**End of Term Evaluation Report**

###### Project: MAONO SINGIDA- SUSTAINABLE PROVISION OF EYE CARE &

###### MAONO SINGIDA- SCHOOL EYE HEALTH

**Project numbers: 24027 & 24030**

**Submission of Final Report: 10 August 2020**

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We are very grateful to all the eye care coordinators at regional and district levels, clinical and managerial eye health staff who took time out of their normal work to take part in interviews, especially during the difficult period of the COVID-19. Thanks are also due to the regional education and social welfare officers, and the many primary school teachers who took part in telephone key informant interviews, during this period of uncertainty outside of their normal working routine.

The evaluation could not have been conducted without this support and coordination. Any errors or omissions remain the responsibility of the authors.

### List of acronyms and abbreviations

|  |  |
| --- | --- |
| AMOO | Assistant Medical Officer in Ophthalmology |
| CCHP | Council Comprehensive Health Plans |
| CHMT | Council Health Management Team |
| CSO | Cataract Surgical Outcome |
| DEC | District Eye Care Coordinator |
| DEO | District Educational Officers |
| DEOH | School Health Officers |
| DMO | District Medical Officer |
| DSWO | District Social Welfare Officer |
| EHSA | Eye Health System Assessment |
| EQ | Evaluation Question |
| FGD | Focus Group Discussion |
| FY | Financial Year |
| HMIS | Health Management Information System |
| KII | Key Informant Interview |
| MOHCDGEC | Ministry of Health, Community Development, Gender, Elderly and Children |
| MTR | Mid-Term Review |
| NECSP | National Eye Care Strategic Plan |
| NGO | Non-Governmental Organisation |
| OECD/DAC | Organisation for Economic Cooperation and Development/Development Assistance Committee |
| OA | Ophthalmic Assistant |
| OM | Ocular Morbidity |
| ON | Ophthalmic Nurse |
| PHW | Primary Health Worker |
| PO-RALG | President’s Office – Regional Administration and Local Government |
| QSAT | Quality Standards Assessment Tool |
| RAAB | Rapid Assessment of Avoidable Blindness |
| REO | Regional Educational Officers |
| RHMT | Regional Health Management Team |
| RSWO | Regional Social Welfare Officer |
| RMO | Regional Medical Officer |
| SRRH | Singida Regional Referral Hospital |
| TCO | Tanzania Country Office |
| TGNP | Tanzania Gender Networking Programme |
| TZS | Tanzanian Shilling |
| TOR | Terms of Reference |
| URE | Uncorrected Refractive Error |
| USD | US Dollar |
| VHW | Village Health Worker |
| WHO | World Health Organisation |

### Executive Summary

###### Background Information and description of projects

The Singida region of Tanzania was not prioritised in the National Eye Care Strategic Plan (NECSP) 2011-2016, despite being one of the most underserved regions in the central zone. In response to this, Standard Chartered Bank has funded two projects in the region: the Maono Singida[[1]](#footnote-1) Sustainable Eye Care project launched in April 2016 to contribute to the sustainable provision of eye care services in the region, focusing on demand creation and improvements in current delivery mechanisms; and Maono School Eye Health project in January 2018, to address visual impairment of primary school children in the region. This report presents the findings from the end term evaluation undertaken between 1st March and 30th June 2020 by a team of consultants from Tropical Health.

###### Purpose of evaluation

The end of term evaluation was commissioned to review the extent to which the projects’ objectives have been accomplished and what have been the factors affecting or influencing the achievements including experienced challenges, according to evaluation questions presented in the evaluation terms of reference (ToR). The target audience for the report is funders, partners, programme staff and global programme support teams within Sightsavers. It is intended that the learning, findings and recommendations emerging from this evaluation will be important for Sightsavers’ and partners’ wider programming design and decisions.

###### Evaluation approach

The evaluation approach used the framework of the ten key evaluation questions (EQs) identified in the evaluation’s ToR in order to explore the areas of interest identified and to validate the achievements, performance and impact of the project objectives. It also sought to assist better understanding of the drivers of success and challenges experienced, and to capture additional learning. Data from both primary and secondary sources was utilised. The evaluation used the following criteria as the basis for assessment, analysis and reporting: relevance, effectiveness, efficiency, impact, sustainability, scalability/replicability and coherence/coordination[[2]](#footnote-2) and rated the projects in regard to the extent to which they had met the criterion in question. This produced a set of specific recommendations for similar, future project designs, while identifying further cross-cutting or organisational level lessons and key learning points.

###### Main findings

The findings under each EQ are summarised and a criterion rating applied in the sections below for each project, as relevant.

|  |  |
| --- | --- |
| **Relevance** |  |

****

Maono Singida Sustainable Eye Care – **Satisfactory**

The gender dimension of this project is an extremely relevant issue in the uptake of eye services. The project has made considerable efforts to address this dimension in a variety of ways. Deeply set social norms still exist and it would be hard to expect these to change over a four year time scale, however a systematic approach to analysing gender trends has not been undertaken. In regard to the alignment of this project with national policies and partners priorities this was felt to be excellent. Overall, considering both the TOR evaluation questions under Relevance for this project, it is concluded that the project mostly meets the aspects of Relevance due to the lack of systematic approach to gender, and is thus rated as **Satisfactory.**

Maono Singida School Eye Health - **Excellent**

In regard to the extent that the project was aligned to national policies and partners priorities, the overall scoring is **Excellent.** It is felt that the project was extremely relevant to the school eye health issues of the region as well as national policies and priorities for school health.

|  |  |
| --- | --- |
| **Effectiveness** |  |

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Maono Singida Sustainable Eye Care - **Satisfactory**

The project has definitely strengthened the eye health system in the region, through training of a range of staff in surgical and surgical support skills, data management and technical maintenance skills. In tandem with significant investments in infrastructure this has amounted to a much stronger capacity to provide eye care in the region, and training of primary health care staff and community groups has stimulated demand for services. Improvements could be made on provision of suitable spectacles to improve uptake and also in data usage to better understand patterns of access to services. There were some setbacks in realising the full potential of HR investments, but partly outside the control of the project. For these reasons, overall this criterion is rated **Satisfactory.**

|  |  |
| --- | --- |
| **Efficiency** |  |

****Maono Singida Sustainable Eye Care – **Satisfactory**

Maono Singida School Eye Health – **Satisfactory**

Although there have been some implementation difficulties arising, overall in both projects, challenges have been dealt with promptly and proactively, and some have been, to some extent, outside the responsibility of the project. In other cases, there is scope for improved and more efficient planning through foresight and the learning gained, especially for the School Eye Health project. For these reasons, the criterion of Efficiency is rated as **Satisfactory** for both projects.

|  |  |
| --- | --- |
| **Impact** |  |

Maono Singida School Eye Health – **Attention**

The school screening project has been implemented under a short time scale and is understood to have been the first of this type run by Sightsavers in Tanzania, and it may have been a rather steep learning curve which was exacerbated by some initial delays in procurements. Nevertheless, it has reached very high numbers of children for primary and secondary screening in just two years, and anecdotal evidence indicates that children who took up wearing spectacles at school have significantly benefitted. However, contextual, negative community and parental attitudes have reduced the impact of the project by limiting the number of children who accepted spectacles and continue to wear them. Under this criterion, the project is therefore marked as **Attention** as there is a rich and valuable amount of learning generated by this project, and a key opportunity for further investigation and learning to be incorporated in future programming. The learning generated from this will help to fully realise the potential for significant impact that this sort of project has on school children’s education and well-being.

****Maono Singida Sustainable Eye Care - **Satisfactory**

The project team and partners have worked hard and very effectively at advocating for higher levels of government funding through continual advocacy in a variety of ways and within crucial decision-making mechanisms such as district and regional planning processes. Rather than allowing partners to become donor dependent, this has maintained the emphasis on the need for domestic funding sources. In terms of the impact of the advocacy this is rated as **Satisfactory,** as while the indications of influence are very good, budgets are still highly variable and may not represent a sustained and solid commitment to eye care in the future.

|  |  |
| --- | --- |
| **Sustainability** |  |

Maono Singida Sustainable Eye Care - **Excellent**

The creation of a financing framework strategy and the clear examples of advocacy efforts and results which it has generated, demonstrate extremely good progress in strengthening the focus on government funding of eye health and alternative financing mechanisms. This can be a challenging aspect of eye health services. There is a lack of a formal monitoring and evaluation process for the financing framework, and a reliance on narrative reporting of progress, so this aspect could be strengthened. Nevertheless, this is a really promising start on a long journey to full financial sustainability. This section is rated **Excellent** in recognition of the major steps done in the area of sustainability, which many projects struggle to tackle**.**

Maono Singida School Eye Health - **Attention**

While the establishment of a revolving fund for spectacles to support the funding of eye care services is an excellent idea and has begun well, there is not enough evidence that it is being implemented in a way that takes account of target groups for spectacles sales, nor is being tracked in a financially sound manner. Therefore, in relation to sustainability this project is rated **Attention.**

|  |  |
| --- | --- |
| **Scalability/replication** |  |

****Maono Singida Sustainable Eye Care - **Satisfactory**

Maono Singida School Eye Health - **Satisfactory**

The approaches to provision of sustainable eye care services are tried and tested methods, and have been implemented well in this context, so are rated as satisfactory. The school screening services are an excellent conceptual model but have not been implemented in a way which should be replicated. However, on balance replicability is rated as mostly met for this project, so long as the significant implementation learning is taken on board. Overall, this criterion for both projects is rated as **Satisfactory.**

|  |  |
| --- | --- |
| **Coherence/coordination** |  |

Maono Singida School Eye Health - **Attention**

In terms of the Coordination criterion, this is rated as **Attention.** Although there was clearly good ministerial level coordination at the outset regarding the overall strategic aims of the screening programme, in the stages of more operational implementation it is felt there were gaps in the engagement with teachers about the overall aims and schedules for primary screening.

