised HMIS is planned to be active by the end of the year; the registers have been designed and are to be distributed once a nationwide HMIS training has taken place. The new eye health indicators relate to cataract, glaucoma, refractive error and irreversible blindness/low vision – additional ones were planned as relating to uveitis, diabetic retinopathy and retinopathy of maturity though were excluded based on the need to prioritise (that may be added in future reviews in line with evolving needs). These four indicators will be added to the current sole indicator of ‘eye infection’, which will also continue (there is no overlap with the new indicators), though was of little previous use as an aggregate given the range of conditions it incorrectly reflected. A clearer definition of ‘eye infection’ and what this includes may be useful however.

**Table 8: Proposed eye health indicators to be introduced into HMIS and DHIS2**

Eye health indicators*	Disaggregation	Frequency
Cataract		
No. cases diagnosed with cataract	Sex, age, disability, EVD survivors, complicated/ non-complicated	Monthly, quarterly, yearly
No. cataract operations performed		
No. patients +50yrs screened		
Glaucoma		
No. new cases of glaucoma diagnosed	Sex, age, disability, EVD survivors, degree of visual impairment	Monthly, quarterly, yearly
No. people treated conservatively for glaucoma (with medication)		
No. people who had glaucoma treatment procedures performed		
Refractive error		
No. people screened for refractive error	Sex, age, disability	Monthly, quarterly, yearly
No. people dispensed with spectacles		
Irreversible blindness/low vision		
No. people who received clinical low vision assessment	Sex, age, disability, EVD survivors, degree of visual impairment	Monthly, quarterly, yearly
No. people clinically diagnosed with irreversible blindness/LV		
No. people dispensed with low vision devices		
Eye infection		
No. people diagnosed with eye infection	Sex, age, disability, EVD survivors	Monthly, quarterly, yearly
No. people treated for eye infection		
No. people referred for eye infection		

\*Just aggregates for each eye condition (e.g. suspected cataract Y/N) and action taken (e.g. treatment/ referral) will be recorded at the PHU level. It should also be noted that a range of summaries of the proposed indicators were seen and as such, these indicators and their disaggregation may not completely match those which may have been finally agreed during the drafting of this report.

As with any revisions to HMIS, the process has been long and has involved many stakeholders with a range of measurement interests. It is expected that data collection against the new HMIS, including the electronic version used from the district level upwards – DHIS2 - will be active by the end of the year. Training has taken place but the revised HMIS registers have yet to be distributed.

This achievement presents both opportunities and challenges. It offers the potential for a more evidenced, up to date, regular picture on the range of eye cases seen across the health system, which will help with monitoring and planning service delivery (including outreaches), staff training and deployment, surveillance of infection outbreaks (e.g. of conjunctivitis) and referral strengthening mechanisms. It will also enable more detailed feedback on PHU performance, and is expected in time to form the basis for a pull system of supplies and medications. However, bad data is worse than no data and it is critical that the data is of a high quality to enable any use. While PHU staff have been trained earlier in the project in the diagnosis and management of a range of eye conditions, capacity generally remains low and there is an urgent need to strengthen skills in this area if patients are to receive appropriate care and data is to be recorded correctly against the indicators. This should in part be addressed by the two-day PHU training (as mentioned in section 2.2.5 above), and from the training content observed, the language is appropriately lay. However, a training plan will also need to be developed based on adult learning techniques, practical application, follow-up support supervision on an ongoing basis. The HMIS training is also expected to help in this regard.

As to whether project progress in improving the systematic integration of recording of eye health patients and treatments into PHC record keeping has had any influence on the integration of eye health into existing PHC systems more generally, it is considered too early to judge this given the new indicators are not yet in use.

## 2.2.8. Vitamin A supplementation for children under five

Since 2004, VAS has nominally been available to children aged 6-59 months from clinics, though in the years that followed, supply was not consistent, uptake remained low and Vitamin A deficiency among children remained high (reportedly around 40% prevalence). As a consequence, VAS was shortly afterwards made available to children in their communities through maternal and child health week (MCHW) events and a MDA approach. Funding available under this project has enabled this important activity to continue and VAS coverage has remained high and equitable throughout the project at over 90%<sup>34</sup>. This has helped reduce the prevalence of Vitamin deficiency to 17%<sup>35</sup>, and has likely contributed to a reduction in under five mortality from 194/1,000 live births (2004-2008) to 156/1,000 live births (2009-2013)<sup>36</sup> (most recent available data – further gains are expected to have been made in subsequent years). This achievement is considered to be the result of many factors, all directly supported by the project, including effective coordination at both national and sub-regional levels, the inclusion of hard to reach areas, social mobilization involving high-level dignitaries as well as community leaders and IEC activities such as radio jingles (though KAP study does question level of radio listenership), and daily debriefings to enable rapid responses to weak performing areas<sup>37</sup>.

However, while VAS coverage was high, there were concerns that infants who turned six months after the event may need to wait until they were up to 11 months old before they received their first dose of VAS (the first six-month contact point is a critical for the child as this is when complementary feeding tends to start and there is heightened risk of onset of Vitamin A deficiency). Also, continuing with MDA approach was expensive, posing issues for sustainability. In 2013, the MoHS and partners

<sup>34</sup> Sesay FF, Hodges MH, Kamara HI, Turay M, Wolfe A, Samba TT, Koroma AS, Kamara W, Fall A, Mitula P, et al: High coverage of vitamin A supplementation and measles vaccination during an integrated Maternal and Child Health Week in Sierra Leone. *Int Health* 2015, 7:26-31.

<sup>35</sup> Wirth JP, Rohner F, Woodruff BA, Chiwile F, Yankson H, Koroma AS, Russel F, Sesay F, Dominguez E, Petry N, et al: Anemia, Micronutrient Deficiencies, and Malaria in Children and Women in Sierra Leone Prior to the Ebola Outbreak - Findings of a Cross-Sectional Study. *PLoS One* 2016, 11:e0155031.

<sup>36</sup> Statistics Sierra Leone (SSL) and ICF International. *Sierra Leone Demographic and Health Survey 2013*. Freetown, Sierra Leone and Rockville, Maryland, USA: SSL and ICF International; 2014.

<sup>37</sup> Hodges MH, Sesay FF, Kamara HI, Turay M, Koroma AS, Blankenship JL, Katcher HI: High and equitable mass vitamin A supplementation coverage in Sierra Leone: a post-event coverage survey. *Glob Health Sci Pract* 2013, 1:172-179.

decided to refocus on integrating VAS into the routine EPI at health clinics, specifically targeting 'six-month contact points'. This project led the initiation of the integration effort through a phased approach initiated early in 2017, initially targeting three districts, with an additional four districts to be targeted every year with the aim of phasing out the MDA approach completely by 2021<sup>38</sup>. While coverage of VAS through EPI in the scale-up areas is understandably still lower than under the MDA, it is understood that this will take time and there have already been considerable improvements (reportedly from 5 to -67% over the last few months, according to project implementation staff). EPI attendance is also high in Sierra Leone, at 84-98% based on DPT3 uptake<sup>39</sup>, offering potential for further increases. Overall, the number of children who have benefited from VAS has far exceeded the target (1,674,479 children as relating to 424,000 children, as conveyed in Table 4). While this is impressive on an aggregate level, it is recognised that the remaining 'gap' relates to remote communities and mothers who may find it hard to reach the PHUs, and as such, advocacy and sensitisation activities at the community level (targeting both EPI attendance and increasing regular dietary Vitamin A intake in children) will continue to be needed, as will some outreach, particularly during the rainy seasons. It was also suggested by some key informants that men should also be targeted when promoting EPI attendance given they tend to play a significant role in deciding whether women should travel to access certain interventions. The supply chain, continuing to be funded by the Canadian International Development Agency and provided by UNICEF, will also need to adjust to routine delivery if coverage is to continue to grow and then be maintained.

PHU Case Study 2 highlights the reality of integrating VAS into EPI delivery at the PHU level, including the challenges in reaching high coverage levels and ensuring a regular supply of doses.

#### **PHU Case Study 2: PHU – Community Health Post (CHP), Makeni town, Northern province.**

The town-based PHU has a catchment population of almost 30,000 and targets 407 children under five for EPI each month. The clinic staff are proud that they usually meet their targets for EPI, which includes Vitamin A Supplementation (VAS) at six monthly contact points. They give out between 40 and 50 doses of VAS each month.

The staff believe the re-integration of VAS into routine EPI delivery is going well: *“there is a high demand now for Vitamin A. The coverage is high,”* says an ante-natal care nurse. But, they are aware that their catchment population does not face the same access issues as those in some of the more remote, rural areas: *“Some people, they are deep. Even if they know to come, how do they come?”*

<sup>38</sup> This activity will continue with funds from Irish Aid, UNICEF and the Canadian International Development Agency (who have paid for the actual supplementation over the last few years).

<sup>39</sup> World Health Organization (WHO) and UNICEF. *Sierra Leone: WHO and UNICEF estimates of immunization coverage: 2016 revision*. Geneva, Switzerland: WHO and UNICEF; 2017.



*Mothers with their babies attend a VAS health education session (Photo credit: Clare Strachan)*

There are many posters up across the clinic highlighting the importance of attending EPI, which is supplemented by active IEC activities including songs about immunisation and talks on mother and baby nutrition. The PHU is busy, full of mothers and babies, talking while babies feed, sleep and fidget; no one seems to be in a hurry. “*We like to come here,*” a mother says. While the staff are confident in the demand at the PHU, they face issues with supply - although they have plenty of supply of VAS for children aged above twelve months (“red supply” as per the packaging colour), they are running low in the stock to be given to children aged from six to twelve months (“blue supply”) and don’t know when to expect the next stock consignment.

At the moment, they are not using the new ANC registers which enable registration of Vitamin A distributed to children under five, though they are available in some PHUs, however they make their own row in the register, “*but then we are organised – maybe other PHUs may not do that*”.

## 2.3. Efficiency

**Rating: Satisfactory**



In the extreme and unprecedented context of the EVD outbreak, and its implications in terms of the MoHS and its partners having to refocus resources, time and attention away from most other routine project activities for a one-year period, delivery under the project must be considered impressive, given almost all targets were met and some exceeded. The project was appropriately ambitious but despite the fragile context of Sierra Leone, the funds were absorbed effectively. The evaluation considers the financial resources of the project to have been well managed and in line with priorities as stipulated by the project objectives. However, a ‘satisfactory’ rating has been assigned given the ineffective monitoring and evaluation of the project in line with the logframe, which has implications for the efficiency in reporting, documentation and management.



### 2.3.1. Efficiency in project delivery

The EVD outbreak that started in March 2014 was unprecedented, not just for Sierra Leone but also for the worldwide community, which meant there was no prior experience to be drawn on from anywhere. Inevitably combatting the epidemic quickly became – had to become – the only priority for the entire country. It re-focussed resource allocation, time and attention across the board to the extent that just about every aspect of life, such as commerce, agriculture and education was impacted. The World Bank<sup>40</sup> estimates the country's economy grew just over 20% in 2013 followed by a fall of 20% in 2015. In this context it is likely that any development programme would have had to be halted and adjusted, but for a project so embedded in the MoHS and its facilities, and one run from the country's main referral hospital, the effect was always likely to be massive – both for project activities and for SLCO staff and partners. To have remained resilient therefore, to have delivered the project and completed most activities as planned during the extension period warranted, and to have contributed to the post-EVD re-construction is much to SLCO's credit. One donor also reflected that it seemed unlikely that efficiency could have been improved.

There was no evidence of looking for the most cost-effective model when exploring different implementation strategies, though it is possible that this is merely not reflected on paper though given due consideration. From review of the financial reports, overall, the resource distribution of the project has been good and appropriate given priorities as stipulated by the objectives, and well-managed. The spend on outreach has been large though necessary to enable achievement of high outreach targets. It is clear this has been a big focus of the project, though outreach was intended to be a temporary measure to enable a high proportion of the population to be screened. How this spend translates into actual outcomes, however, in terms of number of people actually entering the health system for eye care, does raise the question of the cost effectiveness and sustainability of this approach. As will also be discussed in more detail in section 2.4.1, the focus on achieving high screening numbers was not necessarily consistent with the approach to build capacity among PHU level health workers and, thus, overall integration aims of the project. Though in the short/ immediate term, this spend and prioritisation was considered necessary so as to raise the awareness of the importance of eye care and the services available from PHU level upwards among vastly rural communities.

There is also no evidence to suggest that project data was analysed to see where better efficiency could be improved but again, it is possible that this effort was not documented. More funds were spent than were specified in the original budget as extra funding from Sightsavers UK covered the additional outreach work identified by the MTR, including as arising from the EVD outbreak. With approval of the donor, other budget lines were also used to support this. There was limited budget for consumables including eye ointment/drops for neonates because it was assumed that the government would fund these, though, possibly due to unprecedented circumstances, funds were not available.

The SLCO team in general is small given the scale of their work and expectation of output, and from discussions with SLCO, the project team have always been stretched. However, its design enabling implementation through MoHS and district health systems alleviated immediate project team pressure whilst maintaining implementation at scale. Reporting suggests that targets, following their revision after the MTR, were generally achieved on time. Resources were considered to be appropriately reallocated based on changing context, such as to outreach activities to screen EVD survivors for eye complications.

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<sup>40</sup> World Bank. *Databank: Sierra Leone*. Available from: <https://data.worldbank.org/country/sierra-leone?view=chart> [Accessed 23<sup>rd</sup> October 2017].

It was suggested by a donor that there were some minor issues regarding the quality of financial reporting, which were likely due to staff changes in SLCO. While there were challenges in performance management against the logframe as already discussed, this is not likely to have impacted notably on the efficiency of project delivery.

## 2.4. Impact

**Rating: Satisfactory**



Impact under the project has been impressive. Integration of eye care into primary eye care delivery has made important strides and there is increased capacity to deliver quality eye care services across the health system. Access to care appears to have improved for the population at large, including for poor and remote populations. The project is also broadly on track with elimination targets for onchocerciasis and LF. Further attention must be given to raising the eye care capacity further at the PHU level, including in remote areas, translating outreach output statistics into referral uptake, improving routine monitoring of surgical outcomes and patient follow-up, the collection of patient perception data to inform service provision, boosting spectacles dispensing and glasses wearing in response to need.

### 2.4.1. Integration of eye health into government health systems

The project has been instrumental in influencing the integration of eye health into governmental health systems over the last five years and this has had a considerable effect on service coverage, quality of eye care services and increase in both access and demand across the country. As one health worker commented:

*“Eye care was like a vertical programme in Sierra Leone before this project.”*

At the national level, the MoHS has been fully supportive and engaged in integrating eye care into government policies and planning for service delivery. Human resources for eye health are now fully integrated in broader health policies, plans and implementation frameworks, such as the overall Human Resources for Health Strategy 2017-2021 and related Policy document, DHMT management plans, and overall support supervision approaches. As previously mentioned, despite the delays in its development, the National Eye Care Policy is close to being finalised, which outlines how eye health is linked into the MoHS in terms of policy, legal and institutional frameworks, overall vision and objectives, health service delivery, skills development, drugs, supplies and equipment planning and financing mechanisms. While this is an important milestone, the extent of integration also depends on the resources and capacity to support it, which beyond Sightsavers' projects, are rather lacking. However, the fact that all ophthalmic specialists trained under the project are linked to the government payroll is an important basis for sustainability of this integration effort.

As a result of efforts under this project, all key eye care drugs, which at the PHU level includes tetracycline and eye drops for newborn babies, were for the first time included on the essential drugs list, according to SLCO staff. In 2013, a big procurement was made by the MoHS which included eye care drugs, though largely because the quantifications were based on estimates made at the central

level rather than locally developed projections, resultant mismatch between supply and demand has unfortunately led to the expiry and disposal of a considerable amount of stock. As PHU visits demonstrated, there are also ongoing challenges with a regular supply of instruments, consumables and materials (e.g. visual acuity charts), especially at the lower levels of the health system, which is meant to be supported by the government.

