

End of Term Evaluation Report

A new vision for eye health in Pakistan's Khyber Pakhtunkhwa province

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List of acronyms and abbreviations

BHU	Basic Health Unit
CBO	Community-based organisation
CECC	Comprehensive Eye Care Cell
CSC	Cataract Surgical Coverage
DCC	District Coordination Committee
DCEC	District Comprehensive Eye Care
DHQ	District Headquarters
DPIU	District Program Implementation Unit – LHWs
DPO	Disabled people's organisation
FHF	Fred Hollows Foundation
HMIS	Health Management Information System
IEC	Information, Education and Communication
INGO	International Non-Governmental Organisation
IOL	Intraocular Lens
KII	Key Informant Interview
KPI	Key Performance Indicator
KPK	Khyber Pakhtunkhwa province
LHW	Lady Health Worker
LHS	Lady Health Supervisor
LRBT	Layton Rehmatulla Benevolent Trust
MO	Medical Officer
MT	Medical Technician
MTR	Mid-term Review
NCD	Non-communicable Disease
OPD	Outpatient Department
OT	Operating Theatre
PCO	Pakistan Country Office
PEC	Primary Eye Care
PHC	Primary Health Care
PICO	Pakistan Institute of Community Ophthalmology
POVOs	Post-Operative Visual Outcomes
PPIU	Provincial Program Implementation Unit
PCECC	Provincial Comprehensive Eye Care Cell
QSAT	Quality Standard Assessment Tool
RAAB	Rapid Assessment of Avoidable Blindness
RHC	Rural Health Centre
SDG	Sustainable Development Goal
SiB	Seeing is Believing
THQ	<i>Tensi</i> Headquarters (sub-district)
TOR	Terms of Reference

Executive Summary

Background Information

Pakistan has made tremendous progress in developing eye care services since Vision2020. However, avoidable blindness remains an important public health problem.¹ The Rapid Assessment of Avoidable Blindness (RAAB) conducted in two districts under this project found the prevalence of blindness in Swabi district was 4.2%, while in Mansehra it was 1.8%, with cataract and refractive error the most common causes of blindness and visual impairment in both districts. In Swabi district, prevalence of blindness was significantly higher among women.² In both districts, unaffordability, fear and lack of perceived need were the major reasons for not having undergone cataract surgery.³

Description of project

“A new vision for eye health in Pakistan’s Khyber Pakhtunkhwa province (KPK)” worked to strengthen eye health service delivery and increase demand for eye care services at the district level for people in four districts to reduce the prevalence of avoidable blindness. The four-year, 1.25 million USD project was jointly implemented by the Pakistan Institute of Community Ophthalmology (PICO), Sightsavers, and the Fred Hollows Foundation (FHF) with support from “Seeing is Believing” (SiB).⁴ The project combined two broad strategic approaches: (1) strengthening district health systems and (2) integrating primary eye care into primary health care through the training of primary health care (PHC) workers and the development of a referral chain from community and primary care level facilities to the secondary level. Key priorities were infrastructure and technology development, capacity building of human resources, disease control, effective management and advocacy, research and public-private partnerships in support of Vision 2020 targets. The project also sought to generate demand for services, through awareness raising and social mobilisation campaigns.

Purpose of Evaluation

The purpose of this End of Term Evaluation was to review the achievements of the project against the project objectives and understand the key successes and challenges the project has encountered. It also sought to document key learnings to inform future project design and delivery.

Evaluation approach

Seven criteria were used as a framework for Evaluation, analysis and reporting: relevance, effectiveness, efficiency, impact, sustainability, scalability/replicability and coherence/coordination. Gender, equity and sustainability were considered as cross-cutting issues. The Evaluation was retrospective and used primarily qualitative methods, supported by quantitative components. Analysis of quantitative output data assessed the overall performance against the project targets. The Evaluation was conducted remotely during the COVID-19 pandemic and required adjustments to the design and scope. This limited exploration of some evaluation questions and reduced the

¹ A 2004 National Blindness and Visual Impairment Survey revealed that the prevalence of blindness in Pakistan was 0.9%, and that 80% of blindness is avoidable if diagnosed and treated at an early stage. Illiterate survey participants were much more likely to have a presenting visual acuity and the prevalence of blindness and visual impairment was higher amongst women. The more recent RAAB conducted in two districts found that 82.4% of total blindness was due to avoidable causes that could be easily treated or prevented. [Dr. Muhammad Zahid Jadoon, Rapid Assessment of Avoidable Blindness (RAAB) and Diabetic Retinopathy, District Swabi And District Mansehra, Report 2016-17.]

² In Mansehra, differences in prevalence by sex were not significant.

³ Dr. Muhammad Zahid Jadoon, Rapid Assessment of Avoidable Blindness (RAAB) and Diabetic Retinopathy, District Swabi And District Mansehra, Report 2016-17.

⁴ January 2016-2020, plus a six-month no-cost extension to June 2020. Funding provided under Phase V - Tranche 3 of SiB.

range and depth of viewpoints solicited through data collection. The Evaluation focused on documenting project learning for the design of future programmes, drawing heavily on insights from project management staff and hospital-level eye health care workers, as well as a review of project documents, data and secondary research.

Key informants (KI) were purposefully selected and prioritised according to their level of project involvement and availability for interview. Informants from all four programme districts and all implementing partners were targeted for data collection. Key informants included project management staff, hospital-level staff (ophthalmologists, optometrists, social organisers), Lady Health Worker (LHW) programme staff, PHC workers and a few men and women who received services under the project. In total the Evaluation reached 51 key informants, which exceeded the 31 KIs targeted as high priority. 20% of key informants were women. The low proportion of female informants reflected the focus on district and hospital-level stakeholders, and the near absence of female post-holders at these levels. The limited primary and community-level data collection and depth of viewpoints is a key limitation of the Evaluation. Qualitative operational research conducted under the project elicited the views and experience of LHWs and a range of community-level stakeholders and provided an important complementary data source for this Evaluation.

Main findings

Relevance

Rating



There was wide consensus that the project was relevant and responded to important needs related to accessing eye care in the four targeted districts. These included low levels of provincial government budgetary allocations for health and eye care, geographic barriers to accessing urban-based eye care services, women's restricted access to health care and education, and low awareness. The project was based on the established model of the District Comprehensive Eye Care Programme (DCECP), which underpins the priorities of the Provincial Programme for Prevention and Control of Blindness. A situation analysis of the four districts identified service delivery gaps and assessed hospital-level human resources, infrastructure, and equipment. To address documented gaps the project combined the DCECP model with a PHC model to bring eye care closer to communities and strengthen the referral pathway.

Effectiveness

Rating



The numbers of men and women screened at primary and secondary levels under the project, obtaining refractive services, spectacles, and surgical care met or exceeded most of the project targets. Women benefited from half of all surgical interventions delivered under the project. Although this fell short of the revised gender equity target of 65%, the project registered an increase in the proportion of surgeries provided to women in the second half of the project, achieved in part through prioritisation of female patients. The project effectively generated demand, vastly exceeding primary and secondary screening targets. There was a three-fold surplus of secondary-facility screening relative to the target; this was attributed in part to the deployment of project-funded optometrists. An equitable proportion of primary screenings were provided to women (70%), due to the strategy of training LHWs which improved both inclusion and reach. LHWs were motivated, perceived to effectively screen, refer, and share eye care messages. The approach of developing an Information, Education and Communication (IEC) strategy and new channels of communication was perceived positively, however the project did not define communication objectives or assess whether or how these were achieved. There was low documented uptake of referral from LHWs and primary care facilities (15-20%); however, there was

no marked difference in rates of referral completion for men and women. This suggests that key barriers to referral completion remain universal, although there are likely important gender dimensions in how these are experienced and acted upon.

Efficiency

Rating



The cost-efficiency of equipment and infrastructure investments was increased through: multiple phases of needs assessment; a transparent procurement process involving all partners; negotiating longer warranties; and choosing investments wisely based on functionality, generic specifications and verification of end user capacity. The selection of rigid intraocular lenses (IOLs) for procurement was based on a public health approach, which was appropriate but met with low acceptance by some ophthalmologists. The consortium approach was perceived to increase effectiveness, transparency and accountability, and has provided a model for future collaborations. Having regular, frequent Steering Committee meetings early in the project helped to develop processes enhancing efficiency. The charity hospitals were not initially well-engaged in project design, needs assessment and early implementation; this created some missed opportunities for strengthening private-public sector linkages, and data and information sharing.

Impact

Rating



The project invested resources in the existing health system through human resource development, infrastructure development and quality improvement. Increased service availability was registered at the four District Headquarters (DHQ) hospitals, in terms of both offer (availability of refractive and low vision assessment, counselling and health education) and quantity. Increased capacity was reported to lead to reduced surgical wait times. Project identification of gaps in waste management systems and infection control policies led to improvements in hospitals across the province. Consistent recording of post-operative visual outcomes improved but remains a challenge. The creation and budgeting of 24 optometrist posts at DHQs, and the approval of 96 positions for *Tensil* Headquarters (THQ) Hospitals across the province was an important project achievement and provides a model for future advocacy work. Referral pathways were well-established and integrated with existing systems.

Sustainability

Rating



The project contributed to provincial and district health system strengthening by increasing the presence of trained eye care personnel and primary health care workers, the provision of equipment, the establishment of District Coordination Committees (DCCs) and activating decision-making on the eye care agenda. Some key elements to support sustainability are in place. These include budget lines and allocations for equipment maintenance and repairs and the approval of optometrist postings. The project integrated Primary Eye Care (PEC) data with routine reporting and supervision mechanisms; data recording and reporting within the public system are expected to continue. However, there are important sustainability concerns related to the overall diminished human resources post-project and the effects on coordination and motivation in the absence of the project. PHC-level attention will shift to other priorities when consistent monitoring and oversight disappear. There is no mechanism in place for reporting or integrating data from the charity hospitals into the public sector Health Management Information System (HMIS). The project partners have documented routine actions they will take to sustain achievements; these should be carefully monitored going forward.

Scalability/replication

Rating



The project design was based on well-established, scalable approaches for secondary-level strengthening of eye care service delivery and PEC integration into PHC. The main innovation of the project was to combine these models for a more comprehensive approach. The operational research study results regarding LHW roles and barriers to referral provide actionable findings which can be taken up on a national level to improve future LHW training on PEC and orientation of referral facility providers. The project also supported the establishment of optical shops at charity hospitals, a cost-recovery based system for provision of quality spectacles at subsidised rates; this model should be assessed further for effectiveness, business viability and replicability. The experience of appointing optometrists could be written up as a more detailed advocacy case study to inform future projects.

Coherence/coordination

Rating



The project engaged a large number of key actors within the government health system and charity hospitals. There was good ownership of the project at PICO and the provincial health department and regular coordination at both the district (DPIU) and provincial (PPIU) levels. The DCC was a useful approach for carrying forward key project initiatives, raising awareness of eye care, as well as for advocacy, and resource mobilisation. The lack of involvement of charity hospitals was a key gap; this could have been an opportunity to improve linkages between the public and private sector and improve coordination and sharing of data. Linkages with the department for the control and prevention of non-communicable diseases (NCDs) were not prioritised. The project design was coherent, effectively combining different elements of previous eye care projects to work towards a more comprehensive approach to eye care systems. A key gap in the project design was the lack of support for enhancing district comprehensive eye care at the sub-district (THQ) secondary facilities. The project design did not plan for extensive outreach, but this was significantly expanded over the course of the project. Key informants reported that screening camps and outreach activities appeared to improve reach and encourage referral uptake and should be prioritised in future efforts.

Conclusions

The project succeeded in improving access to eye care services for men and women, achieving or exceeding most of its service delivery targets. Although not the original ambition of the project, the project sought to, but did not fully succeed in delivering surgical services proportional to sex-disaggregated prevalence. However, current evidence regarding the extent of a gender gap in accessing cataract surgery in Pakistan is mixed. More investigation and formative research are needed on the gender dimensions of barriers to surgical uptake and the most appropriate and effective approaches for creating an enabling environment to support care-seeking decision making and surgical uptake. The presence of the project-funded optometrists expanded service delivery, allowed for the reorganisation of eye care departments and task shifting, and ensured the delivery of refractive services which were previously deprioritised in some facilities. Provincial government allocations and recruitment for these posts at DHQ and THQ levels can be expected to have an important, long-term and province-wide impact on eye care service availability and quality going forward. Although the project has put in place key elements for sustainability, concerns remain regarding gaps in human resources, service delivery and data continuity post-project. Overall, the project was well-implemented, with effective project management and coordination across multiple health system actors. The partnership approach was perceived to improve effectiveness, transparency, and accountability. Future projects should consider expanding and clarifying the role

of charity hospitals and more actively engaging these partners in project design, coordination, data sharing and advocacy efforts.

Recommendations

The following recommendations focus on actions which will support the extension and uptake of quality eye care services in KPK⁵, with attention to equity and sustainability.

	Recommendation
Skilled Human Resources	<ol style="list-style-type: none"> Sustainably increase skilled human resources through a strategic approach that combines advocacy and leveraging project support to obtain government commitments. When designing future projects in coordination with the public sector, partners could use the opportunity to secure government commitments for the provision of human resources in line with the agreed requirements and priorities outlined in the World Report on Vision (i.e. ophthalmic teams at all secondary facilities, both DHQ and THQ hospitals).⁶ These commitments can then be incorporated in the MOU with the provincial health department. Explore deterrents to the uptake of DHQ and THQ level posts by female eye care professionals and identify the most appropriate mitigation strategies, incentives or other approaches to improve gender balance in the eye care workforce in remote areas. One approach may be to prioritise female applicants from remote districts in optometry training programmes. Planning for this might be informed by a consultative process with female eye care professionals, trainees, health workers originating from remote areas, and perhaps gender or workplace experts. Approaches should be evaluated for feasibility, effectiveness and scalability.
Service delivery	<ol style="list-style-type: none"> Continue advocacy for and investment in the expansion of eye care services at the THQ level, as outlined in the provincial integrated people-centred eye care plans. This might include follow-through on securing government appointment of ophthalmologists, ophthalmic teams and development of eye care departments. Broaden the strategy for PEC integration and service delivery close to communities. This might include advocating for the sanction of optometrist and ophthalmic technician posts at the RHC level, prioritising investment to improve the functionality of BHUs/RHCs, and planning additional capacity building at these facilities, based on needs assessment.
Referral uptake	<ol style="list-style-type: none"> Develop measures to improve the reception or prioritisation of referred patients in consultation with health departments, hospitals, and LHW/PHC referring health workers. This should include the orientation of all staff in the eye departments at referral hospitals to appropriately receive and value LHW referrals. Conduct further literature review and data analysis to better understand patterns in eye care referral completion. This could include more detailed analysis of eye care referral patterns by reason for referral as well as within the context of the wider health system, e.g. comparative analysis of referral patterns for other health seeking. Based on evidence, orient appropriate strategies for referral completion. These may include the development of health worker training modules on patient communication and counselling techniques to support decision making and referral visit planning (including resource mobilisation to cover transport and accommodation costs). LHWs may require refresher training to support referral completion.
Strategies for improving equity and inclusion	<ol style="list-style-type: none"> Conduct formative research on (1) the gender dimensions of barriers to surgical uptake and (2) the most appropriate and effective approaches for creating an enabling environment to support women's care seeking decision making and surgical uptake.

⁵ Health service delivery is decentralised to the provincial level, so any non-policy recommendations and decision-making are targeted to that level.

⁶ Ophthalmologist, optometrist, orthoptists, ophthalmic technologist, ophthalmic technicians and ophthalmic nurses. The World Report on Vision (October 2019) calls for making eye care part of universal health coverage and using integrated people-centred eye care approaches to increase coverage, including bringing eye care services closer to the communities.

	Recommendation
	9. Develop a consistent approach to incorporating disability awareness modules and messages in training plans and health education sessions at all levels. Training LHWs in PEC is a full coverage strategy that offers the potential to reach men and women with disabilities and enhance community awareness. A future project might consider piloting a disability awareness module in LHWs' PEC training curriculum in a selected province. This would align with the national programme's focus on "inclusive eye health" but would need to be balanced with LHW workload concerns.
<i>IEC</i>	10. Develop clear objectives for a communications strategy and plan to assess impact. This should be supported by a budgeted plan for: IEC strategy implementation using diverse communication channels; a pilot-testing phase for acceptability and effectiveness prior to roll-out; and monitoring and impact assessment of communication approaches.
<i>Quality Assurance</i>	11. Develop efficient systems to facilitate consistent post-operative follow-up and recording of post-operative visual outcomes (POVOs). These should consider how to organise service delivery and human resources to support the change. For example, organisational approaches might include developing a follow-up clinic, where follow-up exams are conducted on a regular schedule and VA indicators are routinely recorded. 12. Continue discussions and advocacy with eye health boards, the provincial health department and national eye health committee to develop a policy statement to support consistent recording and reporting of POVOs as a standard tool for quality assurance.
<i>Coordination / Partnership</i>	13. Expand the role and involvement of charity hospitals and more actively engage these partners during project design and implementation. They should be engaged in all activities, participate in Provincial Boards and DCCs, encouraged to generate comprehensive monthly reports and share these data with the public sector, and participate in joined-up advocacy efforts.
<i>Data systems</i>	14. As part of ongoing discussions around the revision of eye care indicators and health management information systems (HMIS), advocate for the development of a routine reporting mechanism and integration of data from the charity hospitals with the public sector HMIS.
<i>Sustainability</i>	15. Outline a detailed sustainability plan from the project design phase. This should identify threats and opportunities, key actions, and responsible persons.

Introduction and background

1.1. Background

Pakistan has made significant progress in developing quality eye care services since Vision2020. However, avoidable blindness remains an important public health problem. At the time of this project development, data on blindness and vision impairment were outdated, with the last national blindness and visual impairment survey undertaken in 2002-2004. This survey revealed a prevalence of blindness of 0.9%, with approximately 1,140,000 adults irreversibly blind as a result (114,000 blind adults residing in Khyber Pakhtunkhwa [KPK]). Illiterate survey participants were more likely to have a presenting visual acuity of <6/60 and the prevalence of blindness and visual impairment was higher amongst women.⁷ The more recent Rapid Assessment of Avoidable Blindness (RAAB) conducted in 2016-17 in two project districts found that 82.4% of total blindness was due to avoidable causes that could be treated or prevented. The prevalence of blindness in Swabi district was 4.2%, while in Mansehra it was 1.8%, with cataract and refractive error the most common causes of blindness and visual impairment in both districts.⁸ The proportion of poor post-surgical visual outcomes in both districts was high (26.6%). In Swabi district, prevalence of blindness was significantly higher among women.⁹ In both districts, unaffordability, fear and lack of perceived need were the major reasons for not having undergone cataract surgery.¹⁰

Pakistan adopted the District Comprehensive Eye Care (DCEC) model in 1999. In line with the VISION 2020 targets, this national approach focused on strengthening the primary health care (PHC) system, improving health service availability at the district level, supporting infrastructural improvements, and reducing eye health worker shortages. However, in 2011, eye health was decentralised to the provincial level and commitment to DCEC implementation waned in some areas. The project was implemented in four districts of KPK province which has a combined population of 6.2 million people, the majority of who (83%) reside in rural areas. As documented in the project proposal, women lag behind men in almost every social indicator; up to 72% of women in KPK have never attended school. High rates of illiteracy and restricted mobility inhibit women's health seeking decision making and access to care.. The concentration of eye care services in urban areas inhibits access by the mostly rural population in KPK. Travelling long distances has a significant associated cost and public transportation is not always accessible; these barriers are experienced more acutely by women and girls, persons with disabilities, the elderly and other vulnerable groups.

1.2. Purpose of Evaluation

As detailed in the Terms of Reference (ToR) (Appendix 2), the purpose of this End of Term Evaluation was to review the achievements of the project against the project objectives and understand the key successes and challenges the project has encountered. In addition, it sought to document key learnings to inform future project design and delivery. It also assessed the extent to which it was possible to implement the agreed project Mid-Term Review (MTR) recommendations and associated action plan formulated in the Management Response.

⁷ Jadoon Z, Dineen B, Bourne R R A. et al on behalf of the Pakistan National Eye Survey Study Group. Prevalence of blindness and visual impairment in Pakistan. The Pakistan National Blindness and Visual Impairment Survey. Invest Ophthalmol Vis Sci 2006;47(11):4749–4755

⁸ Dr. Muhammad Zahid Jadoon, Rapid Assessment of Avoidable Blindness (RAAB) and Diabetic Retinopathy, District Swabi And District Mansehra, Report 2016-17.

⁹ In Mansehra, differences in prevalence by sex were not significant.

¹⁰ Jadoon, 2016-17.

1.3. Project description

Beginning in January 2016, “A new vision for eye health in KPK” worked to strengthen eye health service delivery and increase demand for eye care services at the district level for people in four districts to reduce the prevalence of avoidable blindness. Jointly implemented by the Pakistan Institute of Community Ophthalmology (PICO), Sightsavers, and the Fred Hollows Foundation (FHF), the four-year, 1.25 million USD project was supported by “Seeing is Believing” (SiB).¹¹

The project combined two broad strategic approaches: (1) strengthening district health systems, through building capacity of the government’s human resources, supporting quality service delivery, strengthening referral systems, improving infrastructure and advocating for increased eye health financing; and (2) integrating primary eye care into primary health care through the training and support of Lady Health Worker (LHWs) and PHC workers and the development of a referral chain from community and first-level care facilities to the secondary level. Project partners included the four District Headquarters (DHQ) hospitals, two of which were teaching hospitals, and three private charity hospital systems: Layton Rehmatulla Benevolent Trust (in two districts) Lakson Medial Trust and the Shifa Eye Foundation. In this report, these institutions are referred to as “charity hospitals”.

1.4. Methodology and ethical considerations

1.4.1. Evaluation Approach

Seven criteria were used as a framework for evaluation, analysis and reporting: relevance, effectiveness, efficiency, impact, sustainability, scalability/replicability and coherence/coordination. Under these criteria, 18 Evaluation questions were defined in the ToR. An Evaluation Matrix (Appendix 3) outlines these questions and the data sources used to explore them. The Evaluation was retrospective and used mixed methods, enabling the triangulation of findings during analysis. Analysis of quantitative output data was used to complement the donor reports by assessing the overall performance against the project targets and linking this assessment with the qualitative exploration of key successes and gaps. Gender, equity and sustainability were considered as cross-cutting issues.

This Evaluation was conducted during the COVID-19 pandemic and required adjustments to the design and scope, as detailed below. The Evaluation focused on assessing and documenting project learning that would be valuable in the design of future programmes. It drew on insights from project management staff and hospital-level eye health care workers (e.g. ophthalmologists/optometrists) and a review of all project documents, data and secondary research.

1.4.2. Evaluation Design

Scope: The Evaluation covered the period from January 2016 to March 2020, with quantitative data provided through December 2019. The Evaluation sought input from individuals in all geographic areas (the four project districts) and partners (see data collection section).

Team: The Evaluation was carried out by a team of two persons, each of whom conducted some primary data collection. The team was supported by the technical and management teams at Tropical Health (see Appendix 4: team structure).

¹¹ January 2016-2020, plus a six-month no-cost extension to June 2020. Funding provided under Phase V - Tranche 3 of SiB.

Phases: The Evaluation was carried out in three phases (See Appendix 5: workplan). During the **inception phase**, the Evaluation Team reviewed background documents and project data to inform the methodology and understand the project context and spoke with the project management teams to clarify project implementation, prioritise key informants, and plan data collection.¹² The **data collection phase** involved primary data collection from key informants via phone/video interviews (13-22 May). A debriefing session with the project management teams and partners was held remotely (4 June). A **data analysis and report writing phase** involved the collation and analysis of primary data collected, and the contextualisation of these findings with secondary data.

1.4.3. Data collection methods

The Evaluation used primarily qualitative methods, supported by quantitative components. The qualitative enquiry explored the “how” and “why” of successes and challenges, and probed sustainability issues and learning points. The quantitative analysis assessed project achievements against planned targets and in reaching women (drawn from existing project data as reported in data systems and donor reports).