**Summary and conclusions**

Both projects have been found to be highly relevant to the eye health needs of the region. The Sustainable Eye Health project has increased awareness on women’s eye health needs among eye health partners and managers, and considerable effort has been made to encourage women in communities to come for treatment. The project’s implementation has been very well integrated into existing health systems and has considerably strengthened the eye health provision capacity through infrastructure, human resource training and HMIS investments. The project has the recognition and support from senior health figures. In addition, project advocacy appears to have influenced levels of funding for eye health and has helped establish the financing initiative to improve sustainable income streams for eye care. The School Eye Health project has been welcomed by health and education staff and has reached very high numbers of children in just two years. However, there have been aspects of implementation which have not gone as planned, or which could have been done more effectively. Both projects have elements which are replicable / scalable.

**Lessons learnt**

Reaching women for eye health services still presents a challenge, and additional strategies need to be developed to improve the gender balance towards women, for those accessing services and taking up surgery in order to meet the targets set. Collaborative approaches and sustained advocacy for financial sustainability can increase commitment to eye care. For School Eye Health, engaging communities in sensitisation activities before initiating a screening programme, and also involving teachers in the design of such activities, would be a benefit. The barriers among parents to supporting spectacle wearing for children have been found to be very high, and these need to be addressed if project investments are not to be wasted, and for the full potential of such a programme to be realised. Better coordination and planning are required in areas such as teacher numbers trained being appropriate to school size, and clearer guidelines, screening schedules and protocols developed to support teachers screening work.

###### Recommendations

**Recommendation 1:** Detailed analysis of gender disaggregated project data should be conducted to better understand trends in uptake, for instance, according to service delivery type (i.e. outreach or static facilities) and by district, and use this in combination with upcoming barrier analysis study to develop additional strategies for reaching more women.

**Recommendation 2:** Ensure that there is cross country learning occurring from other Sightsavers projects, and other SiB projects in East Africa or similar contexts of any successful strategies employed elsewhere to encourage the uptake of eye care by women.

**Recommendation 3**: The newly trained Assistant Medical Officer in Ophthalmology (AMOO) at Sokoine should be provided with as much opportunity to consolidate surgical skills learnt by conducting surgeries at other facilities which have appropriate equipment or conducting surgeries at outreach.

**Recommendation 4:** In future projects, to report on patients treated across all treatment categories disaggregated by services provided at static facilities versus outreach events in order to better understand any emerging trends of patients accessing different types of service. This will support planning and also provide more detailed evidence of changes in numbers accessing all types of eye health services.

**Recommendation 5** In future school screening projects, consider capturing and reporting a) number of children identified with an eye problem at primary screening, and b) cases of ocular morbidity (OM) as well as OM treatment given, and to use analysis of such data, as well as supervision visits, to review screening practice to improve efficiency and effectiveness of screening, if necessary.

**Recommendation 6: Any new funding for school eye health in the Singida region should include at least some** continuation activity at the same schools engaged under this project.

**Recommendation 7: Future school screening projects should ensure adequate and appropriate parental, child and community sensitisation prior to any screening activities, and to explicitly include ward and village leaders. Initial consultation with teachers in chosen districts should also be considered in support of this. Sensitisation activities should recognise that** different target groups: i) parents, ii) children, and iii) community, may require different approaches.

**Recommendation 8: Future school screening projects should ensure adequate and appropriate sensitisation of school management teams, (in addition to the primary screening training conducted for teachers) in order that a more coherent programme is developed.**

**Recommendation 9: Future school screening projects should give consideration to the size of the selected schools when determining numbers of teachers to be trained to conduct primary screening, so that numbers of trained teachers are commensurate with pupil numbers.**

**Recommendation 10: Indicators and systematic reporting of income and expenditure on spectacles (if not for all eye care services) should be enhanced to better understand the percentages generated from and spent on spectacles and other eye care activities. This data capture should use existing financial management indicators and reporting within the health system, if robust enough, where possible.**

**Recommendation 11: Recognise the limitations of trying to generate income in poor and rural communities where individuals are less likely to have the means to pay for spectacles, or may have exemption certificates, and to factor this into any revolving fund for spectacles for school screening projects.**

### Introduction and background

##### Background

The Singida region of Tanzania is home to 1.5 million[[3]](#footnote-3) people, however the region was not prioritised in the NECSP 2011-2016, despite being one of the most underserved regions in the central zone. In response to this, the Maono Singida[[4]](#footnote-4) Sustainable Eye Care project funded by the Standard Chartered Bank was launched in April 2016 to contribute to the sustainable provision of eye care services in the region, focusing on demand creation and improvements in current delivery mechanisms. This was followed by the commencement of the Maono School Eye Health project, also funded by Standard Chartered Bank which began in January 2018. Both projects contribute towards sustainable provision of eye health services in the Singida region of Tanzania. This report presents the findings from the end term evaluation undertaken between 1st March and 30th June 2020 by a team of consultants from Tropical Health.

##### Purpose of evaluation

The end of term evaluation was commissioned to review the achievements of both projects against their objectives. Through secondary and primary data triangulation, the evaluation was designed to explore the extent to which the projects’ objectives have been accomplished and what have been the factors affecting or influencing the achievements including experienced challenges, according to EQs presented in the evaluation Terms of Reference (Appendix 1). The target audience for the report is funders, partners, programme staff and global programme support teams within Sightsavers. It is intended that the learning, findings and recommendations emerging from this evaluation will be important for Sightsavers’ and partners’ wider programming design and decisions.

##### Project description

Both the Maono projects have been implemented in seven districts in Singida: Singida Municipal, Singida District, Ikungi, Iramba, Itigi, Manyoni, Mkalama. The Maono Singida Sustainable Eye Care project, which began first in April 2016, was centred on treating adult cataract. In addition to this, in 2017 Standard Chartered Bank provided funding for expansion of the project to reach school children and teachers, and in January 2018 Maono Singida School Eye Health project commenced. This second project aimed to address visual impairment of primary school children in the region which was found to be around 5% in neighbouring countries[[5]](#footnote-5). The two projects' key objectives are:

**Maono Singida – Sustainable Provision of Eye Care project – Objectives**

**1:** Strengthened eye health systems to deliver eye health services in all six districts of the Singida region.

**2:** Men and women with visual impairment access eye health services in the six districts of Singida.

**3:** Increased support and commitment to eye health from local and central government.

**Maono Singida – School Eye Health project objectives**

**1**: Strengthened human resources and health facilities to deliver refractive error services.

**2**: Girls and boys with refractive error and visual impairment access eye health services.

Together the projects intend to reach over 300,000[[6]](#footnote-6) people, consisting of eye care patients and health personnel.

##### Methodology and ethical considerations

###### Evaluation Approach

The evaluation approach used the framework of the ten key EQs identified in the evaluation’s ToR in order to explore the areas of interest identified and to validate the achievements, performance and impact of the project objectives. It also sought to assist better understanding of the drivers of success and challenges experienced, and to capture additional learning. The evaluation used a health system strengthening lens to assess the project, based on the World Health Organisation (WHO) six building blocks.[[7]](#footnote-7) The evaluation also assessed the extent to which it has been possible to implement the agreed projects mid-term review (MTR) recommendations and associated action plan formulated in the Management Response. Data from both primary and secondary sources was utilised. Analysis of quantitative output data assessed performance against project targets and linked this assessment with the qualitative investigation of key successes and challenges. The evaluation uses the following criteria as the basis for assessment, analysis and reporting: relevance, effectiveness, efficiency, impact, sustainability, scalability/replicability and coherence/coordination[[8]](#footnote-8), and produces a rating under each of the extent to which the projects have met the criterion in question (see Appendix 2 Evaluation Criteria Rating). The report produces a set of specific recommendations for similar, future project designs, while identifying any further cross-cutting or organisational level lessons and key learning points.

At the outset, the evaluation planned to explore the EQs through a variety of methods, which included a combination of documentation and data review, skype interviews and a field trip. However, the emergence of the Covid-19 pandemic meant that the evaluation had to be re-planned and undertaken as a desk-based evaluation, as data collection which involved face-to-face interviews or meetings with study participants was prohibited in Tanzania and travel to or within Tanzania was restricted (see section 1.4.6 below and Appendix 3 COVID-19 response).

###### Evaluation design

**Scope**

The two projects were evaluated against the following periods: Maono Singida Sustainable Eye Care project: 1st April 2016- 31st March 2020, and Maono Singida School Eye Health: 1st January 2018- 31st December 2019. Key informants from relevant levels of regional and district government health and education departments and staff were interviewed across five of the seven districts. The criteria for site selection locations were decided with project staff according to relevance to the EQs and what was feasible within the timescale. In addition, quantitative output data for the project as a whole was analysed to assess performance against project targets.

**Team roles and responsibilities**

The evaluation team comprised of a Team Leader based in the UK, and a Team Member based in Tanzania who collected primary data, both of whom were supported by the team at Tropical Health.