At the district level, important strides have been made under the project. According to SLCO staff and DHMT representatives, as well as from discussions with health workers at different levels, eye health now appears to be embedded into the District Health Programme guidelines. There is also now an eye health focal person in each district (combined with another speciality, such as HIV or malaria), all eye health trainings are led by the DHMT, and eye health is fully integrated into district support supervision activities (each PHU is meant to be visited three times per month). At monthly in-charge meetings in some districts, eye health now also reportedly has its own presentation, enabling focus on key areas for refresher training, feedback on performance and announcement of eye health related developments.

Especially in the Northern province, eye care service delivery has been considerably boosted by the introduction of a specialist eye clinic at Makeni District Hospital, managed by one of the ophthalmologists trained under the project. Substantial progress has been made since the clinic opened in May 2017, specifically, the clinic now has six dedicated staff members including one ophthalmologist and two ophthalmic nurses, two dedicated assessment rooms, two wards (though one has been borrowed back by another hospital department temporarily), one dedicated operating theatre, and a growing number of patients, up to around 25 per day. While there are still space limitations, there appears to be, according to hospital management, the political support to expand further. Over time, it is anticipated that as the local PHU level capacity in eye care also grows, Makeni Hospital may act as more of a referral centre.

It is at the primary level where there are perhaps the most gains to be made from integrating eye care into broader health service delivery, but where there are the most challenges in doing so. Very few PHUs have specifically trained ophthalmic personnel (just 18 OCHOs trained and six in training, and 23 Ophthalmic Nurses trained and seven in training, and these are inequitably distributed as discussed in section 2.2.5), and while there was some in-service training for PHU staff earlier in the project, this has been minimal compared with the need. In general, skills, experience and confidence in diagnosing and managing eye conditions is lacking among most PHU staff; more training, and intensive, practical (case-based) support supervision is needed. Outreaches are often done at the PHUs so as to encourage the flow of patients to the PHU sites and to boost a quality outreach service offering. That these are often directly supported by district ophthalmic staff provides capacity building opportunities for PHU staff but can also have the feel of not being 'led' by the PHU and therefore may end up being missed opportunities in terms of skills development given the focus on seeing all the patients. While IEC materials in the form of posters seem to be well displayed in the PHUs visited, there is reportedly a lack of clinical guidance in eye care available at this level (one health worker, for example, remembered the delivery of pamphlets but could not locate them). While not seen, the Primary Health Care Handbook is currently being reviewed and according to SLCO, the revised version will include eye care, though this effort was not specifically under the project.

*"We need to continue the training, the capacity building for the PHUs. We know their level - they are ones who were essentially trained for deliveries and all - they are the ones in all the PHUs. So, if you want to do things that they were not trained for during their pre-service, it is not once - it has to be completed regularly. But this is hard for time and funding and the like." (Sub-regional government partner)*

Despite the efforts made under the project, while more patients may be entering the system at the primary level, the predominant recommendation for all eye (including simple) conditions seen across outpatient registers seen during PHU visits continues to be “refer”. As a result, at the referral sites, it appears that the capacity building efforts at the PHU level are not yet filtering the simpler cases to a notable extent. Other general but impactful limitations at this level, as observed during PHU visits and discussed with PHU staff, include the lack of availability of drugs and supplies, challenges in locating staff in remote PHUs, and general infrastructure challenges, such as water and power supply and building maintenance.

PHU Case Study 3 highlights the opportunity presented by outreach, whilst at the same time the challenge in sustainably raising the staff capacity at the PHU level. It also gives insight into the financial barriers to access felt by many rural based people affected by eye conditions, and the lack of standardisation in applying the cost recovery strategy to those who appear unable to afford care.

### **PHU Case Study 3: PHU – CHC, a village outside of Bo town, Southern region**

The PHU is nearly an hour’s drive from Bo town. It is located high in the hills and access by road is possible but difficult.

There are no specific eye health people located at this PHU. Minor eye cases like conjunctivitis are treated here when the medicines are available, but other commonly seen conditions such as cataract and trauma, are referred to the Eye Clinic at Bo Hospital. No clinical guidance is available for diagnosing and managing eye care conditions – pamphlets were reportedly provided at some point, but they could not be located.



*Elderly man with suspected stage 4 glaucoma identified during outreach at a PHU (Photo credit: Clare Strachan)*



However, there is a regular outreach activity here. *"We have outreach here where ophthalmic people come and give us time, they see people and then they go back. They come every month – they are always here,"* says the Community Health Assistant and acting-in-charge. When asked whether many of the patients go when referred he says, *"most of these things are cost recovery and they have to pay for their services. I have not heard of that one where if they can't afford, they don't have to pay. Some say that, but no. The problem with accessing care here is poverty."* When an elderly man with suspected stage 4 glaucoma attending the outreach was asked whether he would go for surgery, he says, *"I don't know, maybe, I will speak to my wife. It is not easy to get there. We will see if we find the way of doing it."*

The CHA says there has been a lot of sensitisation in the communities and people are now thinking about their eyes and the importance of looking after them. He believes the CHWs will help more in further raising awareness and that *"it will be good to have stronger links with them and for it to also include eyes. They will first come to us if they are referred from the community, as we are their closest PHU. This will ease our work. But outreach may still be needed to bring the ophthalmic people close."*

At the community level, the project's collaboration with CHWs has focused on training and supporting them in the conduct of eye health sensitisation and awareness programmes and more recently at the central level in terms of incorporating eye health as one module into the eighteen-month CHW curriculum<sup>41</sup>, which is still being finalised. Key informant opinion generally reflected both optimism around the opportunity presented by CHWs for bringing eye care capacity closer to communities, as well as concerns around the capacity of CHWs to effectively respond to eye health needs. Potential issues were also raised as to the subsequent role of the PHUs within the referral pathway given the capacity challenges which already exist at the primary care level. As with any CHW cadre, aspects of motivation, retention and sustainability also need due consideration (this is discussed more in the Sustainability section).

*"The CHWs are in their communities and they are closest to their people and family members feel confident when they have them around. In a community, the CHW is like above them, the people will come and listen to them."* (SLCO)

*"Eye care will be part of one module so it won't be extensive training. It is not enough for their level of education. It will do more harm than good - if they are not monitored properly. They may think - we have been qualified - they may misuse the privilege to them. Eye problems are very delicate things."* (Sub-regional government partner)

*"If I refer someone with an eye problem, I refer them straight to the district eye clinic - not the PHU - eyes are very delicate and you have to have the right care. There is a closer PHU but they don't take care of eyes – and they won't know too much more than us."* (CHW)

## 2.4.2. Access to eye health services

While there is no definitive, population level survey data or other project data indicating any change in access to services over the course of the project, anecdotally, as indicated from discussion with a range of informants, it appears likely that the number of people accessing eye care services has grown, through a combination of enhanced awareness, increased service provision, and reduced

<sup>41</sup> Sierra Leone has received UNICEF funding to enable support to the countrywide CHW cadre for a two-year period.

financial barriers through the FHCI. As a government partner representative said, “*you can’t go anywhere now without meeting someone who has had cataract surgery.*” Faith-based hospitals, in particular Lowell and Ruth Gess Eye Hospital in Freetown and Baptist Eye Hospital in Lunsar, have also contributed to making services available in areas where there are no government facilities and they undertake a considerable proportion of the cataract surgeries in Sierra Leone<sup>42</sup>. Outreach in schools, PHUs and communities, has been a big priority for the project and the output numbers are impressive, as discussed in the Effectiveness section. The aim has been to cover each chiefdom at least once per year, though some have been covered more regularly and some not at all, mostly due to perpetual access challenges, specifically, bad roads, particularly during the rainy season. There has been a lot of sensitisation in communities and as one health worker put it:

*“The chief has helped – he has been telling them – ‘sight is life’. And if you have problems with your eyes, it is not just you, there will be a child who will be taken out of school and walking around with you.”*

Nevertheless, it is still the poorest and those living the most remotely who are affected by eye conditions with some people residing more than 50 miles away from a health facility along bad roads, and even if the project reaches them in their communities and refers them to a clinic, the critical question of “*but, how do I go?*” remains.

*“Those indirect costs are still high - transport costs, they have to maybe pay for a guide. Screening in the community and organising the patients to come to us is good. But some of these places are far - if they need to cross water, sometimes they fear it - and also for outreach, some of these places are hard to reach by road and a motorbike may be dangerous.”* (National government partner)

There is considerable confusion among patients (and some health workers), about what services or drugs should be provided for free, which does have an effect on both access and service provided. While eye care services, and essential eye medication, are included in the BPEHS for Sierra Leone, these BPEHS drugs are not always available, meaning the health worker may have to charge for ‘cost recovery’ drugs (unless the patient is exempt through the FHCI). How much is charged is dependent on the health worker, clinic and pressure from management/ supervisors. As communicated by one health worker:

*“The issue is that people expect it to be free. But it can’t be unless they are for Essential Package drugs or people with disabilities or survivors. We just have to charge them for cost recovery - just to try and get those costs back. If we can see they can’t afford - we don’t want to let anyone go out blind. We have a gratis book and we document there. We are under pressure from hospital management not to have too many of those. Sometimes, you say - ok what do you have now? Ok you give me that and pay the balance later - but they don’t come back. But, the most important thing is that they come.”*

Two further issues highlighted in the MTR which may affect quality of care and therefore access to services are the lack of routine monitoring of surgical outcomes, as well as collection of patient perception data. While recommendations were made to address these, little progress appears to have been made; monitoring of surgical outcomes continues to be more ad hoc than systematic, according to discussions with health workers, and there was no evidence of any efforts to collect

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<sup>42</sup> Potter AL, Vandy M, Smart N, Blanchet KI. *Eye Health Systems Assessment (EHSA): Sierra Leone Country Report*. Freetown, Sierra Leone: Ministry of Health and Sanitation, International Centre for Eye Health and Sightsavers.



feedback from patients on their care received at any point in the health system. These measures will help support the long-term functioning and quality of facilities<sup>43</sup> and so do require consideration and planning.

The challenge of school screening is also worth highlighting. All teachers and pupils in all schools are screened every few months for refractive error, conjunctivitis, and “brown eyes” (verruca conjunctivitis). Antibiotics and eye ointment (*tetracycline*) can be dispensed and discussions take place on improved eye hygiene, but glasses cannot be dispensed on site because the child needs to be referred to the clinic where a proper assessment of visual acuity can be done. From the sites visited, no children were seen wearing glasses in schools, though a pile of referral slips was awaiting distribution to parents at each. The Ophthalmic Nurses who do the refraction in schools and who also train the teachers to do so, admitted that some children were given referral slips because they couldn’t be sure of the assessment outcome, in part because the lack of light control in the school rooms made refraction challenging (too dark to be able to investigate the eye well and too light to be able to carry out an effective refraction). According to SLCO staff, health workers and teachers, the costs of acquiring glasses remain too high for most people, considering transport costs, lens and frame costs, especially when a certain ‘power’ of lens needs to be ordered from Freetown or a provincial town. While the project in total prescribed 40,768 spectacles and dispensed 17,530, which is a notable number, the gap between spectacles prescribed and dispensed is notable (spectacles prescribed was above target with a variance of +5% while spectacles dispensed was below target at -5%). It is recognised that the project wants to avoid the encouragement of donor dependence on the provision of spectacles, and it is important that efforts to boost supply consider prospects for financial sustainability. However, how cost effective continual screening is in the absence of financial support in the dispensing of glasses and given the low willingness to pay for glasses in comparison to other household priorities, must be considered. That culturally, glasses are not well accepted is an issue. As conveyed by a SLCO staff member:

*"Women say in villages that glasses are a man's thing - women just do household duties and look after the children - why do they need glasses? Sometimes they even have them but put them away and just bring them out at Christmas, New Year or function times when they dress up, cook food and move around to see people."*

This is itself a complex topic which requires well considered solutions, including perhaps some formative research around glasses wearing so as to shape the design of effective health education activities.

### 2.4.3. Project partner capacity building

Partners reported an improvement in their capacity thanks to the project. As one donor commented:

*"The project is successful because it has strengthened partnerships with local committees and government".*

A national level partner noted that Neglected Tropical Disease (NTD) co-ordination had been strengthened and that strategic planning now happens together, and many stakeholders noted the project’s success in bringing parties together for better co-ordination and collaboration, leading to synergies. Capacity building in relation to different levels of the health system has been discussed elsewhere in this report.

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<sup>43</sup> Ogundimu, K. Macdonald, D. *Sightsavers Comprehensive Eye Care in Sierra Leone Project – Mid Term Review: April 2016*. Freetown, Sierra Leone: Sightsavers; 2016.

## 2.4.4. Progress towards the elimination of lymphatic filariasis and onchocerciasis

The elimination of LF involves the distribution of *ivermectin* and *albendazole* to ≥80% of the eligible at-risk population in endemic areas annually for at least five years. Additional benefits are that persons in onchocerciasis hypo endemic areas (<20% mf prevalence) receive *ivermectin* (and eligible persons under-five years of age receive *ivermectin* and *albendazole* annually to treat soil transmitted helminths (STHs))<sup>44</sup>. As indicated by both project plans and from discussions with SLCO staff, the project has supported MDA for LF and onchocerciasis across the country, as per need (based on district prevalence), including the training of community drug distributors (CDDs), direct support in the conduct of the MDAs including sensitisation, registration, distribution and mop-up, as well as support in planning and evaluation at national and international levels for strategic planning in cross-border elimination efforts. The MDA targets all members of the community, apart from children under five, pregnant women and people with sickness.

This activity is considered to be one of the big achievements under the project. Table 9 provides summary data on the population treated and therapeutic coverage achieved in the targeted districts for both LF and onchocerciasis from 2013 to 2016. Coverage has been good and little dip is shown for 2014/15 during the EVD outbreak (though two years were combined), but for the last two years, coverage is slightly below the 80% coverage target, the required minimum so as to progress towards elimination. However, according to SLCO and national NTD programme informants, there has been a significant decrease in prevalence for both diseases in recent years, though there is still some way to go towards elimination; for both this is targeted for 2020-25. The NTD Technical Advisory Committee within the MoHS has been established to support the process of elimination of NTDs specifically.<sup>45</sup>

*"You hear people say that you don't hear about people going blind from LF or oncho in Sierra Leone anymore and that is a big achievement. The last oncho blindness case I am aware of was about ten years ago. There is also not so much polyparatism now." (National implementing partner)*

**Table 9: Population treated and therapeutic coverage for mass drug administration of targeted NTDs, 2013-2016**

Disease	Popn treated 2013	Therapeutic coverage 2013 (%)	Popn treated 2014/15	Therapeutic coverage 2014/15 (%)	Popn treated 2016	Therapeutic coverage 2016 (%)
Lymphatic filariasis	5,494,161	80.6	5,398,483	77.4	5,592,548	78.3
Onchocerciasis	2,667,365	80.9	2,642,193	78.3	2,709,504	78.5

For onchocerciasis, WHO recommends annual treatment with *ivermectin* for at least 10–15 years before elimination can be achieved<sup>46</sup> and semi-annual treatment is recommended where

<sup>44</sup> Hodges MH, Sonnie M, Turay H, Conteh A, Maccarthy F, Sesay S: Maintaining effective mass drug administration for lymphatic filariasis through in-process monitoring in Sierra Leone. *Parasit Vectors* 2012, 5:232.

<sup>45</sup> Sightsavers. *Seeing is Believing 2017 - Expression of Interest – Extension Project*. Freetown, Sierra Leone: Sightsavers; 2017.

<sup>46</sup> World Health Organization. *Guidelines for stopping mass drug administration and verifying elimination of human onchocerciasis: criteria and procedures*. Geneva, Switzerland: WHO; 2016.

epidemiological data is not on track to achieve elimination by the target date. As reported during the interview with the national NTD programme, in Sierra Leone, MDA has been supported twice per year in 12 districts where there is reportedly  $\geq 1\%$  prevalence, geographic coverage is expected to have reached 100% and therapeutic coverage at around 75-80%. Transmission assessment surveys (TAS) are conducted every three years to determine whether infection has been reduced below target thresholds and MDA can stop. For LF elimination, also guided by WHO recommendations<sup>47</sup>, considerable progress has been made and MDA now targets just five districts once per year, based on  $\geq 1\%$  prevalence, according to project documentation. The EVD outbreak resulted in a temporary break from MDA, as was the case with other activities on the health calendar, and in any case, there was heightened suspicion and fear of health workers arriving in communities with the aim of distributing medicines during that time, according to a number of health workers. A small rise in prevalence was reportedly seen for both onchocerciasis and LF but this is expected to have been reduced with the resumption of MDA activity and acceptability levels have returned.