Key Informants and Sampling

Key informants were purposefully selected and prioritised according to their level of project involvement, ability to inform on the Evaluation questions, and availability for interview (Appendix 7). Informants from all four programme districts¹³ and all implementing partners were targeted for data collection, with the overall aim of achieving a range of geographic areas, facilities, and informant types. 48 potential key informants were identified at inception, 31 of whom were considered “high priority” and were targeted for individual interview.¹⁴ Project teams subsequently identified six PHC workers (four Medical Ophthalmologists (MOs) / Medical Technicians (MTs) and two LHWs) in Swabi and Haripur district and four service recipients for interview in Swat district. All targeted high priority key informants were reached. In total, the Evaluation reached 51 key informants; 20% of whom were women (

Table 1). The low proportion of female informants reflects the lower number targeted due to the emphasis on hospital-level informants and the near absence of female post-holders at this level. In Haripur district, the ophthalmologist was not available due to recent reassignment.¹⁵

Table 1. Summary of key informants, by category and district

Key informant category	Global/ National/ Provincial	Swat	Swabi	Haripur	Mansehra	n (%) Women	Total
Project management/ oversight (INGO)	7	n/a	n/a	n/a	n/a	3 (43%)	7
Project management/ oversight (Provincial Partner – PICO/CECC, PCB)	2	n/a	n/a	n/a	n/a	0	2
National Government Stakeholder	1	n/a	n/a	n/a	n/a	0	1
Government Hospital / District IP	n/a	1	2	0	1	0	4
Charity Hospital IP	1	<i>national respondent</i>	1	1	<i>national respondent</i>	0	3

¹² During this phase, a kick-off meeting provided an overview of programme implementation and discussion of the scope and methodological adjustments required due to the COVID-19 pandemic.

¹³ As described in the “Situational Analysis of the Four Districts” (June 2015), eye care hospitals in two districts (Swat and Mansehra) were higher-performing (numbers of cataract surgeries) at baseline and two districts (Haripur and Swabi) featured lower-performing hospitals. RAAB results reflected this differential (for example, the prevalence of age and sex adjusted blindness was 4.2% among people aged 50 and above in district Swabi) [RAAB, 2016]

¹⁴ Two duplicates were identified in the list, leaving 29 high priority KIs.

¹⁵ A new ophthalmologist was recently appointed in the district but was not involved in the project.

Key informant category	Global/ National/ Provincial	Swat	Swabi	Haripur	Mansehra	n (%) Women	Total
Hospital-based project staff (optometrists and social organisers)	n/a	3	4	4	4	0	15
LHW Programme (PPIU, DPIU, LHS, LHW)	1	2	2	4	2	5 (45%)	11
PHC workers (MOs/MTs)	n/a	0	2	2	0	1 (25%)	4
Service Recipients	n/a	4	0	0	0	1 (25%)	4
Total	12	10	11	11	7	10 (20%)	51

Data collection

Primary data collection: Semi-structured key informant interviews (KIIs) were conducted remotely (phone/videoconference) over a three-week period. Project teams made a first contact with potential key informants to verify availability and obtain an initial consent. Three topic guides were developed (Appendix 9) for use with: (1) national and provincial-level partners and hospital staff (ophthalmologists, optometrists, project teams); (2) primary health care level informants (DPIU, Lady Health Supervisors (LHS)); and (3) service recipients. All approaches used semi-structured guides to ensure exploration of key topic areas, while allowing for new/unexpected perspectives to be raised. Interviewers broadly followed the guides' questions, adjusting wording during the interviews in-line with points raised by informants. Interviews were conducted in English or Urdu and lasted 30 minutes to one hour. Some in-depth interviews with key project staff were conducted in two one-hour sessions. Transcripts were produced on a rolling basis, with preliminary analysis informing subsequent interviews.

Secondary data sources: Quantitative and qualitative information as reported by the project or evidenced in national/provincial documents was reviewed by the Team Leader. Project quantitative output data was reviewed to assess project achievements against planned targets, including success in reaching women and referral system. The document review was iterative, with documents revisited and additional information reviewed to cross-reference findings. 93 documents were provided by Sightsavers and reviewed by the Evaluation team (listed in Appendix 6). These documents included the report from the RAAB carried out under the project, which provided baseline information on prevalence and barriers to care seeking. An operational research study was conducted in 2019. This study explored LHW roles in eye care referral and factors affecting patient compliance with referral. Study findings were made available at the time of evaluation report writing; these have been incorporated in this report but did not inform lines of enquiry for the Evaluation.

1.4.4. Analysis and projection of evaluation report

The Evaluation Team summarised data on a rolling basis, to refine lines of enquiry as data collection proceeded. A debriefing session with project partners provided an opportunity to validate preliminary findings and learning points and develop recommendations. Key quotes were documented in an Excel file according to themes arising from the data. Thematic analysis of qualitative data followed a framework based on the Evaluation questions and allowed for labelling of four cross-cutting themes (gender, learning, sustainability and coherence). Quantitative output data was analysed in Excel to assess performance against project targets, with a focus on gender equity. Data from all sources were triangulated, through review and comparison of themes across sources, and dialogue within the Evaluation Team. Report writing was led by the Team Leader.

1.4.5. Ethical considerations

Informed consent was obtained from all participants. Where a first contact via email was feasible, an Information Sheet and Consent Form (Appendix 8) was emailed to the informant prior to interview, with a request for written (emailed) consent. Where first contact was by phone, the project coordinator at PICO/CECC obtained an initial consent and information on participant availability and scheduled the interview. A formal SMS was then sent by the Evaluation Team the evening prior to interview to restate the purpose of the interview, request consent for participation and confirm availability. At the start of the interview, informed oral consent was subsequently obtained from all participants. In-country ethical approval was not required. Sightsavers' Pakistan Country Office (PCO) reviewed topic guides and consent procedures in advance of data collection for appropriateness. The external consultants completed UNICEF's 'Ethics in Evidence Generation' course and agreed to comply with Sightsavers' safeguarding policy. All identifiable data, including recordings, have been stored in a secure location, e.g. password encrypted files, accessible only to the Evaluation Team. Data were de-identified (labelled by informant categories, e.g. hospital staff, project management staff) at the analysis stage.

Conducting interviews during the pandemic carried specific ethical considerations, given participants' unique and sometimes challenging personal and professional circumstances. When contacting potential key informants, project staff and the Evaluation Team took care to respect individuals' time and verify that the request for participation did not pose undue burden.

1.4.6. Limitations of the evaluation

This Evaluation was conducted in the context of the COVID-19 pandemic and, as such, did not entail any fieldwork or in-person meetings.¹⁶ The impact of this on the Evaluation's ability to explore specific evaluation questions is reported in the Evaluation Matrix (Appendix 3). Remote data collection required adjustments to the design and scope, and resulted in the following limitations:

- Some reduction in the range and depth of viewpoints solicited through data collection, which limited exploration of the project's work on PHC integration to increase uptake of services.¹⁷ The Evaluation was able to reach a larger than expected number of key informants remotely. Nevertheless, fieldwork would have allowed for group discussions, more engagement with PHC and community-level stakeholders and increased the participation of women and of men and women with disabilities. Some participants also may have been more comfortable sharing feedback in person.
- Seven of the Evaluation questions outlined in the ToR were not fully explored due to low feasibility of data collection at community and sub-district levels.¹⁸ While these gaps were important, the Evaluation nonetheless generated sufficient evidence to assess and rate the project against each of the Evaluation criteria.
- Differential patterns in service delivery by facility or district were not well-explored in primary data collection due to later receipt of facility-level data.
- The team lacked opportunities for informal discussions and exchanges with project partners and implementing staff as well as for observations at physical project sites, which may have generated new insights and learning.
- Key informants from the charity hospitals were at coordination/management level; the absence of health worker viewpoints and site visits limited exploration of service delivery

¹⁶ Decision taken during Kick-off meeting, 19 March 2020. Consideration was given to postponing fieldwork, however, this option was not privileged due to the high level of uncertainty with regards to the duration and effects of the pandemic.

¹⁷ This gap was partially offset by evidence from the operational research study on the role of LHWs in the referral pathway and referral compliance.

¹⁸ Feasibility of the Evaluation questions was discussed during the Kick-off meeting on 19 March 2020.

and referral management at these hospitals and, in particular, of the effectiveness and efficiency of the optical shops established under the project.

1.5. Report structure

The Evaluation Report has three main sections:

- The **Introduction and Background** section provides an overview of key background information and the project, and describes the Evaluation purpose, methods and limitations.
- The **Results** section reports the findings for the 18 Evaluation questions defined under the seven Evaluation criteria and rates the project achievements for each criterion according to the parameters outlined in Appendix 1. Key learning points and recommendations are reported for each criterion.
- A **Conclusions and Recommendations** section discusses key observations on the findings, summarises key learnings to inform future project design and delivery, and provides recommendations for the extension and uptake of eye care services in KPK.
- **Appendices** provide supplementary detail where required, a complete list of key informants and documents reviewed, and data collection tools.

Results

2.1. Relevance

Rating



The extent to which the project or programme is suited to the priorities and policies of government of Pakistan, needs of the target beneficiaries, national partners, and donors and international commitments such as sustainable development goals (SDGs), where applicable.

Q1: How aligned are the project's objectives with provincial and national level eye health policies?

Q2: How aligned is the project with the needs of beneficiaries in project areas, including women and people with disabilities?

2.1.1. Provincial and national policy alignment

The project design was based on the well-established DCEC model, which forms the basis for the priorities outlined in the Provincial Programme for Prevention and Control of Blindness in KPK Province (2015-2018). The major focus of the DCEC model is on infrastructure development (standardised basic ophthalmic equipment and instruments), capacity building of human resources, disease control (common eye diseases, mostly cataract), and raising mass awareness and advocacy. However, it was understood that this model was insufficient for bringing comprehensive eye care services closer to communities and ensuring that those services are accessible and affordable.

The partnership approach underpinning the project was an important factor influencing project design (see 2.3.2). A collaborative approach was taken to identifying the needs and challenges to be addressed through the project, with active discussions between PICO/comprehensive eye care cell, FHF and Sightsavers, and the involvement of national and provincial level government partners. The partners assessed previous work in district comprehensive eye care and decided to retain a focus on this approach, while adding some key components to address observed gaps and extend beyond the supply side and secondary-level facilities. These components included training PHC workers and developing a referral pathway from primary to secondary level, involving charity hospitals for wider reach, and increasing demand-side investments. By combining the DCEC and PHC approaches, the project aimed to sustainably address demand and supply side barriers to accessing quality eye care services at district level in four districts of KPK. This was broadly aligned with the overall national health policy and eye care mission of promoting access free from discrimination.

Table 2. Alignment of project objectives and provincial programmatic priorities

Project Objective	Key Outputs	Alignment with provincial/national programmatic priorities
1. Men and women with visual impairment access eye health services in four districts	<ul style="list-style-type: none"> IEC strategy and awareness raising Training LHWs, MOs, MTs in PEC and visual acuity testing 	Access free from discrimination (national mission statement) <i>DCEC:</i> <ul style="list-style-type: none"> Human resource development, mass awareness raising <i>PEC integration with PHC</i> <ul style="list-style-type: none"> Integration of PEC into existing community-level service delivery system (LHW programme) Adopted/strengthened existing government PHC training manuals (visual acuity testing, eye health topics) Provincial programme priority on capacity building of human resources
2. Eye health systems deliver quality eye	<ul style="list-style-type: none"> Equip government hospitals with physical and human resources 	<ul style="list-style-type: none"> Provincial programme priorities/DCEC on infrastructure and technology development and capacity building of human resources at district-level

Project Objective	Key Outputs	Alignment with provincial/national programmatic priorities
health services in four districts	<ul style="list-style-type: none"> Optical Labs set up at charity hospitals Service provision at government and charity hospitals 	<ul style="list-style-type: none"> Partnership strategy with PICO/CECC (mandate/provincial oversight for eye care) Eye health system strengthening; links between government (PICO, district and sub-district hospitals, RHCs and BHUs) and private sector institutions (LRBT)
3. Government commitment to eye health at provincial level increases	<ul style="list-style-type: none"> Joint advocacy plans to increase resource mobilisation and for integration of PEC into PHC 	<ul style="list-style-type: none"> Partnership strategy with PICO/CECC (has government mandate) DCEC pillar focused on advocacy

The project activities directly supported Pakistan’s commitment to the health SDG (3.8: universal coverage) and, in particular, to the SDG target to substantially increase the recruitment, development, training and retention of the health workforce in developing countries (3.c). The project indirectly supported the gender equality (5), reducing inequality (10) and poverty reduction (1) goals.

2.1.2. Alignment with needs of men and women in the project area

Overall alignment: There was wide consensus among project partners and stakeholders that the project was relevant and responded to important needs related to accessing eye care in the four targeted districts. Key informants emphasised the following:

- **low level of investment in the province:** relatively underdeveloped health services due to low government health department investment, given insecurity and working conditions; lack of optometrists and optometry services at DHQ hospitals; ophthalmologists deployed at only two of seven THQ Hospitals in Swat district and none deployed at THQ level in the other districts
- **geographic barriers to accessing urban-based eye care services:** mountainous territory, isolated in winter, limited transport facilities to cover long distances and difficult terrains; a predominantly rural population whereas specialised eye care services are urban-centred (in Peshawar and at eye units of DHQ hospitals)
- **women’s restricted access to health care and education:** women lag behind men in almost every social indicator. Up to 72% of women in KPK have never attended school and the literacy rate is 65% for men and 28% for women¹⁹
- **low awareness and demand:** demand suppressed by low awareness, poor geographic access to eye care and affordability of care-seeking

There is a lot of disparity within Pakistan [...] Since this province was hit by terrorism in the past – the entire country was impacted, but this province was most affected. The level of services was not really good and awareness not really there, training of human resources not really there because no organisation could properly work in this province in the recent past. – Project management partner

Awareness of communities on avoidable blinding eye diseases (majorly cataract, diabetic retinopathy, and glaucoma) and their consequences on one hand, accessibility and affordability on the other hand do prioritise the need of such a project, and certainly this project has served the need. – Ophthalmologist

Swat is a huge district having vast landscape miles and miles away from the district headquarters hospital. One may well imagine how much difficult could be to access the eye

¹⁹ Proposal

care services available at DHQ Hospital especially by the non-affording segment of society, women, children and the persons with disability. – Optometrist

District selection: The districts for project implementation were selected based on an analysis of existing eye care service delivery. Two well-performing districts and two low-performing districts were selected to allow for comparative analysis. All four districts featured government hospitals; in two districts, these were DHQ and in two, these were teaching hospitals (Mansehra and Swat). Charity hospitals were also present in all four districts, although in some cases these were already operating at capacity. Prevalence data was not available at the time of project design, but a RAAB was carried out in two districts under the project.

Response to documented gaps: A situation analysis of the four districts was carried out in 2015 to support proposal development. This was focused primarily on identifying service delivery gaps at the facility level and documented existing levels of Outpatient Department (OPD) attendance and OT services, human resources, infrastructure, and equipment.²⁰ The situation analysis also considered stakeholder capacities and linkages between the different providers. Quality of care was not assessed at this stage. As recent prevalence data was not available for the area, a RAAB of two districts was planned and budgeted under the project.

There was a huge cataract backlog in the district of Swat and waiting time for cataract surgery used to be over one month. Even the simplest refractive services were provided on a very limited scale because of non-availability of optometrists. Specific ophthalmic equipment either was deficient or if available in stock, had completed its life and become non-functional because of needed repair or maintenance. – Ophthalmologist

The project did not directly assess demand-side barriers to access, however formative evidence on gender and utilisation of eye care services in other provinces was available to the project during implementation.²¹ There were no formal consultative processes with DPOs, women's groups or other CBOs undertaken early in the project; however there was some engagement with these groups during project implementation, primarily as a conduit for outreach and community mobilisation. Importantly, an operational research study was planned under the project to explore referral uptake from LHWs.

Gaps in responsiveness to needs: The Evaluation did interview a few patients but was unable to directly consult groups of community members in the project areas to elicit their perceptions of needs. However, secondary sources consistently identify cost as one of the main reported barriers to accessing eye care services.²² The project sought to reduce out-of-pocket costs through provision of IOLs and consumables to the DHQ hospitals, which patients would otherwise have been asked to purchase. The four patients interviewed in the Evaluation all highlighted their appreciation that surgical care was provided free. However, there were no provisions for reducing care-seeking costs related to transport and accommodation, which may have remained barriers to referral uptake and to compliance with recommended post-operative follow-up visits. This and other gaps in responsiveness to population needs are discussed under Service Delivery and Gender Equity 2.2.1.

²⁰ Sightsavers and the Fred Hollows Foundation, "Seeing is Believing Tranche III, Situational Analysis of 4 districts", June 2015

²¹ Dr Shabnum Sarfraz, Dr Tasleem Akhtar, Dr Roomi Aziz, Aliza N Khan, "Pakistan Gender Situation Analysis for Utilization of Eye Care Services", Research Report, Fred Hollows Foundation: March 2017

²² RAAB



The extent to which the programme has attained its objectives.

- Q3: *How effective has the project been in ensuring that it attains gender equity (in line with prevalence data) of people accessing services?*
- Q4: *What strategies have been most effective in targeting women, including women with disabilities, and why?*
- Q5, 12: *How effective was the project in generating demand, including raising awareness at the community level to increase uptake of eye care services? How successful was the IEC strategy of the project for raising awareness in communities regarding eye health issues? (IMPACT)²³*
- Q6: *How effective has the role of LHWs been in identification and referral of eye patients from the community to secondary level?*

2.2.1. Service Delivery and Gender Equity

The project aimed to reach both men and women, with the recognition that women face substantial social and economic barriers and restrictions which contribute to unequal access to health services.²⁴ Attaining gender equity was not an explicit ambition of the project or planned at the design stage. At mid-term, the project had reached roughly equal numbers of men and women overall, as planned in the original targets. Following the MTR, the project adjusted some targets²⁵ and approaches to aim for provision of services proportional to prevalence, as estimated in the RAAB conducted under the project.²⁶

Overall, the project succeeded in improving access to eye care services for men and women. The numbers of men and women who were screened at primary and secondary levels under the project, obtained refractive services, spectacles, and surgical care met or exceeded most of the project targets as of December 2019.²⁷ Project data were drawn from the biannual donor reports (through the second half of 2019) and KPI reports summarising outputs by hospital and district.

Surgeries

As of December 2019, over 50,000 surgeries had been performed under the project. Total cataract surgeries exceeded the project target, however slightly fewer minor surgeries were performed than targeted. Project staff documented that some minor surgeries may have been performed at sub-district secondary hospitals (THQ), primary-level facilities (RHCs) or private facilities and not tracked in project data.²⁸ The Evaluation did not conduct a detailed facility-level analysis of the surgeries recorded under the project²⁹, but a large proportion of the documented surgeries were conducted at charity hospitals.

Women benefited from half of all surgical interventions delivered under the project. Although this fell short of the revised gender equity targets, the project registered some improvement in increasing the proportion of cataract surgeries provided to women. Over the

²³ There was no means of verification to assess the impact of the IEC strategy. The Evaluation therefore explored this question in conjunction with assessing project approaches to demand generation and awareness raising.

²⁴ The project proposal observed that the cataract surgical rate tends to be lower amongst women due to associated indirect costs, transportation and lack of access to information.

²⁵ The MTR reported that the revised targets were to be implemented starting from Y3 (2018). In practice, the targets for cataract surgeries were progressively increased, to 55% in Year 3 and to 65% in the second half of Year 4.

²⁶ The RAAB found differential prevalence of blindness in Swabi: 4.2% (95%CI 3.1-5.3) among females and 1.9% among males (95%CI 1.2-2.5). The RAAB underscored the need for "gender-sensitive awareness programs regarding cataract surgery and provision of refractive services at primary levels" of the health system.

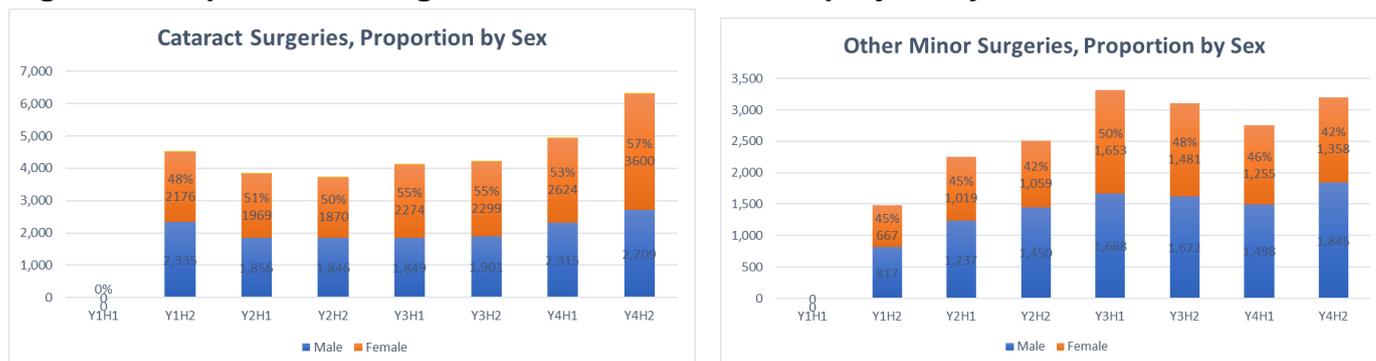
²⁷ With regards to overall performance, it is also important to report that while the project targeted adults, there were knock-on achievement in some districts where the project helped mobilise school-based screening of children and conducted targeted outreach camps for refugees and transgender people.

²⁸ The gap in data tracking likely reflects that these facilities were not directly supported by the project and the wide variation in RHC functionality. Given the project used a district-wide approach, indicators would optimally capture district-wide changes (% increase of services).

²⁹ Due to late receipt of facility data and prioritisation of data analysis in relation to the evaluation questions.

entire project, 53% of all cataract operations were provided to women. Over time, the project showed a marked increase in the proportion of cataract surgeries delivered to women, rising from 48% in the first year to 57% in the second half of year 4 (**Figure 1**). The shift in balance in the second half of year 4 primarily reflects **the prioritisation of female cataract patients** at Layton Rehmatulla Benevolent Trust (LRBT) Swat during this period³⁰, rather than any substantial changes in identification, referral, or acceptance patterns. There was no marked change in the proportion of female patients accessing **other surgical interventions**. Female patients benefited from less than half of other minor surgical interventions over the course of the project (46%, six-month reporting period range 43%, 50%; target 49%).

Figure 1. Proportion of surgeries delivered under the project, by sex



Screening

As was documented in the MTR, the project began exceeding its screening targets at secondary hospitals early in the project. Overall, **there was a three-fold surplus of secondary-facility screening relative to the target**. According to project staff and partners, this was due to significant patient inflow and the deployment of optometrists at partner hospitals (the expected effect of which was not accurately estimated). Other factors such as increased awareness and screening by LHWs may have driven increased patient demand, particularly in the latter half of the project. **53.7% of secondary screenings at hospitals were provided to women which was in line with the revised cumulative project target**.

Similarly, primary-level screening at BHUs and RHCs exceeded the cumulative target by 269%; this figure captured screening conducted by MO, MTs and optometrists during outreach activities. Again, project partners explained that they were not able to accurately estimate the effect that the increased human resources would have on service delivery and demand. 48% of screenings at BHUs/RHCs were provided to women, which was under the overall equity target; no change in proportion by sex was registered over time.

The project succeeded in providing an equitable proportion of primary-level screenings to women, due to the strategy of engaging LHWs, which targets women by design and government mandate. 71.4% of patients screened by LHWs were women. Gender targets were appropriately adjusted in the second half of the project to align with the actual proportions of men and women routinely reached by LHWs. Although the total number of people screened at primary level by LHWs was slightly under target as of December 2019, this reflected external factors outside the control of the project: a delay in the roll-out of training due to health worker strikes and scheduling constraints, and to work stoppages resulting from health worker strikes later in the project.

³⁰ In the second half of 2019, at LRBT Swat, 66% of cataract surgeries were performed on women (1300 of 1966 cataract surgeries).

The project's overall screening achievement vastly exceeded expectations, which calls into question the utility of the targets. Analysis of demand suppression at very low-performing facilities may have facilitated more accurate target setting.