**Phasing**

The evaluation consisted of three phases (see Appendix 4: Detailed Evaluation Workplan). During the ***inception phase*,** the evaluation team reviewed background documents/data to inform the evaluation methodology and to understand the project context and develop an Evaluation Matrix to detail the specific lines of enquiry to address the EQs. The team took part in two kick-off and planning meetings to clarify available data, prioritise key informants, and plan data collection[[9]](#footnote-9). The ***data collection phase*** involved both desk-based review and analysis of quantitative data collected under the project across the seven districts. In-depth primary qualitative data collection at regional and district level was conducted remotely as telephone and skype interviews with key informants (see Appendix 5: Key Informants). The ***data analysis and report writing phase*** involved the collation and analysis of both primary data collected and further analysis of secondary data (document review and quantitative project outputs). Initial findings were shared and discussed with the Sightsavers project teams, soon after the data collection period. Preparation of draft and final reports includes one round of consolidated comments from Sightsavers and a second round focused on ensuring all initial comments have been addressed.

###### Ethical considerations

Informed consent or assent were obtained from all informants, guided by the Information Sheet and Consent Form (Appendix 6). In-country ethical approval was not required. However, the Sightsavers country offices reviewed topic guides and consent procedures in advance of data collection to advise on appropriateness. All evaluation consultants have completed UNICEF’s ‘Ethics in Evidence Generation’ course and read the Sightsavers’ Safeguarding Policy, Sightsavers Ethical Considerations in Evaluations and signed the Code of Conduct. All identifiable data, including recordings, are stored in a secure location, e.g. password encrypted files. Only those directly involved with the evaluation have access to them. Data has been de-identified at the analysis and reporting stages.

###### Data collection methods

**Key Informants**

Appendix 5 describes the categories of informants who were consulted during data collection and their roles in the project. The list of key informants was developed based on the list of key stakeholders provided by Sightsavers, review of project documents and initial discussions with the project team, and represents the main actors involved in delivering the project. In total, 47 key informants were interviewed (against a planned target of 46) during 47 interviews conducted (against a planned target of 46). Scope for group interviews was explored during the planning but was discounted as it was deemed technically difficult to arrange as most interviews were conducted by telephone.

**Primary Data Collection**

Topic guides were developed for the various informant groups and were designed to be adapted according to the type of key informant or informant group (Appendix 7 – Interview Topic guides). These were reviewed by Sightsavers’ country staff for appropriateness in advance of data collection. All the approaches used semi-structured guides to ensure exploration of all EQs, while allowing for new/unexpected perspectives to be raised. The Tanzania-based team member conducted interviews with key informants by telephone across the following selected districts: Singida Municipal, Iramba, Manyoni, Singida District and Mkalama during the period 11th – 21st May 2020. Interviews were conducted in English or Swahili, as preferred by the informant. The Key Informant Interviews (KIIs) took approximately 20 – 90 minutes and were conducted by telephone or by skype, as appropriate, in an undisturbed, confidential environment. Key informants other than teachers, were selected using purposive sampling. The teacher interviews were selected through random selection of six primary schools (and an additional two back-up schools) from each of the five selected districts. From this sample, one teacher, of the two who had been trained at each of the selected schools, was randomly selected. If a teacher was unavailable, the back-up strategy was for the second teacher from that same school to be interviewed. If the second teacher was also unavailable, then one of the two additional back-up schools in that district would be randomly selected and teachers drawn from this list by the same method. Where possible interviews were recorded electronically as back-up to notes written during interviews. Summary transcripts of notes were produced for further analysis.

**Secondary Data Sources**

**Document review:** Quantitative and qualitative information as reported by the project or evidenced in national documents was collated by the team leader. The document review was iterative, with documents revisited and additional information reviewed throughout the evaluation to cross-reference findings. Appendix 8 presents the list of documents provided by Sightsavers and other project partners or sourced by the evaluator, and shows the 44 documents which have been reviewed.

**Project output data:** Quantitative output data was collated using a quantitative data tool (Appendix 9 – Quantitative Data tool) as part of the document review, drawing from project data and reports.

The extent to which it has been possible for the project team to implement the agreed MTR recommendations and associated action plan formulated in the Management Response was assessed via a Self-Assessment tool (see Appendix 10) which was filled in by Sightsavers project staff and validated by the evaluation team.

###### Analysis and projection of evaluation report

Thematic analysis of KII data followed the ‘framework’ approach[[10]](#footnote-10) under the structure of the EQs. Quantitative output data was analysed in Excel to assess performance against project targets (Appendix 9). Data from all sources was triangulated, through review and comparison of themes across all sources, and through dialogue within the evaluation team.

###### Limitations of the evaluation

The desk-based approach, which had to be undertaken due to the COVID-19 pandemic, meant that no field visits to actual health or educational facilities could be undertaken. Every effort was made to conduct the originally planned evaluation as a desk-based exercise, but this meant that Focus Group Discussions (FDGs) originally planned with school children could not be carried out, thus the evaluation is based on adult interviews only. Nor could any observations of facilities and project activities be captured. However, due to time saved travelling to locations a more random and wider selection of teacher interviews could be undertaken to include 30 schools. Interviews with health staff had to be mindful of avoiding any additional pressures on staff during the COVID-19 pandemic, and it was not possible to include Ophthalmic Assistants (OAs) in the schedule, although senior interviewees such as District Medical Officers (DMOs), were available.

The breadth of the lines of enquiry in the TOR evaluation questions across two projects, and the absence of FGDs with children meant that there were limitations to the extent of cross-cutting enquiry and analysis on gender equity and inclusion under the School Eye Health project.

Some time was lost on conducting secondary data analysis on a data set which was later said to be inaccurate (collation spreadsheet). This meant that some analysis had to be done again using a different data source[[11]](#footnote-11) provided towards the end of the evaluation. This meant less time could be spent on other areas of analysis.

##### Report structure

The report structuring follows the structure of Sightsavers Evaluation Criteria presented above. Recommendations emerging for the evaluation findings are situated within the relevant topic discussion section, and also summarised at the end of the report. Twelve Appendices are included, which include the Evaluation Terms of Reference, Criteria Rating, Covid-19 Overview, Evaluation Workplan, Documents Reviewed, Informed Consent Form, List of key informants, Key informant interview guides, Quantitative Data Tool, MTR Management Response action plan self-assessment form, table used in MTR to assess Gender Mainstreaming workshop action plan and the DEC report template. Throughout the report, the two projects are referred to as the Sustainable Eye Care project and the School Eye Health project, respectively.

### Results

This chapter presents the main findings of the evaluation based on the seven criteria as specified in the TOR and their specific lines of enquiry. It should be noted that some EQs relate to both projects and some to just one. This is indicated under each EQ. For each of the EQs under consideration the evaluation team has given a rating on the extent to which the evaluation criterion has been met. The Evaluation Criteria Rating is explained at Appendix 2. The evaluation team has used these definitions to assign a rating to each of the evaluation criteria, based on the findings and evidence presented in this evaluation report.

|  |  |
| --- | --- |
| Relevance |  |

**Evaluation Question 1: *Sustainable Eye Care project -* the mid-term review highlighted further support around reaching women. What has been done to explore and overcome barriers women might face when accessing eye health services? How have the gender mainstreaming workshop’s recommendations and actions plans been implemented and what has been the result?**

Low uptake of screening and treatment services by women is a common problem in the African setting due to barriers such as the domestic nature of women’s work which may prohibit them taking time away from home, low decision-making power about finances within the household. This EQ considers what is known about this in the region and what the project has done to overcome these barriers.

**Level of prevalence and barriers faced by women**

The Rapid Assessment of Avoidable Blindness (RAAB) funded by the project and undertaken in the Singida region in June/July 2017 has been a key source of data for the project on the level of eye health needs in the region, and the gender dimension of these. It revealed that the prevalence of blindness in the region for those 50 years and older is estimated to be 3.9% for men and 5.2% for women[[12]](#footnote-12). Untreated cataract was found to be by far the most common cause of blindness at 70.5% of cases in this age group. It was also the cause of severe and moderate visual impairment in 82% and 60.3% of cases, respectively, with women in the Singida region estimated as more than twice as likely to be bilaterally blind from cataract (2.6% female vs 1.2% male)[[13]](#footnote-13). The RAAB also found that, in terms of who had previously been treated, there is a higher coverage for cataract surgery for males (CSC[[14]](#footnote-14) = 65.1%) than females (CSC = 43.1%). Thus, the study confirmed that not only do women suffer from higher prevalence but also are less likely to receive surgery in the region.

It is widely acknowledged that reaching women for eye care services is challenging. The RAAB included questions on why treatment for cataract may not have been sought. The most common barriers found were cost of treatment, and lack of awareness that treatment was possible, and that these barriers were also experienced by a higher proportion of women than men. However, the number of respondents to this question (n = 185) is a very small proportion of the overall number taking part in the RAAB (3,722 people), so these findings cannot be assumed as representative of community attitudes, and clearly a deeper understanding of the specific barriers to women in these districts is needed.

KIIs undertaken as part of this evaluation confirmed common beliefs that there are barriers to women. These include the fact that men in the family tend to be the decision makers over household finances and need to give permission for wives to go for surgery. There is a strong cultural perception and expectation that women should always be at home to do domestic duties. Reticence by women to take up surgery is also exacerbated by the cataract recovery instructions not to be in a smoky environment such as cooking areas for a week after surgery, which clearly has implications for women’s work when returning home from surgery.

**Project strategies and activities to address gender issues**

As with many Sightsavers projects, the Sustainable Eye Care project makes specific efforts to address these gender disparities in its implementation. All data is disaggregated by sex, both patient and training recipients, and the gender balance of patients reached is regularly reported in donor reports, so it is clear that there is a gender-aware mind set among project staff from the outset. At project design stage, RAAB data for Singida was not available, and the gender targets for screening and eye care treatments were set at 50:50 female to male. However, once RAAB data were available these were revised for the remainder of the project to be 55:45 female to male for 2018, 2019 and 2020. This does not fully reflect the prevalence of cataract found in the RAAB but was seen as an appropriate expectation given the population dynamics of the region.