*"Prevalence may have gone up a bit during Ebola - but now there is big demand again. There is high acceptability. There are always the odd refuser for no good reason - we have to go to them to explain and if we get tired, we involve the local authorities. There is a lot of black fly around here, so people know oncho and can recognise it and want it to reduce." (Sub-regional government partner)*

Despite the progress made, this activity has seen a number of challenges which will also need attention as the MoHS and partners move forward with the elimination effort. These include the late arrival of medication, the availability and motivation of unpaid CDDs (complicated by the EVD during which time they were paid for their efforts with the aim of urgently defeating EVD), terrain and mobility challenges (especially during the rains), concurrent distribution of other health commodities such as Long Lasting Insecticide Treated Nets or integration within the MCHWs which can affect targeting and coverage levels, rapid urbanisation and employment seeking population migrations, and the need for effective cross border collaborations<sup>48</sup>. It can also be challenging to acquire donor commitment for the last elimination push, as was also acknowledged by a member of a national level partner organisation.

## 2.4.5. Added value

It was noted that good coordination by SLCO has helped build the gathering of momentum around eye care in Sierra Leone, including within government. As a donor put it:

*"Whatever is being done they [SLCO] are doing with the communities: that is a very, very big achievement. It [partnership] has helped with effective utilisation of resources and technical sharing of knowledge and information has been really good and joint planning has also been good and learning from each other."*

Also, as already mentioned, the project's responsiveness to the EVD outbreak, in particular the outreach screening programme for survivors, has been very successful: so far, as reported by a regional representative of the NEHP, 3,000 EVD survivors have been screened and a high prevalence of uveitis has been detected and responded to. According to a national level partner, Sierra Leone has paved the way in this area in the region, with Liberia and Guinea replicating some

<sup>47</sup> Addiss D. The 6th meeting of the global alliance to eliminate lymphatic filariasis: a half-time review of lymphatic filariasis elimination and its integration with the control of other neglected tropical diseases. *Parasit Vectors*. 2010, 3(1):100.

<sup>48</sup> Hodges MH, Sonnie M, Turay H, Conteh A, Maccarthy F, Sesay S: Maintaining effective mass drug administration for lymphatic filariasis through in-process monitoring in Sierra Leone. *Parasit Vectors* 2012, 5:232.

of the approaches, and a delegation from Sierra Leone attended a sub-regional conference to present their work.

## 2.5. Sustainability

**Rating: Satisfactory** 

Project emphasis has been on the integration of eye care into government health systems, development of government human resource capacity, awareness raising around the importance of eye care, and the strengthening of a strong eye care partner network across the country which are important foundations for sustainability. However, the demand created for eye care needs to be sustained through feasible access to PHUs and through overcoming financial constraints because large outreach spend is not sustainable in the long term. Eye care is far from being cost recoverable given the biggest need is among the poorest people. That eye care service delivery is almost entirely dependent on external funding is of concern. Training achievement needs to be maintained by intensified support supervision, and further skills gaps need to be filled. There is a real need to recognise the importance of the next phase given the recent gains that need to be sustained and built upon.

### 2.5.1. Opportunities for sustainability

Sustainability for the foreseeable future will require some work, nevertheless, some key ingredients are in place, as discussed in depth in the sections above:

- Development of the core infrastructure required for eye health in most parts of the country;
- Development of a human resource base with eye health cadres that are accepted, funded by (salary paid) and integrated into the health workforce of the MoHS;
- Eye care – *to some extent* integrated into health care delivery at all levels of the health system from the national referral centre to the community;
- Achievement of a reasonable level of service delivery – relative to the region;
- The prospect of eye care data availability and a greater insight into the need and capacity to respond;
- Anecdotally reported raised awareness of the importance of eye care, throughout the country.

The shift towards the integration of primary eye care into primary health care, should imply a lower need for outreach in the long term, though access challenges remain for remote living communities. The EVD outbreak in a country emerging from an emergency situation has brought up the need for outreach in the short term but in the longer term, stronger integration at the primary level should promote a more sustainable means of service delivery; this point was also made in the MTR<sup>49</sup>. As suggested in the Recommendations section, criteria for the prioritisation of ongoing eye care outreach activities (such as a minimum of e.g. 5km from a PHU) could be considered, with the aim of phasing out of universal outreach activity given the capacity raising of PHUs and the introduction of a comprehensive network of CHWs.

<sup>49</sup> Ogundimu, K. Macdonald, D. *Sightsavers Comprehensive Eye Care in Sierra Leone Project – Mid Term Review: April 2016*. Freetown, Sierra Leone: Sightsavers; 2016.

In the short term, the management of the NEHP continues to be demanding and has grown beyond the capacity of a single Programme Manager. Moving the programme forwards to a more sustainable future phase, and many of the recommendations in this report will require planning and documentation, development of forecasts and other management documents. In addition, strong advocacy and networking will be required to ensure policy and planning is fully implemented and translates into sustainable system changes. As was recommended in the MTR, additional support to this post is therefore recommended in order that the progress in eye health to date can be built on<sup>50</sup>; it was suggested by SLCO staff that financial and administrative barriers at the MoHS are preventing progress on this

It is also worth noting that the effective and much appreciated collaboration by Sightsavers with other stakeholders (see below) has played a contributory role in supporting sustainability. As one government official at district level put it:

*“The success is down to very good collaboration and integration, so that when the project ends its benefits will go on.”*

## 2.5.2. Challenges with sustainability

There are a number of challenges relating to eye care in Sierra Leone to be overcome, the most basic of which is that the public budget for eye care is inadequate and mainly covers administration rather than service delivery. Moreover, as discussed in depth in the sections above:

- There is an inequitable distribution of government eye facilities and staff, particularly in the North.
- While access has improved, huge financial and logistical barriers remain for many of Sierra Leone’s rural population, still preventing many cases from entering the system; while the demand for eye care generated under the project is certainly positive, it is unclear how the demand will be sustained. Essentially, if people are more aware of the need for eye care, they need to be supported to access the health system and the health system needs to be able to effectively absorb them.
- Further substantial support to outreach activity is not sustainable from a financial or access point of view, and while the more formal introduction of a CHW cadre trained in eye care offers the opportunity to raise awareness of the need and availability of services, access still remains the issue.
- As with any CHW cadre, aspects of motivation, retention and sustainability also need due consideration.
- Despite the investment under this project, the capacity to respond to many eye care cases at the primary health level remains limited (and therefore there is still minimal filtering of cases at this level); any further training will need to be sustained with considerable focus on follow-up, practical support supervision and refresher trainings which are time and resource intensive.
- Referral uptake remains low, again largely due to access issues.
- While a shift to a pull supply chain system is on the horizon as a result of the introduction of a revised HMIS and electronic DHIS2 system from the district level upwards, for now, there is an irregular supply of drugs, consumables and materials and they are not quantified based on individual clinic need.
- Capacity to maintain Internal equipment is almost non-existent.
- Weak monitoring systems exist for patient feedback, eye care activity or outcomes (including surgery outcomes).

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<sup>50</sup> Ogundimu, K. Macdonald, D. *Sightsavers Comprehensive Eye Care in Sierra Leone Project – Mid Term Review: April 2016*. Freetown, Sierra Leone: Sightsavers; 2016.



- Fee for service (cost-recovery) will continue to be a source of funding of the eye care policy (apart from patients exempt under FHCI) though most eye care patients cannot afford to pay for their care.
- The intensification of eye care coordination activity through the NEHP has not been matched by enhanced human resource support at the NEHP, which limits the capacity to sustain and further the gains made centrally.
- NTD elimination experience suggests that funding for the elimination of onchocerciasis and LF will be a challenge to acquire the closer Sierra Leone progresses towards elimination (challenge of the 'last mile').

## 2.6. Coherence/co-ordination

**Rating: Excellent**



A key factor in the project's success has also been the extensive and much appreciated collaboration and co-ordination with all the relevant stakeholders, including government departments and clinics, private not for profit hospitals, NGO and civil society partners and community leadership at the national, sub-regional and community levels.

### 2.6.1. Effective coordination

One of the highlights and a key factor in the project's success has been the extensive and much appreciated collaboration and co-ordination with all the other relevant stakeholders. Indeed, Sightsavers was commended on this aspect by all stakeholders' sides. One INGO partner commented positively on how their two organisations work collaboratively for mutual benefit, sharing skills where appropriate and making referrals. Sightsavers often took the lead in calling inter-agency meetings and promoting collaboration, and this clearly led to good working relations and smoother project implementation.

Some comments from a range of stakeholders to illustrate this point:

*"Sightsavers have organised regular meetings and ensure clear understanding of roles and responsibilities. Everything they do they keep us informed. They provide a level playing field for all their local partners."* (Donor)

*"Coordination has been fantastic - Sightsavers has been very proactive - calling meetings with partners, going to districts, MTRs, other reviews - that has been fantastic. The NTD programme too - all has been cordial. There are no issues. They are our sister organisation in country."* (National implementing partner)

*"Sightsavers - they call stakeholders before they design a project, then we review, there is that collaboration throughout. At all levels of the health system. That collaboration is very good."* (Sub-regional government partner)

*"The good coordination has really enabled the gathering of momentum around eye care in Sierra Leone, including within government." (Donor)*

*"They are not doing it in isolation. Whatever is being done they are doing with the communities: that is a very, very big achievement. If I document all their success we'll be here all day." (Sub-regional government partner)*

## 2.6.2. Co-ordination challenges

While overall co-ordination was very good, the evaluators did hear of instances at the district level when it did not work so smoothly. Here, attendance was found to be less reliable at meetings, with invitees often prioritising other tasks. This is especially the case if transport is required to attend the meeting. As a government official put it:

*"When you hold Vision2020 meetings, often in districts, people do not come. The partner coordination is there at the national level, but the district level can be more challenging."*

There was also an awareness, as indicated by a number of national level informants, that government co-ordination needs to be strengthened so that different aspects (supplies, job descriptions, recruitment etc.) of the health system function better, starting at the national level for later replication at the district level.

## 3. Conclusions and recommendations

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### 3.1. Summary and conclusions

The project is considered highly relevant to the needs of Sierra Leone in terms of strengthening and improving eye care service delivery and extending its reach to poor and remote communities. The project targets were ambitious but the revised targets were considered realistic and have mostly been met, and in some cases, exceeded. This is despite the pause in activity of the EVD outbreak over 2014/15 and the extra work taken on by the project in response to the EVD outbreak, such as the screening of EVD survivors for eye complications.

Significant gains have been made across project activity areas, most noteworthy relating to human resources for eye health at all levels of the health system, the introduction of eye health indicators into the HMIS. The high coverage of VAS through MDA and recent progress in its integration into EPI, and elimination targets for onchocerciasis and LF are also broadly on track. Integration of eye care into primary eye care delivery was a key objective of the project and there has been significant progress here, though more attention must be given to raising the eye care capacity further at the PHU level, including in remote areas, also limiting the number of cases presenting higher up the referral system. Training activity at all levels has been extensive but ongoing skills sharing or mentoring has not been structured or systematic, in large part limiting its effect to direct beneficiaries. Outreach activity has been impressive and access to care appears to have improved for the population at large, including for poor and remote populations. With fewer funds available to support outreach, however, it should be targeted at particularly remote areas, with more deliberate efforts to use outreach as an opportunity to build capacity in health workers at the PHU level. The emerging CHW cadre trained in basic eye health will also need to be considered in line with the outreach strategy.

Service delivery has continued to be hampered by an unreliable drugs supply, though the introduction of DHIS2 expected by the end of the year offers opportunity to strengthen the data available to inform drugs and supplies allocation, potentially in time shifting to a pull system. Ongoing support to this effort at the national and district levels will be important. Quality of care will also be boosted by improvements in routine monitoring of surgical outcomes and patient follow-up, and the collection of patient perception data to inform service provision. Furthermore, Sierra Leone does not have a 'glasses wearing' culture and glasses are not prioritised in household expenditure even where there is need, resulting in a considerable gap between spectacles prescribed and those dispensed. Refraction testing should continue to be promoted, alongside formative research to understand better the barriers and opportunities to inform health education efforts.

While output has been impressive, on a project management level, there have been some inefficiencies, most notably assessment of project effectiveness which was not consistently done against the logframe. The monitoring plan was not effectively designed in response to key data needs and the impact data sources were not available; this should be given more attention in the planning and management of future projects. Financial resources of the project were considered to be well managed, however, and in line with priorities as stipulated by the project objectives.

Overall, the project has laid important foundations for sustainability, specifically its emphasis has been on the integration of eye care into government health systems, the development of government human resource capacity, awareness raising around the importance of eye care, and the

strengthening of a strong eye care partner network across the country. The next stage is critical for consolidating and strengthening these gains.

## 3.2. Lessons learned

Lessons learned have been highlighted throughout the report and as such, this section highlights key lessons learned only:

- The value of a flexible and adaptable approach, coupled with a good relationship with the donor built on regular communication and collaboration, enabled an effective response to the EVD crisis without deterring focus from existing activities over the lifetime of the project. This meant the project was able to remain highly relevant despite the significant change in context.
- The strategy to integrate eye health into the overall health system necessarily needed to be reflected in simultaneous targeted activities at all levels from the central to the community level if it was to be effective, as was the case under this project.
- The close partnership with the NEHP enabled efforts to boost eye health service delivery through the health system to be reflected in revised and updated policies and procedures, necessary for ongoing sustainability of achievements and the continuation of strengthening efforts.
- The training of eye health specific staff enabled the prioritization of eye health among a proportion of the health workforce. However, unless incentives and structures are put in place for the ongoing sharing of skills, the training effort to some extent reflects an anti-integration approach, despite the fact that capacity may have been raised among a selection of health workers.
- While access to care appears to have improved for the population at large, including for poor and remote populations and people with disabilities, high outreach or screening outputs has not translated into referral uptake. It is broadly accepted that outreach is not an inherently sustainable activity and needs to be both geographically prioritized and done in conjunction with a broader capacity building aim at lower levels of the health system.
- Efforts to raise capacity and raise the quality of service delivery for eye health will be hampered by broader challenges in the health system, such as eye health drug shortages and quality of HMIS data and, consequently, engagement is also required in these areas at this level.
- The project would have earned better evaluation ratings if its monitoring and evaluation strategy was more effectively developed based on feasible, specific data sources and if performance monitoring activity was done systematically against the logframe. Whilst it is recognised that donors have varying reporting and monitoring requirements, some of the differences in monitoring across the SiB and EC project, despite their overlap in activity, made overall assessment of contribution across both projects challenging.