We started from the baseline level. Predicating the changes from a new human resource that was never there, the impact of that is not programmable because we don't have any [data]. We had baselines to work with in the NGO sector, but in government system, we had less than optimal assumptions when doing something new. – Project Management Partner

Referral Completion

The project had an effective referral recording system (registers, referral slip with two duplicates) and tracked the number of referrals completed from primary to secondary. A detailed analysis of project referral data was not within the scope of this Evaluation. However, analysis of data from the second half of 2019 is indicative of general trends and suggests overall low uptake of referral, with **15% of the total patients referred by LHWs and BHUs/RHCs reported to reach referral facilities (1,904 of 12,578 people).**

The **low referral completion rate** seen in the project data might in part be explained by data completeness: patients uptake of services elsewhere (another facility or even another district); gaps in data recording which are likely to occur when tracking and reporting new indicators; and denominator issues related to time period which may be compounded by delayed care seeking. However, incomplete data would not account for an 85 % loss to follow-up. **Over-referral** also did not appear to be a significant contributor, although this should be explored further and in relation to expected referral rates for the prevalence of eye conditions in the context. In the second half of 2019, LHWs had a referral rate of 16% and BHUs/RHCs/primary outreach had a referral rate of 13%.³¹ Although **reason for referral** is recorded in the facility data, this was not tracked in the project data, so we are unable to assess for differences by eye conditions or severity. Similarly, we are unable to differentiate LHW referrals to first and secondary-level facilities. More detailed analysis of this will be particularly important considering the operational research study finding regarding some ambiguity in the role of LHWs, who reported referring for even minor conditions³² (see 2.2.3. Objectives of LHW Training and Role).

Importantly, the data suggest that there was no marked difference in referral completion between men and women. For example, in the second half of 2019, women had a higher overall referral completion rate, 16% for women compared to 13% for men. This would suggest that key barriers to referral completion remain universal, however much there may be important gender dimensions in how these barriers are experienced and acted upon.

This is one of the most important challenges we face under the project. We know, when it comes to eye OPDs you can see that more women are visiting for eye check-ups. But when it comes to OT and cataract surgeries there are very less. [...] We are referring more women, but generally the uptake of services and compliance is low for everyone. – Project management partner

The operational research study found the main driver of patient health-seeking behaviour was their perception of eye health problems and the need for treatment seeking. **Identified barriers to referral compliance included specific challenges related to the organisation and provision of referral services as well as more generic barriers (e.g. proximity, affordability).** Key barriers are highlighted in **Box 1**. With regards to women's referral care seeking, key informants

³¹ Number of patients referred / number of patients screened

³² Sightsavers. Understanding the role of lady health workers in improving access to eye health services in Khyber Pakhtunkhwa (KPK) Province of Pakistan: Study Report. Islamabad (Pakistan): Sightsavers. p. 14-15

also reported that referred individuals were not sufficiently empowered to influence decision-making.

Box 1. Key barriers to referral compliance reported in operational research study

- Low knowledge of adverse consequences of delaying treatment
- Lack of information about the costs and services at the referral facilities. Many patients did not know what to expect at the secondary-level hospitals; LHWs also indicated low awareness of service organisation and costs at the referral facilities.
- Poor reception at the referral facility or poor patient perceptions of services. In turn, this resulted in poor satisfaction with the referral experience, which impacted on LHW reputation
- Lack of trust in public sector hospitals. Patients reported a preference for visiting the charity hospitals because of perceived quality of care, confidence in provider availability and free service provision, availability of all services in one place, and shorter wait times.
- Lack of financial resources to cover the costs of specialist eye care services and transport.
- Distance to hospitals and difficulties in travel. Female patients had to find money to cover the costs of her own transport and that of a family member to accompany her.

It would also be useful to contextualise the project eye care referral data within the overall health system and referral patterns in the district. This might include exploring how LHW or BHU/RHC eye care referral completion rates compare to referral for other health conditions in the district. Combined with qualitative data, this may give insight into how patients prioritise care-seeking decisions and value eye care services. Partners also reported that the eye care sector was currently focused on strengthening referral as part of its five-year eye care planning process; this includes the use of digital platforms to assess and monitor activity around referral uptake.

Refractions

The project exceeded targets for refractions, spectacles prescribed and low vision devices, however the outputs are difficult to interpret due to the absence of clear baseline data for spectacles.³³ 302,250 people received refractive services, with more than half of these (55%) provided to women. Low vision devices were provided to 451 people (39% women). The targets were achieved predominantly through services via the optical shops at the charity hospitals, although the deployment of optometrists at government hospitals also contributed.

Overall, a more detailed analysis of service provider data would be useful for understanding the project's achievements and assessing which strategies are most effective, efficient and sustainable. Indicators are defined as absolute numbers, calculated as an excess of the baseline levels, rather than as a proportional increase. To measure effectiveness, it would be useful for the project to be able to report that, for example, X services were increased by X% in the public sector and by X% in the charity hospitals.

³³ The data reported for screenings and refractions were a calculation of the increase from the baseline data. However, the baseline for the number of patients receiving prescriptions was zero as partner hospitals were not recording this data at the time of the baseline. The number of prescriptions would be expected to be lower than the number of screenings and refractions. However, the project reported actual numbers for spectacles, which were prescribed to 437,470 people.

Specific strategies for targeting women

Training LHWs to screen and refer was a key element of project design and accounts for a large proportion of women screened under the project. This full coverage approach removes the barriers to care-seeking, as LHWs know all members of the community, proactively visit women in their homes, are well-accepted in communities and have a clear mandate to provide health education, screening and referral. Following recommendations from the RAAB, the project teams also **increased the number of screening sessions in communities**, which key informants perceived to be a very effective approach for extending reach. Special emphasis was also placed on **communicating there would be no cost** at the point-of-care.

LHWs were the best tool because they have access to household level and can do a lot of follow-up as well. But at the same time, we also got engaged with some local CBOs and in some limited locations with some self-help groups working for disabled people and transgender people. We organised some camps for transgender people and these were very well received. – Project management partner

The execution of community awareness sessions by the social organisers, and screening eye camps by the ophthalmic teams have also been a key action in mobilising the communities in general and women with eye conditions in specific to access the eye care services. – District Ophthalmologist

The village was not very far off from the [name of hospital] but because of our financial constraints and fearing about an expensive eye examination and cost of operation we could not get her eyes examined by an ophthalmologist [...] One day, the lady health worker visited our house as a routine, and she told my mother that for her eye problem she may get examination of her eyes in the screening eye camp scheduled at the BHU, and if she would need any kind of operation, that will be done free of cost. We (me accompanied with my mother) visited the eye camp, and the eyes of my mother were examined and she was told having cataract in her eyes. She was issued a referral slip for further examination at the eye department of [name of hospital] on the day of admissions to hospital with assurance that her cataract operation will be done at the DHQ Hospital free of cost. – Son of female patient operated for cataract

Few targeted approaches were used to promote access for women with disabilities. The project engaged with DPOs in some areas and supported secondary-level facilities to improve accessibility. It is reasonable to expect that LHWs also would have been effective in reaching women with disabilities; however, there was no specific documentation of this and disability awareness training was not provided to LHWs. Inclusion may have depended heavily on individual and community sensibilities and awareness.³⁴

Overall, the project had limited success in increasing women's access to cataract surgery, relative to men. The project generally encouraged project teams at the government hospitals and staff at LRBT (which was conducting more cataract surgeries) to **guide their staff to refer and prioritise women**. As observed above, the shift in the proportion of cataract surgeries provided to women was driven by active prioritisation of female patients at LRBT. Project partners suggested a few strategies that could be pursued to improve reach and uptake:

- **Providing services closer to communities, via an increased number of camps and through expanded service delivery (surgical capacity) at sub-district facilities (THQ and**

³⁴ Although disability awareness training was conducted at the hospital level (following QSAT recommendations), the project did not plan for this to be cascaded down or incorporate disability awareness modules into the LHW training.

BHU/RHC). Distance to referral facility is likely one of the key barriers to referral completion for both men and women. There was wide consensus among key informants that increasing the number of screening camps at the BHU level would be an effective means for reaching women, the marginalised and those unable to afford care seeking. Where these were conducted, this was able to serve as an intermediary service, with LHWs identifying and referring individuals to the camps, essentially expanding the service offer at the BHU level on a punctual basis.

In other provinces, the eye care services are being taken to the sub-district level. The government should take these services to the sub-district level. Sometimes these districts are really big, particularly for the women and the elderly it is not really easy to reach. The government has to look at this side. [...] The first step comes under the domain of the government to be able to create the position of ophthalmologist at the sub-district level and place ophthalmologists over there. – Project Management Partner

- **Providing the opportunity for every woman to receive health care services from a female service provider.** This issue is discussed under the appointment of optometrists (2.4.2).

They [women] should be examined by female health professionals. This was a demand heard very strongly. If we are going to design the project again, I would emphasise from the very beginning that in selection of staff there should be strong consideration on gender balance. There should be enough female staff available to cater to the needs of female population. – Project management partner

- **Addressing socioeconomic access barriers, particularly related to cost and health seeking decision-making, and more formative research on these.** While, a few participants noted that these broader challenges were beyond the scope of an eye care or health care project, it was also acknowledged that future projects would need to develop comprehensive and creative approaches to challenging or circumventing these barriers. Cost in particular is frequently cited as the major barrier to surgical uptake, and even more so for women.³⁵ A 2017 study of barriers to women's eye care seeking in non-targeted provinces also highlighted the need to bring services close to communities, and the need for behaviour change communication to create an enabling environment and support decision-making.³⁶ Even where project-supported or charity hospital services are provided free of charge or where point-of-care costs are covered by the government social protection system ("health cards")³⁷, indirect (travel, food, lodging) and opportunity costs may weigh heavily in decision-making and prioritisation.

Females in these areas cannot travel alone. So when the female has to have a decision for the cataract surgery, they have to visit the hospital with other family members and have to stay overnight, so it involves cost. These issues need a comprehensive kind of approach. That was not a scope of this project, but in the future, we should allocate more resources for this. If the most marginalised are not coming and not able to access those services, then maybe it is not so effective. We need some more in-depth research and more resources for this. – Project management partner

2.2.2. Demand Generation and Awareness Raising

As reported above, an overall increase in demand can be observed in the screening data and OPD attendance. The project pursued two approaches to eye care awareness raising and demand

³⁵ RAAB

³⁶ Dr Shabnum Sarfraz, Dr Tasleem Akhtar, Dr Roomi Aziz, Aliza N Khan, "Pakistan Gender Situation Analysis for Utilization of Eye Care Services", Research Report, Fred Hollows Foundation: March 2017

³⁷ *Sehat Sahulat*, the Provincial government's health insurance programme, includes coverage for eye care. Key informants indicated that the programme currently provides coverage for half of the households in the province, selected for need based on the Benazir Income Support Programme methodology.

generation: (1) awareness raising through the dissemination of eye care messages, and (2) establishing eye care information as part of routine primary-level service delivery.

An **IEC strategy** was developed early in the project and a specialist agency (involved in previous SiB projects) was engaged to develop a communications campaign. Formative focus group discussions (FGD) were held with LHWs and health professionals to explore the kinds of messages needed and the most effective channels (e.g. mainstream media, awareness raising sessions). Eye care messages were developed based on the FGD findings.

This was the first time that partner organisations had developed a communications strategy drawing on evidence from FGDs. Overall, the process and output of working with the communications agency was perceived to be successful. Findings from the FGDs prompted the use of some new approaches for the partners, including the development of large-sized billboards and patient testimonials aimed at inspiring other community members to seek care. The testimonial was produced as a video message that was disseminated on local media channels. Initially, both “negative” (late care-seeking) and “positive” (successful care seeking) patient stories were identified, but ultimately the positive story was not produced due to a change of mind on the part of the patient.

A teacher developed problems but did not take it seriously and went here and there to traditional healers and didn't consult an eye specialist for check-up. Though he was an educated person, he was blind, he went to the doctor, but it was too late. That was a strong story, so we developed a video around this. He narrates his own story; he made this mistake so you shouldn't. – Project Management Partner

Challenges related to the IEC strategy were documented in the MTR. One of these related to the **poor acceptability of a leaflet** that was produced for distribution via LHWs and other outreach. Due to budget constraints, content that was designed for use on billboards was printed as leaflets. The content included holy pictures which would have been acceptable on a billboard, but were not appropriate for leaflets, as people were reluctant to take them for fear the leaflet might be discarded on the ground. Although the content was developed through an evidence-based process, a final pilot-testing of the product before printing and dissemination likely would have identified the poor acceptability. The MTR recommended reallocating budget to produce the billboards, which was effectively carried out in the second half of the project.

Some brochures and pamphlets were designed and got printed, but without having had an impact study or community test. While used for community awareness a few sensitivities surfaced, so that was a great learning. – Project management partner

It is very important to know each and everything about local culture and norms, what would and would not work in these local communities. We included holy pictures because we thought that this is very religious area, so that this would work for us. We needed to explore more in depth, and make sure it was not in conflict with norms. – Project Management Partner

In addition, some project partners and stakeholders noted the limited value of distributing leaflets in communities with low literacy, and questioned the cost-effectiveness of the approach, given these could not be sustainably reprinted and may be discarded. The PEC posters posted in PHC facilities and the health houses of the LHWs were perceived to be a more continuous source of health education.

PEC posters depicting the illustrated common eye conditions, and the triage to proceed further. These posters were very effective IEC material as those are hanging on walls of the offices of GDMOs, health centres, and health houses of the LHWs. It is a ready resource for

the health personnel on knowing about the common eye conditions and triage, and the patients and their escorts do look on quite interestingly, and thereby a good source of health education and promotion in communities.” – DPIU Coordinator

Finally, although many of the messages and materials were well-perceived by the stakeholders, the strategy did not identify clear objectives or plan for a means to verify the effectiveness of IEC approaches or messages. The one-page strategy document focused on the methods and materials and did not detail knowledge or awareness indicators, target audiences, or specific messages. This issue was also raised in the MTR, and the project attempted to estimate the reach of media channels, based on the number of subscribers. However, there was no baseline assessment of eye care awareness and no exploration of changes in attitudes, awareness or knowledge about eye care and eye care service availability. At the close of project, it is not clear what change the project expected to achieve, or whether and how this was achieved.

Until now we do not have a systematic way of calculating who received these messages. As well as we do not have a systemic way to assess the impact of these approaches have had on attitude and awareness levels. – Project Management Partner

Though we took a very rigorous process for developing these materials. We haven't thought about having an impact study to see what kind of impact these awareness campaigns really have. This is not something new, but whenever planning to have a communications plan, you need to put some budget for impact assessment as well. – Project Management Partner

2.2.3. Role of LHWs

The project design identified LHWs as a key strategy for improving both inclusion and reach, by providing screening and referral at the household level and disseminating eye care messages in communities.

LHW Training and Supervision: The project trained over 3000 LHWs in the four districts in primary eye care, via a one-day training. Training was conducted using a cascade approach, involving LHSs as master trainers. This was followed by a half-day refresher training on PEC in 2018, which covered all trained LHWs and provided mop-up training for additional LHWs. The project also trained 250 MOs and MTs based at BHUs and RHCs, which enhanced both their capacity to provide PEC as well as train and coordinate with LHSs/LHWs.

Findings from the operational research raised questions around the use of LHSs as master trainers. On the one hand, the approach ensured the effective training and involvement of LHW supervisors, facilitating supervision of LHW's eye care work. However, LHWs questioned their supervisors' capacity, given the LHSs' themselves lacked direct experience in eye care management.³⁸ Moreover, the operational research raised challenges related to awareness of and support for LHW eye care screening work on the part of secondary-level eye care providers. Project-employed optometrists provided oversight for LHW training, however wider involvement of the ophthalmic teams from the referral facilities as master trainers may have helped to build key linkages, ensuring secondary-level eye care providers had a clear understanding and support for the roles and capacities of LHWs and providing LHWs with more direct information on service organisation at the referral facility.³⁹

LHW Role: Key informants across all levels perceived LHWs were effective at identifying and referring for cataract and basic eye conditions, as well as capturing data. LHWs themselves

³⁸ Sightsavers. Understanding the role of lady health workers in improving access to eye health services in Khyber Pakhtunkhwa (KPK) Province of Pakistan: Study Report. Islamabad (Pakistan): Sightsavers., p. 13

³⁹ *Ibid.*, p. 17: "Most LHWs and LHSs themselves were unaware of how eye care hospitals work, many had never visited an eye care department and did not know how much time patients needed for their referral or how much money the hospitals would charge"

reported that the training had improved their knowledge and skills and they could now identify eye conditions and either manage them at the community level or refer patients to the hospital. LHWs in the operational research study also reported that the training had “equipped them with the skills to talk to the patients and encourage them to seek treatment as a matter of urgency.”⁴⁰

The operational research study observed some ambiguity in the perceived objectives and role of LHWs in primary eye care. LHWs themselves reported “a tension between the degree to which they were expected to manage minor conditions, or universally identify eye conditions and refer, regardless of severity.”⁴¹ Severity of the eye condition has implications for referral uptake and should be clarified. More attention may also need to be given to strengthening capacity for early management of basic eye conditions at LHW and BHU/RHC levels.

Although the project design and RAAB results indicated that LHWs’ focus should be on female cataract case finding, the operational research study findings suggested it was not clear if this was a communicated objective or LHW perception of their role. Under the project, the majority of the screened patients were women, but LHWs were also an effective strategy for reaching men and the wider household.

Supply Chain: During the PEC training, LHWs were provided with kits comprising a PEC manual (describing eye conditions), torch light, eye pads, measuring tape, and ointment. Consumables were provided once at the beginning of the project and in limited quantity; procurement of eye care consumables or replacement of kit items was not integrated within the LHW programme procurement systems.

LHW coordination, targets and motivation: The primary role of LHWs focuses on family planning and maternal child health, with considerable time devoted to EPI and polio campaigns. In the initial phase of the project, LHW screening was lower than planned. In response, the project began more active coordination at both the district and provincial levels. On a monthly basis, project teams visited the LHW district coordinator office to inquire on progress, verify referral slips and capture data. This hands-on coordination provided an opportunity to align district and sub-district eye screening targets with other LHW programme activities and adjust targets as required by external conditions and shifting priorities (e.g. a polio outbreak, health worker strikes). Key informants suggested the proactive planning and coordination may have also helped to improve the feasibility and acceptability of the eye care workload. LHWs are salaried health workers and eye screening targets were achieved without providing any monetary incentives. (In other areas, programmes have provided incentives to LHWs.) This was achieved by ensuring that activities were incorporated into routine health education work, and that the agreed targets were responsive to LHW workloads, determined rationally (e.g. 20 patients/month) and adjusted appropriately. However, in the operational research study, LHWs reported workload challenges in the face of an ever-expanding range of activities and complained of additional reporting and follow-up burdens related to the project.⁴²

The LHW programme are too much engaged. First the official commitment for dengue and MCH. Some other organisations take them to support on a malnutrition programme. We have coordinated with that organisation for the work burden and in terms of monetary incentives. During our monthly coordination meeting [we say], first of all, eye health is part of the curriculum. You are doing your work within office hours and also getting some monetary

⁴⁰ *Ibid*, p. 13

⁴¹ *Ibid*, p. 15

⁴² Sightsavers. Understanding the role of lady health workers in improving access to eye health services in Khyber Pakhtunkhwa (KPK) Province of Pakistan: Study Report. Islamabad (Pakistan): Sightsavers. 2020, p. 17

incentive from other organisations. You can do your work for eye screening without any extra incentive. – Project Management Partner

Some LHWs argued that the eye care programme increased their paperwork and required additional visits to the villages to remind people about hospital referrals. Some said that the monitoring visits organised specifically by the project to boost the uptake of referrals was particularly stressful for them. – LHW Operational Research Report, p. 17

It is reasonable to expect that LHW attention will shift to other priorities when consistent monitoring and oversight disappear. This risk is more acute in the context of the Covid-19 pandemic. Most key informants acknowledged that LHW screening performance would likely decline over time post-project.

We need to realise the role of LHWs. Keeping their motivation high to deliver as part of their core work is not an easy task. Partners have good relationships at all levels with the LHW programme – that keeps them engaged even after project ends. But the expectation that they will continue at same pace as they have during the project might be a stretch. – Project Management Partner

Moreover, the operational research findings related to the poor reception of patients at referral facilities highlight how a single gap in the referral system can have a cascading impact, fuelling a cycle of negative patient feedback which undermines the credibility of LHWs and their motivation to continue referring. The Evaluation did not capture perceptions of how effective LHWs and PHC workers were at counselling patients on referral uptake, discussing a referral plan and identifying resources or support necessary to complete referral. Some key informants, including interviewed patients, reported that LHWs sometimes accompanied patients and provided extra support to complete referral. In the operational research study, LHWs reported they were only trained to refer patients and not to ensure referral uptake.⁴³ Additional training on counselling and patient communication may be needed for LHWs to promote referral completion, and for all eye care staff at referral facilities to appropriately receive and value the referral.

2.3. Efficiency

Rating



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.

Q7: How efficient have the project's strategies been in dealing with challenges to financial planning and in ensuring the project resources are used in the most cost-effective manner?

Q8: How conducive was the partnership approach (between Sightsavers, FHF and PICO) to effective project management?

2.3.1. Cost-efficiency

The project had an important level of expenditure (40%) marked for the procurement of diagnostic and surgical equipment and consumables and developed some standard approaches to enhance cost-efficiency (**Table 3**). The procurement process was led by FHF, with the involvement of all partners. An initial needs assessment was followed by a more detailed assessment of the presence and functionality of equipment and infrastructure at the government hospitals. This was carried out by a team from FHF, Sightsavers and PICO, which included medical personnel to generate a list of the required equipment and resources. With the support of the implementing partner, detailed specifications were prepared, quotes solicited, and selection made based on price and quality. In

⁴³ Sightsavers. Understanding the role of lady health workers in improving access to eye health services in Khyber Pakhtunkhwa (KPK) Province of Pakistan: Study Report. Islamabad (Pakistan): Sightsavers. 2020, p. 14

addition, the project negotiated two-year warranties for equipment malfunctions. This was prioritised given awareness of the potential for repair delays in the government system.

The overall learning is that you have to be really well-versed with the functionality of the equipment that you wish to provide and then come up with generic specifications. [Sometimes people request some specific brand that they like] and that investment is not really worth making. It is important that you know the functionality of the equipment and develop generic specification and go for the best quality and price offered. – Project Management Partner

In addition, the project pursued a public health approach with regards to selection and procurement of rigid IOLs. While this approach was based on outcomes and cost-effectiveness evidence (district eye units also did not have phacoemulsification machines at the time), the project confronted acceptability challenges (also documented in the MTR) with some ophthalmologists advising patients to purchase foldable lenses. While treatment decision-making is the purview of providers and patients, this impacted on patient acceptance of and benefit from the resources provided under the project, which undermines the overall effectiveness and efficiency. Where this strategy is agreed in future projects, buy-in should be obtained from ophthalmologists at the project design phase. Some key informants suggested that, where appropriate, future projects might consider more flexible resource allocation to allot a small amount for foldable lenses (phaco surgeries). However, this may be impractical, as for both quality and efficiency, projects must set minimum service delivery standards and agree on standardised quality IOLs, equipment and consumables.

Other efforts to improve cost-efficiency included minimising travel costs through remote monitoring and combining field visit travel. Project officers set up Skype groups with the team, organised bimonthly and sometimes weekly meetings, and held video calls from the field, for example to observe outreach camps. This reduced costs and also allowed for more frequent meetings, shifting to a weekly basis rather than monthly. Efforts were also made to combine travel for field visits between partners.

Table 3. Project approaches to enhance cost-efficiency

Equipment and consumables	<ul style="list-style-type: none"> • Multiple phases of hospital needs assessment and development of specifications • Robust procurement process (committee constituted of all partners, transparent, accountable) • Negotiating longer warranties; providing initial stock of replacement parts (e.g. bulbs) for continuity • Choosing investments wisely: knowing functionality and generic specifications; verifying end user capacity • Public health approach to cataract surgery/IOL selection
Project implementation	<ul style="list-style-type: none"> • Remote monitoring with project teams • Joint partner travel for field visits • Purchase of motorbikes rather than vehicles

The project encountered some challenges with regards to financial planning. These included **inadequate budget for the IEC campaign** (see Section 2.2.2), a lack of resources to address QSAT recommendations and help hospitals meet a standard of care, and the low FTE (.5) allotted for the Project Coordinator position at PICO, which some key informants perceived to be inadequate in hindsight for the scope of work. With regards to the IEC campaign, the project was able to successfully reallocate budget to cover costs for the communication plan.