The project has also clearly tried to address these issues through awareness raising and messaging which specifically focuses on encouraging women, as well as other disadvantaged groups such as those with disabilities, to undergo cataract surgery through a number of different channels. Throughout the project there have been continuing and increasing community mobilisation messages to women in particular, and the involvement of senior figures to reinforce this in public messaging[[15]](#footnote-15).

As part of the project’s radio community sensitisation campaign in April – Sept 2019, the Singida Regional Commissioner made direct appeals to women during eye health sensitisation radio messaging, before and after the news,

*“To all my fellow women, I encourage you to accept to undergo cataract surgery when found in need of one. This is because the surgery is safe and will not hinder you from your roles but rather enable you to carry out your activities more confidently. As a woman, it will enhance your productivity as you contribute to our country’s economic position as a middle-income country.”*

The project has taken the step to involve Regional/District Social Welfare Officers (R/DSWO) which has helped to increase the gender focus and also disability inclusion. These officers work with the most vulnerable, including people with disabilities, to make sure they access the health services they need. Engagement of this cadre has helped the project to tap into and coordinate with sectors other than health departments which are concerned with social welfare. The Regional Social Welfare Officer (RSWO) liaises with the Regional Health Management Team (RHMT) and Council Health Management Teams (CHMTs) to consider gender issues in their planning, such as outreach activities, to make sure more women are targeted and reached. A key role of the R/DSWOs is also making sure those who are exempt from paying for services do indeed receive free treatment through social welfare department exemptions at each council, and this can specifically favour women who may not have their own finances. This also applies to other vulnerable groups such as those with disabilities. Including this type of partner in project planning and activities supports a stronger focus on women and people with disabilities.

Village Health Workers (VHWs) have been trained on primary eye care but also on the gender dimension of eye care, so that they can specifically help create awareness among women in the region, and encourage referral to eye care services in the district, especially during outreach activities. The project has also worked directly with some women’s groups locally in the region to encourage uptake of eye care services offered by the project. The project has invested time in sensitising 55 women’s groups to eye heath (five in Yr1, 28 in Yr2 and 22 in Yr3)[[16]](#footnote-16), and has also been identifying female positive-outcome cataract patients to be ambassadors for surgery in their communities. The project team feel that these activities can be correlated to observed increases in female patient numbers during the same reporting period.

*“Fifteen women’s groups from Iramba (7 groups) and Singida Rural districts (8 groups) were oriented and trained on eye health services to encourage more women to participate during outreach services and subsequently agree to undergo cataract surgery (as necessary)... in Iramba district, 113 women have undergone cataract surgery compared to only 31 in the last reporting period. In Singida Rural district, 152 women were operated compared to only 31 in the last reporting period. In total the number of women accepting cataract surgery has increased from 397 in the last reporting period to 884 in this period.” [[17]](#footnote-17)*

Social Welfare Officers also mentioned that these trainings have started to work with women’s groups’ husbands who are also trained together during those gender trainings. Reaching out to male counterparts in sensitisation activities, is likely to be an important initiative as men tend to be the main decision-makers, they are therefore also most likely to be agents of change in the situation. Indeed the evaluation team was informed that other Sightsavers projects (e.g. in Mozambique) have prioritised not only women coming for screening and surgery, but also men who bring their wives are given priority over other men who have come alone to eye services. This has apparently been a successful strategy, and clearly gives a message that allowing your wife to have access to services is a valuable thing (even if only to help oneself).

Strategies employed at service delivery point have also changed during the course of the project. The outreach camps used to be organised with two days of screening followed by a day of surgery for those diagnosed. Now, the outreach is run so that all women identified for cataract surgery are operated on the same day as diagnosis to reduce the risk of them not returning for surgery after diagnosis. Outreach eye camps themselves were also felt to have a gender dimension by key informants, as they are a way of serving more remotely placed populations, but also women in particular, because they reduce the travel time and cost required. Both of which are thought to be common barriers experienced by women.

**Gender mainstreaming workshop**

A key event in Tanzania was a gender mainstreaming workshop held in Feb 2017 in which the project team and certain partner staff participated. Key informants in the evaluation who had not had any prior gender sensitisation felt this event was very useful and capacitated them on how to engage with, and identify people with disabilities and manage gender issues. The workshop provided R/DSWOs with a tool to support collection and analysis of statistics on people with disabilities, and this is currently being used in the whole region for records. Some informants who had been participants had been unaware of how to conduct gender analysis but can now use the skills gained during the workshop i.e. the four ‘A’s approach (awareness, affordability, access and availability) in routine duties even in other health areas. Since the gender workshop there was an initiative by the R/DSWOs to discuss what were the best approaches to reach women’s groups with Village Health Workers. As a result of this various different types of groups such as VICOBA (Village Community Banking) which was set up across the country by CARE Tanzania, have been visited and gender training conducted on women’s empowerment and other issues. Some of the Tanzania Country Office (TCO) project staff have also made contact with other gender-orientated organisations and other community-based organisations focusing on marginalisation (Tanzania Gender Networking Programme (TGNP) and SHIVYAWATA) at the national level to gain more insight into these issues from a broader perspective. The project team fully recognise the challenges of reaching more women and some informants acknowledged that the workshop had helped identify gaps and shown how to target more women than men, but it did not come up with solutions to challenges.

Another intention of the workshop has been that learning and raised awareness of gender in eye health programming acquired at the workshop would be cascaded out to other partner staff. The TCO MTR Management Response Action Plan (Appendix 10) acknowledged the need to continue following up with focal persons and regional and district key decision makers. Interviews with senior health informants do indeed confirm that gender is now a regular topic at planning and senior level meetings with health management teams and the Regional Authority, as a result of the advocacy and awareness raising on gender through the project.

The workshop report made available to this evaluation did not contain any recommendations so this cannot be commented on, however an Action Plan was devised. This was assessed by the MTR of the project undertaken in 2018, and has been reassessed by this evaluation. All actions now appear to be complete (see Appendix 11).

To understand barriers to women in more depth, the RAAB report recommended that a study should be undertaken to investigate this. The MTR also recommended a market research/observational study on barriers to women accessing eye health care. Although there was no project funding for this available at the time, it was recently commissioned using project extension funding. This should help to deepen understanding of the particular obstacles faced by women so that more targeted strategies could be developed. Unfortunately, this is not yet available from the commissioned consultant so cannot be reviewed by the evaluation team for this report. This will be useful for future projects but unfortunately comes too late in this project to enact any recommendations (see Appendix 10).

While there is an increasing occurrence of reporting to include gender disaggregated results (as evidenced in project reports), there is scope for more gender analysis to be conducted for various time periods, examination of data by district, or of outreach compared to static facility services. This could help identify any gender trends and take account of circumstances that may skew data, such as one of screening events for specific groups. For example, in the first half of Year 3, 16,473 people (7,121 women and 9,352 men) were reached. The lower number of women reached during that particular period was in part due to the screening of drivers, the majority of whom were men[[18]](#footnote-18). This evaluation has not had the capacity to do this, but it is recommended that Tanzania Country Office conduct deeper analysis of existing data to understand the situation better based on existing project data to inform future projects. In combination with the upcoming findings from the study on barriers to women, this could provide very useful learning to address the gender dimension of eye care.

* **Recommendation 1:** Detailed analysis of gender disaggregated project data is conducted to better understand trends in uptake, for instance, according to service delivery type (i.e. outreach or static facilities) and by district, and use this in combination with an upcoming barrier analysis study to develop additional strategies for reaching more women.
* **Recommendation 2:** Ensure that there is cross country learning occurring from other Sightsavers projects, and other SiB projects in East Africa, or similar contexts to include successful strategies employed elsewhere to encourage the uptake of eye care by women.

In conclusion it is fair to say that the project has employed a range of different strategies and activities to engage women and raise awareness of female eye health needs both among communities and also among health partners at operational and senior levels, and the gender workshop encouraged and supported this activity. During short term time periods such as outreach, it is suggested that there’s evidence that community sensitisation has been effective. These project efforts and approaches may well be influential, but changes in attitude and behavioural norms take time, and although there may have been short term increases during particular 6-month periods, sustained increases are not evident from the project data examined.

The gender dimension is an extremely relevant issue in the uptake of eye services. The project has made considerable efforts to address this dimension in a number of ways and described above, although a systematic approach to analysing gender trends has not been undertaken. However, as deeply set social norms still exist and it would be hard to expect these to change over a four year time scale. An overall rating for the Relevance criterion for this project is given under Evaluation Question 2, below.

Evaluation Question 2: *Both projects* - How were both projects aligned with national health systems policies/ government priorities for eye health/ implementing partners?

Maono Singida Sustainable Eye Care

The Sustainable Eye Care project aligns with Vision 2020: The Right to Sight global initiative, and the project was designed to be firmly in line with the NECSP 2011-2016, as is clear from the project proposal. For example, project objectives were aligned with priorities laid out in the NECSP 2011-2016 including increasing the availability of skilled eye personnel at all levels, enhancing eye care infrastructure, provision of equipment and supplies, and enhanced community awareness, while the design and implementation approach of the project fostered collaborative capacity building through the participation of governmental and non-governmental stakeholders at a variety of levels[[19]](#footnote-19).