## 3.3. Recommendations

Some recommendations are made, below in Table 10, for the immediate next phase of activity to support eye care in Sierra Leone, based on the findings of this evaluation. The levels of priority for

the recommendations were assigned by the evaluators based on the perceived importance and urgency of each recommendation for sustaining the current gains into the immediate next phase of eye care activity in Sierra Leone. Priorities were assigned based on the findings of this evaluation and the evaluators and stakeholders views on the next steps. They can be classified as follows:

- High: Critical and urgent for the immediate next phase of eye care activity in Sierra Leone
- Medium: Important for the immediate next phase of eye care activity in Sierra Leone
- Low: Desirable for the immediate next phase of eye care activity in Sierra Leone

**Table 10: Recommendations for the next phase of support to the improvement of eye care in Sierra Leone**

Recommendation	Responsibility	Level of priority
<i>Human resources for eye health</i>		
1. Prioritise PHU essential training on the diagnosis and management of eye conditions/ infections through the DHMTs as per planned curriculum, and ensure follow-up practical support supervision, peer support, refresher training plans are in place and implemented.	NEHP	H
2. Support the development of KPIs for in-service training as part of training cascades to encourage any PHU or district level health worker staff to give deliberate effort to passing on comprehensive training to other clinic staff members; this should be followed up and monitored by DHMTs.	NEHP	H
3. Advocate at the central level to address a) challenges in locating health workers to remote PHUs given the lack of available incentives, allowances, accommodation or requirement post-training and b) gender imbalances in health worker training so as to boost the further recruitment and training of female health workers across the health system	NEHP, SLCO) and other partners	M
<i>Outreach</i>		
4. Develop criteria for the prioritisation of ongoing eye care outreach activities, such as a minimum of e.g. 5km from a PHU, with the aim of phasing out of universal outreach activities given efforts to raise capacity raising of PHUs and the introduction of a comprehensive network of CHWs.	NEHP	M
<i>Eye care promotion</i>		
5. Continue to promote the importance of eye care and appropriate health seeking behaviour, including for the EPI, through IEC activities as funds allow and as recommended for the context based on likely effectiveness, such as community dialogues in collaboration with district leadership. Men should also be targeted given the influential role they have in deciding whether women should access certain interventions.	NEHP, SLCO and other partners	M
6. Give more focus to refractive error testing and glasses wearing in IEC activities in communities, PHUs and schools, and explore ways of reducing prohibitive costs to accessing	NEHP, SLCO and other partners	M



Recommendation	Responsibility	Level of priority
spectacles, including collaboration with other programmes or insightful formative research on barriers to glasses wearing		
<i>Data analysis and use</i>		
7. Support in-country effort as required for HMIS/DHIS2 training, and ensure a comprehensive focus on eye health indicators is included in district level support supervision on an ongoing basis.	NEHP	H
8. Conduct targeted data quality assurance checks for eye health indicators data three-six months post introduction to inform further support needs	NEHP, SLCO	M
9. Explore conducting a case study on the range of eye health cases presenting, managed and referred at different levels of the health system in one ideally typical district based predominantly on outpatient registers over a period of around three months. This will give more detailed insight into the extent of case filtering at lower levels, within-district referral and a more accurate prevalence of eye conditions, beyond which the HMIS/ DHIS2 data may be able to provide, particularly as the new monitoring system is being rolled out.	NEHP, SLCO	L
<i>Supply chain</i>		
10. Enhance technical or logistical support or collaboration at the central level with the specific aim of addressing eye health drug shortages, as dependent on specific bottlenecks. For example, support to the analysis of stock data and quantification to enable a more responsive pull system (will be particularly important once DHIS2 is up and running) or support to specific procurement planning efforts.	NEHP, SLCO and other partners	H
<i>Health financing</i>		
12. Advocate where possible for government to allocate funding to eye care service delivery through a phased and targeted approach, e.g. training activities and equipment maintenance.	NEHP, SLCO and other partners	H
<i>NEHP coordination and management</i>		
13. Support the recruitment of an assistant manager to the NEHP, preferably a person with some management/finance skills, to assist the NEHP Coordinator in the management and coordination of the programme.	NEHP	H
<i>Project management</i>		
14. Ensure any project monitoring and evaluation plans are based on realistic yearly targets, with measurable, defined output, outcome and impact indicators linked to specific and available data sources. Achievements against targets should be monitored and analysed on defined periodic basis and all project monitoring and quantitative reporting should be linked to the monitoring plan (logframe).	SLCO/M&E teams	H



## Appendices

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Appendix 1: SiB Project End of Term Evaluation Terms of Reference

Appendix 2: Evaluation Matrix

Appendix 3: Detailed work plan

Appendix 4: Documents list

Appendix 5: Data collection schedule

Appendix 6: KII topic guide

Appendix 7: FGD topic guide

Appendix 8: PHU visit – observation guide

Appendix 9: Information Sheet and Consent Form

Appendix 10: List of key informants

Appendix 11: The evaluation questions and where they are addressed in the report

Appendix 12: Quantitative analysis of project achievements against logframe

Appendix 13: Evaluation criteria rating

# Appendix 1: SiB Project End of Term Evaluation Terms of Reference

## Terms of Reference

### Sightsavers Comprehensive Eye Care in Sierra Leone – Seeing is Believing (SiB)

#### End of term evaluation

#### 1. Background

**Project name**

Sightsavers Comprehensive Eye Care in Sierra Leone Project

**Project number**

57002 (NTDs), 57003 (NECP), 57004, 57005, 57006, 57009

**Project duration**

1st Sep 2012 –31<sup>st</sup> August 2017

**Project budget**

\$1,250,172 (\$1,000,138 from SiB; \$138,863 from Sightsavers; \$77,703 from CBM; \$33,469 from HKI). Funding contributed from Sightsavers is unrestricted, provided mostly through Financial Times funds.

**Project partners**

Ministry of Health and Sanitation (MoHS) including Western Area Eye Care Project (WAECP), Southern Province Eye Care Project (SPECP) and Eastern Province Eye Care Project (EPECP); Lead implementing partners: Helen Keller International (HKI) and **Christoffel Blinden mission** (CBM).

**Key stakeholders**

Ministry of Health & Sanitation, Eastern Province, Southern Province and Western Area eye care projects; National Eye Health Programme; National Neglected Tropical Diseases Programme; eye care hospitals (Baptist eye hospital and Lowell & Ruth Gess eye hospital in Lunsar and Freetown respectively); Standard Chartered Bank local office.

**General information on project area**

Together with a complementary EC-funded project, the entire country is covered. The SiB project covers all four regions including the North, while the EC project covers the three regions of the East, South and West. While eye care is fully integrated at national level, integration at the district

level is still incomplete as eye care services are limited in those areas with low uptake of services, particularly among the most vulnerable including women.

### **Project design, goal, objectives, and outputs.**

The project will contribute to the reduction in avoidable blindness and vision impairment in Sierra Leone through country wide provision of comprehensive eye care (CEC) services, targeting over 2,300,000 people over the four-year project duration. This is to be achieved by strengthening eye health systems through integration of primary eye care (PEC) services into primary health care (PHC). Also promotion of community participation in preventive eye health activities, particularly in underserved and marginalised communities, including administering vitamin A drops in new born babies which is closely associated with blindness in that age group.

The following are the stated objectives of the project:

1. Support National Eye Health Project (NEHP) to strengthen health systems through improved human resources for eye health, including the training and deployment of required eye care professionals.
2. Effectively integrate primary eye care (PEC) services into primary health care through support to peripheral health unit (PHU) staff.
3. Develop and improve community participation in preventive eye health activities, particularly in underserved and marginalised communities.
4. Reduce vitamin A deficiency-associated blindness and mortality by ensuring high and sustained Vitamin A Supplementation (VAS) for children.

## **2. Purpose of Evaluation**

The end of term evaluation will review the achievements of the project against objectives and outputs as detailed in the project documents, as well as assess the long-term effects made by the project on accessibility to eye health services by people with disabilities in the regions. Specifically, the evaluation will focus on understanding what have been the key successes and challenges in the implementation of the project, that can help inform the future design of our programmes.

The evaluation of the project will use the following six criteria which will be the basis for evaluation, analysis and reporting: relevance, effectiveness, efficiency, impact, sustainability and coherence/coordination.

The evaluation will produce a set of specific recommendations for similar, future project designs, and identify any further cross-cutting or organisational level lessons and recommendations.

The target audience for the report will be funders, partners, programme staff and global programme support teams within Sightsavers.

### **2.1. EVALUATION CRITERIA - QUESTIONS**



**Relevance** – the extent to which the project or programme is suited to the priorities and policies of the target beneficiaries, national partners, and donors, where applicable.

The internal mid-term review MTR found the project aims to be very relevant to eye health needs of the country and in targeting various specific beneficiary groups.

1. What has been the outcome of the knowledge and strategies which emerged from the Knowledge Attitudes and Practice (KAP) study completed in 2015, in regard to shaping project focus and objectives in the second part of the project?
2. Did any changes in the context of the project (post EVD outbreak) impact upon the relevance of the project, and if so what measures were put in place to mitigate this?

**Effectiveness** – the extent to which the objectives have been achieved and the anticipated results have been realized.

3. To what extent have the planned outputs been delivered, including planned targets for women, and the project objectives been met? And what were the major factors influencing the achievement or non-achievement of the objectives?
4. To what extent was the learning from the project monitoring, and the MTR adequately incorporated during project implementation and recommendations appropriately responded to?
5. What progress and/or achievements have there been regarding development of a joint district level advocacy plan by all project partners, to influence integration of primary eye care in the Basic Package of Essential Health Services
6. To what extent has the project enhanced human resources for eye health, and is deployment of project trained staff achieved?
7. What progress has been made on improving the systematic integration of recording of eye health patients and treatments into PHC record keeping, as recommended in the MTR, and has this had any influence on the integration of eye health into existing PHC systems?
8. To what extent has the project been able to reduce vitamin A deficiency-associated blindness and mortality by ensuring high and sustained Vitamin A Supplementation (VAS) for children, and is this fully integrated into PHC/ Child Health service delivery now?

**Efficiency** – the extent to which results have been delivered with the least costly resources possible, and the manner in which resources have been efficiently managed and governed in order to produce results.

9. Was the project implemented in a timely and efficient manner with resources used according to plan?

**Impact** – the long-term change or effects (positive or negative) that have occurred, or will occur, as a result of the project or programme.

10. To what extent has the project been able to influence the integration of eye health within government health systems, and strengthen the national health systems in the Eastern Province, Northern Province, Southern Province and Western Area through support to Primary Health Units (PHUs)?
11. To what extent has the project improved the capacity of the project partners in project planning, management and implementation, across the national provincial and district levels? E.g. Have recommendations from Sightsavers Quality Standards Assessment Tool exercise been satisfactorily addressed?
12. What progress has been made regarding the proposed review of the national human resourcing plan for eye health?
13. Are there any other impacts (intended or unintended, positive or negative) which have resulted from the project?
14. How has the break in MDA due to Ebola affected the Elimination of LF and ONCHO cycle in the project locations?

**Sustainability** – whether benefits of the project or programme are likely to continue after donor funding has ceased.

15. To what extent are the project benefits sustainable beyond the end of the project?
16. What are the major factors that have influenced the achievement or non-achievement of sustainability of the project?

**Coherence/coordination** – the extent to which the project or programme has coordinated with other similar initiatives, interventions or actors, and the degree to which the project design and implementation is internally coherent.

17. How well has the project coordinated with other similar initiatives, or activities and actors within the country? And if so has improved coordination and collaboration led to enhanced efficiency by preventing duplication and improving learning/sharing etc?

### 3. Review Team

This evaluation will be undertaken as part of the Framework Agreement. This evaluation will be carried out as a joint evaluation exercise with the EC complementary eye health project, but two separate reports will be produced, one for each funder according to the relevant project objectives. These TOR should therefore be read in conjunction with the TOR for the EC Sierra Leone Eye Care Programme.

## 4. Methodology

The evaluation should review all aspects of the Sierra Leone Eye Care Programme. The evaluator(s) should detail the approach and methodologies to be used to indicate how they will fulfill the requirements of the ToR. These may include qualitative and quantitative tools as appropriate to conduct this evaluation.

The evaluation team is responsible for developing the evaluation methodology, in consultation with Sightsavers, in order to address the key evaluation questions. The evaluation team will define an appropriate sample size, where relevant, for those areas of data collection which they are leading on, and specify what mechanisms will be adopted to avoid selection bias.

The evaluation team should also outline how they will address any ethical issues arising for this evaluation assignment.

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

1. Review relevant reference material and data, as listed in Section five below.
2. Development of a detailed Inception Report including details on the development and application of appropriate data collection tools (e.g. questionnaire schedules and tools, interview checklists and focus group templates) for interviews and discussions with stakeholders.
3. Field visit to the intervention region – interviews/focus groups with project implementers, partners, other relevant actors in the sector, and if appropriate, service recipients/beneficiaries.
4. A debriefing session for partners and stakeholders at the end of the field work period.
5. Analysis and production of a draft and final Evaluation Report.

## 5. Reference Material

Various sources of information will be made available to the consultant/team. These will include relevant project documents such as:

- Project proposal
- Logframe
- Project reports (Narrative and financial)
- Project M&E data
- Reports of meetings with partners, trip reports
- Training programme reports
- Training materials
- MOUs
- Research and KAP study reports
- Mid-term Evaluation report
- Monitoring and evaluation reports
- Reports from NEHP, including annual plans
- Data collection tools now utilized at clinic level
- VAS data

## 6. Timeframes

The time frame for the evaluation will be between August and Dec 2017. It is expected that work on the inception stage will start in August, and field work is planned between 18<sup>th</sup> and 30<sup>th</sup> Sept 2017. The report will be finalized by beginning of December 2017.

## 6.1 INDICATIVE STRUCTURE AND PHASING OF THE EVALUATION

Phase	Activity
<b><i>Phase I – Desk study: Review of documentation and elaboration of field Study</i></b>	Desk research /literature and data review
	Inception Report
	Revision of collection methods and tools based on inception report comments
<b><i>Phase II: Field Data Collection</i></b>	Field visits & further data-collection
<b><i>Phase III – Analysis and production of evaluation report</i></b>	Debriefing (In-country)
	Data analysis and preparation of draft report
	Review of draft report from feedback.
<b>Total</b>	

## 7. Outputs/ Deliverables

### 7.1 INCEPTION REPORT

The report should describe the conceptual framework the evaluation team will use in undertaking the evaluation and should contain the methodology, quantitative and/or qualitative data collection methods and instruments, the assessment questions, sampling methodology, work plan etc. The report should reflect the team's review of literature and the gaps that the field work will fill.

Fieldwork will only commence once this report has been reviewed and agreed with Sightsavers.

### 7.2 DRAFT REPORTS

The draft findings will be presented in-country during a debriefing session. Two draft reports, one tailored for each of the EC and SiB donors should be submitted to Sightsavers within three weeks of completion of the field activities.

Sightsavers will provide feedback on the draft versions to the evaluation team.

### **7.3 FINAL REPORTS**

The two Final Reports will be submitted to Sightsavers within 10 working days after receiving the feedback from Sightsavers on the draft reports. The final donor-facing reports should be a detailed report of not more than 50 pages each (excluding annexes), written in English.

### **7.4 DATA SETS**

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

## **8. Reporting Format**

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



## Appendix 2: Evaluation matrix

### Sierra Leone End of Term Evaluation Evaluation Matrix

The matrix presented below summarises, for each review sub-question, the scope of relevant primary and secondary data collection activity.