A few areas were raised which may merit consideration in future projects. More work could be done to better understand the **cost-recovery models employed at the optical shops** and business viability of these. Further costing analysis might also assess **efficiency at government hospitals**. This relates to the wider issue of how best to engage partner hospitals and prioritise investments in the context of eye care system.

The project is basically designed in a way that most of investment is going to the government system, but as a result the government system is not performing as actively as charity hospitals are. Whenever we design the same kind of project in the future, we need to expand the role of charity hospitals. The referral points were on government hospitals initially. If we had invested more resources in charity hospitals –they have their own satellite centres where they screen and refer patients to hospitals [...] – it could have a positive impact as well. – Project management partner

2.3.2. Partnership approach and project management

Partnership approach: The three partners evoked a positive partnership relationship, in a national context in which eye health INGOs are operating in a spirit of collaboration rather than competition. These relationships were the genesis for the joint application and were strengthened over the course of needs assessment, proposal development and project implementation. Key factors supporting successful collaboration were trust, recognition of respective strengths (e.g. technical, geographical, networks), shared history/tenure of key staff, and the use of established and regular mechanisms for information-sharing and collaboration (initially through the national committee for eye health and subsequently through the eye health INGO forum).

All eye health community [in Pakistan is a] very closely knit community [...] We are not competitive of each other and should support each other. On the national committee for eye health we used plan so that we can maximise our impact and not duplicate resources. In our eye INGO forum we also share and discuss information, where we are present and what are the challenges we are facing and how we can combinedly address those challenges to increase impact, draw experiences from each other and reach the most people in need. – Project Management Partner

Partners reported that this was a valuable internal learning experience for the organisations themselves, providing exposure to different management approaches and experience with overcoming challenges. The experience also demonstrated the benefits of collaborative projects – such as increased effectiveness, transparency and accountability – to national and provincial actors, increasing their receptiveness to and providing a model for future collaborations. **Similar partnership approaches have since been used in other projects (e.g. a trachoma project).**

This project helped the local partners to see that it is not difficult to work with two very strong international organisations on the same project, they are each bringing strengths and own added value. It is not two different things, happening in two different places. There have been challenges, they are part of the process, but this also provided the partners an opportunity to see that these challenges can be overcome. This is a new dynamic within the public sector. – Project management partner

Steering committee: As this was a first attempt at a tripartite arrangement, the partners decided there should be an overall project steering committee involving the key partners, which would meet regularly in the beginning and continue for one to two years. For PICO, in particular, it was the first experience collaborating with multiple partners, so it was important to clearly define roles and responsibilities across and within the different partners. Key informants reported it took some time to define these across the partners. Having regular, frequent meetings early in the project was cited

as an important success factor for smooth project implementation. Through Steering Committee meetings, partners were able to tackle key issues early on and develop processes that enhanced efficiency, transparency and accountability. These included defining the monitoring framework for the project, establishing procurement processes, and forming a procurement committee. Key project decisions were made jointly through consensus of the three partners.

That was a very unique and different experience. There was a lot of learning for each organisation; we have our own processes and systems. This gave us more time to understand each other's systems and make joint processes. – Project management partner

I think that Steering Committee really helped us navigate through these issues quickly, in a transparent way, and in an accountable way. These things were sorted out at the very beginning and we didn't face challenges later on. – Project Management Partner

The Steering Committee was also key in activating decision-making on key areas of the provincial eye health agenda, helping PICO to influence change early in the project and providing a base for many pending decisions across the province. For example, a key informant recalled one Steering Committee meeting in which PICO raised the need for regular provincial eye coordination meetings. The committee helped PICO engage with other peer organisations and through contacts, reach out to the provincial secretary of health.

The partnership approach was also a key factor in the effectiveness and efficiency of advocacy efforts. The joined-up advocacy efforts through the consortium were perceived to work particularly well, with collective influencing and lobbying having a greater impact.

It was a wonderful experience in terms of matching expertise, especially district-wise. In district networking, Fred Hollows Foundation has strong relationships, and similarly, for Sightsavers. PICO representatives are closely working with district authorities and also the provincial health department. The presence of the provincial eye health board at PICO, it does provide a lot of boost to the project. They are very closely talking to provincial authorities. That helped us to achieve a lot of our advocacy objectives through this close networking. – Project management partner

Gaps in the partnership approach: Charity hospitals were not well-engaged in project design, needs assessment and early implementation. This created some inefficiencies as well as missed opportunities to bring their viewpoints, needs and experience into the project. One key informant also mentioned that it would have been useful to hold more frequent formal meetings between partners in the latter half of the project.

2.4. Impact

Rating



- Q9: To what extent has the project contributed to the strengthening of eye care services at the partner hospitals?
- Q10: What role has the project played in advocating for the approval of the optometrist posts in hospitals and what is the likely impact this will have?
- Q11: How well established are the referral pathways and follow-up mechanisms of the project, particularly in relation to the links between the primary and secondary levels?

2.4.1. Hospital strengthening

The project invested resources in the existing health system through human resource development, infrastructure development and quality improvement.

Human resources: The needs assessment identified gaps in skilled human resources, with limited presence of certain cadres, such as ophthalmic technicians, ophthalmic nurses, refractionists, and optometrists. The development of ophthalmic teams had been promoted and advocacy carried out with the Ministry, PICO, COAVS and a few other institutions to develop these eye care cadres. As a result, in Punjab, the positions for the ophthalmic technicians and the optometrists had already been created and deployed in all the DHQ and THQ Hospitals. Therefore, the project funded two optometrists and two social organisers per district to provide refractive services and conduct outreach activities. The counterpart approach was designed to avoid service interruptions, allowing one staff to practice at the facility while the other conducted outreach. In addition, key informants observed that the project contributed to broader changes in the working environment in eye care departments, and enhanced cooperation and coordination mechanisms.

Infrastructure and equipment: As described under Section 2.3.1, cost-efficiency, a detailed needs assessment identified required diagnostic and surgical ophthalmic equipment, which was provided and installed at OPDs, OTs and optical labs to improve services in all partner hospitals. Stakeholders generally perceived that the project was able to adequately resource and equip hospitals, although it was acknowledged that some technology needs could not be met. The project also evaluated **accessibility for persons with disabilities** and made some investments to address gaps (e.g. ramps, railings). This provoked a reflective process on the part of hospital management teams regarding the importance of making services accessible for persons with disabilities.

Expanded service availability: Increased service availability was documented at the four DHQ hospitals, in terms of both offer and quantity. Key informants described that patients used to go to Peshawar for more comprehensive eye care services, but now these services had been effectively brought down to the district level. In particular, the training and appointment of the eight project optometrists increased the availability of refractive and low vision assessment, counselling and health education. Key informants reported that the increased capacity also led to reduced surgical wait times, although delays at public hospitals were still reported.

*A significant portion of OPD patients would need provision of just refractive services, under the existing scenario those refractive services were being provided by the medical officer or the ophthalmologist when they have to examine a lot more patients requiring diagnostic, medical or surgical management. Therefore, patients who would need provision of only refractive services would either overburden the ophthalmologists or be ignored. –
Optometrist*

Quality of care: The project aimed to improve the surgical quality and visual outcomes by introducing Sightsavers' quality standards for refractive error and cataract surgeries. QSATs were conducted at four government hospitals (in Haripur and Swabi districts in 2016/17 and in Mansehra and Swat in 2017/18). The assessment identified gaps in the provision of high-quality care and provided guidance and motivation for partners to improve the quality of services where appropriate. One challenge was that although the QSAT identified gaps and strategic action points, it did not commit financial resources to support the implementation of recommended actions; some recommendations required immediate attention, but hospitals lacked resources to address these. In the first two QSATs, it was observed that hospitals did not have guidelines regarding waste management and infection control policy. The project was able to reallocate budget to introduce a waste management system in the four districts. With the provincial health department, the project identified that an infection control policy existed, but had not been provided to hospitals. Based on the QSAT recommendation, the project developed an infection control protocol in the form of bullet points and developed posters for placement in different locations in the eye departments. The QSAT findings also drew attention to the gap in waste management and infection control policies in

hospitals across the province, and PICO disseminated these to all secondary and tertiary hospitals in the province.

The MTR highlighted gaps in the **consistent recording of post-operative visual outcomes** at some of the project hospitals. In some cases, outcomes were only being recorded on the prescription (received by the patient), but not monitored in hospital records. Key challenges related to low follow-up rates, sub-optimal data systems, inadequate human resources (pre-project) and the absence of clear policy guidance. With the concerted effort of the social organisers and optometrists, the project was able to increase patient awareness of the importance of follow-up, however follow-up rates remained low.⁴⁴ QSAT action points included institutionalising a formal visual outcome monitoring system. Though not fully adopted, the project introduced recording of visual outcome of surgeries through tele-sheets and software at some facilities.

Whenever the patient came, they take post-op vision and record that vision on the documents and the prescription and that goes with the patients. Hospitals were not practicing to record post-op outcomes. –

We had meetings through PICO, with ophthalmologists, MS, with project teams and guided them and made them realise this is really an important area. The teams took a proactive approach whenever cataract surgery happened and guided [patients] to come back for post-op follow-up. The number of follow-ups increased. – Project Management Staff

This is really a good contribution that they have started recording. It is not going away on the prescription of the patients. These registers are there in these departments. Particularly the charity hospitals are recording on regular basis, so they realise the importance of post-operative outcomes and started it. – Project Management Staff

Key informants indicated that recording of POVOs would continue to be a challenge going forward, particularly given the withdrawal and partial replacement of the project-supported human resources in the eye departments. The project held discussions with the MS and district ophthalmologists to encourage continuity of recording practices, but realistically it is expected that systematic recording will continue only in the charity hospitals and the teaching hospital (Saidu) in Swat, where there are large eye departments with adequate human resources.

We are continuing these discussions with eye health boards and national eye health committee. [It would help] if we have a policy statement from government to record and report post-op visual outcomes. We are advocating through different forums. – Project Management partner

It is not only about the human resources, it is about the willingness and motivations of the ophthalmologists. There are ophthalmologists that believe that recording of post-operative visual outcome, that that is kind of something that their work is monitored. They are afraid. – Project Management Partner

2.4.2. Approval of Optometrist Posts

Advocacy process: At project design, there was recognition that the influx of human resources under the project would need to be sustained for long-term change to occur. The project quickly documented evidence of the impact optometrists were having on eye health department functionality and service delivery, including task shifting. PICO carried out evidence-based advocacy and lobbying with the Ministry of Health for the creation of posts for the deployment of optometrists at district eye units. Data were presented to provincial health authorities,

⁴⁴ In 2018, less than a third presented for final VA

demonstrating a dramatic increase in service delivery. These data were complemented by qualitative testimonials from a district ophthalmologist, who could describe the impact of task shifting on his overall caseload, organisation of service delivery and prioritisation of complicated cases. Advocacy was carried out at both the provincial level and also with the national eye health committee, so there was simultaneous pressure from the federal level as well.

It was possible because we created some evidence for them. At the start of the project, the health department authorities were not very convinced; 'How can their [optometrists] placement make such change that they are anticipating?' After six to eight months, we were able to create some evidence. They could see a graph of how many patients have benefited. Secondly, the district ophthalmologist explained that when he didn't have the support of the optometrists, all of the burden of OPD was on his shoulders and he had to deal with refraction and minor eye problems. – Project management staff

Impact: The ongoing advocacy work conducted by partners resulted in the Ministry agreeing to the creation and budgeting of 24 optometrist posts (at DHQs) and eight posts at the tertiary level as of September-October 2019. These efforts also led to increased provincial investment in some sub-specialities. Recruitment for the new posts was completed, but, at the time of Evaluation, the selected optometrists had not yet been deployed due to the COVID-19 pandemic. Provincial authorities reported this would proceed once routine health service delivery resumes. In addition, as a direct result of the presentation made under project, 96 mid-level eye care professionals / optometrists' positions have been approved to fill the gap at THQ Hospitals across the province. Although many of these positions will not be immediately filled, the approval of these posts represents a meaningful commitment of resources for the near future.⁴⁵

While the approval of optometrist posts was a major project achievement, key informants suggested the project might have pursued other strategies to increase government investment in human resources in the project area. When designing future projects in coordination with the public sector, partners could use the opportunity to leverage project support to seek government commitments for the provision of relevant human resources, codifying this in the MOU. Importantly this strategy would have avoided the disruption in staffing currently being experienced and would have maintained eye care team continuity (the public service recruited optometrists will replace the project-appointed optometrists).

Another gap in this important achievement was the low number of women initially recruited for the project-supported optometrist and social organiser positions.⁴⁶ This issue was also documented in the MTR.⁴⁷ Although the project actively sought female applicants, project staff reported that they were unable to identify female optometrists for the positions due to contextual barriers deterring women from taking up these posts. If this is true, **future efforts may wish to consult potential recruits, female eye care professionals and other stakeholders to identify specific barriers and develop strategies to mitigate these.**⁴⁸

The government should also think of placing more women in eye department, they announce openly and everyone has to compete and most of the time males are keeping those positions. The government needs to think about gender balance. Though we have also advocated and tried to influence that [...] so far we could

⁴⁵ A meeting had been scheduled for 25 March 2020 with policymakers (e.g. Chief secretary, Finance and Health Secretary) to finalise the creation of 96 more seats of optometrists in the province, and deployment of ophthalmologists in THQ Hospitals. By that time, the COVID-19 pandemic lockdown was in place in the province and the meeting could not happen. The meeting will be rescheduled once normal routines resume.

⁴⁶ Although this project recruitment is not the same as the public service recruitment described above, the gap remains the same.

⁴⁷ MTR: "Although the Optometrists posts for the project were advertised in a local paper and a number of female Optometrists were encouraged to apply, we received no female applicants for the roles. The main reason for this is that the project area is highly conservative, and so women were deterred by that. In general, people do not like or encourage women to work in these areas, particularly in roles that will involve field activities such as this project. The project will continue to encourage the participation of women in future training, although given that there are few women working in the province there will continue to be difficulties in recruiting women for the training of Technicians and Officers."

⁴⁸ For example, initiatives to make working environments more accommodating, developing support networks or other professional mentoring, providing commitments to female health workers, structuring field activities to improve acceptability to communities, health systems and individuals.

only influence the training institute to increase the number of training slots. But with regards to recruitment, the government does not have any specific quota, it is open competition. More males apply, so more will be recruited. – Project Management partner

Beyond the project, specific **recruitment approaches will likely be required to achieve gender parity in these positions**. PICO and partners have been able to successfully increase the numbers of qualified female eye care professionals through allotment of training slots. However, partners reported that it is incumbent on the government to ensure that female candidates are given equal opportunity, through either targeted recruitment strategies or affirmative actions to increase the number of women in these posts. In addition to training programs and outreach efforts, other positive steps may be needed to increase the number of women in the eye health workforce, in particular identifying and addressing the factors which deter women from taking up posts in peripheral areas.

Finally, there was a gap with regards to the **sustainability of the social organiser positions**. These individuals played a key role in implementing and monitoring project activities, working as part of a team with the optometrists and other hospital staff. Although the social organiser position exists elsewhere in the country, in these districts, the position was not related to the health system.

Deficiency of skilled human resource is the major factor, and we wonder at the exit of the project, when the services of the social organisers and the optometrists would be withdrawn, how the ophthalmologists will be able to manage all those activities in place without the proper human resources in place. – Project management partner

2.4.3. Referral Pathways and Follow-up Mechanisms

LHWs and PHC workers know when, how and where to refer, which has been evidenced in the high number of patients screened and referred from BHUs/RHCs and LHWs. These referrals were achieved without external motivation. PHC workers were equipped with supportive tools (PEC manual, torch, referral slip with check boxes for eye conditions). Moreover, the project ensured there was increased service availability at referral facilities to meet demand. There was good documentation and recording of the referral process, and this was aligned and integrated with existing referral and supervision systems. Periodic review meetings were held with stakeholders. All stakeholders involved in the referral pathway appeared to be well-aware of the mechanism. However, findings from the operational research suggested that some staff at referral hospitals were not oriented on LHW referral.

Referral completion: Although these systems appear to be well-established, the low documented rate of referral completion (see Effectiveness) undermines the impact of this achievement. Moreover, a decrease in service availability post-project (due to decreased human resources at referral facilities) could lead to longer wait times and a deterioration in patient experience, which in turn would further threaten referral uptake and LHW/PHC worker motivation. A key gap identified in the MTR⁴⁹, reported during this Evaluation, and emerging from the research study relates to the disconnect between patient expectations and their referral facility experience. The MTR documented a need to improve the reception or prioritisation of referred patients, a crucial element to promote a virtuous cycle of positive referral experience and future uptake. Project partners discussed the potential prioritisation of referred patients with hospital management but were unable to identify workable approaches.

⁴⁹ MTR, p.: "To encourage and enhance the level of motivation of LHWs, a special counter should be developed at the eye department for facilitated and speedy management of referred cases, and priority be given to them if surgery indicated. It will enhance the trust and confidence of communities and LHWs as well in the available eye care services. – DPIU Coordinator, Swat"

One thing we heard quite a lot from LHWs: patients referred by them are not very well received at hospital. They had to wait in long queues. They are going there with the expectation that they will be dealt with as priority or some concern. They complained to the LHWs referring them, affecting reputation of LHWs in their communities as well. We need to advocate, build up some system with the local health department with a separate reception desk, or dedicated days this can be done for the referrals being sent by LHWs so they receive some level of satisfaction that they are able to access the required services. They get frustrated and don't go again. – Project management partner

Follow-up mechanisms: Referring LHWs and PHC providers promoted follow-up visits, but the project relied on the use of project teams to guide and counsel patients on the importance of post-operative follow-up. Post-operative follow-up remains a key challenge given that surgical care is urban-centred and the majority of the population must travel long distances. Particularly in the absence of complications, patients may be inclined to consult a nearby doctor for follow-up, rather than return to the hospital where surgery was performed. Other delivery strategies (satellite clinics) might have been pursued to bring follow-care closer to communities.

2.5. Sustainability

Rating



- Q13: *What arrangements have been made to ensure continuity of data collection and availability beyond the project?*
Q14: *What are the key factors that may contribute towards sustainability of the project beyond SiB V-Tranche-III? (e.g. post project operational expenditure, continuation of eye care services, provision of spectacles, human resources)*

The project contributed to provincial and district health system strengthening by increasing the presence of trained eye care personnel and primary health care workers, the provision of equipment, the establishment of DCCs and activating decision-making on the eye care agenda. The project design and implementation identified and planned for key elements to support sustainability (e.g. budget lines and allocations for equipment maintenance and repairs; the approval of optometrist postings; integration of referral system). However, the project lacked a clear sustainability plan. The MTR recommended the development of a plan, drawing attention to maintaining the engagement of the LHW programme.⁵⁰ Partners reported that this was drafted and agreed with key stakeholders in the second half of the project, capturing which activities will continue and how. A final document showing what routine actions partners will take to sustain achievements would be useful for future monitoring. In the future, planning for a phased withdrawal of resources and project oversight may also help to monitor continuity and threats to sustainability.

Factors favouring sustainability and threats to the sustainability of project achievements are summarised in **Table 4**.

⁵⁰ The MTR recommended the project “continue to monitor the prospects for sustainability of the project gains, working closely with the project stakeholders at all levels to ensure that practices are embedded into the systems in place before the end of the project. This is particularly important with the PPIU which is a vital stakeholder in ensuring the continued engagement and commitment of the LHWs programme. It is recommended that the implementing partners put together a sustainability plan against which progress can be monitored/measured.”

Table 4. Factors favouring sustainability and risks to sustainability

Project strengths and factors favouring sustainability		Threats to sustainability
Service Delivery / Outreach	<p><u>Referral linkages</u></p> <ul style="list-style-type: none"> Referral chain from primary to secondary level likely to remain functional PEC integrated into existing PHC: LHWs/MOs know how screen and where to refer; used existing reporting and supervision systems Specialised eye care referral slips will not be provided, but LHWs can shift to using conventional referral slips <p><u>Public Hospitals</u></p> <ul style="list-style-type: none"> Refurbishment of eye departments, physical infrastructure improvements will remain No expected decline in services at charity hospitals <p><u>Charity Hospitals</u></p> <ul style="list-style-type: none"> Optical shops established at the LRBT Eye Hospitals: refractive glasses will continue to be dispensed at subsidised rates, provision of low vision aids <p><u>Outreach/Screening</u></p> <ul style="list-style-type: none"> In Haripur, district/private resources mobilised for screening camps 	<p><u>In public sector</u></p> <ul style="list-style-type: none"> Referred patients may not receive eye care management or eye surgeries free of cost in long-run Low rate of referral completion. Decrease in service availability (due to decrease in HR post-project) and/or poor referral reception may further discourage patients and LHWs. No system for prioritising or valuing referrals: missed opportunity to promote virtuous cycle of referral experience Limited proximal referral facilities (lack comprehensive services at THQ level in most districts; low capacity/functionality at BHU/RHC) LHW motivation for screening and referral may decrease without active project monitoring and coordination Low completion of follow-up visits is likely in the absence of guidance and counselling from project teams (social organisers) <p><u>Outreach</u></p> <ul style="list-style-type: none"> Outreach likely to decline without social organisers
Human Resources	<p><u>In public sector</u></p> <ul style="list-style-type: none"> Most trained staff are permanent government staff, will remain part of the system (ophthalmologists, MOs/MTs, LHWs) LHWs motivated; no monetary incentives attached to targets 24 optometrist posts approved, budgeted, and recruited for DHQ level 96 postings have been provisionally approved for THQ Hospitals Primary eye care (PEC) included in the curriculum for LHWs 	<p><u>In public sector:</u></p> <ul style="list-style-type: none"> Lack of government MoU binding human resources Recruited optometrists not yet deployed, causing gap in eye care HR Staff turnover: recruited optometrists not postholders under project Assuming recruited optometrists are deployed, eye departments will lack three to four staff members present for last four years Social organiser position not financed or mapped to system PEC not integrated/funded into refresher training as part of existing training schedules for the PHC workforce Absence of project oversight, active coordination and data capture may decrease active monitoring and supervision
Quality of Care	<ul style="list-style-type: none"> Improved recording of post-operative visual outcomes 	<ul style="list-style-type: none"> Consistent post-operative outcome recording unlikely to continue in many hospitals (due to decline in HR; absence of policy statement from government to record and report POVOs)
HIS / Data Continuity	<ul style="list-style-type: none"> Existing reporting systems and supervision of LHWs LHWs motivated to capture their own performance <u>Opportunity:</u> in current provincial planning process, update eye health indicators in DHIS and align with reporting tools 	<ul style="list-style-type: none"> Integration of public and charity hospital data not routine; project did not create linkages or foster data sharing from charity to public sector

	Project strengths and factors favouring sustainability	Threats to sustainability
Financing / Access to essential consumables	<p><u>Public sector</u></p> <ul style="list-style-type: none"> • Procurement and installation of surgical and diagnostic equipment; entered as permanent hospital assets • District health authorities and DHQ Hospital Management have budget lines and allocations for repair and maintenance of ophthalmic equipment and supplies • Equipment warranties / maintenance; negotiation with vendors to reduce burden of maintenance for hospitals and include initial stock of maintenance items (microscope bulbs, etc) for use post-project • Patient out-of-pocket costs may be reduced through government social protection mechanism, “health cards” <p><u>Charity hospitals</u></p> <ul style="list-style-type: none"> • Optical labs/shops established at charity hospitals and run as private businesses; LRBT uses tiered system based on ability to pay for services and will continue to cover spectacle costs 	<p><u>Public sector</u></p> <ul style="list-style-type: none"> • Financing for IOLs and consumables; out of pocket surgical costs likely to increase at government hospitals • LHW consumables provided once at the beginning of the project and in limited quantity; procurement of eye care consumables or replacement of kit items not integrated within the LHW programme procurement systems to ensure an uninterrupted supply
Leadership/ Governance	<ul style="list-style-type: none"> • Good ownership by provincial and district health teams via partnership approach • DCCs are planned to continue to meet; effective mechanisms for identifying bottlenecks and solutions, resource mobilization and engaging district stakeholders 	<ul style="list-style-type: none"> • Linkages with the provincial non-communicable diseases control department at the directorate general for health services not established • DCCs did not include charity hospitals
Community Engagement	<ul style="list-style-type: none"> • LHWs may continue eye care awareness activities as part of routine work 	<ul style="list-style-type: none"> • Continued message dissemination via channels other than LHWs / health service delivery points is unlikely

Key sustainability concerns relate to diminished human resources (and service availability), the loss of subsidised/free of cost eye care management, reduced referral over time, and the effects on coordination and motivation in the absence of the project. It is reasonable to expect that PHC-level attention in particular will shift to other priorities when consistent monitoring and oversight disappear; this is all the more likely in the context of the Covid-19 pandemic. While LHWs appear motivated to continue service provision, a number of external factors threaten this over the long-term, including the lack of support/validation at secondary referral facilities and the absence of eye care consumables in LHW programme procurement systems.