In terms of national eye health priorities and policies, Vision 2020 was ratified by the Government of Tanzania in 2003 and it underpins the stated goal of the NECSP 2011-2016. As Sightsavers is one of the founding members of Vision 2020, projects designed by them have this initiative at their heart. Although the region of Singida was not prioritised in the NECSP 2011-2016, it is one of the most underserved regions in the central zone with a scarcity of Non Governmental Organisations (NGO) to support eye health services at scale, thus making this sort of project highly relevant.

The RAAB and other Sightsavers’ supported assessments, including an Eye Health System Assessment (EHSA) at national level in 2017, provided guidance and input for the next strategic national eye health plan spanning 2018-2022, which has its stated strategic objective as,

*“This strategic plan builds on the second eye health strategic plan 2011 – 2016, and aims at decentralizing eye health care, and primary health care scale up, down to community level. Also, one of the main features of this third eye health strategic plan is innovative strategies to finance and sustain eye health care*.”[[20]](#footnote-20)

In regard to this later strategic plan, the Sustainable Eye Care project focuses on development of human resources for eye care especially at the primary level, with the training of some 289 primary health workers in eye care. The project also has a key initiative on eye health financing, having commissioned a study to develop a financing framework to support moves towards sustainability, both of which are key components of the strategic aims above (discussed specifically in section EQ7 below).

The EHSA Tanzania[[21]](#footnote-21), carried out in collaboration with MoHCDGEC and other specialists gave a number of recommendations for improving eye health systems in the country, and the project is contributing to the following EHSA recommendations:

Financing

* Earmark allocations for eye health in the government’s health expenditure;
* Establish mechanisms for ring-fencing eye care revenues at the facility level;

Service delivery

* Develop guidelines and establish mechanisms for the regular monitoring of cataract surgery outcomes;

Human Resources

* Develop strategies to address challenges in training mid-level personnel for eye health;

Health Management Information System (HMIS)

* Develop mechanisms for capturing eye health data from national and zonal hospitals, outreach activities and private sector providers;
* Strengthen capacities for collating and analysing eye health information at all levels.

Key informants confirmed that each leader at regional and district level is advised to reinforce eye care policies, and Singida region has been seen as a pioneer region across the country. At the regional level, as a result of Sightsavers work, eye care coordinators indicated that the ‘regional authority including the Regional Commissioner have been front-liners in advocating for eye care at community level, schools and health facilities’.

In summary, under the criterion of Relevance, the gender dimension of this project is an extremely relevant issue in the uptake of eye services. The project has made considerable efforts to address this dimension in a variety of ways. However, as deeply set social norms still exist and are liable to change slowly, a systematic approach to analysing gender trends is needed but has not yet been undertaken. The project is seen as satisfactory in this regard. In relation to the alignment of the project with national policies and partners priorities this was felt to be excellent. Overall, considering both the TOR evaluation questions under Relevance for this project, it is concluded that the project mostly meets the aspects of Relevance due to the lack of systematic approach to gender, and is thus rated as **Satisfactory.**

****Maono Singida Sustainable Eye Care – **Satisfactory**

Maono Singida School Eye Health

The School Eye Health project was begun in January 2018 as an extension and complement to the Sustainable Eye Care project, which was already running. The project is delivered under a contractual agreement between Sightsavers and the Regional Secretariat, and has two specific objectives:

1. Strengthened human resources and health facilities to deliver refractive error services
2. Girls and boys with refractive error and visual impairment access eye health services

The control of blindness in children is one of the main priorities of the World HealthOrganisation’s (WHO) Vision 2020 (The Right to Sight) global initiative. Uncorrected refractive error (URE) can potentially cause delay in educational and social development for children, and in more serious cases OMs, and early diagnosis is critical especially in children. Outreach primary eye care services to schools is listed as one of the three priorities for primary eye care and community eye health in the strategic implementation plan of the National Eye Health Strategic Plan (NEHSP) 2018-2022. In addition the Plan aims to “Collaborate with Ministry of Education and local education authorities to reinforce vision assessment as a prerequisite for all school going children once yearly” as one of the elements of Strategic Objective 1: To foster Leadership, evidence-based planning, results-based management and coordination of the eye health in Tanzania[[22]](#footnote-22). School Eye Health addressed through school screening programmes is clearly a key policy objective under the NEHSP 2018-2022.

In terms of national priorities identified in the Education Sector Development Plan (2016/17-2020/21), school children’s eye health is considered under the School Environment section where Strategy 6 aims to “Strengthen school health and nutrition in collaboration with MOH” in order that *“*School health and nutrition services are available in schools, in line with national minimum standards”. This is envisaged through “providing schools with trained and equipped specialist teams in every region to help schools and communities identify children with special educational needs”, and would include support for those with minor sight and hearing impairment by working with health services to “ensure that they can be provided with spectacles or hearing aids if possible”[[23]](#footnote-23).

The School Eye Health project proposal is also based on the premise that school children can act as ambassadors for eye health and eye health services in this project, and will be an effective way of addressing broader issues of the need to raise awareness of eye health among children’s families, and thus the wider population. Although there is no evidence of this within the project, it does indicate the school screening project’s relevance to wider eye health issues.

The overall scoring for the School Eye Health project in terms of Relevance is **Excellent** as it is felt to be extremely relevant to the school eye health issues of the region as well as national policies and priorities for school health.

Maono Singida School Eye Health – **Excellent**

|  |  |
| --- | --- |
| 2.2. Effectiveness |  |

**Evaluation Question 3: *Sustainable Eye Care project -* How effective has the project been in strengthening the existing health system[[24]](#footnote-24) in: service delivery, health workforce, health information systems, access to essential medicines, financing and leadership/ governance?**

This report has assessed the effectiveness of the Sustainable Eye Care project in a number of ways and addresses the EQ across relevant WHO health system building blocks. One of the main approaches has been to consider project performance across logframe indicators using the Quantitative Data Tool (see Appendix 9) which assesses achievements against targets. Document review and KIIs were also used to obtain qualitative perspectives from across three project districts (Singida Municipal, Manyoni and Iramba).

Where targets existed and across the whole Eye Care project, performance can be seen to be generally on target or exceeding the targets across all but a few indicators (see Appendix 9). Those underperforming against targets below 80% were the number of spectacles dispensed (73% of target overall), the refurbishment of facilities (75% of target overall) and annual growth rate of patients receiving cataract surgeries (64% of overall target). These are all discussed below.

The rest of this section below considers this EQ across the health system building blocks indicated.

**Service Delivery**

Demand is clearly being stimulated by the project. Overall numbers screened under the project exceeded targets in Years 2 and 3, leading to an overall total of 83,944 people screened, a 98% achievement against the target. Those indicators on eye care treatments are generally in line with expectations although cataract surgeries are more consistently under target, while OM treatments are generally over target (see Table 1 below).

**Table 1 Numbers screened and receiving cataract and ocular morbidity treatments.**



**Cataract surgeries**

One of the Outcome indicators (outcome 1.3) looks at growth rate in cataract surgery year on year over the course of the project and compared to the baseline. It is an interesting indicator to include and it is presumed that the intention is to track the rate of growth of provision of services. The overall target average growth is an ambitious 73% (see Table 2 below). Calculating from indicator 1.1 (Table 2) the targeted growth for cataracts performed each year is – Yr1 125%, Yr2 25%, Yr3 100%, and Yr4 -33%, giving an overall target average growth of 55%, (see Table 2 below – red text denoted figures calculated by the evaluation), rather than 73% target given for indicator 1.3. Therefore, it seems that the targeting for outcome indicator 1.3 has not been aligned with the targeting for number of cataracts under 1.1. This may be considered as not very useful, although it potentially could be a useful indicator of expansion of service provision.

**Table 2 Calculated growth rate of cataract surgeries**



In terms of improved service delivery, eye health informants confirmed that before the project commencement there were very few diagnoses identified and almost all patients were given the same type of drug (eye steroids). However, as a result of the project there are now far more appropriate diagnoses due to improved diagnostic tools, and more drugs are being prescribed including different antibiotics. Also, with a wider range of diagnostic tools, current patients are given the right referral to the specialised services at appropriate facilities (e.g. SRRH) for specific care such as cataract surgeries.

**Surgical quality and cataract outcomes**

The project has included three outcome indicators looking at scale and quality of services to measure strengthened eye health systems (see Appendix 9) which indicates an increasing focus on outcomes and results in project monitoring and evaluation. The first was discussed under the section on Service Delivery (outcome indicator 1.3). The other two indicators are discussed in this section.

The Singida RAAB found that the visual outcome of those surveyed and who had previously received cataract surgery was below the WHO-recommended standard with only 54.7% having a good outcome and 26.1% having a poor outcome. The RAAB also noted that visual outcomes were better in people who were operated on in private and government hospitals as compared to those who were operated on in voluntary hospital and eye camps[[25]](#footnote-25). Cataract surgical outcomes are clearly a significant factor in contributing to the impact of eye surgery on the lives of patients.

At the beginning of the project an eye care protocol was developed with reference to the 2015 national guidelines[[26]](#footnote-26) which helped to establish and maintain quality procedures, including those for cataract surgery. In February 2018, the project undertook a second assessment using Sightsavers’ Quality Standard Assessment Tool (QSAT) at Singida Regional Referral Hospital (SRRH) to follow up on the baseline QSAT done before the project start in 2015. This shows significant improvements in the quality score of the QSATs conducted, from 56.0% in 2015 to 84.7% in 2018 (see outcome indicator 1.1 in Appendix 9 Quantitative Tool). These quality improvements have been mainly in the area of eye health workforce, post-training continuing professional development, and supervision, and patient and provider safety, which are likely to have an influence on cataract outcomes. This shows that SRRH cataract services practice is very good, and that as staff from this facility are supervising and supporting district-based staff, this bodes well for improving surgical outcomes across the region. There are numerous references in project reports about quarterly technical supervision visits for clinical staff from the REC and ophthalmologist from SRRH. This is very important as surgical skills develop and refine through practice, and following key protocols is extremely important for good surgical outcomes, and strong support from experienced clinicians is key. However, it is understood from KIIs that the ophthalmologist has relocated to another region, which will leave a significant gap in the eye specialist resourcing, and in the supervisory capacity available.