S/N	Key Evaluation question to be addressed	Notes on EC/ SiB differed focus	Primary Data Collection		Secondary Data Review
			Data collection tool	Key Informant level	
Relevance - the extent to which the project or programme is suited to the priorities and policies of the target beneficiaries, national partners, and donors, where applicable.					
1.	What has been the outcome of the knowledge and strategies which emerged from the Knowledge Attitudes and Practice (KAP) study completed in 2015, in regard to shaping project focus and objectives in the second part of the project?	Same	KIIs	National	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
2.	Did any changes in the context of the project (post EVD outbreak) impact upon the relevance of the project, and if so what measures were put in place to mitigate this?	Same	KIIs	National; sub-regional	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
Effectiveness - the extent to which the objectives have been achieved and the anticipated results have been realized					
3.	To what extent have the planned outputs been delivered, and the project objectives been met? What were the major factors	SiB: To what extent have the planned outputs been	KIIs; FGDs; PHU visits	National; sub-regional; community	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and

S/N	Key Evaluation question to be addressed	Notes on EC/SiB differed focus	Primary Data Collection		Secondary Data Review
			Data collection tool	Key Informant level	
	influencing the achievement or non-achievement of the objectives?	delivered, including <u>planned targets for women</u> , of the objectives?			supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
4.	To what extent was the learning from the project monitoring, MTR and ROMs adequately incorporated during project implementation and recommendations appropriately responded to?	SiB: To what extent was the learning from the project monitoring, <u>and the MTR</u> adequately incorporated	KIIs; FGDs; PHU visits	National; sub-regional; community	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
5.	What progress and/or achievements have there been regarding development of a joint district level advocacy plan by all project partners, to influence integration of primary eye care in the Basic Package of Essential Health Services, <u>and to allow full representation of Disabled People's Organisations to foster equitable access to eye health services for people with disabilities?</u>	SiB: without addition <u>highlighted</u>	KIIs; PHU visits	National; sub-regional	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports; advocacy plans
6.	To what extent has the project enhanced human resources for eye health, and is deployment of project trained staff achieved?	Same	KIIs; PHU visits	National; sub-regional	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual

S/N	Key Evaluation question to be addressed	Notes on EC/SiB differed focus	Primary Data Collection		Secondary Data Review
			Data collection tool	Key Informant level	
					and quarterly reports and ROM; SiB annual and quarterly reports
7.	Did the project respond to any identified differences in men and women's access to services and project related activities/training, especially among people with disabilities?	EC only	KIIs; FGDs; PHU visits	National; sub-regional; community	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
8.	What progress has been made on improving the systematic integration of recording of eye health patients and treatments into PHC record keeping, as recommended in the MTR, and has this had any influence on the integration of eye health into existing PHC systems?	Same	KIIs; PHU visits	National; sub-regional; community	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
9.	To what extent has the project been able to reduce vitamin A deficiency-associated blindness and mortality by ensuring high and sustained Vitamin A Supplementation (VAS) for children, and is this fully integrated into PHC/Child Health service delivery now?	SiB only	KIIs; FGDs; PHU visits	National; sub-regional; community	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports; Vitamin A Supplementation data
<b>Efficiency – the extent to which results have been delivered with the least costly resources possible, and the manner in which resources have been efficiently managed and governed in order to produce results.</b>					
10.	Was the project implemented in a timely and efficient manner with resources used according to plan?	Same	KIIs	National	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and

S/N	Key Evaluation question to be addressed	Notes on EC/SiB differed focus	Primary Data Collection		Secondary Data Review
			Data collection tool	Key Informant level	
					supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
11.	Was gender disaggregated data recorded and reported on for children and the elderly, and can this help to draw any conclusions around the gender targeting for this project, or for future Sightsavers' projects?	EC only	KIIs; PHU visits	National; sub-regional	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
<b>Impact - the long term change or effects (positive or negative) that have occurred, or will occur, as a result of the project or programme.</b>					
12.	To what extent has the project been able to influence the integration of eye health within government health systems, and strengthen the national health systems in the Eastern Province, Southern Province and Western Area through support to Primary Health Units (PHUs)?	SiB: Additional geographic focus on the Northern Province	KIIs; PHU visits	National; sub-regional	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
13.	To what extent has the project been able to empower people with disabilities to gain increased access to health care services?	EC only	KIIs; FGDs; PHU visits	National; sub-regional; community	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
14.	To what extent has the project improved the capacity of the project partners in project planning, management and implementation? E.g. Have	SiB: To what extent has the project improved the capacity of the	KIIs	National; sub-regional	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual

S/N	Key Evaluation question to be addressed	Notes on EC/SiB differed focus	Primary Data Collection		Secondary Data Review
			Data collection tool	Key Informant level	
	recommendations from Sightsavers' Quality Standards Assessment Tool exercise been satisfactorily addressed?	project partners in project planning, management and implementation, <u>across the national provincial and district levels?</u>			and quarterly reports and ROM; SiB annual and quarterly reports
15.	What progress has been made regarding the proposed review of the national human resourcing plan for eye health?	Same	KIIs	National	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
16.	The MTR recommended that a mechanism needed to be established to strengthen recording and follow-up for those people with disabilities referred to other services, so that the potential barriers can be more clearly identified. Was this established and as a result, is it more possible to demonstrate the project's impact in this area?	EC only	KIIs; PHU visits	National; sub-regional	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
17.	Are there any other impacts (intended or unintended, positive or negative) which have resulted from the project?	Same	KIIs; FGDs; PHU visits	National; sub-regional community	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and



S/N	Key Evaluation question to be addressed	Notes on EC/SiB differed focus	Primary Data Collection		Secondary Data Review
			Data collection tool	Key Informant level	
					supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
18.	How has the break in MDA due to Ebola affected the elimination of lymphatic filariasis and onchocerciasis cycle in the project locations?	SiB only	KIIs; FGDs; PHU visits	National; sub-regional; community	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
<b>Sustainability – whether benefits of the project or programme are likely to continue after donor funding has ceased.</b>					
19.	To what extent are the project benefits sustainable beyond the end of the project?	Same	KIIs; FGDs; PHU visits	National; sub-regional; community	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
20.	What are the major factors that have influenced the achievement or non-achievement of sustainability of the project?	Same	KIIs; FGDs; PHU visits	National; sub-regional; community	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports
21.	What sort of capacity has been built for continued support of people with disabilities in understanding their rights and advocating for access to services?	EC only	KIIs; FGDs; PHU visits	National; sub-regional; community	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports

S/N	Key Evaluation question to be addressed	Notes on EC/ SiB differed focus	Primary Data Collection		Secondary Data Review
			Data collection tool	Key Informant level	
	<b>Coherence/coordination</b> – <i>the extent to which the project or programme has coordinated with other similar initiatives, interventions or actors, and the degree to which the project design and implementation is internally coherent.</i>				
22.	How well has the project coordinated with other similar initiatives, or activities and actors within the country?	SiB: Additional question: And if so has improved coordination and collaboration led to enhanced efficiency by preventing duplication and improving learning/ sharing etc?	KIIs; FGDs; PHU visits	National; sub-regional; community	Background documents; core project documents (EC); core project documents (SiB); MTR (EC); MTR (SiB); MTR internal and supporting documents; EC annual and quarterly reports and ROM; SiB annual and quarterly reports

## Appendix 3: Detailed workplan

Stage	Description	SS/SSCO/TH	Responsible	July				August				September				October				November				December				Jan-18				Feb-18				Mar-18				Apr-18						
				3	10	17	24	31	7	14	21	28	4	11	18	25	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	5	12	19	26	5	12	19	26	2	9	16	23
Preparation	TOR development in collaboration with country teams	SS/ SSCO /GTL																																												
	Define scope and budget	SS/ SSCO																																												
Draw down contract	Collate and share ToR package	SS																																												
	Comment on draft ToR	TH																																												
	Finalise ToR	SS/ SSCO																																												
	Develop technical proposal	TH																																												
	Review and comment on technical proposal (request a 'drawdown meeting' F2F or phone if needed)	SS																																												
	Finalise proposal based on SS comments	TH																																												
	Prepare drawdown letter including as annexes the final ToR, technical proposal and agreed budget.	SS																																												
	Sign draw down letter	TH/SS																																												
Inception phase	Provide full background document package to be reviewed a week prior the inception phase start	SS/ SSCO																																												
	Appoint country focal person(s) to work with Tropical Health. Define the communication between Sightsavers' HQ and Sightsavers' country office and Tropical Health.	SS/ SSCO																																												
	Review key background documents before kick-off meeting	TH																																												
	Kick off meeting	TH/SS/SSCO																																												
	Provide additional background information agreed to be shared during the kick-off meeting (e.g. key stakeholders list).	SS																																												
	Fieldwork planning - detailed proposal for country timeline and agenda and associated logistics requests. Flights and visas logistics support requests.	TH																																												
	Fieldwork planning - review and approve plans, book and pay for flights, accommodation, support ethical clearance request if needed	SS																																												
	Field work planning - propose, review and approve plans. Arrange all in-country logistics.	SSCO																																												
	Draft and submit inception report (V1)	TH																																												
	Review and circulate for comment on inception report	SS/ SSCO																																												
	Collate all comments in one report to share and request a phone meeting to discuss if needed.	SS																																												
	Develop a comments tracking sheet documenting how comments are addressed. Submit finalised inception report (V2) based on SS comments.	TH																																												
	Approve final inception report	SS																																												

SS Sightsavers  
SSCO Sightsavers Country Office  
ETL Evaluations team lead  
SSRT Sightsavers Review Team  
EO Evaluations Officer  
EM Evaluations Manager  
TH Tropical Health  
TL Team Leader  
TC Technical coordinator

Tasks  
Meeting  
Deliverables

## Appendix 4: Documents list

S/N	Document title	Sightsavers' prioritisation guidance (H/M/L)	Received (Yes ✓ / No X)	Reviewed to date (Yes ✓ / No X)
<b>A.</b>	<b>Background documents</b>			
1	2015 57008 Knowledge Attitudes and Practices (KAP) Eye Health and disability – comprehensive report final (12.11.15)	M	✓	✓
2	2015 57008 KAP Eye Health and Disability – Research Summary	M	✓	✓
3	Ebola Impact Situational Analysis – Sierra Leone Country Team	H	✓	✓
4	Funding information on EC, SiB and IA	L	✓	✓
5	Post Ebola Analysis June 2015	L	✓	✓
6	Rapid Assessment of Avoidable Blindness (RAAB) 2011	M	✓	✓
7	Sierra Leone Eye Health System Assessment (EHSA) 2013	M	✓	✓
8	2015 57009 Sierra Leone Country Office Ebola Update July 2015 - International Agency for the Prevention of Blindness (IAPB)	L	✓	✓
9	National Eye Health Policy Review	M	✓	✓
10	Disability in and around urban areas of Sierra Leone – Leonard Cheshire Centre for Disability and Inclusive Development (2009)	L	✓	✓
11	Data collection tools	M	✓	✓
<b>B.</b>	<b>Core project documents</b>			
<b>EC project documents</b>				
12	Sightsavers Sierra Leone EC Revised Post ROM MTR Logframe 2016 Final – 290916 2	H	✓	✓
13	2016 57008 Logframe, implementation plan and budget	M	✓	✓
14	EU Sightsavers Sierra Leone Application - Revised Description of Action (2016)	H	✓	✓
15	EC Description of Action - Sierra Leone project document (2013)	M	✓	✓
16	EC Ebola update - August 2015	M	✓	✓
<b>SiB project documents</b>				
17	2012-2016 PFA 57009 Eye Care Project	M	✓	✓
18	SiB ph5RtP Proposal Sierra Leone - Final 280912	H	✓	✓
19	SIB Logframe Gantt Sierra Leone 280912 Original	M	✓	✓
20	2016 57009 Logframe, Implementation Plan and Budget (please disregard this version)	H	✓	n.a

S/N	Document title	Sightsavers' prioritisation guidance (H/M/L)	Received (Yes ✓ / No X)	Reviewed to date (Yes ✓ / No X)
21	SIB Sierra Leone Letter of Variation (LOV) - Final 160816	M	✓	✓
22	SIB Sierra Leone LOV revised budget – Final 16082016	M	✓	✓
<b>C.</b>	<b>Projects' Mid Term Review (MTR)</b>			
<b>MTR – EC</b>				
23	Terms of Reference - EC MTR (4th Sept)	M	✓	✓
24	EC Sierra Leone MTR Final Report	H	✓	✓
25	Management Response to EC MTR	Not known	✓	✓
<b>MTR – SiB</b>				
26	Terms of Reference - SiB Sierra Leone MTR with IAPB feedback	M	✓	✓
27	SiB Sierra Leone MTR Final Report	H	✓	✓
28	Management Response to SiB MTR	Not known	✓	✓
<b>Internal</b>				
29	Sierra Leone Eye Health Programme Review - FINAL 18-03-16	M	✓	✓
<b>Supporting documents</b>				
30	Actual targets EU and SiB	L	✓	✓
31	EC and SiB targets	L	✓	✓
32	Mapping project partners activities and locations	L	✓	✓
33	NTDs (Neglected Tropical Diseases) activities, targets and current challenges in SiB comprehensive eye care in Sierra Leone	H	✓	✓
<b>D.</b>	<b>Projects' Reports</b>			
<b>EC Annual reports</b>				
34	Annual report for 2012 – 2013	H	✓	✓
35	Annual reports 2014 for submission (folder) – includes financial and narrative reports	H	✓	✓
36	Annual reports 2015 for submission (folder) – includes financial and narrative reports	H	✓	✓
37	Annual reports 2016 for submission (folder) – includes financial and narrative reports	H	✓	✓
<b>EC Quarterly reports</b>				
38	Dec 2012	H	✓	✓
39	March 2013	H	✓	✓
40	July 2013	H	✓	✓
41	April– June 2014	H	✓	✓



S/N	Document title	Sightsavers' prioritisation guidance (H/M/L)	Received (Yes ✓ / No X)	Reviewed to date (Yes ✓ / No X)
42	Sep – Nov 2014	H	✓	✓
43	Dec 2014 – Feb 2015	H	✓	✓
44	March – May 2015	H	✓	✓
45	Sep – Nov 2015	H	✓	✓
46	Dec 2015 – Feb 2016	H	✓	✓
47	March – May 2016	H	✓	✓
48	Sep – Nov 2016	H	✓	✓
<b>EC Monitoring visits</b>				
49	Kono monitoring visit report – May 2013	Not known	✓	✓
50	Kono Management Response – May 2013	Not known	✓	✓
51	Monitoring Mission Report Sightsavers – May 2013 (Scan Doc)	Not known	✓	✓
52	Management Response to EU Monitoring Visit – May 2013	Not known	✓	✓
53	Monitoring Mission Report Sightsavers – July 2014	Not known	✓	✓
54	Management Response to EU Monitoring Visit – July 2014	Not known	✓	✓
55	Monitoring Mission Report Sightsavers – July 2015	Not known	✓	✓
56	Management Response to EU Monitoring Visit - October 2015	Not known	✓	✓
57	Monitoring Mission Report Sightsavers – July 2015	Not known	✓	✓
58	Management Response to EU Monitoring Visit - October 2015	Not known	✓	✓
<b>EC Results Orientated Monitoring (ROM)</b>				
59	ROM action plan – 2013	M	✓	✓
60	ROM Report – 2013	M	✓	✓
61	Sierra Leone Country Office (SLCO) EC ROM Mission Report - 2013	M	✓	✓
62	ROM Management Response – 2013	M	✓	✓
63	Final ROM Report from the EC Delegation - 2015	M	✓	✓
64	ROM Management Response – 2015	M	✓	✓
<b>SiB Reports</b>				
65	2012 57009 Implementation Plan	M	✓	✓
66	2012-13 SiB Sierra Leone Report 1 Sep 12 - Jun 13	H	✓	✓
67	2012-13 SiB Sierra Leone Report H2 July 13 – Dec 13	H	✓	✓
68	2014 - 57009 APR Financial Analysis	M	✓	✓

S/N	Document title	Sightsavers' prioritisation guidance (H/M/L)	Received (Yes ✓ / No X)	Reviewed to date (Yes ✓ / No X)
69	2014 SIB Sierra Leone Narrative Report Y2/H1 (Jan 14 – June 14)	H	✓	✓
70	2014 SIB Sierra Leone Narrative Report Y2/H2 (July 14 – Dec 14)	H	✓	✓
71	2015 H1 57009 SiB Sierra Leone Comprehensive Eye Care Project Narrative Report Y3/H1	H	✓	✓
72	2015 H1 Appendices	H	✓	✓
73	2015 H2 57009 SiB Sierra Leone Comprehensive Eye Care 2 Half year -Y3/H2 Narrative Report	H	✓	✓
74	2015 H2 57009 Sierra Leone SiB Eye Care Prog Update Consolidated SiB - Y3/H2 Appendices	H	✓	✓
75	2016 H1 57009 SiB Sierra Leone Comprehensive Eye Care Project Donor - Narrative Report	H	✓	✓
76	2016 H1 57009 Consolidated SiB Sierra Leone - Appendices (Final)	H	✓	✓
77	2016 SIB 57009 Y4 H2 - Narrative Report Final (Revised 030317)	H	✓	✓
78	2016 SIB 57009 Y4H2 Consolidated – Appendices (Revised 030317)	H	✓	✓
79	2017 SiB Yr 5 H1 - Narrative Report (Final)	H	✓	✓
80	2017 SiB Consolidated Report - Appendices (Final)	M	✓	✓
<b>Others</b>				
81	2014 - 57008 and 57009 - Annual Project Report Eye Health	M	✓	✓
82	EU and SIB 2017 Targets - updated	H	✓	✓
83	Key Performance Indicators (KPIs) for Sept 2016 – June 2017	H	✓	✓
<b>E.</b>	<b>Quality Standards Assessment Tool (QSAT)</b>			
84	Cataract Services Assessment (CAS) – 2013 - Connaught Hospital	H	✓	✓
<b>F.</b>	<b>Advocacy plans</b>			
85	Updates on IA Advocacy Plan - Jan - June 2017 (July 2017)	H	✓	✓
86	Sierra Leone Advocacy Plan 2016	M	✓	✓
87	Sierra Leone Advocacy Plan - Final 2015	M	✓	✓
88	Sierra Leone Advocacy Plan - Updated 2014	M	✓	✓
89	Sierra Leone Advocacy Plan - Updated 2013	M	✓	✓
90	Sierra Leone Advocacy Plan 2012 - Updated Oct 2012	M	✓	✓
<b>G.</b>	<b>Additional documents</b>			
91	Training programme reports (to be viewed/shared during field visit)	L	X	X