When an eye department will not have four staff members that will work there for last four years, part of the team, they were taking a lot of the burden. It will have an impact on performance of eye department. At least one optometrist will be joining soon. – Project Management Partner

Teams very closely coordinate with LHS, asking for submission of data. The LHWs were on their toes. But when project is closed, there will not be any staff to follow them and participate in monthly meeting. Motivation level will be there for some time, but later on, slowly their motivation level will go down. This number of patients screened and referred from primary to secondary may drop in the long run. – Project Management Partner

Continuity of Data Systems

As noted above (see referral linkages), the project integrated PEC data with routine reporting and supervision mechanisms in the public sector. Key informants reported that all patient data is recorded at the eye units of DHQ Hospitals, whether patients are referred or attend the OPD spontaneously, and these data are then reported as part of regular HMIS of the DHQ Hospital, and subsequently to DHIS or PHMIS. Key stakeholders expressed few concerns about the continuity of data recording and reporting within the public system following the end of project. However, key informants did observe a number of challenges related to completeness and integration of data.

Most importantly, there is no mechanism in place for reporting or integrating data from the charity hospitals (LRBT, Lakson Trust Hospital, Shifa Eye Foundation) into the public sector HMIS. Under the project, data from charity hospitals were collected directly by the project staff/social organisers; no system was put in place to routinely share data between the charity hospitals and the district database. Moreover, the data provided to the project consisted of figures reported against the agreed targets and did not reflect a comprehensive report, making it difficult to understand referral patterns for example. Going forward, charity hospital data will only be available through a specific request to the hospital administration.

Key informants reported the government currently has a strong focus on developing a comprehensive DHIS; considerable discussion around HMIS strengthening is occurring through the current provincial eye care planning process. Four eye health indicators are currently included in the system and there is limited reporting of these, in part because the district indicators are outdated and not clearly aligned with reporting tools. Project partners have been invited to participate in a consultative workshop, which will provide an important opportunity to push for inclusion of evidence-based indicators that are more aligned with needs on the ground.

Finally, the ownership and use of data, and uptake of learning can always be strengthened. Although this was not a major focus of the project, some key informants noted future projects

could seek to develop a continuous learning framework, to sustain engagement and learning after the life of the project.

We tend to analyse the data coming from different sources, and how that leads into some learning and modification and adaptation of interventions. I'm not sure how a continuous learning framework can be based into these projects. [...] It happens when the project is happening and when there is a high level of engagement from NGOs, but it fizzles out once engagement decreases. It is just a matter of how we can have something in place to make sure that learning doesn't stop when project life ends. – Project Management Partner

2.6. Scalability/replication

Rating



Q15: *What are the key learnings that can be taken from this project to inform strategies for replication or scale up?*

The project design was based on well-established, scalable approaches for secondary-level strengthening of eye care service delivery and PEC integration into PHC. The main innovation of the project was to combine these models for a more comprehensive approach. There was also important implementation learning generated around these approaches, coordination and working relationships. The project partners pursued a conscious, reflective approach of testing out and modelling approaches: first identifying gaps, then generating evidence of need or effectiveness and producing guidance which can inform scale-out to THQ Hospitals and other districts and provinces. As such, the project has generated a number of key learnings which have been highlighted throughout and are summarised under 3.2 Learning points. The experience of appointing optometrists could be written up as a more detailed case study to inform future projects.

2.7. Coherence/coordination

Rating



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.

Q16: *How effective have the project's efforts been in coordinating and collaborating with other key actors to achieve the project objectives?*

Q17: *How effective were the forums of District Coordination Committees (DCCs) in project implementation and decision making at the local level?*

Q18: *Are the activities and outputs of the project consistent with the overall goal?*

2.7.1. Coordination with Key Actors

The project engaged a large number of key actors within the government health system and charity hospitals. The DCCs (discussed further below) provided a forum for bringing these actors together, beginning in 2017. The project review meeting process was also perceived to be useful, not only for monitoring progress, but for mutual learning and sharing challenges and practices between teams.

Provincial level structures/committees: Overall, there appeared to be good ownership of the project at PICO and the provincial health department, which was consistent with the strong partnership approach described under efficiency/project management (2.3.2).

They [PICO and the health department] were interested in the project. I have been working with different organisations where there are different implementing partners [...], most of the time they don't own that project. [Here] they were very much owning the project. They come up with ideas and come up with solutions. When they had any issue on the ground, they would handle it themselves. – Project Management Partner

The ownership and leadership and how it sits within the public system is a major achievement. We implemented this project in not a very easy geographical terrain, public health and education system. It has been an achievement, seeing this evolve to something where it is embedded with the government system taking charge and taking it forward. – Project Management Partner

This project helped us to build that strong relationship with the provincial health department and influence their thinking for eye care plans, and approval of different human resources decisions, some that were pending for a long time but were not approved because they were not considered very important [relative to other health priorities]. – Project Management Partner

Linkages with the department for the control and prevention of NCDs did not appear to have been prioritised, although prevention and control of blindness should lie with the NCD department.⁵¹ For integration and sustainability, the project and the provincial eye department should have liaised and coordinated with the provincial non-communicable diseases control department at the directorate general for health services.

LHW programme: Following low screening performance of LHWs early in the project, the partners worked to improve coordination at both the district (DPIU) and provincial (PPIU) levels. This was largely achieved through visits from the project teams to the LHW coordinator office to review data and adjust targets. Partners credited this regular coordination and engagement with achieving buy-in to carry out screening work.

We coordinated at district and provincial level simultaneously. It was important that both levels at the same time. We have mutually discussed, each month our teams will be visiting LHW coordinator office, will ask about progress of the month, verify referral slips and will take the data from the district coordinator, and will be coordinating through this approach. – Project Management Partner

2.7.2. District Coordination Committees

The project design included the establishment of DCCs, which were chaired by the highest ranking district official, the Deputy Commissioners, and which aimed to engage all district stakeholders (e.g. district health authorities, MS of hospitals, district ophthalmologists, and other key stakeholders influencing project implementation). The DCCs planned to meet quarterly to share project progress, plan for the next quarter and raise any issues the project was facing; in practice most of the DCCs met two to three times per year due to scheduling constraints.

There was wide consensus among stakeholders that the DCC was a useful approach for carrying forward key project initiatives, raising awareness of eye care, as well as for advocacy, resource mobilization and raising the profile of the project.

⁵¹ The Prevention and Control of Blindness program was previously implemented as a vertical program, through the national and provincial comprehensive eye care cells. It should be integrated into the health system, under NCDs.

That concept [DCCs] was really useful in terms of building the relationship with district stakeholders as well as raising the profile of project... The deputy commissioner mentioned this was the very first time that an eye care project has been brought to the table and can benefit our local communities. – Project Management Partner

Key informants observed that the meetings were action-oriented and that they were designed to be forums for identifying bottlenecks and solutions. For example, one key informant described resource mobilisation that occurred during the last DCC meeting in Haripur district in response to the need raised by the hospital MS for additional budget for surgical consumables and IOLs:

The deputy commissioner chairing the meeting, he said, why don't we mobilise the local philanthropy. This is a district where there are a lot of industrialists, local influential and affluent people. He said he has some personal contacts and while sitting there he dialled a few numbers and said at least for 300-400 surgeries we can support. This kind of resource mobilisation was possible through such platforms. – Project management partner

Success factors: DCC effectiveness was perceived to be due to strong ownership, seriousness of purpose, fostering an open dialogue, respecting a regular schedule, documenting action points and sharing progress on action points. This was underpinned by the resources invested by the project. However, DCC effectiveness may in part depend on the orientation of the Deputy Commissioner; in one district, the district ophthalmologist did not perceive the DCC to be useful or responsive to needs.

The ownership of those committees and the kind of sincerity you show toward the cause and seriousness you bring to the table. Then bringing in the right stakeholders, having open dialogue and setting the stage from the beginning where you can come and honestly give your feedback – that the issues that are brought to these committees would be discussed and actions agreed upon. [...] If people feel that these committees are just for the sake of committees, then they don't get anything out of that and don't pay the required attention. [...] To be able to make these committees work they need to show seriousness to the cause. – Project Management Partner

Gaps: A key gap in DCC implementation was the lack of engagement by charity hospitals, the largest service delivery providers in some areas. This would have been an opportunity to improve linkages between the public and private sector and improve coordination and sharing of data.

2.7.3. Coherence of Project Design

This project combined different elements of previous eye care projects to work towards a more comprehensive approach to eye care systems. The district comprehensive eye care model focuses on the supply side and strengthening service delivery at the secondary level. This project added some elements to this approach, including involving high-performing charity hospitals and simultaneously working through the existing PHC system to generate demand and deliver services near to remote communities. These elements were perceived to add value and improve the coherence of the project. A key strength of the project design was the incorporation of operational research to explore the project experience with referral uptake.

Role of charity hospitals: Key informants suggested that in future projects, there should be earlier and more extensive engagement with the charity hospitals. In part due to the adjustments in project strategy, the charity hospital partners had less initial involvement in the project design. Key informants from LRBT noted that in future collaborations it would be useful

to increase their involvement at the planning stage to understand the concept and build working relationships, as well as in the development of reporting/monitoring mechanisms and KPIs. More regular sharing of data and limitations to address gaps was also suggested. Project management key informants also suggested that the role of charity hospitals should be expanded: they should not just be considered as a service delivery partner, but should be engaged in all activities, in Provincial boards and DCCs, encouraged to generate monthly reports and share with the public sector, and participate in joined-up advocacy efforts.

When the project was designed, we were not on board. Later, we had a separate meeting with Sightsavers and inducted. [It would have been better] if we had been initially on board when project designed. – LRBT representative

We need to expand the role of charity hospitals in these kinds of projects. We talk about eye care systems and it includes both government and private and the not-for-profit sector. – Project Management Partner

Overall, charity hospitals performed a large proportion of surgical and refractive services under the project and some key informants suggested that the overall impact may have been increased if more screening camps were organised with patients referred to these hospitals. In the two districts where LRBT was operating, it was observed these facilities were located away from the city, and that practically speaking from a patient's perspective, these hospitals were more accessible than the urban-centred government hospitals.

THQ level: A key gap in the project design was the lack of support for enhancing district comprehensive eye care at the sub-district (THQ) secondary facilities. This was due to the absence of government-appointed ophthalmologists in those facilities. As suggested earlier, the project could have considered leveraging project resources to activate provincial authorities to appoint ophthalmologists and ophthalmic teams at THQ facilities. Future investment should focus on strengthening service availability at this level.

Outreach/Screening Camps: There was consensus that conducting more screening camps would have been effective for improving reach, including marginalised populations and encouraging referral uptake. Where these were held, they were perceived to be an important intermediary between community-level awareness raising and identification and secondary referral, essentially bridging the gap created by the absence of comprehensive eye care services at the THQ and RHC levels. In particular, PHC workers and LHSs/LHWs all emphasised the value of screening camps and community awareness sessions led by social organisers, reporting that these supported the routine work done by LHWs (who could identify and encourage patients to attend the camp) and provided an entry point into the eye care referral system. Other service delivery strategies, such as satellite clinics, may have also been useful for bridging the distance to the DHQ level and, importantly, would have improved the offer with regards to early identification of glaucoma and diabetic retinopathy. For example, charity hospitals might have been engaged to fill the gaps at sub-district by developing satellite clinics that could have continued post-project with their own budget.

Conclusions and recommendations

3.1. Summary and conclusions

The project succeeded in improving access to eye care services for men and women, achieving or exceeding most of its service delivery targets. Although not the original ambition of the project, the project sought to provide equitable rather than equal service delivery based on sex. Overall, the project had limited success in increasing women's access to cataract surgery relative to men; the project did not meet gender equity targets for cataract surgeries. However, current evidence regarding a gender gap in accessing cataract surgery in Pakistan may be mixed. A recent CSR mapping study, funded by Sightsavers and implemented across Pakistan in 2018, found that overall more cataract surgeries were performed in women than men, with a male to female ratio of 0.95,⁵² indicating that women have benefited from the rising tide of improved access to cataract surgery. However, the study was not able to obtain complete age and sex-disaggregated population data to contextualise this finding and detailed analysis for the project districts was not available. More investigation and formative research are needed on the gender dimensions of barriers to surgical uptake and the most appropriate and effective approaches for creating an enabling environment to support decision making and surgical uptake.

The presence of the project-funded optometrists expanded service delivery, allowed for the reorganisation of eye care departments and task shifting, and ensured the delivery of refractive services which were previously deprioritised in some facilities. Provincial government allocations and recruitment for these posts at DHQ and THQ levels can be expected to have an important, long-term impact on eye care service availability and quality going forward, which extends beyond the targeted districts.

Overall, the project was well-implemented, with effective project management and coordination across multiple health system actors. The partnership approach was perceived to improve effectiveness, transparency, and accountability; stimulate learning; provide a platform and greater influence for advocacy efforts; and drive all partners to strengthen organisational policies and practices. The partners should continue to pursue consortium approaches where appropriate. The joined-up advocacy approach should include charity hospitals, which are among the largest eye care service providers. More broadly, future projects should consider expanding and clarifying the role of charity hospitals and more actively engage these partners in project design, coordination, data sharing and advocacy efforts.

The combination of the DCEC and PHC models, and the involvement of charity hospitals resulted in more a comprehensive approach to supply and demand side factors affecting eye care access. The project engagement of LHWs was a key strategy, however, as the operational research found, "training is not enough and does not equal improved access" to specialist eye care services.⁵³ Referral pathways are complex, requiring simultaneous attention at many levels to build effective systems and enable referral completion. Although the project has put in place key elements for sustainability, concerns remain regarding gaps in human resources, service delivery and data sharing post-project.

⁵² Sightsavers, *Mapping of Cataract Surgical Services in Pakistan, A Report 2019*.

⁵³ Sightsavers. Understanding the role of lady health workers in improving access to eye health services in Khyber Pakhtunkhwa (KPK) Province of Pakistan: Study Report. Islamabad (Pakistan): Sightsavers. 2020 27p.

3.2. Learning points

In this section, the Evaluation summarises key learning points from the project experience which may be useful for future programme design and wider organisational learning.

Programmatic Area	Learning Points
<i>Service delivery and gender equity</i>	<ul style="list-style-type: none"> • Investment in direct service providers such as optometrists can be expected to have a dramatic effect on the number of health services produced (services/day/facility) where demand has been suppressed. This effect may be increased where efficiencies are gained through task-shifting and re-organisation of service delivery. Technical guidance on estimating targets based on projected services/day/facility may be helpful. • Where demand has been generated (patients screened and referred), active prioritisation of female cataract patients may be one of the most direct means for achieving surgical service provision that is proportional to prevalence. • Important barriers to referral completion appear to relate to decision making, patient expectations for referral care and patient satisfaction with the care seeking experience – all areas which future projects can influence. • Consistent and simultaneous coordination and planning with the LHW programme at both district and provincial levels was a key success factor in achieving buy-in for and prioritisation of eye care screening. • The continuity of LHW engagement remains a concern; more attention should be given to what mechanisms can put in place to support long-term motivation and engagement in eye care work, particularly in the absence of provincial resources. This should relate to the larger ambition of improved integration of PEC in PHC through expanded functionality of BHUs/RHCs.
<i>IEC Strategy</i>	<ul style="list-style-type: none"> • Small changes or assumptions in a communications approach can have a big effect. Any modifications should be retested with the targeted community to validate acceptability and effectiveness. • A well-developed communications plan requires adequate budget. Although it may not be possible to pre-identify the different channels, the budget should consider a range of materials and mediums. • Monitoring of communications approaches and an effectiveness assessment must be planned and budgeted in project design.
<i>Hospital strengthening</i>	<ul style="list-style-type: none"> • Cost-efficiency of equipment and infrastructure investments can be increased through: multiple phases of hospital needs assessment and specifications development; a transparent and accountable procurement process involving all partners; negotiating longer warranties and providing an initial stock of replacement parts; and choosing investments wisely based on sound knowledge of functionality, generic specifications and verifying end user capacity. • Where IOL procurement is based on a public health approach, care should be taken to obtain buy-in from ophthalmologists at the project design phase.

	<ul style="list-style-type: none"> • Project-supported human resources had an important effect on service delivery, but this investment needs to be planned sustainably. The withdrawal of social organisers and optometrists (only partially replaced and not yet deployed) will lead to gaps in staffing and disruption of eye care team continuity; this will likely lead to decreased service availability and increased burden on ophthalmologists. Although precedent for the social organiser position exists in other areas, this was not related to these districts' health system. Advocacy for the sanction of these posts could have also been pursued. • Consideration should be given to the balance of support between government hospitals and charity hospitals as part of a comprehensive approach to strengthening eye care systems for the most impact. • Quality of care was not captured in early needs assessments. Conducting a QSAT at the design stage (as a component of a situation analysis) would help inform planning and resource allocation; an assessment later in the project could then assess change and guide further improvements. • Improving consistent recording of post-operative visual outcomes is challenging and requires systematic change and support on many levels: policy guidance, the development of data systems, the organisation of service provision and creation of workflow systems to support the behaviour change of hospital staff. • The project offers a model for creating and using project evidence to advocate for health system change: using project resources to pilot a change (ophthalmic teams), collecting evidence of impact, bringing key respected messengers to the cause (ophthalmologists) and converting this evidence into advocacy messages for multiple levels of influencers. Moreover, this was achieved in a relatively short period of time which allowed the project to follow-through on the commitment. This experience could be written up as an advocacy case study for wider organisational learning.
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3.3. Recommendations

In addition to the learning points above, this section outlines specific recommendations for the project partners. The focus of recommendations is on actions which will support the extension and uptake of quality eye care services in KPK⁵⁴, with attention to equity and sustainability. Project partners provided input to these recommendations during the debriefing session.

Recommendation	
Skilled Human Resources	<ol style="list-style-type: none"> 1. Sustainably increase skilled human resources through a strategic approach that combines advocacy and leveraging project support to obtain government commitments. When designing future projects in coordination with the public sector, partners could use the opportunity to secure government commitments for the provision of human resources in

⁵⁴ Health service delivery is decentralised to the provincial level, so any non-policy recommendations and decision-making are targeted to that level.

Recommendation	
	<p>line with the requirements defined in Vision2020 (i.e. ophthalmic teams at all secondary facilities, both DHQ and THQ hospitals).⁵⁵ These commitments can then be incorporated in the MOU with the provincial health department.</p> <p>2. Explore deterrents to the uptake of DHQ and THQ level posts by female eye care professionals and identify the most appropriate mitigation strategies, incentives or other approaches to improve gender balance in the eye care workforce in remote areas. This might take the form of a consultative process with female eye care professionals, trainees, health workers originating from remote areas, and perhaps gender or workplace experts. This could then be followed by pilot-testing of different approaches to assess feasibility and effectiveness.</p>
<i>Service delivery systems and hospital strengthening</i>	<p>3. Continue advocacy for and investment in the expansion of eye care services at the THQ level. This might include follow-through on securing government appointment of ophthalmologists, ophthalmic teams and development of eye care departments). Where delays in HR deployments occur, evidence generated from the THQs in Swat under this project may be used to support the case, following the model from this project of using data and testimonials to advocate for optometrist appointments. Future project support may also be leveraged to secure these human resources.</p> <p>4. Broaden the strategy for PEC integration and service delivery close to communities. This might include advocating for the sanction of optometrist and ophthalmic technician posts at the RHC level, prioritising investment to improve the functionality of BHUs/RHCs, and planning additional capacity building at these facilities, based on needs assessment.</p>
<i>Referral uptake</i>	<p>5. Develop measures to improve the reception or prioritisation of referred patients in consultation with health departments, hospitals, and LHW/PHC referring health workers. This should include the orientation of all staff in the eye departments at referral hospitals to appropriately receive and value LHW referrals.</p> <p>6. Conduct further literature review and data analysis to better understand patterns in eye care referral completion. This could include more detailed analysis of eye care referral patterns by reason for referral as well as within the context of the wider health system, e.g. comparative analysis of referral patterns for other health seeking.</p> <p>7. Based on evidence, orient appropriate strategies for referral completion. These may include the development of health worker training modules on patient communication and counselling techniques to support decision making and referral visit planning; and resource mobilisation to cover transport and accommodation costs. LHWs may require refresher training to support referral completion.</p>
<i>Strategies for improving equity and inclusion</i>	<p>8. Conduct formative research on (1) the gender dimensions of barriers to surgical uptake and (2) the most appropriate and effective approaches for creating an enabling environment to support women's care seeking decision making and surgical uptake.</p> <p>9. Develop a consistent approach to incorporating disability awareness modules and messages in training plans and health education</p>

⁵⁵ Ophthalmologist, optometrist, orthoptists, ophthalmic technologist, ophthalmic technicians and ophthalmic nurses

Recommendation	
	<p>sessions at all levels. Training LHWs in PEC is a full coverage strategy that offers the potential to reach men and women with disabilities and enhance community awareness. A future project might consider piloting a disability awareness module in LHWs' PEC training curriculum in a selected province. This would align with the national programme's focus on "inclusive eye health" but would need to be balanced with LHW workload concerns</p>
Community Engagement and IEC	<p>10. Develop clear objectives for a communications strategy and plan to assess impact. This should be supported by a budgeted plan for: IEC strategy implementation using diverse communication channels; a pilot-testing phase for acceptability and effectiveness prior to roll-out; and monitoring and impact assessment of communication approaches.</p>
Post-operative Follow-up	<p>11. Develop efficient systems to facilitate consistent post-operative follow-up and recording of POVOs. These should consider how to organise service delivery and human resources to support the change. For example, organisational approaches might include developing a follow-up clinic where follow-up exams are conducted on a regular schedule and VA indicators are routinely recorded.</p> <p>12. Continue discussions and advocacy with eye health boards, the provincial health department and national eye health committee to develop a policy statement to support consistent recording and reporting of POVOs as a standard tool for quality assurance.</p>
Coordination / Partnership	<p>13. Expand the role and involvement of charity hospitals and more actively engage these partners during project design and implementation. They should be engaged in all activities, participate in Provincial Boards and DCCs, encouraged to generate comprehensive monthly reports and share these data with the public sector, and participate in joined-up advocacy efforts.</p>
Data systems	<p>14. As part of ongoing discussions around the revision of eye care indicators and health management information systems (HMIS), advocate for the development of a routine reporting mechanism and integration of data from the charity hospitals with the public sector HMIS.</p>
Sustainability	<p>15. Outline a detailed sustainability plan from the project design phase. This should identify threats and opportunities, key actions, and responsible persons. Consider planning for a phased withdrawal of project resources and oversight to monitor service continuity and threats to sustainability.</p>

Appendices

Appendix 1: Evaluation Criteria Rating

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

Appendix 2: Evaluation Terms of Reference

A new vision for eye health in Pakistan's Khyber Pakhtunkhwa Province

End of term evaluation

1. Background

Project name: A new vision for eye health in Pakistan's Khyber Pakhtunkhwa province (KPK)

Project number: 75067

Project Duration: January 2016 – June 2020

Project budget: \$1,250,000

Project partners:

Fred Hollow Foundation (FHF), Pakistan Institute of Community Ophthalmology (PICO) and Sightsavers jointly manage this project.