Surgical quality has also been considered directly through outcome indicator 1.2 which measures number of facilities using a cataract surgical outcome (CSO) tool[[27]](#footnote-27). Starting from a baseline of zero for this indicator, the project is now reporting that the target of four facilities regularly using the tool has been met (see Appendix 9) and Sightsavers Global Technical Lead for Eye Health ECSA confirmed that all facilities conducting surgery are using the WHO tool. The ophthalmologist from SRRH has been conducting supervisions of OAs and District Eye Care Coordinators (DECs) to ensure understanding of procedures on how to carry out and record follow-up with patients and CSO assessments.

The eye care team is hoping to move to a new CSO tool called BOOST[[28]](#footnote-28) which predicts outcomes from the 24 hour post surgical assessment. This reduces the need for patients to return for the normal four-week post surgical check-up, which is always difficult to achieve for 100% of cataract patients. Therefore, the establishment of BOOST will bring a huge advantage to the monitoring of CSO. Training on BOOST has been provided and both tools are being used in order to verify that the use of BOOST is capturing outcomes successfully.

While there appears to be some use of CSO monitoring tools at outreach camps, this is likely to be more difficult if patients are required to return for post-operative check-ups to a different venue from the camp itself. Considering the historically poorer surgical outcomes found by RAAB at eye camps, ensuring CSO monitoring is established in these services is of particular importance. This is important for the outcome itself, but also for the reputation of outreach surgery among district communities. The BOOST tool may be especially helpful in these settings.

**Refractive error services**

Refractive Error services were another main part of the project service provision. In terms of numbers reached, these have vastly exceeded targets for numbers of refractions, showing that the project has been meeting a large untapped need. This echoes the RAAB findings that uncorrected presbyopia is very high in the region, with 96.5% of people aged 50+ not having reading glasses[[29]](#footnote-29). Nevertheless, the project has been less successful in dispensing spectacles, which seems to have fallen off against targets during the project (see Table 3).

**Table 3 Number of patients receiving refraction and being dispensed spectacles**



The number of prescriptions helps to give the overall picture but is not captured in the logframe from which the Quantitative tool was taken, however, it is reported to the donor and also recorded in the collation spreadsheet. The data for refractions, prescriptions and spectacles dispensed is given below in Table 4.

**Table 4: proportion of those refracted who were prescribed and proportion dispensed spectacles.**



Table 4 above shows that the prevalence of URE to be high ranging from 52% to 83% of those refracted. However, as well as low number of spectacles dispensed against target, this table shows that the actual conversion rate of those prescribed spectacles, who took up spectacles on offer from the project is low.

The dispensing and sale of spectacles is discussed in more detail in section EQ8 below in relation to the revolving fund for spectacles, but it seems from project reports that part of this low uptake of spectacles was thought to be due to the SRRH not having the required strengths of spectacles, nor a range of options including stylish designs. It was found that only 35% of the people receiving prescriptions acquired their spectacles from the SRRH eye department in the period of April-September 2019[[30]](#footnote-30). It appears that once this was realised, the hospital ordered an additional 465 spectacles using the revenue generated from refractive error services.

**Health Workforce**

As an important aspect of health systems strengthening, as well as a NEHSP 2018-2022 priority, the project has trained important cadres of eye health staff to support not only surgical capacity in the form of AMOOs and OAs but also a technician in the first year of the project to support equipment maintenance, along with 16 staff (DECs and other relevant facilities staff) on using a computerised HMIS to support data collection and management for decision-making (see table 5 below).

**Table 5: Numbers of staff trained by the project during project term**

| Cadre of staff | Target | Male | Female | Total | Perf. % |
| --- | --- | --- | --- | --- | --- |
| No. of AMOOs trained | 4 | 2 | 1 | 3 | 75 |
| No. of OAs trained | 14 | 6 | 8 | 14 | 100 |
| No. of PHWs trained on PEC | 288 | 133 | 156 | 289 | 100 |
| No. of Equipment Technicians trained | 1 | 1 | 0 | 1 | 100 |
| HMIS staff and Eye Care Coordinators trained on eye care HMIS | 16 | 5 | 11 | 16 | 100 |

Source – Collation spreadsheet

The original plan was four AMOOs but due to limited availability of mid-level staff for training this was not immediately possible. Two AMOOs were able to be enrolled in October 2016 on the two year course. By the end of 2018 both were in post; one is working at Manyoni District Hospital in charge of the new eye unit once it was completed there, and the other is working at SRRH, and is also acting as the REC. A third trained AMOO is based in Singida Municipal (Sokoine Health Centre). The intention was that the third AMOO would be working at SRRH as well, but unfortunately due to administrative changes, permission for this is no longer in place and he continues to work at Sokoine Health Centre where he has no equipment or supplies to undertake his new surgical skills. A fourth AMOO has been enrolled now and will be placed in Iramba district, but will not be completing the two-year training at Kilimanjaro Christian Medical Centre (KCMC) until after the project has finished. The training in this case started later than intended due to lack of available places at KCMC and a lack of suitable candidates being identified in the first year of the project. Currently the OA in Iramba is acting as the DEC, and for surgical services, a surgeon comes from SRRH.

While the project has contributed three AMOOs (with a fourth in progress) who are able to perform cataract surgery and therefore add to the region’s eye health human resource pool, the full potential of this has not yet been realised due to delayed or constrained deployment. Much of this is outside the control of the project but emphasises the difficulties of working within the existing system where decisions beyond the influence of the project can significantly reduce the effectiveness of project investments and activities, as decisions about staff availability for project training and their subsequent deployment are largely made by the health departments.

* **Recommendation 3**: That the newly trained AMOO at Sokoine is provided with much more opportunities to consolidate surgical skills learnt by conducting surgeries at other facilities which have appropriate equipment or conducting surgeries at outreach.

The other components of human resources strengthening have gone more smoothly. Thirteen OAs (three men and 10 women) were enrolled in the first six months of project onto a 3-month course on eye care, with the fourteenth trained later on the project, and have been in post providing these duties since the second year of project. There was also an opportunity to train an optometrist at SRRH on low vision services on a 3-month course in India who qualified in Sept 2018[[31]](#footnote-31). Primary Health Care Workers (PHWs) have also been trained in primary eye care, one more than the target, with 289 trained, all during the first year (see Appendix 9: Quantitative Data Tool). The referral system improvements carried out by these PHWs are discussed under HMIS section below. Unfortunately, the ophthalmologist has now relocated to another region since June 2019, so there is no ophthalmologist in the region. The Medical Officer at SRRH has said they will be sending someone for training at KCMC but this will of course take four years until qualification. This represents a critical gap for the region, which is very regrettable, but one which is totally outside the control of the project

**Health Information Systems**

Another key element of the project was to improve HMIS and data collection and analysis. To this end, the project provided eight computers (twice as many as target) which have been deployed at SRRH and three district hospitals. Training of 16 staff members (DECs and other data staff) was undertaken in year 1 alongside computer provision in order to build capacity in hospital HMIS, and HMIS book number 16, which records eye health data and is now being used across all seven districts. Trained OAs enter the data by hand on paper forms at each health facility, and on a monthly basis this is submitted to the district HMIS Coordinators so data can be entered into the online database on the computers provided.

PHWs trained in HMIS (book number 16) are now able to record eye referrals systematically. This has been observed in Ikungi and Singida rural districts where it was confirmed by project monitoring visits that eye care Book no. 16 is used to record all eye patients who went for eye screening at health centres and dispensaries[[32]](#footnote-32). This information collected at the lower level facilities is seen as critical for facility planning and budgeting by eye health informants. In addition, referral advice is more organised now with clear guidance on designated centres for referral in the districts, rather than PHWs referring patients automatically to SRRH[[33]](#footnote-33). It would be interesting to know if attendance at district facilities has increased as a result, but successful referrals are not tracked by the project so this data is not available.

Informants also indicated that previously there was no data captured on cataract surgeries performed, but during the project these have now been incorporated in the HMIS. Eye care coordinators confirmed that more indicators were now included in the HMIS, which is felt to be assisting with planning services, as well as supporting the new diagnostic skills which clinical staff had gained from project training.

With improved data recording and management, there are opportunities for better understanding of trends in comparative numbers of patients accessing static or outreach services. While outreach plays a key role in providing services, eye health staff are keen that potential patients do not wait for the next outreach which may be some time away, but access cataract or other eye care services from relevant district static facilities as soon as they can.

* **Recommendation 4:** In future projects, report on patients treated across all treatment categories disaggregated by services provided at static facilities versus outreach events in order to better understand any emerging trends of patients accessing different types of service. This will support planning and also provide more detailed evidence of changes in numbers accessing all types of eye health services.