S/N	Document title	Sightsavers' prioritisation guidance (H/M/L)	Received (Yes ✓ / No X)	Reviewed to date (Yes ✓ / No X)
92	Information on annual government spend on eye health	M	X	X
93	District Health Management Team reports (to be viewed/shared during field visit)	M	X	X
94	Documentation on progress of establishment of cataract surgical outcome audit system (to be viewed/shared during field visit)	M	X	X
<b>H.</b>	<b>Additional documents gathered during field visit or consultants' own research</b>			
95	Addiss D. The 6th meeting of the global alliance to eliminate lymphatic filariasis: a half-time review of lymphatic filariasis elimination and its integration with the control of other neglected tropical diseases. <i>Parasit Vectors</i> . 2010, 3(1):100			✓
96	Courtright P, Mathenge W, Kello AB, Cook C, Kalua K, Lewallen S. Setting targets for human resources for eye health in sub-Saharan Africa: what evidence should be used?. <i>Human Resources for Health</i> . 2016 Mar 16;14(1):11.			✓
97	GAVI CSO. <i>Project Fact Sheet, No. 5: What are the Health System Building Blocks?</i> Geneva, Switzerland: GAVI Alliance; 2013.			✓
98	Gustavsen K, Sodahlon Y, Bush S. Cross-border collaboration for neglected tropical disease efforts—Lessons learned from onchocerciasis control and elimination in the Mano River Union (West Africa). <i>Globalization and Health</i> . 2016 Aug 22;12(1):44.			✓
99	Hodges MH, Koroma AS, Conteh I, Sonnie M, Turay H, Kandeh, J. Attendance for essential nutrition actions during the Ebola emergency demonstrate resilience when fully integrated maternal and child health services were available in Freetown, Sierra Leone. <i>Unpublished, year unknown</i> .			✓
100	Hodges MH, Sonnie M, Turay H, Conteh A, Maccarthy F, Sesay S: Maintaining effective mass drug administration for lymphatic filariasis through in-process monitoring in Sierra Leone. <i>Parasit Vectors</i> 2012, 5:232.			✓
101	Hodges MH, Sesay FF, Kamara HI, Turay M, Koroma AS, Blankenship JL, Katcher HI. High and equitable mass vitamin A supplementation coverage in Sierra Leone: a post-event coverage survey. <i>Global Health: Science and Practice</i> . 2013, 1:172-179.			✓
102	Long, M. <i>Report on a visit to Sierra Leone for Sightsavers, ADD International report for Sightsavers – May 2014</i> . Freetown, Sierra Leone: ADD International and Sightsavers; 2014.			
103	Ministry of Health and Sanitation (MOHS). <i>National Health Sector Strategic Plan: 2010-2015</i> . Freetown, Sierra Leone: MOHS, Government of Sierra Leone; 2009.			✓
104	Ministry of Health and Sanitation (MOHS). <i>Basic Package of Essential Health Services for Sierra Leone</i> . Freetown, Sierra Leone: MOHS, Government of Sierra Leone; 2010.			✓
105	Mitra S, Posarac A, Vick B. <i>Disability and poverty in developing countries: a snapshot from the world health survey</i> . Social Protection discussion paper; no. SP 1109. Washington, DC, United States: World Bank; 2011.			
106	National Eye Health Project. <i>Eye Conditions Training Manual for PHU Staff (Sierra Leone Version)</i> . Edited 2017. Freetown, Sierra Leone: Ministry of Health and Sanitation; 2017.			✓

S/N	Document title	Sightsavers' prioritisation guidance (H/M/L)	Received (Yes ✓ / No X)	Reviewed to date (Yes ✓ / No X)
107	Pope C, Ziebland S, Mays N. Qualitative research in health care. Analysing qualitative data. BMJ. 2000;320(7227):114-6.			✓
108	Sesay FF, Hodges MH, Kamara HI, Turay M, Wolfe A, Samba TT, Koroma AS, Kamara W, Fall A, Mitula P, et al: High coverage of vitamin A supplementation and measles vaccination during an integrated Maternal and Child Health Week in Sierra Leone. <i>International Health</i> . 2015, 7:26-31.			✓
109	Sightsavers. <i>10-year Strategy to respond to the Human Resources for Eye Health Crisis in Africa: June 2013</i> . London, UK: Sightsavers; 2013.			✓
110	Sightsavers. <i>Sierra Leone Irish Aid Eye Health Proposal - Towards Universal Eye Health Services in Sierra Leone</i> . Freetown, Sierra Leone: Sightsavers; 2016.			✓
111	Sightsavers. <i>HMIS Presentation for Partners (Excel)</i> . Freetown, Sierra Leone: Sightsavers; 2017.			✓
112	Sightsavers. <i>Seeing is Believing 2017 - Expression of Interest – Extension Project</i> . Freetown, Sierra Leone: Sightsavers; 2017.			✓
113	Statistics Sierra Leone (SSL) and ICF International. <i>Sierra Leone Demographic and Health Survey 2013</i> . Freetown, Sierra Leone and Rockville, Maryland, USA: SSL and ICF International; 2014.			✓
114	World Bank. Databank: Sierra Leone. Available from: <a href="https://data.worldbank.org/country/sierra-leone?view=chart">https://data.worldbank.org/country/sierra-leone?view=chart</a> [Accessed 23 <sup>rd</sup> October 2017]			✓
115	World Health Organization (WHO) and UNICEF. <i>Sierra Leone: WHO and UNICEF estimates of immunization coverage: 2016 revision</i> . Geneva, Switzerland: WHO and UNICEF; 2017.			✓
116	Wirth JP, Rohner F, Woodruff BA, Chiwile F, Yankson H, Koroma AS, Russel F, Sesay F, Dominguez E, Petry N, et al: Anemia, Micronutrient Deficiencies, and Malaria in Children and Women in Sierra Leone Prior to the Ebola Outbreak - Findings of a Cross-Sectional Study. <i>PLoS One</i> 2016, 11:e0155031.			✓
117	World Health Organization. <i>Guidelines for stopping mass drug administration and verifying elimination of human onchocerciasis: criteria and procedures</i> . Geneva, Switzerland: WHO; 2016.			✓
<b>I.</b>	<b>Additional documents received from Sightsavers 17<sup>th</sup> November 2017</b>			
118	Consolidated KPIs for EC			✓
119	Consolidated KPIs for SiB			✓
120	MDA summary results for the treatment of four targeted NTDs: 2014/2015			✓
121	National Human Resources for Health Policy: 2017-2021			✓
122	National Human Resources for Health Strategy: 2017-2021			✓
123	NEHP reporting form for PHU staff (developed by Dr Vandy)			✓
124	NTD Summary Data: 2013			✓
125	NTDCP Summary result for LF and Oncho PCT: 2013			✓
126	NTDP Result for LF PCT: 2014			✓

<b>S/N</b>	<b>Document title</b>	<b>Sightsavers' prioritisation guidance (H/M/L)</b>	<b>Received (Yes ✓ / No X)</b>	<b>Reviewed to date (Yes ✓ / No X)</b>
127	NTDP result Oncho PCT: 2015			✓
128	TAS report			✓



## Appendix 5: Data collection schedule

Date/Time	Planned activity
<b>Sunday - 17th September 2017</b>	
	Arrival of Clare and Martin
<b>Monday - 18th September 2017</b>	
8.30am	Pick up from Hotel
9.00am - 10am	Welcome and Opening Review of programme, tasks and logistics Discussions/Interviews with SLCO staff
10.30 - 11.30am	Visit to National govt partner
12.00 - 12.45pm	Visit to National govt partner
1.00 - 2pm	Visit to Other national partner
2.00 - 3.00pm	Visit to National govt partner
3.30 - 5.30pm	<b>LUNCH</b> Visit to Hospital/ clinics (H/C) and National govt partner Visit Disability partner (DP)
<b>End of Day One</b>	
<b>Tuesday 19th September 2017</b>	
8.30am	Pick up from hotel
9.00 - 10.00am	Visit donor
9.00 - 10.00am	Interview with SLCO staff
10.30 - 11.30am	Visit to Other national partner
12.00 - 1.00pm	Visit National govt partner
	Visit to National implementation partner
	Visit to Other national partner
1.30 - 2.30pm	<b>LUNCH</b>
3.00-5.00pm	Interview with SLCO staff
3.00 - 5.00pm	Visit to Hospital/clinics
5.30-6.30pm	De-brief / planning for trip
<b>End of Day Two</b>	
<b>Wednesday 20th September 2017 - Clare</b>	
6.00am	Pick up from hotel
11.00am	Arrive in Kenema
11.30 - 12.00noon	Visit the Sub-regional govt partner/hospital/clinic
12.30 - 1.30pm	School visit
2.00 - 3.00pm	<b>LUNCH</b>
3.30 - 4.30pm	Visit to Disability partner
5.00pm	Check into Ericsson Hotel in Kenema
<b>Wednesday 20th September 2017 - Martin</b>	
6.00am	Pick up from hotel
10.30am	Arrive in Moyamba
11.00am - 1.00pm	Visit Disability partner
1.00 - 2.00pm	<b>LUNCH</b>
2.30 - 3.30pm	Visit Disability partner
4.00 - 5.00pm	Return to Bo and check in to J and M hotel
<b>End of Day Three</b>	
<b>Thursday 21st September - Clare</b>	
8.00 - 10.30am	Visit Beneficiaries in their communities
10.30 - 11.30am	En route visit Health worker
11.30 - 2.30pm	Witness Outreach
2.30 - 3.30pm	<b>LUNCH</b>
3.30 - 4.00pm	<b>Wrap up</b>
4.00 - 5.00pm	Return to Kenema
<b>Thursday 21st September - Martin</b>	
9.00 - 1.30pm	Visit Disabled Peoples Organisations
2.00 - 3.00pm	<b>LUNCH</b>
3.00 - 5.30pm	Visit Beneficiaries in their communities
<b>End of Day Four</b>	
<b>Friday 22nd September 2017</b>	
8.30am	Pick up from Hotel
9.00 - 10.00am	Visit Community based health workers
10.15 - 11.15am	Travel to Bo
11.30 - 2.00pm	Visit to Sub-regional govt partners
2.15pm-3.00pm	<b>LUNCH</b>
3.00- 4.30pm	Visit Training Institute
5.00pm	Check into J and M Hotel in Bo
7.00- 8pm	Debrief
<b>End of Day Five</b>	
<b>Saturday 23rd September 2017</b>	
9.00am	Martin Check out of hotel for airport
8.30 - 9.30am	Leave for Gbaima Songa
9.30am - 12.30pm	Outreach visit
12.30 -1.30pm	Return to Bo
1.30 - 2.30pm	<b>LUNCH</b>
2.30 -4.00pm	Visit Community Health Workers
<b>End of Day Six</b>	
<b>Sunday 24th September 2017</b>	
10.00am	Leave for Makeni
2pm	Arrive in Makeni and check into D and S Resort
1.30 - 2.30pm	<b>LUNCH</b>
<b>REST</b>	
<b>End of Day Seven</b>	
<b>Monday 25th September 2017</b>	
9.00 - 1.00pm	Visit Sub-regional govt partners and Hospital/clinic
1.00 - 2.00pm	<b>LUNCH</b>
2.00 - 4.00pm (tbc)	Visit a PHU
<b>End of Day Eight</b>	
<b>Tuesday 26th September 2017</b>	
9.00am	Leave for Lunsar
9.30am - 11.30am	Visit Hospital/Clinic
12noon	Leave for Freetown
3.00pm	Arrive in Golden Tulip Hotel
<b>End of Day Nine</b>	
<b>Wednesday 27th September 2017</b>	
9.00 - 10.00am	Visit to donor
10.30am - 12.30pm	De-brief with Sightsavers and key partners
12.30 - 1.30pm	<b>LUNCH</b>
1.30 - 2.30pm	Internal Debrief
3.00pm	Clare leaves for sea coach
<b>End of In-country Evaluation Visit</b>	
<b>Key</b>	
Clare and/or Martin	
Clare	
Martin	

## Appendix 6: KII topic guide

### Sierra Leone End of Term Evaluation

#### Key Informant Interview Guide

##### A. Notes for interviewer

In line with the Terms of Reference, the discussion will look at six areas of enquiry, as relating to the specified evaluation criteria. The overall scope of enquiry of each section is provided for the benefit of the Facilitator – this is not to be read out.

The questions to, and discussions with, individual informants will be tailored to suit the category of informant and to match their particular area of expertise and their relationship to the programme. Prompts are included in the guide in italic text.

This tool will be used for national level informants and some sub-regional and community level informants (as indicated below in the table). It is important not to be too prescriptive about what will be asked to who upfront so as not to limit the scope of opinion generated or insight shared which could lead to bias in the data. However, as understanding of the programme grows during the data collection phase, the questions will become increasingly tailored to the individual's experience as relating to the project.

All participants will sign an information and consent form prior to initiation of the interview.

*N.B. This is a semi-structured interview 'guide' – not all questions will be relevant and many of the sub –questions (in italics) can be used as prompts. The questions may be approached in a different order, may not cover all subjects or may cover subjects not listed.*

##### B. Introduction of the interview to the respondent

*I/we have been asked to undertake an end of term evaluation of the Sightsavers' Sierra Leone Eye Care Programme and you have been identified as a key stakeholder to be consulted to inform the review findings. I/we want to thank you for taking the time to meet with me/us today to give us your insights and perspectives on the programme to date. I/we should not take more than an hour of your time for this interview.*

*We will explore what you feel might be the project achievements, successes and challenges, prospects for sustainability and any broader learning from the programme which we could use for any further implementation activity. Don't worry if some of my/our questions are not so relevant to your situation; if that is the case we can move quickly on.*

All your responses will be kept confidential. This means that your interview responses will only be shared with evaluation team members and we will make sure that any information we include in our report does not identify you as the respondent.

Are there any questions or clarifications before we begin?