The project implementing partners are;

1. District Headquarter hospital Haripur
2. Shifa Eye Foundation, Haripur
3. District Headquarters Hospital Swabi
4. Lakson Medical Trust Hospital, Swabi
5. Saidu Group of Teaching Hospitals Districts Swat
6. Charity hospitals include Layton Rehmatulla Benevolent Trust (LRBT) in Swat and Mansehra
7. King Abdullah Teaching Hospital District Mansehra

Key stakeholders:

The key stakeholders of the project include:

- Provincial Health Department
- National Eye Health Committee
- Provincial Eye Health Board
- Pakistan Eye INGO Forum
- District Health Department
- Aid to Leprosy is implementing similar activities in some project areas with funding from CBM, which requires coordination from the implementing partners
- Communities in project areas

General information on project area:

The project is being implemented in four districts of Khyber Pakhtunkhwa (KPK) province which has a combined population of 6.2 million people, the majority of who (83%) reside in

rural areas. Women lag behind men in almost every social indicator and KPK has one of the highest gender based differences in school attendance. Up to 72% of women in KPK have never attended school and the literacy rate is 65% for men and 28% for women.

Under-five mortality is almost three times as high in rural areas and the province has the second highest incidence of low birth weight in the country. Gender inequality in Pakistan is widespread, and women are subjected to customs and cultural practices which can restrict their mobility, prevent them from working and see them at risk to violence and abuse.

District level prevalence data is not available, however a National Blindness and Visual Impairment Survey was conducted in 2004. This revealed that the prevalence of blindness was 0.9 per cent and approximately 1,140,000 adults were irreversibly blind as a result (with 114,000 blind adults residing in KPK). Illiterate survey participants were much more likely to have a presenting visual acuity and the prevalence of blindness and visual impairment was higher amongst women.

Data has been extrapolated from this survey to support programme planning in KPK province. The major causes of avoidable blindness are expected to be cataract (70%), corneal opacity (16.5%) and refractive errors (refractive error)/aphakia (7.5%). Other common causes of visual impairment are glaucoma, retinitis pigmentosa, optic atrophy, senile changes and retinitis which accounts for 6.0% of cases.

A situation analysis of district health facilities was conducted by Sightsavers and Fred Hollows Foundation (FHF) in June 2014 which revealed that eye conditions are largely aligned with the 2004 National Blindness and Visual Impairment Survey. The cataract surgical rate in these districts is 2,000 which is below the national average of 3,600.

Although there are no in-depth studies of gender and blindness in KPK, it is likely that women are more adversely affected than their male counterparts. High rates of female illiteracy prevent women from independently making health decisions and limited freedom of mobility inhibits access to health care. The cataract surgical rate tends to be lower amongst women due to associated indirect costs, transportation and lack of access to information. It is also evident from the Rapid Assessment of Avoidable Blindness (RAAB) survey carried out in this project in district Swabi and Mansehra.

The project seeks to strengthen eye health service delivery at the district levels to reduce the prevalence of avoidable blindness. Surgical interventions are designed to reduce the cataract backlog and refractive error services should also be strengthened. The project in KPK is aligned with the Provincial Programme for Prevention and Control of Blindness in KPK Province (2015 - 2018). This programme prioritises infrastructure and technology development, capacity building of human resources, disease control, effective management and advocacy, research and public private partnerships in support of Vision 2020 targets.

The national eye care programme has created 185 eye health posts in varying cadres of ophthalmology in the KPK province in 2014. Since 2005, over 2,719 posts for eye care cadres at teaching hospitals, districts and sub-districts level were created by the government which shows a high level of buy-in and commitment.

Project description, goal and objectives:

The project is following a health systems strengthening approach by building capacity of the government's human resources, supporting quality service delivery, establishing and strengthening referral systems, improving eye health infrastructure and advocating for

increased eye health financing. Each of these inputs focus on different aspects of the six building blocks of the eye health system in the four districts of KPK.

Goal: To contribute to sustainable provision and increased demand for eye care services at the district level for people in four districts of Pakistan

- **Objective one:** Men and women with visual impairment access eye health services in four districts
- **Objective two:** Eye health systems deliver quality eye health services in four districts
- **Objective three:** The government commitment to eye health at provincial level increases

2. Purpose of Evaluation

The end of term evaluation will review the achievements of the project against the project objectives, and understand the key successes and challenges the project has encountered. It also seeks to document key learnings that can be taken forward from this project to inform future project design and delivery. The evaluation will also assess the extent to which it has been possible to implement the agreed MTR recommendations and associated action plan formulated in the Management Response. Equity is also a cross cutting issue that the evaluation will consider, including assessing if there were any specific barriers for women or people with disabilities to access the project's services.

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

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

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

The learning, findings and recommendations emerging from this evaluation will be important for Sightsavers' and partners' wider programming design and decision making.

Evaluation criteria - questions

Relevance – the extent to which the project or programme is suited to the priorities and policies of government of Pakistan, needs of the target beneficiaries, national partners, and donors and international commitments such as SDGs, where applicable.

- How aligned are the project's objectives with provincial and national level eye health policies?
- How aligned is the project with the needs of beneficiaries in project areas, including women and people with disabilities?

Effectiveness – the extent to which the programme has attained its objectives

- How effective has the project been in ensuring that it attains gender equity (in line with prevalence data) of people accessing services?
- What strategies have been most effective in targeting women, including women with disabilities, and why?
- How effective was the project in generating demand, including raising awareness at the community level to increase uptake of eye care services?
- How effective has the role of LHWs been in identification and referral of eye patients from the community to secondary level?

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.

- How efficient have the project's strategies been in dealing with challenges to financial planning and in ensuring the project resources are used in the most cost-effective manner?
- How conducive was the partnership approach (between Sightsavers, FHF and PICO) to effective project management?

Impact – the direct or indirect changes or effects (positive or negative) that have occurred, or will occur, as a result of the project or programme

- To what extent has the project contributed to the strengthening of eye care services at the partner hospitals?
- What role has the project played in advocating for the approval of the optometrist posts in hospitals and what is the likely impact this will have?
- How well established are the referral pathways and follow-up mechanisms of the project, particularly in relation to the links between the primary and secondary levels?
- How successful was the IEC strategy of the project for raising awareness in communities regarding eye health issues?

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

- What arrangements have been made to ensure continuity of data collection and availability beyond the project?
- What are the key factors that may contribute towards sustainability of the project beyond SiB V- Tranche-III? (e.g. *post project operational expenditure, continuation of eye care services, provision of spectacles, Human Resources*)

Scalability/replicability – whether any aspects of the programme are suitable for replication or scaling up.

- What are the key learnings that can be taken from this project to inform strategies for replication or scale up? For example, aspects of key supplier contracting; benefits of using optometrists.

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.

- How effective have the project’s efforts been in coordinating and collaborating with other key actors to achieve the project objectives, including:
 - o LHW programme
 - o Primary health care facilities (BHUs and RHUs)
 - o Hospital senior management
 - o Provincial level structures/committees
 - o National level structures/committees
- How effective were the forums of District Coordination Committees (DCCs) in project implementation and decision making at the local level?
- Are the activities and outputs of the project consistent with the overall goal?

3. Review Team

Tropical Health LLP consultancy has been commissioned to conduct this evaluation under Sightsavers Evaluation Framework Agreement. The team allocated to this will have strong MEL and programmatic expertise for undertaking project evaluations in the health sector with a focus on eye health. Team members will have the following competencies: international development experience in eye health, evaluation expertise, project/programme analysis, knowledge management and dissemination, report writing, oral presentation and facilitation skills, as well as a good understanding of the eye health context in Pakistan.

4. Methodology

The evaluators should detail the approach and methodologies to be used to indicate how they will fulfil the requirements of the ToR and address the evaluation objectives and evaluation questions. These will include qualitative and quantitative tools as appropriate, but should be participatory in nature and seek the voices of those who may otherwise be marginalised. The evaluation team will define an appropriate sample size, where relevant, and specify what mechanisms will be adopted to avoid selection bias. The evaluation team should also outline how they will address any ethical considerations arising for this assignment in the methodology section.

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

1. Review relevant reference material and data, as listed in Section five below, plus any additional relevant documents identified by Sightsavers or the consultant team.
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. Desk based data review and data collection 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 fieldwork period.
5. Analysis and production of a draft and final Evaluation Report, as well as a PowerPoint presentation to present the key findings and learnings.

The evaluation team will adhere to the contractual terms and conditions with Sightsavers, including clauses in relation to confidentiality, data protection and intellectual property rights. It is expected that the evaluation will fully follow ethical principles for evaluation, and that the team will adhere to Sightsavers guidelines on ethical considerations for evaluation (Appendix 1), [Safeguarding policy](#) and code of conduct (Appendix 2). It is also a requirement that all members of the evaluation team have completed the short online [UNICEF ethics training](#), or equivalent, before embarking on the evaluation.

5. Project documentation

- Project proposal
- Logframe
- Budget
- MTR report
- Donor contract and LOV
- Agreements with implementing partners
- Monthly KPI sheets and consolidated annual KPI reports by partner and district
- A list of facilities and their locations
- Donor reports and appendices
- Available primary and secondary research (Operational Research, RAABs, FGD data)
- IEC materials and communication plans
- Advocacy and sustainability plans
- Query logs
- QSAT reports (where available)
- Post operative visual outcomes data of selected partners
- Disaggregated data by gender and disabilities if not included above

6. Outputs/ deliverables

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.

The timeframe for the evaluation will be between December 2019 and the end of May 2020. It is expected that work on the inception phase will start in January 2020 with the fieldwork planned for March 2020. The final report will be signed off by Sightsavers by the end of May 2020, so that it can be shared at a dissemination event planned with SCB in Mid-June.

Indicative structure and phasing of evaluation

Phase	Activity	Timeframe
Phase I – Desk study: Review of documentation and	Desk research /literature and data review	January – February
	Inception Report	February

Phase	Activity	Timeframe
<i>elaboration of field study</i>	Revision of collection methods and tools based on inception report comments	February
<i>Phase II: Field Data Collection</i>	Field visits and data-collection	March
<i>Phase III – Analysis and production of evaluation report</i>	Data analysis and preparation of Draft Report	April
	Review of Draft Report from feedback.	May
	Final report complete	End of May

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.

Draft report

The draft findings will be presented in-country during a debriefing session. A draft report should be submitted to Sightsavers 2-3 weeks after completion of the field activities. Sightsavers will provide feedback on the draft versions to the evaluation team.

Final report

A Final Report will be submitted to Sightsavers after receiving the feedback from Sightsavers on the draft reports. The final report should be a detailed report of not more than 40 pages (excluding annexes), written in English.

Learning products

At the technical proposal stage, Sightsavers and Tropical Health will agree on any specific learning products to be created from this evaluation. This may be in the form of a short PowerPoint presentation (no more than 20 slides) of the key findings from the evaluation, for Sightsavers to distribute or use as appropriate.

Data Sets

The evaluation team will be expected to retain 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 on request.

7. Administrative/ logistical support

Support and advise

Sightsavers' MEL Team and the Project Team will provide coordination and logistical support for the evaluation and consultant/team. Clear lines of and leads for communication between Sightsavers' MEL Team and the Project Team and the consultant/team will be agreed at the initial meeting after the contract has been signed.

The Sightsavers MEL Team's principal function is to ensure that the consultant/team is professional, independent, skilled and experienced and provides a high standard of input and good quality deliverables that promote learning for change and contribute to an evidence base supporting commissioning, project design and implementation. The MEL Team is guided by the principles attached at Appendix 1.

The role of Sightsavers MEL Team includes:

- ToR development in consultation with donors, technical leads and project staff,
- Overall coordination quality assurance and liaison between the project staff and consultant, as well as being the focal point for consultant in respect of contractual issues,
- Advise the consultant on Sightsavers' expectations regarding ethics, including Safeguarding Policies and Code of Conduct,
- Review and advise on methodology, selection of site visits, reliability of and access to secondary data,
- Advise on context-specific and contemporary security assessments, other risks and challenges to the evaluation,
- Review of deliverables: Inception Report, Final Report, Evaluation Communication and Dissemination Plan, Learning products,

The role of the Project Team will be to support with on the ground logistics of the evaluation, including supporting the development of the fieldwork schedule, coordinating with local partners, scheduling of meetings and interviews with key stakeholders. It will also include arranging and facilitating all of the local logistics for the evaluation team (including transport and accommodation). The Project team will also monitor the security situation and liaise with Sightsavers' Security Advisor to ensure that all activities are authorised in terms of safety and security. All key contact points will be identified and shared as part of the Inception stage.

Safety and risk management

In planning the evaluation, the situation in Pakistan will be closely monitored and advice will be taken from Sightsavers' Global Head of Security. Before any travel is authorised, a risk assessment will be conducted to ensure that the evaluation activities would not be affected by any security concerns, and the safety and security of the consultant/team, project staff and stakeholders are prioritised at all times.

Therefore, a field visit will only be conducted to areas or districts that are assessed, at the time, as not presenting any undue security risks to consultants or staff or projects' participants. If restrictions are in place, then remote means such as skype or telephone interviews will be employed to obtain data and information, or alternative locations utilised which do not present a security risk.

Budget

Sightsavers will usually cover the following directly, but the Framework Agreement Lead should outline any other costs likely to be incurred for the assignment so that these can be discussed and approved in advance.

- Economy class airfares
- In-country transportation
- Hotel accommodation and meals during the fieldwork
- Meeting venue hire and associated equipment eg projectors

Schedule of Payment

The following payment schedule will be adhered to:

- On acceptance and approval of inception report: 40%
- On acceptance and approval of final report: 60%

Appendix 3: Evaluation Matrix

The evaluation matrix below outlines the detailed evaluation questions from the ToR, along with the primary data collection techniques and secondary data used to explore each of these questions. Where relevant, notes have been made in italics regarding any modifications due to restrictions on primary data collection in the current context.

	Key Evaluation question to be addressed	Data Collection and Sources		
		Primary Data Collection (level or target group)	Document Review / Secondary Data	Specific Data Sources
<p>Relevance – the extent to which the project or programme is suited to the priorities and policies of government of Pakistan, needs of the target beneficiaries, national partners, and donors and international commitments such as SDGs, where applicable.</p>				
1.	How aligned are the project's objectives with provincial and national level eye health policies?	KII (PM, N, P)	Document Review	<p>Main source will be document review</p> <p>Project documents: concept note, proposal/ logframe, biannual narrative reports; prior evaluation reports</p> <p>National/provincial policy documents: National Eye Care Plan (2015-2020); Provincial Programme for Prevention and Control of Blindness in KPK Province (2015 - 2018); National/provincial plans for community health; Minimum Service Package (MSP); other strategy and planning documents as relevant</p> <p>Situation analysis (extent to which project targeted identified gaps in system relative to policy)</p> <p>Any previous initiatives, assessments, prior evaluations conducted in Pakistan (DR)</p> <p>KII transcripts</p>
2.	How aligned is the project with the needs of beneficiaries in project areas, including women and people with disabilities? <i>Modification: Due to the low feasibility of data collection with community members, service recipients and other stakeholders at</i>	KII (PM, P, H, PHC)	Document review Secondary research	<p>Main source will be document review</p> <p>Project documents: concept note, proposal/ logframe, biannual narrative reports; prior evaluation reports</p> <p>Secondary research: RAAB (differential prevalence; main barriers to uptake of cataract surgery); LHW operational research study report</p>

	<i>the community and PHC levels, the Evaluation will have insufficient evidence to directly explore this question. The Evaluation will explore how (e.g. gender analysis, consultative and planning processes, design of approaches) the project sought to respond to documented needs of the target populations, as reported in project documents and secondary research.</i>			Exploratory research “Pakistan Gender Situation Analysis for Utilization of Eye Care Services: Barriers to Eye Health Care Access for Women in Four Districts in Pakistan” (Not covering project area: Punjab and Sindh provinces) Any other eye care needs assessments of target group in project area
Effectiveness – the extent to which the programme has attained its objectives				
3.	How effective has the project been in ensuring that it attains gender equity (in line with prevalence data) of people accessing services?	KII (PM, P, H, PHC)	Project output data Document review	Main source will be existing programme data Sex-disaggregated output data (as reported in biannual donor reports): proportions of screening, referral, refractive and surgical services by provider/facility type and district; patterns over the course of project implementation in relation to different project approaches RAAB (differential prevalence and gender barriers at baseline) Operational research on LHWs (access) MTR report and management response Monitoring visits reports - TBD KII transcripts
4.	What strategies have been most effective in targeting women, including women with disabilities, and why? Modification: <i>Due to the low feasibility of data collection with community members, service recipients and other stakeholders at the community and PHC levels, the Evaluation will have insufficient evidence to directly explore this question. The Evaluation will draw on any secondary evidence regarding effectiveness and, via KIIs, elicit any learning around project approaches to target women.</i>	KII (PM, P, H, PHC)	Document review Secondary research	Project documents: biannual narrative reports; documents outlining gender strategy, changes in approach, measurement Sex-disaggregated output data Operational research on LHWs (awareness, access) Exploratory research “Pakistan Gender Situation Analysis for Utilization of Eye Care Services: Barriers to Eye Health Care Access for Women in Four Districts in Pakistan” (Not covering project area: Punjab and Sindh provinces)
5.	How effective was the project in generating demand, including raising awareness at the community level to increase uptake of eye care services? Modification/Limitation: <i>This question will be partially explored due to the absence of community-level insights.</i>	KII (PM, H, PHC)	Project output data; Document review	Disaggregated output data (outreach and screening) <i>No KAP or similar pre and post surveys</i> Project communication strategies, IEC materials; any project documents related to IEC material development Operational research on LHWs (awareness) KII transcripts
6.	How effective has the role of LHWs been in identification and referral of eye patients from the community to secondary level?	KII (PM, P, H, PHC)	Document review	Project referral data (screening, referrals by source, referral completion by facility type, district) Referral slips, guidelines, and other referral tools - TBD

	Modification/adjustment: Although the Evaluation will attempt to reach some supervising/coordinating PHC staff (LHS and DPIU), LHWs themselves and other PHC workers (MOs) will not be reached. The lack of primary data collection on the role of LHWs is expected to be offset by the operational research study conducted under the project.			NB: gap in data on referral completion by referral source (have total referred by source, but some patients seek referral care at facilities not supported under the project) Operational research study report on LHW referral and referral compliance (expected end of May 2020) KII transcripts
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				
7.	How efficient have the project's strategies been in dealing with challenges to financial planning and in ensuring the project resources are used in the most cost-effective manner?	KII (PM)	Document review	Project budget and budget notes; contracts; partnership agreements; any other project documents (e.g. workshop or meeting notes) describing VfM, cost analysis, decision-making related to cost-effectiveness KII transcripts
8.	How conducive was the partnership approach (between Sightsavers, FHF and PICO) to effective project management?	KII (PM)	Document Review	Partnership agreements (roles and responsibilities, project steering committee and technical and implementation committee remits) Project narrative reports; meeting minutes
Impact – the direct or indirect changes or effects (positive or negative) that have occurred, or will occur, as a result of the project or programme				
9.	To what extent has the project contributed to the strengthening of eye care services at the partner hospitals?	KII (PM, H)	n/a	Situational analysis of the four districts (June 2015) Partnership agreements QSAT Action plans KII transcripts
10.	What role has the project played in advocating for the approval of the optometrist posts in hospitals and what is the likely impact this will have?	KII (PM, P, H)	Document review Output data	Project narrative reports; Situational analysis of the four districts (June 2015); Advocacy plan; MTR report Project and government HR data – TBD Provincial health department plan or report KII transcripts
11.	How well established are the referral pathways and follow-up mechanisms of the project, particularly in relation to the links between the primary and secondary levels? Modification/Limitation: Due to the limited feasibility of data collection with PHC workers and service recipients, the Evaluation may have limited first-hand evidence to explore this question.	KIIs (PM, H, PHC)	Document review Project data Secondary research	Project referral data Referral slips, guidelines, and other referral tools - TBD Operational research study report on LHW referral and referral compliance (expected end of May 2020) Situational analysis of the four districts (June 2015) MTR report and management response KII transcripts

12.	How successful was the IEC strategy of the project for raising awareness in communities regarding eye health issues? Modification: This “Impact” question addresses long-term change, but there is not enough evidence to assess this. The evaluation will explore the perceived effectiveness of the strategy for wider awareness raising, in conjunction with the effectiveness of other communications approaches for demand generation (Evaluation Question 5). Specific attention will be given to capturing learning from the strategy development experience.	KIIs (PM, PHC)	Document Review	Project narrative reports IEC strategy and materials MTR report and management response Summary of findings from Focus Groups Discussions to inform design of IEC strategy – <i>not available</i> Report on lessons learned from IEC strategy development (as recommended in MTR) - TBD
Sustainability – whether benefits of the project or programme are likely to continue after donor funding has ceased.				
13.	What arrangements have been made to ensure continuity of data collection and availability beyond the project?	KII (PM, N/P H/D)	Document review	KII transcripts Partner planning documents Situational analysis of the four districts (June 2015) [little info on DHIS captured] Examples of registers and data management tools used under project - TBD
14.	What are the key factors that may contribute towards sustainability of the project beyond SiB V-Tranche-III? (e.g. post project operational expenditure, continuation of eye care services, provision of spectacles, human resources)	KII (All)	Document review	Situational analysis of the four districts (June 2015) District health plans Sustainability plan developed as per MTR recommendation - TBD
Scalability/replicability – whether any aspects of the programme are suitable for replication or scaling up.				
15.	What are the key learnings that can be taken from this project to inform strategies for replication or scale up? For example, aspects of key supplier contracting; benefits of using optometrists.	KIIs (All) Debriefing session	Document review	KII transcripts Learnings documented in donor reports or other project documents Debriefing notes
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.				
16.	How effective have the project’s efforts been in coordinating and collaborating with other key actors to achieve the project objectives, including: - LHW programme - Primary health care facilities (BHUs and RHUs)	KII (All)	Project documents	KII transcripts Coordination meeting minutes or reports

	<ul style="list-style-type: none"> - Hospital senior management - Provincial level structures/committees - National level structures/committees <p>Modification/Limitation: Due to the low feasibility of data collection with stakeholders at the PHC level, the Evaluation may have limited evidence to explore this question from key diverse viewpoints.</p>			
17.	<p>How effective were the forums of District Coordination Committees (DCCs) in project implementation and decision making at the local level?</p> <p>Modification/Limitation: Key stakeholders involved in DCCs may not be reached.</p>	KII (PM, P, H)	Project documents	DCC meeting minutes or reports, documentation of outcomes - TBD MTR report and management response KII transcripts
18.	<p>Are the activities and outputs of the project consistent with the overall goal?</p>	KII (PM, N/P)	Project documents	Project design, planning and strategic documents: proposal, logframe, situation analysis, advocacy plan, communication strategy KII transcripts

PM = Project Management (PICO, Sightsavers, FHF); N = National; P = Provincial; H = Hospital staff / districts (both DHQ and Charity hospitals); PHC = DPIU, LHS

TBD = document availability to be determined

Appendix 4: Team Structure

The evaluation was carried out by a team of two consultants, the Team Leader, and a Team Member who were supported by the Technical and Management teams at Tropical Health⁵⁶. Their roles are listed below:

Position	Role
Team Leader	<ul style="list-style-type: none"> • Review relevant reference material and data • Attend (by Skype/phone) the kick-off meeting with Sightsavers • Coordinate the team member's inputs, facilitate internal evaluation planning meetings and provide first level quality assurance of team member's deliverables • Provide regular progress update to Tropical Health and Sightsavers • Lead the development and finalisation of the inception report, including data collection tools • Oversight and coordination of Team member and data collection from desk base • Undertake desk-based data collection as required • Lead presentation of preliminary findings, learning points and development of recommendations at the debriefing session at the end of data collection • Lead and coordinate data analysis • Lead evaluation report and presentation slides writing and finalisation
Team Member	<ul style="list-style-type: none"> • Review relevant reference material and data • Provide overall support to the Team Leader in the evaluation implementation • Provide inputs into the development of data collection tools, as allocated by the Team Leader • Conduct phone-based KIIs and prepare/translate transcripts • Co-lead preparation and presentation of preliminary findings, learning points and development of recommendations at the debriefing at the end of data collection • Contribute to data analysis as agreed with the Team Leader • Contribute to the evaluation report writing as agreed with the Team Leader
Evaluation Coordinator	<ul style="list-style-type: none"> • First point of contact between Sightsavers and Tropical Health • Day-to-day coordination and support to evaluation team to ensure delivery of project • Approve consultants' days payment based on satisfactory delivery of evaluation outputs
Quality Assurance	<ul style="list-style-type: none"> • Technically quality assure design, inception report and evaluation report • Oversight of day to day activities and support to evaluation team to plan and deliver quality work on time

⁵⁶ Katie Nield – Evaluation Coordinator; Caroline Vanderick – Quality Assurance.