As well as HMIS improvements for data management, on the broader issue of data quality, it is confirmed that the Sightsavers Internal Auditor conducted an internal project audit in December 2017, which sampled SRRH and Ikungi district. The findings of the audit rated the data quality at 98%, which indicates eye care staff have developed a strong capacity for data collection and storage. The project team continued to assess the quality of data sent by districts using Sightsavers’ Routine Data Quality Assessment tool (RDQA). In January 2019, the project team conducted an RDQA in Manyoni for December2018 data[[34]](#footnote-34). HMIS book number 16, patient register books and major theatre operations books were reviewed to measure data accuracy, reliability, timeliness, completeness, precision, confidentiality and integrity. The overall score was reported as 93% in all areas assessed. In April, the same process was carried out in various districts with the following scores reported[[35]](#footnote-35):

* 1. Singida Municipal, which scored 90% (October 2018 data)
  2. Iramba, which scored 80% (October 2018 data)
  3. Ikungi, which scored 80% (January 2019 data).

It is evident to the evaluation team that donor reports contain many references to, and make use of, data to support narrative statements in reports. This indicates a recognition of the value of data reporting and the ability to use it effectively in reporting among the project team.

Nevertheless, during the evaluation itself, there was still a lack of correspondence between the data provided from the project in the collation spreadsheet used for project recording and that which came from other sources, such as donor reporting, a problem which had been identified during the MTR as well. This may be partly because there are a number of different data systems into which project staff have to input or collect data from; DEC records from health departments and outreaches, project collation spreadsheet, donor report appendices and the Sightsavers project portal. Efforts have been made by the central Sightsavers teams and project teams to align and rationalise data recording and reporting, but it does appear to be a complex task for both the project team and partners, in terms of the number of different formats and systems. Nevertheless, there has been a lot of energy and activity put into improving data collection and data quality, and progress appears to have been made within the health system itself, which is of main importance.

**Essential Medicines**

In terms of the supply chain for medicines and consumables, interviews indicate that the project team and partners were broadly happy that this was functioning well, and were pleased to have received support through the project in this aspect of the system. Informants also confirmed that this has also encouraged demand as people have found medicines available at facilities. However, some of the clinical staff did mention that more coordination of planning between project and hospital was needed to avoid instances where medicines not needed were supplied and then went out of date. Senior health managers agreed that most eye care supplies were made available through the project compared to the previous period, but that in terms of the health system itself, specific eye drugs are still missing from Medical Store Department as well as from approved regional vendors, as eye care equipment and medicines are not yet included in the National Essential Medicines list.

**Infrastructure**

The project included refurbishment of four eye units in the region; in Manyoni District, Iramba District, Singida District and Ikungi District, in order to provide larger units with an operating theatre, consultation room, refraction section, optometrist’s room, nurse’s room, changing room, extension of waiting area and washrooms, and vastly improve service provision capacity. There were some delays in realising infrastructure plans due to government authorisations, building permits and supplies being late, which required a letter of variation to be agreed with the donor. These delays are not uncommon in these country contexts and many bureaucratic delays are beyond the control of the project.

The Singida District eye unit was completed and operational by September 2018, and Manyoni and Iramba eye units were operational by November 2018, as confirmed by partner informants (although Iramba is still awaiting the AMOO being trained who will complete later in 2020). Ophthalmic equipment procured in the first years of the project has now been installed in these units, and eye health staff indicated they had all the equipment needed at these facilities. In Ikungi refurbishment is still in progress, and there is refurbishment and expansion of the operating theatre in the eye unit of SRRH, although this has been delayed a little further due to decisions needed on which units will move to a new hospital site. Partner informants indicated that this significant expansion of eye care capacity and provision of infrastructure and equipment had *“revolutionised the whole region in terms of eye care services”*. Eye care staff at Manyoni confirmed that the project was the main source of support in this, with the project providing 78% of funding and the council funding the remainder, demonstrating the critical inputs the project has made to eye care service infrastructure. Likewise, in Iramba, the building is said to be the *“talk of the town*” in the region, as it is state of art, and was inaugurated by the Regional Commissioner but later visited by the Prime Minister who hailed the efforts to bring eye care services to the community. Therefore overall, only three of the planned four eye units have been finished by the end of the project, but these three are considered to have made an enormous difference to the capacity for eye service provision in the region, and the fourth refurbishment is in progress.

In terms of the equipment provided to furnish these new facilities, repair and replacement can often be an issue when initial purchase has been from external donors. The technician trained under the project is available for all districts in case of repair and maintenance visits, which is a good start. Eye care coordinators confirmed that equipment was running smoothly and that the hospitals have some budget for repair and replacement, although it was admitted that this was very minor and is likely not to be enough to fully cover replacement in years to come. It seems that in recent years some district hospitals are starting to include eye care devices and equipment in the repair/replacement Council Comprehensive Health Plans (CCHP) budgets which is a very good sign, although this does not signify full independence from external funding. In the case of Manyoni, it was noted that the hospital has allocated budget for repair because the contribution of the new eye department to overall hospital revenue is high, and this shows the direct influence of investments in infrastructure and the increased demand for eye care stimulated by the project, not only in strengthening the health system itself, but also leading to stronger health department commitment and support.

**Governance/ Leadership**

During the course of the project the profile and capacity of the eye care coordinators has increased significantly. In the first year, the project identified a lack of familiarity with the sort of role played by eye care coordinators in supporting and engaging eye health services, and the need for more supportive visits to the districts. The profile of these coordinators has since increased, and a key milestone has been that they are now designated team members of the CHMT and RHMT, so they can advocate for more investment in eye care and allocation of resources at review and planning meetings.

The project team were also keen to cite the efforts of health partners in the collaboration, dedication and strong supervision from the government teams which had kept plans moving forwards despite setbacks. As described in previous sections, the commitment and support from senior managers in the region to eye care is undoubtedly a key factor in raising and maintaining the profile and management of eye care services in the area.

To conclude, the project has definitely strengthened the eye health system in the region, through training of a range of staff in surgical and surgical support skills, data management and technical maintenance skills. In tandem with significant investments in infrastructure this has amounted to a much stronger capacity to provide eye care in the region. Coupled with stimulation of demand through training of PHWs in primary eye care and community sensitisation, this has allowed high levels of eye care treatments to have been achieved. Improvements could be made on provision of suitable spectacles to improve uptake and also in data usage to better understand patterns of access to services. There have also been some setbacks on realisation of the planned AMOO capacity to provide surgical capacity, and the relocation of the ophthalmologist leaving a critical gap in human resources. While the latter is outside the full control of the project it nevertheless affects the project’s ultimate outcomes. For these reasons, overall this criterion is rated **Satisfactory.**

****Maono Singida Sustainable Eye Care - **Satisfactory**

|  |  |
| --- | --- |
| 2.3. Efficiency |  |

**Evaluation Question 4: *Both projects -* How efficient were district-based teams (members of the Council Health Management Teams (CHMT), District Eye Coordinators, Social Welfare Officers and teachers) in completing end of year project plans in a timely manner and overcoming unexpected challenges?**

Maono Singida Eye Care

As discussed in the previous section EQ3, the project experienced some challenges in completing infrastructure plans as intended. However, good relationships and strengthened leadership within the RHMT, CHMTs, MoHCDGEC and President’s Office – Regional Administration and Local Government (PO-RALG) was seen as instrumental in ensuring the smooth construction of the three eye clinics at Iramba, Manyoni and Singida districts, and progress was made due to the collaboration, dedication and strong supervision from the government teams[[36]](#footnote-36).

Key informants also mentioned that there had been some bureaucratic delays in approvals for outreaches from senior management, which had caused some issues with planning. The project team and partners have attempted to mitigate the impact of this by sending outreach permission requests in early and by carrying out tenacious follow-ups.

Theproject also experienced some issues in surgical capacity when the ophthalmologist was appointed to lead SRRH and thus had less time available to conduct surgery. Apparently, this affected numbers operated on. Nevertheless, the Regional Authority managed to engage surgeons from nearby regions to work with the regional ophthalmologist to minimise the risk of failing to achieve the planned targets, and there was also an agreement to carry over any backlog from Yr2 to Yr3 while waiting for the two enrolled surgeons to graduate in August 2018[[37]](#footnote-37).

Maono Singida School Eye Health

The School Eye Health project design planned for the dispensing of spectacles at the same time as the secondary screening to all extent possible, as the learning from previous projects (School Health Integrated Programme) had shown this was more effective. Nevertheless, the School Eye Health project implementation plan indicates that procurement of spectacles and medicines was planned in Yr2, yet a number of screenings, primary and secondary, and also all treatments were planned for Yr1. Therefore, sequencing of activities does not appear to have been as efficient as possible. Informants also mentioned that these delays in procuring spectacles affected the implementation of intended sensitisation activities, which did not proceed according to plans.

In regard to the training of teachers, it appears that two teachers were trained from each school irrespective of the number of pupils at each school. This meant that some teachers faced a large burden of screening, whereas other did not. Some teachers dealt with this by training colleagues to help with screening, which may or may not have been an efficient way of dealing with the challenge. This issue is discussed in more detail under section EQ5.

One unexpected challenge in this project was that the primary screening undertaken by teachers identified far greater numbers of children with an eye problem than anticipated during the second year of the project. These far outstripped the targeted numbers and also the capacity of the three optometrists in Yr2 who were available in the region to carry out secondary screening. The team dealt with this quickly by drawing in six further optometrists from other regions, which was a good response to dealing with the immediate challenge, and succeeded in meeting and exceeding the target for secondary screenings (performance against target was 174%). However, this type of situation needs to be pre-empted in future projects as it resulted in a budget overspend of 49% in that year, and is not a sustainable strategy, and depletes other regions of their capacity.

Generally, in both projects, challenges have been dealt with promptly and proactively, and some have been, to some extent, outside the responsibility of the project. In other cases, there is scope for improved and more efficient planning through foresight and the learning gained, especially from the School Eye Health project. For these reasons, the criterion of Efficiency is rated as **Satisfactory** for both projects.