### C. Interview details

- Date of interview
- Interviewee category
- Name of interviewee
- Job title/details of involvement in programme
- Gender
- Would you describe yourself as disabled?
- Location of interview
- Any notes on interview context
- Length of interview (start/end time)

### D. Key Informant Interview guide

N: national level

SR: sub-regional level

C: community level

Questions (P=probe)	Relevant Stakeholders	Relevant evaluation question
(Greetings and informal conversation.) Can you please tell me about your role in the <i>Sightsavers' Eye Care Programme</i>	All	-
<b>Relevance</b>		
Can you comment on the overall scope of the programme and work undertaken. How relevant, if at all, would you say it has been to addressing eye care needs in Sierra Leone or to improving access to eye health care for people who might not have had access before? P: Was the programme designed appropriately? Did it address key gaps? How could it have been designed differently?	N, SR	3, 12, 13, 17
Have there been any wider changes which have affected the programme's relevance over time? What can you say about the programme's relevance after the EVD outbreak? P: Were there any changes or strategies made to the programme as a result of the EVD outbreak? Were they appropriate? [Ebola situation analysis doc to hand for prompting]	N, SR	2, 4

Questions ( <i>P=probe</i> )	Relevant Stakeholders	Relevant evaluation question
Are you aware of the Knowledge Attitudes and Practice (KAP) study completed in 2015? Were the findings used to change the programme, to rethink the objectives, or amend the scope of the programme? <i>P: If so, how? Were the findings useful? [KAP document to hand for prompting]</i>	N, SR	1
<b>Effectiveness</b>		
Overall, how effective has the programme been? <i>P: Why/why not?</i>	N, SR	3
What do you see as the overall strengths of the programme? What key factors have led to any programme successes or achievements? <i>P: What could have been done to improve the effectiveness of the project?</i>	N, SR,	3
In your opinion, what were the least effective aspects and why? What factors contributed to these? <i>P: How could the weak areas you have identified have been improved or avoided?</i>	N, SR,	
Were you involved in or aware of the Mid-Term Review? If so, what do you think about its findings and recommendations? <i>P: Were these useful? How have they been addressed? Why/why not? [MTR reports and management responses to hand]</i>	N, SR, C	4
Are there any comments you would like to make on the value of any of the project monitoring activities and Results Orientated Monitoring? <i>P: Has the data been used and if so, was it useful in shaping implementation or monitoring approaches? How?</i>	N, SR	4
Can you comment on whether or not the programme has managed to integrate primary eye care into primary health care? <i>P: What have been the specific achievements? What facilitated these? What were the barriers? What would you recommend going forward?</i>	N, SR	8, 12
Looking specifically at the aim of better integrating the recording of eye health patients and treatments into PHC record keeping (as recommended in the MTR) – What have been the achievements?	SR	8, 12

Questions (P=probe)	Relevant Stakeholders	Relevant evaluation question
P: <i>How, if at all, has it helped with the integration of eye health into overall primary health care systems?</i>		
Can you comment on the progress regarding the development of a joint district level advocacy plan by all project partners, to influence integration of primary eye care in the Basic Package of Essential Health Services?	N, SR	5
Can you comment on any progress made under the project in improving access to health care and specifically eye care for persons with disabilities? P: <i>What approaches have been effective? What challenges continue to exist? How could they be addressed?</i>	N, SR, C	5, 16
Do you think the programme has led to any change in the ability of Disabled People's Organisations to advocate and lobby for fair access to eye health services for people with disabilities? P: <i>Can you cite any specific examples?</i>	N, SR, C	13, 21
To what extent has the project enhanced human resources for eye health, at different levels of the health system? Can you tell me how the training activities have contributed to filling gaps in service delivery as relating to eye care at different levels of the health system? P: <i>What have been the key achievements in this area? And challenges? What could have been done differently? What key gaps or challenges remain?</i>	N, SR	6
Do you think the project has identified any differences in men and women's access to services? If so, can you give examples and what changes, if any, were made. P: <i>Has this shaped any programme activities, such as training, especially among people with disabilities? Have these approaches been effective?</i>	N, SR	7
Can you comment on the Vitamin A supplementation component of the programme? Has this been effective? P: <i>Do you think this may have led to a reduction in vitamin A deficiency-associated blindness and mortality among children? Have there been any challenges with this activity? Any lessons learned? To what extent is this activity integrated into Primary Health Care or Child Health service delivery now?</i>	N, SR, C	9
Efficiency		

Questions ( <i>P=probe</i> )	Relevant Stakeholders	Relevant evaluation question
Would you say that the programme has been implemented in a timely and efficient manner (according to plans and budget objectives?). <i>P: Why/why not? What factors have hindered/supported this?</i>	N	3, 10
Has any programme data been used beyond measuring implementation and performance of the projects? In what other ways could any monitoring and outcome data be usefully used? <i>P: Could any gender specific data help inform thinking around gender targeting for this programme or for future Sightsavers projects?</i>	N	11, 17
<b>Impact</b>		
What can you say about the overall impact of the programme? <i>P: What have been some of the key positive impacts? Were there any unexpected or unintended impacts? Or any negative impacts?</i>	N, SR	17
Through its support to Primary Health Units, how has the programme strengthened the health system, or the organisation and delivery of health care, in each of the provinces and Western Area?	N, SR	12
Do you think the programme has improved partner capacity in project planning, management and implementation? <i>P: Which partners have particularly benefited? How? Are you aware of Sightsavers' Quality Standards Assessment Tool and if so, how do you feel its recommendations have been addressed at your place of work?</i>	N, SR, C	14
What progress has been made regarding the review of the national human resourcing plan for eye health?	N	15
The MTR recommended that a mechanism be set up to strengthen recording and follow-up for people with disabilities referred to other services, so that the potential barriers can be more clearly identified. Was this done, and if so, what impact has this had?	N, SR	16
How has the break in mass drug administration due to Ebola affected the elimination of lymphatic filariasis and the onchocerciasis cycle in the areas targeted?	N, SR, C	18



Questions ( <i>P=probe</i> )	Relevant Stakeholders	Relevant evaluation question
Are there any other impacts or value added from the programme that we haven't discussed and that you would like to raise?	N, SR, C	17
<b>Sustainability</b>		
At this stage of programme completion, what do you think is the likelihood of any programme benefits continuing? What outcomes or benefits are most/least likely to be sustained? Why? <i>P: What factors have contributed to this (achievement or non-achievement of sustainability)?</i>	N, SR, C	19, 20
What could be done to improve sustainability of project achievements?	N, SR	19, 20
Has any capacity been built for continued support of persons with disabilities in understanding their rights and advocating for access to services? If so, can you describe it? How could this further be supported?	N, SR, C	21
<b>Coherence/coordination</b>		
Has the project coordinated with other similar initiatives, or activities and actors within the country? How? <i>P: Were there aspects of coordination which worked particularly well? Were there any challenges? What could have been improved?</i>	N, SR	22
What benefits if any have there been from any improved coordination and collaboration? <i>P: Has this led to enhanced efficiency by preventing duplication and improving learning/sharing etc?</i>	N, SR	22
<b>Other</b>		
Is there anything else you would like to add in relation to what we have already discussed?	All	
Is there anything else you would like to add on the overall value of the programme? What has been learned from the programme? What could have been done differently? How can we maximise the opportunities presented from the project going forward?	All	

Thank you very much for your time and feedback. It has been very useful.

## Appendix 7: FGD topic guide

### Sierra Leone End of Term Evaluation Focus Group Discussion Guide

#### A. Notes for facilitator

A number of guided and open-ended discussions will be held with groups of 5 to 15 individuals, including with direct beneficiaries and their organisations, some of which will be women-only. The evaluation team will need to take care to ensure appropriate gender and disability sensitivity is shown while facilitating these FGDs.

In line with the Terms of Reference, the discussion will look at six areas of enquiry, as relating to the specified evaluation criteria. The overall scope of enquiry of each section is provided for the benefit of the Facilitator – this is not to be read out.

The questions to, and discussions with, individual groups will be tailored to suit their situation, to match their particular area of expertise and their relationship to the programme. Prompts are included in the guide in italic text.

This tool will be used for sub-regional and community level informants (as indicated below in the table). It is important not to be too prescriptive about what will be asked to who upfront so as not to limit the scope of opinion generated or insight shared which could lead to bias in the data. However, as understanding of the programme grows during the data collection phase, the questions will become increasingly tailored to the individual's experience as relating to the project.

All participants will sign an information and consent form prior to initiation of the FGD.

*N.B. This is a semi-structured discussion 'guide' – not all questions will be relevant and many of the sub-questions can be used as prompts. The questions may be approached in a different order, may not cover all subjects or may cover subjects not listed. Specific wording of questions will also be adapted to suit specific informants' roles as relating to, and understanding of, the programme.*

#### B. Introduction of the interview to the respondent

*I/we have been asked to undertake an end of term evaluation of the Sightsavers' Sierra Leone Eye Care Programme and you have been identified as a group of people to be consulted to inform the review findings. I/we want to thank you for taking the time to meet with me/us today to give us your*

*insights and perspectives on the programme to date. I/we should not take more than an hour of your time for this discussion.*

*We will explore what you feel might be the project achievements, successes and challenges, prospects for sustainability and any broader learning from the programme which we could use for any further implementation activity. Don't worry if some of my/our questions are not so relevant to your situation; if that is the case, we can move quickly on.*

*All your responses will be kept confidential. This means that your responses will only be shared with evaluation team members and we will make sure that any information we include in our report does not identify you as the group respondent.*

*Are there any questions or clarifications before we begin?*

### C. FGD details

- Date of FGD
- Key informant category
- Gender
- Would you describe yourself as disabled?
- Location of FGD
- Any notes on FGD context
- Length of FGD (start/end time)

### D. Focus Group Discussion guide

SR: sub-regional level

C: community level

Questions (P=probe)	Relevant Stakeholders	Relevant evaluation question
<i>(Greetings and informal conversation.)</i> Can you please tell me about your group (if it is one), when you were formed, how many members you have and what you do as a group?	All	-
Can you please tell me about your involvement – either as individuals or (where relevant) as a group -in the Sightsavers' Eye Care Programme.	All	-
<b>Effectiveness</b>		
Overall, do you think the programme was beneficial/useful? P: <i>Why/why not? What difference, if any, has the programme made to you or your group?</i>	SR, C	3

Questions (P=probe)	Relevant Stakeholders	Relevant evaluation question
What do you see as the overall strengths of the programme? What led to any programme successes or achievements? <i>P: What could have been done to make the programme more useful?</i>	SR, C	3
In your opinion, what were the areas that were least successful? <i>P: Why? What contributed to these? How could any the weak areas have been improved or avoided?</i>	SR, C	3
Has there been any impact on access to health care and specifically eye care for persons with disabilities? <i>P: What approaches have been beneficial? What challenges have there been with this? Do these challenges still exist? How could they be addressed?</i>	SR, C	13
Have Disabled People's Organisations been able to better advocate and lobby for fair access to eye health services for people with disabilities because of the programme? <i>P: Why/why not? Can you give examples?</i>	SR, C	5, 21
Has the project recognised any differences in men and women's access to services? <i>P: Has this shaped any programme activities, such as training, especially among people with disabilities? Have these approaches been useful?</i>	SR, C	7
Can you comment on the Vitamin A supplementation? Has this been beneficial? <i>P: Why/why not? Do you think this may have led to a reduction in vitamin A deficiency-associated blindness and mortality among children? Have there been any challenges with this activity? Any lessons learned?</i>	SR	9
<b>Relevance</b>		
How well did the programme respond to your needs or others in your situation? <i>P: What impact has it had on access to eye care? Are there any changes in the people who have access to care – new people or the same people? Did the programme address key/important gaps? How/why/why not? How could it have been designed differently?</i>	SR, C	
Have there been any other factors which have affected how relevant or important the programme has been?	SR, C	20

Questions (P=probe)	Relevant Stakeholders	Relevant evaluation question
What can you say about the programme's relevance after the EVD outbreak? P: <i>Were there any changes made to the programme because of the EVD outbreak? Were they appropriate?</i> [Ebola situation analysis document to hand for prompting]		
<b>Impact</b>		
What major benefits, if any, do you think the programme has achieved for you, your group, or others in your situation? Were there any unexpected or unintended impacts? Or any negative impacts?	SR, C	13, 17
One aim of the programme was to improve people with disabilities' access to health services. Were you aware that one way it tried to do this was by strengthening recording of the patients' details and follow-up to understand more why it may be hard for them to access care? Was this done and if so what difference – if any - do you think this has made?	SR, C	13,
Are there any other impacts, problems or benefits of the programme that we haven't discussed?	SR, C	3
<b>Sustainability</b>		
If you have seen benefits from the programme, do you think these will last? P: <i>Why/why not? What could be done to encourage any benefits to last for longer?</i>	SR, C	19, 20
<b>Coherence/coordination</b>		
Has the programme linked with other similar initiatives or activities? If so, has this been useful? P: <i>What benefits has this led to? Were there any challenges? What could have been improved?</i>	SR,	22
<b>Other</b>		
Is there anything else you would like to add in relation to what we have already discussed?	All	-

Thank you very much for your time and feedback. It has been very useful.

## Appendix 8: PHU visit - observation guide

### Sierra Leone End of Term Evaluation

#### PHU Visit - Observation Guide

##### A. Notes for Evaluator

Below is a list of areas to explore, observe and informally discuss with clinic staff during the PHU visits. This data will be triangulated with key informant interviews with health workers (likely the Focal Eye Person at each of the PHUs visited) so as to enable the development of 'clinic case studies'. These case studies will aim to provide valuable insight into, and illustration of, the implementation and performance of the Sierra Leone Eye Care Programme.

This Observation Guide will be used for a small sample of Primary Health Units (PHUs), likely three, depending on feasibility. The focus will be at the primary care level because the integration of eye care into primary health care delivery was a priority of the programme and it is at this level where a more comprehensive insight into the process and effect of the programme will be possible within the time available. The aim will be to select PHUs which offer differing contextual insights, such as well functioning/not well functioning, good/less good access by communities, including marginalised groups, and will be located in different parts of the country. The importance of including a rural-based PHU is recognised so the findings are not biased by an urban location. Specific PHUs will be identified through discussion with SLCO and the sub-regional eye care managers during the data collection phase.

The Observation Guide will facilitate exploration of the following areas: human resources, general functionality and supplies, other areas of quality of care, integration of eye care into primary health care services, disability and gender, sustainability and data for decision-making. Enquiry will be tailored to the specific PHU visited and, as such, not all items included in the Observation Guide may be relevant. Additional items may also be added to this list during the course of data collection. Items may also be explored in any order. The evaluator should make their own notes of findings in the third column of the table. *Note this is a qualitative, rather than quantitative, enquiry – the aim is illustration rather than representation.*

##### B. Observation guide

Areas to explore/discuss informally	Possible useful data sources*	Evaluator's notes
Human Resources		
Availability of project trained staff? Does there appear to be enough staff to respond to patient demand?	Staff records	



Areas to explore/discuss informally	Possible useful data sources*	Evaluator's notes
Availability and/or stock outs (e.g. last three months) of basic eye care consumables and drugs, as well as eye drops and ointments for newborn babies?	Stock cards, clinic reports	
<b>General functionality and supplies</b>		
Availability and functionality of basic amenities, e.g. water, functional latrines, electricity, refrigeration facilities?		
Availability and use of learning materials/clinical guidance on eye care/health to support staff?	Clinical guidance material	
<b>Other areas of quality of care</b>		
Availability and use of IEC materials for the prevention of eye health problems/blindness? What eye care IEC activities are carried-out and how often? Who do they target?	Eye care IEC materials	
<b>Integration of eye care into primary health care services</b>		
What eye conditions are most common? What is the general capacity to manage them?  Do many cases tend to be referred upwards? How likely is that the referrals are completed? Does the PHU get feedback on that?	Clinic records	
How well integrated is the recording of eye care patients and treatments into PHC record keeping, including monitoring systems?*	Clinic records	
<b>Sustainability and data for decision-making</b>		
Is clinic's own data aggregation done to monitor trends at clinic level?	Clinic records	
Evidence on feedback to clinic on performance?	Clinic records	
Does the clinic use its own data on eye conditions/cases to inform any preventive activity or improve clinical activity?	Clinic records	
Does the clinic explore data to assess whether any particular groups (e.g. people with disabilities) are under-represented?		
<b>Disability and gender</b>		

Areas to explore/discuss informally	Possible useful data sources*	Evaluator's notes
Is disability disaggregated data available? If so, what detail (e.g. impairment type?) is kept and who decides if a patient is recorded as being disabled? How is the data used? If not, what other data on people with disabilities is available?		
How is access of all types by people with disabilities supported/ encouraged?		
Have staff had any training in making their services more accessible? And if so how did they rate any such training?		
Are facilities accessible to people with disabilities or are there potential barriers such as stairways, or small writing on signs?		
How is access by women supported/ encouraged? (e.g. patient can choose female staff, option to bring a chaperone etc.)?		
Capacity of health workers on disability issues e.g. understanding of rights and of access issues etc.,		
Scope of activity for outreach screening targeting vulnerable/marginalised groups, women and people with disabilities?	Clinic records	
Efforts to increase awareness and uptake of services for eye conditions and people with disabilities?		