Appendix 6: List of Documents Reviewed

Folder	Documentation	Saved in Sharefile folder?	Prioritised for review	Date Added	Notes
Accessibility audits	15.11.16 accessibility audit report (1)	Yes		07.05.20	
	15.11.16 accessibility audit report (2)			07.05.20	
Advocacy	75067 Advocacy Plan - SiB KPK	Yes		16.03.20	
	Revised PC-1 Proforma	Yes		16.03.20	
Budget	2016 75067 Budget Notes	Yes		16.03.20	
	2016 75067- Budget	Yes		16.03.20	
Contract	2015 75067 Pakistan Ph 5 Tr 3 - Schedule 1 signed	Yes		16.03.20	
	2015 75067 Pakistan Ph 5 Tr 3 - Schedule 2 signed	Yes		16.03.20	
	2015 75067 Pakistan Ph 5 Tr 3 - Schedule 3 signed	Yes		16.03.20	
	2015 75067 Pakistan Phase 5 Tranche 3 signed MoU	Yes		16.03.20	
	2018 75067 Partner Code of Conduct LRBT	Yes		16.03.20	
	2017 75067 PFA with PICO	Yes		17.03.20	
	2017 75067 MOU with Provincial Health Department	Yes		17.03.20	
Data	31-1-18_Post Operative visual outcome District Swat	Yes		16.03.20	
	31-1-18_VA Report Mansehra, Odigram and Kalakalay July-Sep 17	Yes		16.03.20	
	2016 75067 Data Collection Log and M and E Framework	Yes	Yes	16.03.20	
	75067 Baseline 2014	Yes		16.03.20	
DCC meetings	22 8 17 DCC MEETING MINUTES DISTRICT HARIPUR			07.05.20	

Folder	Documentation	Saved in Sharefile folder?	Prioritised for review	Date Added	Notes
	dcc meeting minutes district haripur page 1			07.05.20	
	dcc meeting minutes minutes district haripur 2 page			07.05.20	
	DCC Meeting Minutes Swat on 04 August 2017 (1)			07.05.20	
	DCC minutes Haripur Q1 2018 1s page (1)			07.05.20	
	DCC minutes Mansehra Q1 2018 1s page (2)			07.05.20	
	IMG-20171211-WA0000			07.05.20	
	Meeting Minutes of DCC Mansehra on 1st August 2017			07.05.20	
	Minutes DCC Haripur Q2 2017 (1)			07.05.20	
	Swat Q1 2019			07.05.20	
Donor Reports					
Year 1 Half 1	2016 - 75067 Phase V SIB Pakistan Narrative Y1H1 2016 final 050816	Yes		16.03.20	
	Y1H1 Progress Report Appendices Review 3	Yes		16.03.20	
Year 1 Half 2	2017 - 75067 Phase V SIB Pakistan Narrative Y1H2 2016 final 31-Jan-17	Yes		16.03.20	
	Phase V SIB Pakistan KPK case study Y1H2 2016	Yes		16.03.20	
	Phase V SIB Pakistan Progress Report Appendices Y1H2 2016 24-Feb-17	Yes		16.03.20	
Year 2 Half 1	Phase V SIB Pakistan KPK case study Y2H1 2017	Yes		16.03.20	
	Phase V SIB Pakistan KPK narrative Y2H1 2017_revised 25082017	Yes		16.03.20	
	Phase V SIB Pakistan Progress Report Appendices H1Y2 2017 _revised 25082017	Yes		16.03.20	
Year 2 Half 2	Phase 5.3 SIB Pakistan Progress Report Appendices Y2H2 2017 V2 final revised 2722018	Yes		16.03.20	
	23022018_Phase 5.3 SIB Pakistan Narrative Y2H2 2017 FINAL	Yes		16.03.20	

Folder	Documentation	Saved in Sharefile folder?	Prioritised for review	Date Added	Notes
Year 3 Half 1	Phase 5.3 SIB Pakistan Appendices Y3H1 edited Aug 2018	Yes		16.03.20	
	Phase 5.3 SIB Pakistan Narrative Y3H1 edited Aug 2018	Yes		16.03.20	
	Phase V SIB Pakistan KPK case study Y3H1 2018	Yes		16.03.20	
Year 3 Half 2	75067 Case Study H2 2018	Yes		16.03.20	
	Phase 5.3 SIB Pakistan Appendices Y3 H2 2018	Yes		16.03.20	
	Phase 5.3 SIB Pakistan Narrative Y3H2 2018 final	Yes		16.03.20	
Year 4 Half 1	Phase 5.3 SIB Pakistan Narrative Y4H1 2019 final	Yes		17.03.20	
	Phase 5.3 SIB Pakistan Appendices Y4 H1 2019	Yes		17.03.20	
	75067 Case Study Y4H1 2019	Yes		17.03.20	
Year 4 Half 2	Phase 5.3 SIB Pakistan Narrative Y4H2 2019 final	Yes		17.03.20	
	Phase 5.3 SIB Pakistan Appendices Y4 H2 2019	Yes		17.03.20	
	75067 Case Study Y4H2 2019	YES		17.03.20	
Evaluations	181105 SiB KPK MTR Management Response Final	Yes	Yes	16.03.20	
	KPK Pakistan MTR Final Report	Yes	Yes	16.03.20	
Government Policies and Plans	Draft Health Strategic plan KP 2018-Ver5	Yes		07.04.20	
IEC Materials	23 06 2016 IEC Strategy	Yes		25.03.20	
	Design03-billboard-V03	Yes		25.03.20	
	Design04-billboard	Yes		25.03.20	
	option01a-leafLet	Yes		25.03.20	
	Option02-billboard	Yes		25.03.20	
	PSM-Sightsavers - Patient Message	Yes		25.03.20	
	PSM-SightSavers-Dr Message	Yes		25.03.20	

Folder	Documentation	Saved in Sharefile folder?	Prioritised for review	Date Added	Notes
Implementation Plan	2016 75067 Implementation Plan SiB Tranche III	Yes	Yes	16.03.20	
KPI sheets	75067- H1 2017-Final	Yes		07.05.20	
	75067- H2 2017-Final	Yes		07.05.20	
	75067 KPIs- H2 2016	Yes		07.05.20	
	75067-H1 2018	Yes		07.05.20	
	75067-H1 2019	Yes		07.05.20	
	75067-H2 2018	Yes		07.05.20	
	75067-H2 2019	Yes		07.05.20	
Logframe	2015 75067 Logframe	Yes	Yes	16.03.20	
NCEH meeting	Recommendation of 25th meeting of NCEH	Yes		07.05.20	
Other	2015 75067-Workflow Diagram	Yes	Yes	16.03.20	
	75067 Pakistan SiB start-up workshop notes	Yes		16.03.20	
POVO data	75067 POVO H1 2018 Consolidated	Yes		07.05.20	
	75067 POVO H2 2018 Consolidated	Yes		07.05.20	
	75067 POVO Q3 2017	Yes		07.05.20	
Project coordination	05 10 16 Action Points- meeting at PICO	Yes		07.05.20	
	09 06 17 Meeting with PICO finance team	Yes		07.05.20	
	17 05 16 Action Points - Review Meeting 4 05 2017	Yes		07.05.20	
	19 09 16 World Sight Day - 13th October 2016	Yes		07.05.20	
	19 10 16 Action Points- meeting at PICO	Yes		07.05.20	

Folder	Documentation	Saved in Sharefile folder?	Prioritised for review	Date Added	Notes
	29-8-17_FHF and Sightsavers Meeting Minutes_ Draft	Yes		07.05.20	
	Action Points - Review Meeting 4 05 2017	Yes		07.05.20	
	Action Points	Yes		07.05.20	
	Meeting Minutes - 18th July 16 - FHF SSI	Yes		07.05.20	
Proposal	27-2-15_SiB Tranche-III Concept Note	Yes		16.03.20	
	2015 75067-Proposal	Yes	Yes	16.03.20	
QSAT Action Plans	Pakistan QSAT Action Haripur and Swabi	Yes		17.03.20	
Referral slips	Image	Yes		07.05.20	
	Image	Yes		07.05.20	
	Image	Yes		07.05.20	
	Image	Yes		07.05.20	
	Image	Yes		07.05.20	
Research	Pakistan Gender Situation Analysis for Utilisation of Eye Care Services, Full Report final _2017 04 27	Yes		16.03.20	
	Discussion Guide KPK LHW study Final	Yes		27.04.20	
	LHW-KPK Protocol March 12, 2019	Yes		27.04.20	
	RAAB SiB Pakistan 5.3	Yes		16.03.20	
	Situation Analysis Project districts	Yes		17.03.20	
	18-12-19 FINAL CSR DRAFT	Yes		07.05.20	
Training reports	LHWs Refresher Training Report.docx	Yes		07.05.20	
	MO MT Training - Swabi	Yes		07.05.20	
	MO MT Training- Swat	Yes		07.05.20	
	MT MO Training - Mansehra	Yes		07.05.20	

Folder	Documentation	Saved in Sharefile folder?	Prioritised for review	Date Added	Notes
	Training MOs MTs Haripur	Yes		07.05.20	
	Training of LHWs - Swabi	Yes		07.05.20	
	Training of Project Team on Disability	Yes		07.05.20	
	Training LHWs Haripur	Yes		07.05.20	
Visit reports	11 04 2018 Visit Report 11-12 April, 2016 - PICO	Yes		07.05.20	
	12 04 18 Visit Report - MTR - Peshawar, Haripur, Swat	Yes		07.05.20	
	27 5 16 Action Points of meeting at Shifa Foundation-Haripur	Yes		07.05.20	
	27 5 16 Odigram Visit	Yes		07.05.20	
	Visit Report - 4-5 August 2017	Yes		07.05.20	
	Visit Report - 10-12 Aug, 2016	Yes		07.05.20	
	Visit Report - 15-17th Feb 2017	Yes		07.05.20	
	Visit Report - 19 May, 2016 - LMT	Yes		07.05.20	
	Visit Report - 26 May, 2016- PPIU-PICO	Yes		07.05.20	
	Visit Report - PPIU & PICO - 14th Feb, 2018	Yes		07.05.20	
	Visit Report - Sharing of Audit Findings - 6th Oc, 2017	Yes		07.05.20	
	Visit Report - WSD at PICO - 12th October, 2017	Yes		07.05.20	

Appendix 7: List of Key Informants

Informant Category	Institution or Affiliation	Project Role	Specific Informants	Position or Title	Persons to be consulted (estimated target)*	Suggested priority**	Persons to be targeted as High Priority	KII Completed	Sampling Approach^	Gender	Interviewer	Date Interview Completed
Global Level												
Grantee / Managing Partner	Sightsavers Global	Technical oversight for project		Senior Global Technical Lead	1	H		1	Purposive - informants with most involvement/responsibility with the project	F	RA	21-May-20
Grantee / Managing Partner	Sightsavers Global	Technical oversight for project			1			1	Purposive - informants with most involvement/responsibility with the project	M	RA	21-May-20
Grantee / Managing Partner	Sightsavers Global	Technical oversight for project		Regional Monitoring Manager	1	M			Purposive - informants with most involvement/responsibility with the project	M		not targeted
National and Provincial Levels												
Grantee / Managing Partner	Sightsavers PCO	Oversight / management of project		Senior Programme Officer	1	H	1	1	Purposive - informants with most involvement/	M	RA	13-May-20 14-May-2020
		Oversight / management of project		Country Director	1	H	1	1	Purposive - informants with most involvement/	F	RA	Group Briefing: 05-May-20 KII: 15-May-20
		Oversight / management of project		Senior Finance & Support Services Manager	1	H	1		Purposive - informants with most involvement/	M	RA	not reached
Management Partner (INGO and PICO)	Fred Hollows Foundation	Oversight / management of project		Project Officer, Fred Hollows Foundation	1	H	1	1	Purposive - informants with most involvement/	M	RA	Group Briefing: 05-May-20 KII - 5/15/2020
		Oversight / management of project		Programme Manager Fred Hollows Foundation	1	M		1	Purposive - informants with most involvement/	F	RA	22-May-20
		Oversight / management of project		Country Director, Fred Hollows Foundation	1	H	1	1	Purposive - informants with most involvement/	M	RA	20-May-20
	Pakistan Institute of Community Ophthalmology (PICO) and Provincial Eye Health Board	Oversight / management of project		Community Ophthalmologist, Project Coordinator	1	H	1	1	Purposive - informants with most involvement/	M	IC	22-May-20
		Oversight / management of project		Epidemiologist / Deputy Dean PICO / Provincial Coordinator, PCB	1	H	1	1	Purposive - informants with most involvement/responsibility with the project	M	IC	22-May-20
Government Partner	National Eye Health Committee	Quality assurance		National Coordinator	1	H	1	1	Purposive - informants with most involvement/responsibility with the project	M	IC	22-May-20
	Provincial Programme Implementation Unit - LHWs Programme	Implementing partner: training, supervision and quality assurance of LHWs on PEC		PPIU Coordinator/DPIU Coordinator-LHWs program	1	H	1	1	Purposive - informants with most involvement/responsibility with the project	M		22-May-20
Implementing Partner	Layton Rehmatalullah Benevolent Trust (LRBT)	Implementing partner		CEO LRBT	1	H	1	1	Purposive - informants with most involvement/responsibility with the project	M		22-May-20
Other national stakeholders / informants (OTH)	Pakistan Eye INGO Forum				1	L		0				not targeted
	Aid to Leprosy	Implementing similar activities in some project areas with funding from CBM, which requires coordination from the implementing partners			1	L		0				not targeted
	WhiteRice Communications	IEC communications agency/consultant		CEO	1	L		0	Purposive - informants with most involvement/responsibility with the project	M		not targeted

District level												
Swat												
District Govt Partner/Stakeholder (DGP)	District Health Office Swat	Resp. for district health issues		District Health Officer		M		n/a				
Implementing Partner (IP) - Dist. gov partner (DGP)	Saidu Group of Teaching Hospitals Districts Swat	Hospital Management; Secondary eye care		Medical Superintendent		M		n/a				
Implementing Partner (IP) - Charity Hospital	Layton Rehmatulla Benevolent Trust (LRBT), Swat	Secondary eye care		District Ophthalmologist	1	H	1	1		M	IC	16-May-20
Project staff (hospital based)		Project staff deployed to partner hospitals for refraction services and		CEO LRBT		H		duplicate		M		duplicate
				Optometrist	1	H	1	1	1 Optometrist	M	IC	16-May-20
				Optometrist	1			1		M	IC	16-May-20
District Govt Partner/Stakeholder (DGP)	District Programme Implementation Unit-LHWs Programme, Swat	Coordinating LHWs activities in the district		Social Organiser	1	H	1	1		M	IC	16-May-20
				DPIU Coordinator	1			1	Prioritise DPIU/LHS in districts where OR not conducted	M	IC	16-May-20
				Lady Health Supervisor (LHS)	1	H	1	1	Prioritise DPIU/LHS in districts where OR not conducted	F	IC	16-May-20
Haripur												
District Govt Partner/Stakeholder (DGP)	District Health Office Haripur	Resp. for district health issues		District Health Officer	0	M		n/a				n/a
Implementing Partner (IP) - Dist. gov partner (DGP) - Hospital	District Headquarter hospital Haripur	Hospital Management; Secondary eye care		Medical Superintendent (MS)	0	M		n/a				n/a
				District Ophthalmologist	0	H	n/a	n/a		M		No longer available - new ophthalmologist has been nominated
Project staff, hospital-based		Project staff deployed to partner hospitals for refraction services and community outreach		Optometrists	1	H	1	1		M	IC	20-May-20
				Optometrists	not on original list			1		M	IC	
				Social Organizer	1	H	1	1		M	IC	20-May-20
				Social Organisers	1	H	1	1		M	IC	20-May-20
Implementing Partner (IP) - Charity Hospital	Shifa Eye Foundation, Haripur	Secondary eye care		Chairman Shifa Eye Foundation	1	H	1	1		M	IC	20-May-20
District Govt Partner/Stakeholder (DGP)	District Programme Implementation Unit-LHWs Programme, Haripur	Coordinating LHWs activities in the district		DPIU Coordinator	1	M		1	Prioritise DPIU/LHS in districts where OR not	M	IC	20-May-20
				Lady Health Supervisor (LHS)	1	H	1	1	Prioritise DPIU/LHS in districts where OR not conducted	F	IC	20-May-20

Swabi														
District Govt Partner/Stakeholder (DGP)	District Health Office, Swabi	Resp. for district health issues		District Health Officer	0	M		n/a				n/a		
Implementing Partner (IP) - Dist. gov partner (DGP) - Hospital	District Headquarters Hospital Swabi	Hospital Management; Secondary eye care Project staff deployed to partner hospitals for refraction services and community outreach		Medical Superintendent, DHQ Hospital	0	M	1	1		M	IC	19-May-20		
				District Ophthalmologist	1	H	1	1		M	IC	19-May-20		
				Optometrists (hospital-based project)	1	H	1	1	1	1	1	M	IC	19-May-20
				Social Organisers (hospital-based)	1	H	1	1	1	1	1	M	IC	19-May-20
				Optometrist	1				1			M	IC	19-May-20
	Social Organizer	1				1			M	IC	19-May-20			
Implementing Partner (IP) - Charity Hospital	Lakson Medical Trust Hospital, Swabi	Secondary eye care		Hospital Administrator	1	H	1	1		M	IC	19-May-20		
District Govt Partner/Stakeholder (DGP)	District Programme Implementation Unit-LHWs Programme, Swabi	Coordinating LHWS activities in the district Primary eye care and awareness raising		DPIU Coordinator	1	M		1		M	IC	19-May-20		
				Lady Health Supervisor (LHS)	1	H	1	1		M	IC	19-May-20		
Mansehra														
District Govt Partner/Stakeholder (DGP)	District Health Office, Mansehra	Resp. for district health issues		District Health Officer	1	M		n/a		M				
Implementing Partner (IP) - Dist. gov partner (DGP) - Hospital	King Abdullah Teaching Hospital District Mansehra	Hospital Management; Secondary eye care; Community outreach		Medical Superintendent	1	M		n/a		M				
				District Ophthalmologist	0	H		1		M	IC	18-May-20		
Project staff, hospital-based	King Abdullah Teaching Hospital District Mansehra	Project staff deployed to partner hospitals for refraction services and community outreach		Optometrist	1	H	1	1		M	IC	18-May-20		
				Optometrist	1			1		M	IC	18-May-20		
				Social Organizer	1			1		M	IC	18-May-20		
Implementing Partner (IP) - Charity Hospital	Layton Rehmatulla Benevolent Trust (LRBT)	Implementing partners (Charity Hospital)		Social Organisers	1	H	1	1		M	IC	18-May-20		
				CEO LRBT				duplicate		M	IC	duplicate		
District Govt Partner/Stakeholder (DGP)	District Programme Implementation Unit-LHWs Programme, Mansehra	Coordinating LHWS activities in the district Primary eye care and awareness raising		DPIU Coordinator	1	M		1		M	IC	18-May-20		
				Lady Health Supervisor (LHS)	1	H	1	1		F	IC	18-May-20		
Sub-district or community level - data collection was not planned due to low availability (PHC workers engaged in pandemic control) and access restrictions, however a few Mos and patients were identified by project teams for individual interview														
Primary eye care service providers	Medical Officers (Mos) and Medical Technicians (MTs) trained in Primary Eye Care	Trained under project to provide PEC at BHUs/RHCs (screen and refer)		Medical Technician, Haripur district				1		Convenience - identified by project teams based on availability	M	IC	20-May-20	
				Medical Technician, Haripur district				1			F	IC	20-May-20	
				Medical officer, Swabi district				1				M	IC	19-May-20
				Medical officer, Swabi district				1				M	IC	19-May-20
				LHW, Haripur District				1				F	IC	20-May-20
Service recipients (Men and women the project aimed to help (community members with eye health conditions; received surgery, received refraction services)	LHWS trained in PEC	Trained under project to provide PEC and raise		LHW, Haripur District				1			F	IC	20-May-20	
				Service recipient, Swat District				1		M	IC	16-May-20		
				Service recipient, Swat District				1			M	IC	16-May-20	
				Service recipient, Swat District				1			F	IC	16-May-20	
	Service recipient, Swat District				1				M	IC	16-May-20			
TOTAL					45		28	51			10			

* Phone-based KII; some written responses could be solicited

*Informants from all four programme districts and all implementing partners will be targeted for data collection; aim to achieve a range of geographic areas, facilities and informant types

20%
Female
participants (%)

Appendix 8: Information Sheet and Consent Form

Pakistan KPK End-Term Evaluation

Information and Consent to Participate in Evaluation

You are invited to participate in an Evaluation for the project titled “A new vision for eye health in Pakistan’s Khyber Pakhtunkhwa province (KPK)”, which has been jointly implemented by Sightsavers, the Fred Hollows Foundation (FHF) and the Pakistan Institute of Community Ophthalmology (PICO). This Evaluation is being conducted by a small team consisting of two external consultants.

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 evaluation because you have been involved in the implementation of the project.

Purpose of the evaluation

The purpose of this evaluation is to understand experience with implementing this project, its successes, challenges 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 with the project. We will record the conversation to ensure we capture what you say accurately.

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 evaluation 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 evaluation 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 evaluation team. All data will be kept in a secure location and only those directly involved with the evaluation will have access to them. We may use any information that we get from this evaluation 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 Evaluation Team

Ms. Robin Altaras, Tropical Health (robinaltaras@gmail.com)

Dr. Ismat-Ullah Chaudhry, Tropical Health (dr.ismatch@gmail.com)

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:

Appendix 9: Key Informant Interview Guides

Pakistan KPK End-Term Evaluation

Key Informant Semi-Structured Interview Guide – National and Provincial Partners and Hospital Staff

Interviewer Instructions

Purpose and respondents: This interview guide is to be used for key informant interviews (KIIs) with management partners at country and provincial office levels, as well as other national (N) and provincial (P) level partners and stakeholders. It can also be used for hospital staff. The column “level/who” denotes the target.

The guide follows the key evaluation questions described in the ToR. However, some topic areas (e.g. sustainability, lessons learned) will be integrated and probed on during discussion of other topic areas.

Asking Questions:

- Not all topics will be relevant to all informants.
- Questions should be tailored to the respondent’s involvement in the project and area of expertise.
- For some topics, informants should be asked to reflect on their own role in the project, and for others, they should be asked to comment on the roles of other actors, as appropriate.
- Topics may be asked in a different order. Topics that have already come up spontaneously in the interview may be skipped.
- Probes and follow-up questions are bulleted.
- Standard probes should also be used to encourage respondents to elaborate (“can you tell me more about that”, “can you give me an example”), to ensure that the respondent has nothing further to add (“anything else?”) and to probe for evidence (how do we know this?)
- High priority questions are designated “P”. Non-priority questions may be appropriate to ask of only a few respondents, or until sufficient information (saturation) has been obtained.
- As data collection progresses, questions should be refined based on information obtained. Questions will become increasingly focused on the individual’s experience and opinions. Interviews may also seek to focus on key topics of interest that warrant further exploration, while allowing for open enquiry with all respondents, so as not to limit the scope of opinion or topics covered.

Introduction of the interview to the respondent:

[Greetings]

Thank you for taking the time to speak with me today. My name is _____.

I am working on a project with Tropical Health, a consultancy firm.

We have been asked to evaluate an eye health project in Khyber Pakhtunkhwa that has been implemented by Sightsavers, the Fred Hollows Foundation and PICO.

You have been identified as a key [partner/actor/stakeholder] in the project.