\*The aim here is not validation – but to add illustration to what is observed and discussed.

\*\*It is noted that eye care indicators are in process of being included in the HMIS and so focus here will remain broader.

# Appendix 9: Information Sheet and Consent Form

## Sierra Leone Eye Care Programme: End of Term Evaluation

### Information and Consent to Participate in Evaluation

This form is for both key informant interviewees and focus group discussion informants.

You are invited to participate in an end of term evaluation of the Sightsavers' Sierra Leone Eye Care Programme, which is being conducted by a small team of consultants on behalf of Sightsavers.

Your participation in this evaluation is entirely voluntary. You should read the information below (or it will be read to you) and you should ask questions about anything you do not understand, before deciding whether or not to participate. You are being asked to participate in this study because you are one of the stakeholders of the Sierra Leone Eye Care Programme.

#### **Purpose of the evaluation**

The purpose of this evaluation is to understand the effectiveness of the programme, its successes, challenges and long-term effects, and any lessons learned which could be useful for other projects, either here or in other countries.

#### **Procedure**

You will be asked a series of questions about your experience of the Sierra Leone Eye Care Programme. We will record the conversation to ensure we capture what you say accurately. We may also ask to take photographs, with your permission, to help add more context to the evaluation

#### **Potential risks and discomforts**

We expect that there will not be any risks, discomforts, or inconveniences, but that if any occur they will be minor. If discomforts become a problem, you may discontinue your participation.

#### **Potential benefits to participants and/or to society**

It is unlikely that you will benefit directly from participation in this evaluation, but the study should help the implementers learn how to improve services which may or may not include those available to you. This study does not include procedures that will improve your general health.

#### **Payment for participation**

You will not receive any payment or other compensation for participation in this study. There is also no cost to you for participation.

#### **Confidentiality**

Any information obtained in connection with this evaluation and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained at all times and we will not use your name in any of the information we get from this study or in any of the reports. We will include a list of the people we spoke to according to informant type but nothing you say will be linked back to you in any report or other documentation. Information that can identify you individually will not be released to anyone outside the study, this includes any photographs taken. All data will be kept in a secure location and only those directly involved with the research will have access to them. We may use any information that we get from this study in any way we think is best for publication or education. Any information we use for publication will not identify you individually.

### **Participation and withdrawal**

You can choose whether or not to be a part of this evaluation. If you are happy to participate in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer, to have the conversation recorded or for photographs to be taken. There is no penalty if you withdraw from the study and you will not lose any benefits to which you are otherwise entitled.

### **Identification of the in-country evaluators**

Clare Strachan, Tropical Health (clarestrachan10@gmail.com)

Martin Long, Tropical Health (martin.long@blueyonder.co.uk)

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

---

Name and Signature of Respondent(s)

Date:

KII/FGD:

## Appendix 10: List of key informants

Stakeholder category (code and colour to use in data analysis)	KII (estimated target)	FGD (estimated target)	Actual KIIs	Actual FGDs	Interview date	Interviewer
<b>National level</b>						
SLCO staff (SLCO)	3	0	4	0	19/09/2017	ML
					19/09/2017	ML
					22/09/2017	CS
					25/09/2017	CS
					18/09/2017	CS
Disability partner (DP)	1	0	1	0	18/09/2017	ML
Disability partner (DP)	1	0	2	0	18/09/2017	ML
National govt partner (NGP)	1	0	1	0	18/09/2017	CS
National govt partner (NGP)	1	0	0	1	19/09/2017	CS
Hospital/ clinics (H/C)	1	0	2	0	18/09/2017	CS
					18/09/2017	CS
Hospital/ clinics (H/C)	1	0	0	1	19/09/2017	CS
Hospital/ clinics (H/C)	1	0	1	0	26/09/2017	CS
Donor (DON)	1	0	1	0	27/09/2017	CS
Donor (DON)	1	0	1	0	19/09/2017	CS
National implementation partner (NIP)	1	0	2	0	19/09/2017	CS
Other national partner (ONP)	1	0	2	0	19/09/2017	ML
					19/09/2017	ML
Other national partner (ONP)	1	0	1	0	19/09/2017	ML
<b>Total national level</b>	<b>16</b>	<b>0</b>	<b>19</b>	<b>2</b>		
<b>Sub-regional level</b>						
Sub-regional govt partner (SRGP)	1	0	1	0	22/09/2017	ML
Sub-regional govt partner (SRGP)	1	0	1	0	20/09/2017	CS
Sub-regional govt partner (SRGP)	1	0	1	0	25/09/2017	CS
Sub-regional govt partner (SRGP)	2	0	3	1	20/09/2017	CS
					20/09/2017	CS
					22/09/2017	ML
					25/09/2017	CS
					25/09/2017	CS
Sub-regional govt partner (SRGP)	1	0	1	0	25/09/2017	CS
Disability partner (DP)	2	0	3	3	20/09/2017	CS
					20/09/2017	ML
					20/09/2017	ML
					21/09/2017	ML
					21/09/2017	ML
					21/09/2017	ML
Training institute (TI)	1	0	1	0	22/09/2017	CS
Health workers (H/C)	1	0	1	0	20/09/2017	CS
Health workers (H/C)	1	0	1	0	21/09/2017	CS
Health workers (H/C)	1	0	3	0	22/09/2017	CS
					22/09/2017	CS
					25/09/2017	CS
Health workers (H/C)	0	0	1	0	23/09/2017	CS
Health workers (H/C)	3	0	5	0	21/09/2017	CS
					23/09/2017	CS
					23/09/2017	CS
					25/09/2017	CS
					25/09/2017	CS
<b>Total sub-regional level</b>	<b>15</b>	<b>0</b>	<b>22</b>	<b>4</b>		
<b>Community level</b>						
Community based health workers (CHW)	0	2	2	0	21/09/2017	CS
					23/09/2017	CS
Community based health workers (CHW)	0	1	2	0	22/09/2017	CS
					22/09/2017	CS
Beneficiaries (BEN)	0	3	2	0	23/09/2017	CS
					25/09/2017	CS
Beneficiaries (BEN)	0	2	2	0	21/09/2017	ML
					21/09/2017	ML
Beneficiaries (BEN)	0	2	4	0	19/09/2017	CS
					20/09/2017	ML
					23/09/2017	CS
					23/09/2017	CS
Beneficiaries (BEN)	0	0	1	0	20/09/2017	CS
Schools (SCH)	0	1	3	0	20/09/2017	CS
					20/09/2017	CS
					22/09/2017	ML
<b>Total Community level</b>	<b>0</b>	<b>11</b>	<b>16</b>	<b>0</b>		
<b>Overall Total</b>	<b>31</b>	<b>11</b>	<b>57</b>	<b>6</b>		

Abbreviations: CS - Clare Strachan; ML - Martin Long

## Appendix 11: The evaluation questions and where they are addressed in the report

S/N	Key Evaluation question to be addressed	Report heading / sub-heading
<b>Relevance</b> - <i>the extent to which the project or programme is suited to the priorities and policies of the target beneficiaries, national partners, and donors, where applicable.</i>		<b>2.1. Relevance</b> <b>2.1.1. Overall relevance of the project</b>
1.	What has been the outcome of the knowledge and strategies which emerged from the Knowledge Attitudes and Practice (KAP) study completed in 2015, in regard to shaping project focus and objectives in the second part of the project?	2.1.2. Value of the KAP study
2.	Did any changes in the context of the project (post EVD outbreak) impact upon the relevance of the project, and if so what measures were put in place to mitigate this?	2.1.3. Post Ebola context
<b>Effectiveness</b> - <i>the extent to which the objectives have been achieved and the anticipated results have been realized</i>		<b>2.2. Effectiveness</b>
3.	To what extent have the planned outputs been delivered, including planned targets for women, and the project objectives been met? And what were the major factors influencing the achievement or non-achievement of the objectives?	2.2.1. Project achievements 2.2.2. Factors driving project success
4.	To what extent was the learning from the project monitoring, and the MTR adequately incorporated during project implementation and recommendations appropriately responded to?	2.2.3. Application of learning from monitoring and evaluation activities
5.	What progress and/or achievements have there been regarding development of a joint district level advocacy plan by all project partners, to influence integration of primary eye care in the Basic Package of Essential Health Services?	2.2.4. District level advocacy
6.	To what extent has the project enhanced human resources for eye health, and is deployment of project trained staff achieved?	2.2.5. Human Resources for eye health
7.	What progress has been made on improving the systematic integration of recording of eye health patients and treatments into PHC record keeping, as recommended in the MTR, and has this had any influence on the integration of eye health into existing PHC systems?	2.2.7. Recording eye health data
8.	To what extent has the project been able to reduce vitamin A deficiency-associated blindness and mortality by ensuring high and sustained Vitamin A Supplementation (VAS) for children, and is this fully integrated into PHC/Child Health service delivery now?	2.2.8. Vitamin A supplementation for children under five



S/N	Key Evaluation question to be addressed	Report heading / sub-heading
<b>Efficiency</b> – <i>the extent to which results have been delivered with the least costly resources possible, and the manner in which resources have been efficiently managed and governed in order to produce results.</i>		<b>2.3. Efficiency</b>
9.	Was the project implemented in a timely and efficient manner with resources used according to plan?	2.3.1. Efficiency in project delivery
<b>Impact</b> - <i>the long term change or effects (positive or negative) that have occurred, or will occur, as a result of the project or programme.</i>		<b>2.4. Impact</b>
10.	To what extent has the project been able to influence the integration of eye health within government health systems, and strengthen the national health systems in the Eastern Province, Northern Province, Southern Province and Western Area through support to Primary Health Units (PHUs)?	2.4.1. Integration of eye health into government health systems
11.	1To what extent has the project improved the capacity of the project partners in project planning, management and implementation, across the national provincial and district levels? E.g. Have recommendations from Sightsavers Quality Standards Assessment Tool exercise been satisfactorily addressed?	2.4.3. Project partners capacity building
12.	What progress has been made regarding the proposed review of the national human resourcing plan for eye health?	See under 2.2.3. Application of learning from monitoring and evaluation activities Table 5 – progress reported against the first MTR recommendation, which relate to this question
13.	Are there any other impacts (intended or unintended, positive or negative) which have resulted from the project?	2.4.5. Added value
14.	How has the break in Mass Drug Administration (MDA) due to Ebola affected the elimination of lymphatic filariasis and onchocerciasis cycle in the project locations?	2.4.4. Progress towards the elimination of lymphatic filariasis and onchocerciasis
<b>Sustainability</b> – <i>whether benefits of the project or programme are likely to continue after donor funding has ceased.</i>		<b>2.5. Sustainability</b>
15.	To what extent are the project benefits sustainable beyond the end of the project?	2.5.1. Opportunities for sustainability 2.5.2. Challenges with sustainability
16.	What are the major factors that have influenced the achievement or non-achievement of sustainability of the project?	2.5.1. Opportunities for sustainability 2.5.2. Challenges with sustainability
<b>Coherence/coordination</b> – <i>the extent to which the project or programme has coordinated with other similar initiatives,</i>		<b>2.6. Coherence/ coordination</b>

S/N	Key Evaluation question to be addressed	Report heading / sub-heading
	<i>interventions or actors, and the degree to which the project design and implementation is internally coherent.</i>	
17.	How well has the project coordinated with other similar initiatives, or activities and actors within the country? And if so has improved coordination and collaboration led to enhanced efficiency by preventing duplication and improving learning/sharing etc?	2.6.1. Effective coordination 2.6.2. Coordination challenges

# Appendix 12: Quantitative analysis of project achievements against logframe

## Quantitative tool for the SiB project

Performance scale

0-49%







50-79%

80-100%



Aim/ objectives/ outputs	Indicators	Year 1 Target	Year 1 Achievem ent	Measure of Year 1 Performance	Year 2 Target	Year 2 Achievem ent	Measure of Year 2 Performance	Year 3 Target	Year 3 Achievem ent	Measure of Year 3 Performance	Year 4 Target	Year 4 Achievem ent	Measure of Year 4 Performance	Year 5 Target	Year 5 Achievem ent	Measure of Year 5 Performance
	<b>Impact indicators</b>															
To contribute to the reduction of avoidable blindness and vision impairment in Sierra Leone through country wide provision of comprehensive eye care services	3% Prevalence of blindness among 50+ age group															
	5% additional spending by Government spend on eye health															
	2.3Million people accessing quality eye health services															
	<b>Outcome indicators</b>															
Obj 1: To support NEHP to strengthen health systems through improved human resources for eye health	27% increase in cataract surgical rate															
	Cataract Surgical Coverage (CSC) in target districts															
	% sampled patients reporting good service satisfaction															
	Eye Health worker to population ratio in target districts compared to national assessed standards															
Obj 2: To effectively integrate primary eye care services into primary health care through support to peripheral health units	No. of eye health conditions treated at PHUs															
	No. of patients presenting at PHUs receiving eye health care services															
Obj 3: To develop and improve community participation in preventive, curative and promotive eye health activities particularly in underserved and marginalized communities	No of communicative eye health care actions undertaken in the community															
Obj 4: To reduce vitamin A deficiency-associated blindness and mortality by ensuring high and sustained VAS for children	No lactating mothers sensited on VAS															
	<b>Output indicators</b>															
For objective 1	No. of health cadres trained in eye health															
	No trained cadres deployed															
	No. eye health teams meeting recommended staffing levels															
	Budget allocation by MOH															
	Ongoing post training support and supervision															
	Quality assurance review meetings held quarterly															
	Cataract surgical outcome audit system in place and functional															
For objective 2	No. of PHU staff trained in basic eye conditions															
	No. of patients referred between different levels of care in the health system															
For objective 3	No. of PHUs providing PEC services															
	66% women (of total) screened & examined															
	No. u5 children receiving free eye care services															
	No. cataract surgeries conducted															
	No. of people receiving refractive error services															
	No spectacles dispensed															
	No. patients provided with medications															
For objective 4	No. people reached through MDA per year															
	No. people reached through MDA per year															
	No. children reached with VAS															
	VAS being part of wider immunisation programme															
	PHU staff using VAS protocols															
	No. of lactating or pregnant women/girls receiving free health care services															

## Appendix 13: Evaluation criteria rating

	Excellent	There is strong evidence that the project <b>fully meets all or almost meets all aspects</b> of the evaluation criterion under consideration. The findings indicate <b><u>excellent and exemplary</u></b> achievement/progress/attainment. This is a reference for highly effective practice and an Action Plan for positive learning should be formulated.
	Satisfactory	There is strong evidence that the project <b>mostly meets</b> the aspects of the evaluation criterion under consideration. The situation is considered <b><u>satisfactory, but there is room for some improvements.</u></b> There is need for a management response to address the issues which are not met. An Action Plan for adjustments should be formulated to address any issues. Evaluation findings are potentially a reference for effective practice.
	Attention	There is strong evidence that the project <b>only partially meets</b> the aspects of the evaluation criterion under consideration. There are <b><u>issues which need to be addressed and improvements are necessary</u></b> under this criterion. Adaptation or redesign may be required and a clear Action Plan needs to be formulated.
	Caution	There is strong evidence that the project <b>does not meet the main</b> aspects of the evaluation criterion under review. There are <b><u>significant issues which need to be addressed</u></b> under this criterion. Adaptation or redesign is required and a strong and clear Action Plan needs to be formulated. Evaluation findings are a reference for learning from failure.
	Problematic	There is strong evidence that the project <b>does not meet</b> the evaluation criterion under consideration and is performing very poorly. There are <b><u>serious deficiencies</u></b> in the project under this criterion. There is need for a strong and clear management response to address these issues. Evaluation findings are definitely a reference for learning from failure
	Not Sufficient Evidence	There is <b>not sufficient evidence</b> to rate the project against the criterion under consideration. The project needs to seriously address the inability to provide evidence for this evaluation criterion.