I would like to speak with you about your involvement in the project, as well as ask your opinions about the project and eye care services in Pakistan.

The purpose of this work is to understand and document your experience so that organisations can learn from it and make recommendations for future projects.

For example, I will ask you about different topics and what has worked well and why, what have been some of the challenges you faced and how you were able to address these, and what could be done differently in future projects.

The interview today will last about one hour. During the interview I will take notes so I can remember what you said and I will record our conversation.

I want to mention a few important points before we start:

- There are no “right” or “wrong” answers to any of the questions. We are interested in hearing your opinions, whatever they are.
- Your participation in this interview is voluntary. If you don’t want to answer a question or need to stop the interview at any time, just say so.
- Whatever you tell me will be kept confidential. That means that it will be shared only with the members of the evaluation team. Any information we include in our report will not identify you.

Do you have any questions before we begin?

Can you please confirm that you received and reviewed the information and informed consent sheet?

→ All respondents must review the information and informed consent sheet. [To be sent prior to interview at time of scheduling.]

Now that I've told you about the topics we'll discuss and answered your questions, are you comfortable proceeding with the interview?

Interview and respondent information to be recorded
<input type="checkbox"/> Date of interview
<input type="checkbox"/> Length of interview (start/end time)
<input type="checkbox"/> Name
<input type="checkbox"/> Role in the organisation and time in that role
<input type="checkbox"/> Gender
<input type="checkbox"/> Disability status
<input type="checkbox"/> Location of interview
<input type="checkbox"/> Any notes on interview context and persons present

PM = Project management / project staff (SS, FHF, PICO)

N = national; P = provincial

H = hospital staff

Topic	Level / Who	Eval Q	Priority “P”
A. Introduction / Project Involvement <i>[Interviewer can use these questions to prioritise topic areas on which KI can best comment, according to role and responsibilities in the project]</i>			
[Greetings] 1. Please tell me briefly about your role in this project.	All		
B. Relevance			
2. How would you characterise the need for this project in KPK? • Why? What makes you think it was X [e.g. an important need or not a priority]?	All	1, 2	

Topic	Level / Who	Eval Q	Priority "P"
<ul style="list-style-type: none"> Before the project started, how would you have characterised the level (probe high/medium/low if necessary) of community awareness regarding eye health issues and available eye care services? What about accessing different eye care services for the targeted populations? Are there any factors that made it more difficult for women or other vulnerable groups to get the eye care they need? What about for other vulnerable groups such as transgender people or refugees? 			
C. Effectiveness – Demand Generation and Awareness Raising			
3. What approaches did the project use to generate demand for eye care ? <ul style="list-style-type: none"> Were any new approaches tried? How were these strategies developed? What evidence was used? Was any specific evidence on gender and utilisation of eye care services used? 	PM	5, 15	P
4. How effective were these approaches in reaching men and women in the poorest and most remote communities? <ul style="list-style-type: none"> Has demand for eye care services for women increased? (How do we know this?) Has demand for eye care services for men increased? (How do we know this?) Which approaches were the most / least effective? Why? What were some of the challenges you faced? Are there any groups that were difficult to reach, especially regarding seeking health services? [If increase in demand] Will this change be long-term? What actions or resources are needed to sustain these changes? What gaps remain? 	PM, P		P
5. How useful were the different IEC materials for the project? <ul style="list-style-type: none"> Which materials were the most powerful? Which materials did not work well? Have any leaflets or other materials been revised since the MTR? 	PM	5, 12, 15	
6. IEC Strategy <i>Are you familiar with the IEC strategy for the project?</i> How successful was the IEC strategy for raising awareness in communities about eye health issues? <i>For those involved in strategy development:</i> <ul style="list-style-type: none"> What did the project learn from the experience of strategy development? And from working with a communications agency? What were some of the strengths and weaknesses of this approach? What process was used to select the communications agency? How helpful were the focus group discussions and desk review in developing messages and choosing the best dissemination channels? What other evidence was used to develop the strategy? Were any new approaches or types of materials tried? Was anything specifically developed for use by LHWs? What were the most effective components of the communication strategy? Why do you think these approaches worked well? What were some of the gaps in the communications strategy? What could have been done differently? 	PM (involvement in strategy)	12, 14, 15	P
7. What evidence is there regarding any overall changes in awareness of eye care in communities? <ul style="list-style-type: none"> How has the project measured levels of community awareness? Has there been any uptick of eye care services in utilisation via routine primary care channels? How do we know this? 	PM, P	5	
D. Effectiveness – Gender Equity			
8. To what extent has the project made any special efforts to encourage eye care seeking by women?	PM, H	3-4, 15	

Topic	Level / Who	Eval Q	Priority "P"
<ul style="list-style-type: none"> What approaches has the project used to prioritise women's access to eye care services (screening, referral, surgery, refraction)? Which approaches have worked well? Where do breakdowns occur in the care process? What could future projects do differently? 			
<p>9. In your opinion, how successful was the project in increasing access to and uptake of eye care services by women?</p> <ul style="list-style-type: none"> What do you think were the factors that contributed to this [success / weakness]? Have any new approaches been tried in the second half of the project to strengthen counselling at the point of referral? For example, to increase uptake of cataract surgery for women? (Where?) Which approaches were the most / least effective? Why? What do you think could be done differently to reach these populations? What about people with disabilities? How successful has the project been in improving access for people with disabilities? What are the specific challenges to reaching women with disabilities? What can be done differently in future programmes? Who else needs to be involved to achieve this? 	PM, P, H	4, 15	P
E. Effectiveness – Role of LHWs and Referral System (PHC LEVEL)			
<p>10. Now I'd like to discuss the different approaches the project used to identify and refer people with eye problems. How effective are the LHWs at identifying people with eye problems in the community?</p> <ul style="list-style-type: none"> What has been the impact of training LHWs on primary eye care? What are the major benefits of this approach? Who benefits most? Who gets missed? What are the limitations of this approach? What have been some of the challenges faced? What can be done differently in future programmes? 		6, 11, 14-15	P
<p>11. What other approaches have been used to identify and refer patients at the community level or other first point of contact with the health system?</p> <ul style="list-style-type: none"> How effective are these approaches? What gaps did the project try to address? What changes have occurred under the project? 		11	
<p>12. What approaches has the project used to establish or reinforce linkages in the referral pathway?</p> <ul style="list-style-type: none"> How has the referral process been codified or integrated into the health system? Has this led to any changes in the health system? How well do you think this will continue to function after the end of the project? How helpful is the referral slip? How has this changed referral practices? What gaps remain in the referral pathway? How do you think these gaps can be addressed? Do you collect data on the proportion of patients presenting without referral? How clear do you think this pathway is for patients, for service providers? 	PM, H	11, 14-15	P
<p>13. What has been the project's experience with referral completion?</p> <ul style="list-style-type: none"> Have you been able to track the outcomes for referred patients? Is there a referral feedback mechanism? (If not, what would be required to put in place a referral feedback mechanism? If yes, how often does feedback occur?) 		11, 15	

Topic	Level / Who	Eval Q	Priority "P"
<ul style="list-style-type: none"> What process in place for reception of referred patients? What other barriers are there to completing the referral? 			
14. What approaches have been used to support post-op follow-up care? <ul style="list-style-type: none"> What strategies have worked well? What changes did the project make in the second half of the project to overcome barriers to follow-up? (e.g. shifting follow-care close to communities) What could be done differently? 	PM, H	11, 15	
F. Health Systems Strengthening and Sustainability			
15. What has the project done to improve the quality and availability of eye care services at partner hospitals / your hospital? <ul style="list-style-type: none"> In your view, what has changed as a result? What impact has this had on service delivery? (availability, quality, efficiency) How have these changes been integrated into existing eye care? What gaps remain? What will change after the end of project support? What systems have been put in place for recording post-operative visual outcomes? 	PM (PICO), H	9, 14	P
16. Essential equipment and technology, infrastructure What approaches were used for identifying hospital needs and prioritising investments? (cost-effectiveness) <ul style="list-style-type: none"> What worked well in this process? What did the project learn about key supplier contracting? What plans are in place to support maintenance of equipment and continued material supplies? Has this been budgeted? What will be the situation after the close of the project? 	PM, H	9, 7, 14-15	
17. Human resources: What approaches has the project used to get approval for optometrists posted in hospitals? <ul style="list-style-type: none"> What factors made this approach successful? What were some of the key challenges you faced? How important was the role of the project in getting approval for the optometrist posts? Without this project, how likely is it that these posts would have been approved? What has been the impact on ophthalmologists' workload and task shifting? Has this impacted quality of care? What impact will this have in the long-term? 	PM, H	10, 14-15	
18. Data and Health Information Systems: What approaches has the project used to ensure the sustainability of data systems? <ul style="list-style-type: none"> How will screening, referral and post-op data continue to be tracked after the end of the project? Has this been integrated into existing HMIS (at DHQ? At charity hospital? LHW HMIS?) What have been some of the challenges with making this system sustainable? 	PM, H	13	
19. Now that the project has ended, are there any other project activities that will continue to be implemented? <ul style="list-style-type: none"> Who will support this work? Has the province / district integrated any new resources for basic ophthalmic services into its health plan / budget? Has the project developed a sustainability plan, as recommended in the MTR? Is there anything else you think will affect the sustainability of the project's achievements? 	PM, P	14	
G. Efficiency, Program Management and Value for Money			

Topic	Level / Who	Eval Q	Priority "P"
20. What approaches did the project use to ensure resources were used in a cost-effective manner? <ul style="list-style-type: none"> How did the project monitor costs and make decisions? What choices were made? Can you give an example? What have been the challenges for financial planning? Is there anything that could have been done differently? 	PM (finance staff)	7	P
21. What has been the strategy towards partnership and collaboration between PICO, Sightsavers, and FHF? <ul style="list-style-type: none"> How effective and efficient has project management been? What has worked well? How well has the Project Steering Committee worked? What about the Project Technical and Implementation Committee? (frequency and quality of meetings, decision-making process) In your opinion, what can be done differently in future programmes? 	PM	8	
H. Coordination			
22. How well have the District Coordination Committees (DCCs) functioned for supporting the project implementation and decision-making? <ul style="list-style-type: none"> Can you give an example of their role in making a key decision related to the work of the project? What have been some of the challenges with the DCCs? 	PM, P	17	
23. In your view, how well has the project managed coordination with partners at different levels of the health system and across eye health and primary health care sectors? <ul style="list-style-type: none"> Did this project complement or overlap other initiatives? How could efficiency and use of available resources have been improved? Are there any forums or approaches that have been particularly helpful? Have any new opportunities have been identified as a result of these coordination efforts? What have been some of the challenges you faced? What efforts has the project made to work with other departments or actors outside the health system? 	PM, N, P, H	16	P
24. Did you participate in any provincial/district coordination or planning meetings under the project? <ul style="list-style-type: none"> What was the meeting? What was your involvement? How useful were these meetings? 	P, H	16	
I. Coherence of Project Design			
25. Thinking overall about the project design, in your opinion, how well has this project been able to respond to the eye care needs in the project districts? <ul style="list-style-type: none"> Are there any key needs the project has been unable to address? 	PM, N, P	2, 18	
J. Other Learning / Closing Questions			
26. Is there anything else you'd like to say about the topics we've discussed? Are there any other lessons learned from this project that you wish to share? <p>[Closing / thank for time] [RECORD INTERVIEW END TIME]</p>	All	15	

Pakistan KPK End-Term Evaluation

Key Informant Semi-Structured Interview Guide – PHC Level

Interviewer Instructions

Purpose and respondents: This interview guide is to be used for key informant interviews (KIIs) with district-level partners and stakeholders engaged in primary health care (DPIU, LHS).

The guide follows the key evaluation questions described in the ToR. However, some topic areas (e.g. sustainability, lessons learned) will be integrated and probed on during discussion of other topic areas.

Asking Questions:

- Not all topics will be relevant to all informants.
- Questions should be tailored to the respondent's involvement in the project and area of expertise.
- For some topics, informants should be asked to reflect on their own role in the project, and for others, they should be asked to comment on the roles of other actors, as appropriate.
- Topics may be asked in a different order. Topics that have already come up spontaneously in the interview may be skipped.
- Probes and follow-up questions are bulleted.
- Standard probes should also be used to encourage respondents to elaborate ("can you tell me more about that", "can you give me an example"), to ensure that the respondent has nothing further to add ("anything else?") and to probe for evidence (how do we know this?)
- High priority questions are designated "P". Non-priority questions may be appropriate to ask of only a few respondents, or until sufficient information (saturation) has been obtained.
- As data collection progresses, questions should be refined based on information obtained. Questions will become increasingly focused on the individual's experience and opinions. Interviews may also seek to focus on key topics of interest that warrant further exploration, while allowing for open enquiry with all respondents, so as not to limit the scope of opinion or topics covered.

Introduction of the interview to the respondent:

[Greetings]

Thank you for taking the time to speak with me today. My name is _____.

I am working on a project with Tropical Health, a consultancy firm.

We have been asked to evaluate an eye health project in Khyber Pakhtunkhwa that has been implemented by Sightsavers, the Fred Hollows Foundation and PICO.

You have been identified as a key [partner/actor/stakeholder] in the project.

I would like to speak with you about your involvement in the project, as well as ask your opinions about the project and eye care services in Pakistan.

The purpose of this work is to understand and document your experience so that organisations can learn from it and make recommendations for future projects.

For example, I will ask you about different topics and what has worked well and why, what have been some of the challenges you faced and how you were able to address these, and what could be done differently in future projects.

The interview today will last about one hour. During the interview I will take notes so I can remember what you said and I will record our conversation.

I want to mention a few important points before we start:

- There are no “right” or “wrong” answers to any of the questions. We are interested in hearing your opinions, whatever they are.
- Your participation in this interview is voluntary. If you don’t want to answer a question or need to stop the interview at any time, just say so.
- Whatever you tell me will be kept confidential. That means that it will be shared only with the members of the evaluation team. Any information we include in our report will not identify you.

Do you have any questions before we begin?

Can you please confirm that you received and reviewed the information and informed consent sheet?

➔ **All respondents must review the information and informed consent sheet. [To be sent prior to interview at time of scheduling.]**

Now that I’ve told you about the topics we’ll discuss and answered your questions, are you comfortable proceeding with the interview?

Interview and respondent information to be recorded
<input type="checkbox"/> Date of interview
<input type="checkbox"/> Length of interview (start/end time)
<input type="checkbox"/> Name
<input type="checkbox"/> Role in the organisation and time in that role
<input type="checkbox"/> Gender
<input type="checkbox"/> Disability status
<input type="checkbox"/> Location of interview
<input type="checkbox"/> Any notes on interview context and persons present

Topic	Eval Q	Priority “P”
A. Introduction / Project Involvement <i>[Interviewer can use these questions to prioritise topic areas on which KI can best comment, according to role and responsibilities in the project]</i>		
[Greetings]		
1. Please tell me briefly about your role in this project.		
2. How would you characterise the need for this project in your district ? <ul style="list-style-type: none"> • Why? What makes you think it was X [e.g. an important need or not a priority]? • Before the project started, how would you have characterised the level (probe high/medium/low if necessary) of community awareness regarding eye health issues and available eye care services? • What about accessing different eye care services? Are there any factors that made it more difficult for women or other vulnerable groups to get the eye care they need? 	1, 2	
B. Effectiveness – Demand Generation and Awareness Raising		
3. How effective has the project been in reaching men and women in the poorest and most remote communities?	5, 15	P

Topic	Eval Q	Priority “P”
<ul style="list-style-type: none"> • Has demand for eye care services for women increased? (How do we know this?) • Has demand for eye care services for men increased? (How do we know this?) • Which approaches were the most / least effective? Why? • What were some of the challenges you faced? • Are there any groups that were difficult to reach, especially regarding seeking health services? • [If increase in demand] Will this change be long-term? What actions or resources are needed to sustain these changes? What gaps remain? 		
<p>4. How useful were the different IEC materials for the project?</p> <ul style="list-style-type: none"> • Which materials were the most useful for LHWs? • Which materials did not work well? 	5, 12, 15	
<p>5. Have you observed any changes in awareness of eye care in communities?</p> <ul style="list-style-type: none"> • From your view, has there been any increase of eye care seeking via routine primary care channels? (How do we know this?) 	5	
<p>6. What approaches have you used to prioritise women’s access to eye care services?</p> <ul style="list-style-type: none"> • Which approaches have worked well? • What barriers remain to women accessing cataract surgery or other eye care services? • What could future projects do differently? 	3-4, 15	
<p>7. In your opinion, how successful was the project in increasing access to and uptake of eye care services by women?</p> <ul style="list-style-type: none"> • What do you think were the factors that contributed to this [success / weakness]? • Were any new approaches tried? • Which approaches were the most / least effective? Why? • What do you think could be done differently to reach these populations? • What about people with disabilities? How successful has the project been in improving access for people with disabilities? • What are the specific challenges to reaching women with disabilities? • What can be done differently in future programmes? Who else needs to be involved to achieve this? 	4, 15	
<p>8. How effective are the LHWs at identifying people with eye problems in the community?</p> <ul style="list-style-type: none"> • What has been the impact of training LHWs on primary eye care? • What are the major benefits of this approach? Who benefits most? • Who gets missed? • What are the limitations of this approach? • What have been some of the challenges faced? • What can be done differently in future programmes? 	6, 11, 14-15	
<p>9. In your opinion, how clear is the referral pathway for patients and for health workers?</p> <ul style="list-style-type: none"> • How helpful is the referral slip? How has this changed referral practices? • How well is this referral process integrated into the health system? • Has this led to any changes in the health system? • How well do you think this will continue to function after the end of the project? • What gaps remain in the referral pathway? How do you think these gaps can be addressed? 	11, 14-15	
<p>10. When an LHW identifies an eye care problem, how likely are patients to follow the referral advice?</p> <ul style="list-style-type: none"> • What helps people to complete referral? • What prevents them from completing the referral? 	11, 15	

Topic	Eval Q	Priority “P”
<ul style="list-style-type: none"> Is there a referral feedback mechanism? (If not, what would be required to put in place a referral feedback mechanism? If yes, how often does feedback occur?) How are referred patients received at secondary level facilities? Are there any other barriers to completing the referral? 		
<p>11. Have LHWs been involved in encouraging and supporting post-op follow-up care? What has been their role?</p> <ul style="list-style-type: none"> Are there any strategies for encouraging post-op follow-up that have worked well? What could be done differently to ensure post-op follow-up care? 	11, 15	
<p>12. Have you participated in the District Coordination Committees (DCCs)? How well have these functioned for supporting project implementation and decision-making?</p> <ul style="list-style-type: none"> Can you give an example of their role in making a key decision related to the work of the project? What have been some of the challenges with the DCCs? 	17	
<p>13. In your view, how well has the project managed coordination with partners at different levels of the health system and across eye health and primary health care sectors?</p> <ul style="list-style-type: none"> Did this project complement or overlap other initiatives? How could efficiency and use of available resources have been improved? Are there any forums or approaches that have been particularly helpful? Have any new opportunities have been identified as a result of these coordination efforts? 	16	
<p>14. Did you participate in any provincial/district coordination or planning meetings under the project?</p> <ul style="list-style-type: none"> What was the meeting? What was your involvement? How useful were these meetings? 	16	
<p>15. Is there anything else you'd like to say about the topics we've discussed? Are there any other lessons learned from this project that you wish to share?</p> <p>[Closing / thank for time] [RECORD INTERVIEW END TIME]</p>	15	

Pakistan KPK End-Term Evaluation

Key Informant Semi-Structured Interview Guide – Service Recipients

Interviewer Instructions

Purpose and respondents: This interview guide is to be used for key informant interviews (KIIs) with individuals who received services under the project.

Asking Questions: Simple language should be used to facilitate the response. Although we wish to elicit as much as possible about “why” and “how”, this guide uses some “closed” questions in order to make response easier. These questions can then be followed up, using the prompts to probe for more information.

Consent: Informed consent should be obtained from all respondents

Introduction of the interview to the respondent:

[Greetings, Introduce self]

Thank you for taking the time to speak with me today. My name is _____.

- I have been asked to evaluate an eye health project in Khyber Pakhtunkhwa that has been implemented by Sightsavers, the Fred Hollows Foundation and PICO, international organizations and government bodies working to help prevent and treat eye problems.
- You have been identified as someone who received [eye care, surgery, spectacles...]
- I would like to speak with you about your experience receiving care for your eyes.
- The information you share with me will be used to help make better eye care projects in Pakistan and other countries.
- You don't have to speak with me if you don't wish to. If you don't wish to, it won't have any effect on services you receive.
- The questions will take about 30 minutes.
- If you don't want to answer a question, just tell me, and I will move on.
- If you wish to stop the interview at any time, please also just tell me and we will stop.
- Whatever you tell me will be kept confidential. That means that it will be shared only with the members of the evaluation team. Any information we include in our report will not give your name.
- Do you agree to participate in this the interview?
- Do you have any questions for me before we begin?

Are you comfortable proceeding with the interview?

Interview and respondent information to be recorded

- | |
|---|
| <input type="checkbox"/> Date of interview |
| <input type="checkbox"/> Length of interview (start/end time) |
| <input type="checkbox"/> Type of eye care intervention received |
| <input type="checkbox"/> Name |
| <input type="checkbox"/> Gender |
| <input type="checkbox"/> Age |
| <input type="checkbox"/> Disability status |
| <input type="checkbox"/> Location of interview |

- Any notes on interview context and persons present

Topic
C. Introduction
1. [Greetings, informal conversation]
D. Demand, Awareness, IEC (Effectiveness and Relevance to Needs)
First, I have some questions for you.
2. How did you hear about the [eye care services offered under the project or at x facility]? <ul style="list-style-type: none"> • Where did you hear it? • What was the main message you heard? • Was it useful to you? • What did you think of the information? • Did you see any educational material about what you heard? • Did you share this information with other people?
3. Before the screening at [X], were you aware you had an eye problem?
4. What did you think when you heard about these eye care services? <ul style="list-style-type: none"> • How useful did you think this might be for you? • How important was this to you?
E. Eye Care Experience (Access)
5. Had you tried to access eye care services in the past? What happened? <ul style="list-style-type: none"> • [If yes] What was different this time?
6. After you were first screened at [X], where did you go next for eye care? What was your experience there? <ul style="list-style-type: none"> • Did you receive a diagnosis, i.e. did a health worker give you the name of an eye condition that requires further assessment or treatment? • What services did they offer?
F. Referral Experience
7. Were you referred to another facility for eye care? <ul style="list-style-type: none"> • Who were your referred by? • Which facility were you referred to? • What were you told about why you were referred there? • Did you have any concerns about this? •
8. Did you take up the referral at the hospital? Or did you go to another hospital or facility? <ul style="list-style-type: none"> • Did you use a referral slip? Was it useful? • How easy was it to access the referral facility? What was [easy or difficult] about it? • Was it easy for you to know where you should go to seek treatment? • Do you have any suggestions for improving the process?
G. Impact
9. Were you happy with the service you received? <ul style="list-style-type: none"> • How was the quality? • Do you feel that your needs/concerns were addressed? • Do you feel your expectations were met? • What difference has it made to you now? • Would you recommend it to a family member/friend? Why?
10. Since [your surgery] has there been any follow-up? <ul style="list-style-type: none"> • At the hospital? • By a lady health worker or other person? • [If none] Do you think there is a need for follow-up? What for?
11. Overall, what do you think could be done differently or improve access to these kinds of eye care services? <ul style="list-style-type: none"> • Did you encounter any barriers or challenges?

Topic
<p>12. Based on your experience, how easy do you think it is for women or people with disabilities to access eye care?</p> <ul style="list-style-type: none"> • What do you think are the unique challenges or barriers for women in accessing eye care services? • How do you think these barriers can be addressed? • Are there any specific considerations when it comes to women having eye surgery or wearing glasses? • Can you give any examples?
<p>13. Is there anything else you'd like to tell me about your experience getting care for your eyes?</p> <ul style="list-style-type: none"> • Do you have any concerns for the future? What are your concerns?
<p>14. Is there anything else you'd like to say about the topics we've discussed? Do you have any questions for me?</p> <p>[Closing / thank for time]</p> <p>[RECORD INTERVIEW END TIME]</p>