****Maono Singida Sustainable Eye Care – **Satisfactory**

Maono Singida School Eye Health – **Satisfactory**

|  |  |
| --- | --- |
| 2.4. Impact |  |

**Evaluation Question 5: *School Eye Health project* - Have the children or teachers self-reported any changes in the classroom since the distribution of spectacles?**

This question considers if there have been any reported changes in the classrooms where screening has been undertaken in the School Eye Health project. It seems there has been no project reporting on changes in the classroom by the children or teachers, but the evaluation conducted interviews with trained teachers at 30 of the project schools selected across five of the seven districts, in order to understand teachers’ experiences and perspectives of the school screening project. To set these findings in context it is useful to first outline how the programme worked and some of the issues encountered.

**The screening programme**

The project identified 529 primary schools in the Singida region from which two teachers were trained at each school to identify children with basic vision abnormalities, resulting in 1,059 teachers being trained to conduct these primary screenings. Teachers were all trained in the first year of the School Eye Health project by eye care staff who had been trained as trainers, and teachers were provided with training manuals and screening kits (E-Charts and 3-metres strings) to conduct screening within the selected schools. The approach has allowed 203,741 children to be screened in the Singida region over the two years of the programme which is a very impressive result in terms of scale (see Table 6 below), and equates to an approximate average of 192 children screened by each teacher during the two years.

**Table 6: Number of children who received primary and secondary screenings**

|  | Year 1 | Year 2 | Project total |
| --- | --- | --- | --- |
| Number of girls and boys who received primary screenings by teachers | 99,701 | 104,040 | 203,741 |
| Number of girls and boys who received secondary screenings by optometrist | 10,825 | 31,003 | 41,828 |

Following the primary screening stage, 58 follow up outreach events (15 in Year 1 and 43 in Yr 2) were conducted by optometrists and related eye health staff to carry out secondary screening of children identified with a vision abnormality by teachers. Each outreach event visited a number of project schools in a given area depending on how many children had been identified at each school. Optometrists conducted refraction and diagnosed and treated other eye morbidities at the outreach events. Spectacles were prescribed where necessary. The table above also shows that 41,828 children received secondary screening (10,825 in Yr1 and 31,003 in Yr2) by eye health teams during these dedicated school outreaches. Again, this is really significant achievement in a short timescale. In addition, 3,913 teachers themselves were also screened for vision and 1,550 of them (40%) were prescribed spectacles, and 824 were dispensed with spectacles.

A couple of aspects merit further discussion. A pilot screening had been conducted before the launch of the project in two schools in Singida Municipal districts and had found a level of URE of 30% among children. However, project targets for those anticipated to need a secondary screening do not seem to have been set in the light of the pilot (Yr1 - 11% and Yr2 - 23%). Project reports indicate that numbers of children identified at primary screening with an eye problem that required secondary screening far outstripped the capacity of the three optometrists who were available in the region. Not only did this cause unanticipated human resource problems for the screening programme, as discussed in Section EQ4, but also meant that not all children identified at primary screening received an optometrist screening. As the number of children identified with an eye problem by teachers is not reported within the project (only the number who receive screenings), the extent of this cannot be calculated, but the interviews with teachers found that 14 of the 30 schools in the sample had not received a secondary screening visit. This is somewhat problematic; not only did it mean that children who may have been in need were left out, but also that teachers’, children’s and parents’ raised expectations were unfulfilled. This is likely to reduce confidence in the screening process and undermines efforts to convince parents that it is worthwhile. Interviews confirmed that this was very disappointing for the teachers involved. Other departmental informants commented that it did present a real disincentive to teachers and parents.

Incorrect target setting may be one reason why this situation occurred. The project team acknowledged that the school screening is a new type of project and they had little baseline information on which to base targeting. In this regard, the current project will provide good information and data for any future screening projects.

Another factor may also be present which could affect the level of children identified at primary screening, and that is the accuracy of detection of an eye problem in the screened children. A review of the data available may indicate if there is a possible presence of false positive diagnoses (i.e. the identification of a problem when, in reality, there is not one).

From Table 7 below it can be seen that during the secondary screening for the project overall only 33% of children were found to have URE (Yr1 – 41% and Yr2 – 31%). This implies that quite a high proportion of children screened by the optometrist did not have refractive error, some 67%. These percentages need to be compared to clinical estimates of prevalence of URE in primary school children in order to draw any further conclusions.

**Table 7: Number of secondary screenings, URE diagnoses and OM treatments**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Year 1 | As a % of those screened by optometrist | Year 2 | As a % of those screened by optometrist | **Project total** | **As a % of those screened by optometrist** |
| Number of girls and boys who received secondary screenings by optometrist | 10,825 |  | 31,003 |  | **41,828** |  |
| Number of girls and boys prescribed spectacles | 4,428 | 41% | 9,541 | 31% | **13,969** | **33%** |
| Number of children treated for Ocular Morbidity | 3,129 | 29% | 5,336 | 17% | **8,465** | **20%** |

Other OM conditions will have accounted for some of the 67% of non refractive error eye problems detected at primary screening. As shown in Table 8, the number of OM treatments given is only 29% in Yr1 and 17% in Yr2. However, this level is reported to have been because of a lack of available medicines to dispense, especially in Yr2. Without knowing the numbers for OM cases, as well as the number of OM treatments, it is not possible to conclude anything further that might explain what the 67% non URE cases were found to be. It may be more useful in future to report number of OM cases found, as well as OM treatments given.

More investigation would be needed to determine if there is a possibility of ‘false positives’ at primary screening, adding to the number of children identified as needing secondary screening.

* **Recommendation 5** In future school screening projects, should consider capturing and reporting a) number of children identified with an eye problem at primary screening, and b) cases of OM as well as OM treatment given, and to use analysis of such data, as well as supervision visits, to review screening practice, to improve efficiency and effectiveness of screening, if necessary.

Once prescribed as needing spectacles, children were offered these for purchase at the screening event, unless parents had obtained a low-income exemption certificate. The rate of uptake of spectacles at the screening was very high at 78% which implies good acceptability of spectacle wearing as evident from Table 8. The level of sales of spectacles is discussed below in section EQ8.

**Table 8: Numbers of spectacles prescribed and dispensed**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Year 1 | % prescribed who accepted spectacles | Year 2 | % prescribed who accepted spectacles | **Project total** | **Total** |
| Number of girls and boys prescribed spectacles | 4,428 |  | 9,541 |  | **13,969** |  |
| Number of girls and boys dispensed spectacles | 3,431 | 77% | 7,416 | 78% | **10,847** | **78%** |

**In interviews, teachers were asked about any observed changes in the classroom in children who had received spectacles. Of the 16 teachers, whose class children had accepted spectacles, it was reported by many of them that quite a number** who had received spectacles continued wearing them in class. Where spectacles had successfully been accepted, teachers reported that there had been immediate and noticeable changes in abilities and educational performance, as the quotes[[38]](#footnote-38) below from seven different teachers below indicate,

*“ A lot of good changes - some children were not able to read in the dim light some in the day light, but they can now read and write well”*

*“Children can read and write well, even their handwriting has changed, some were not able to read and write but are doing so now”*

*“We have observed a lot of changes, some children used to take more time to copy sentences from the board. Even during dictation classes they are doing well than before. Also school attendances for the students i.e. some didn’t want to come to school because of poor vision (they experienced pain on reading)”*

*“Students are now comfortable to sit anywhere, they no longer compete where to sit like before”*

*“Children (who has reading problems) are more happy now. They have sensitized/encouraged their parents to buy them glasses”*

*“The three students were happy to gain back their normal sight. Their performance in classes has improved as they can read and write from different angles and distance”*

*“Some parents were thankful for support of the teachers to help children read well”*

Although this is anecdotal evidence, the comments are testimony to the benefits of spectacle provision for children struggling with URE in the classroom, and go some way to showing the potential impact of the project. In the longer term, in regard to developing formal indicators to measure changes in children’s performance from spectacle wearing, changes in educational performance would be one way to capture this systematically. In the shorter term, Regional/ District Educational Officers (R/DEOs) remarked that they had noticed a reduction in the number of large font exams (provided for those with low vision) requested during 2019, and that some schools had also reported reduced numbers of children attending remedial classes offered to give additional assistance to ‘slow’ learners. They felt that both of these observations could well be a result of children having had their vision corrected under the project. These types of indicator could be explored for future screening projects in order to capture more rigorous evidence of the impact of a screening programme.

Nevertheless, as well as these positive changes for many, there were also a high degree of cases where spectacles were not accepted by parents. A further six teachers indicated that in their experience, parents had either not encouraged or had actively stopped their children from wearing the spectacles provided,

*“We could not observe any changes in their performance as children wore glasses and stopped probably by their parents”*

*“For the one month that children wore glasses they reported good vision on the board but their parents did not allow them”*

*“We have not seen much of the changes as students don’t wear the glasses more often as they are not encouraged by their parents. The fact that most people are not using glasses in the villages and they are perceived as they are for town people”*

*“One child put on glasses was feeling better but his parents did not allow him to continue wearing”*

These sorts of barriers were said to be due to prevalent cultural myths that spectacles are only for adults and that if children wear them it can make them blind later in life, or that spectacles are only for ‘town people’. Teachers reported that in terms of the home environment, many of the household activities which children took part in made spectacle wearing difficult, therefore reducing the likelihood of day-to-day acceptability of spectacle wearing.

This reflects a significant issue around information and awareness raising which needs to be addressed to create a culture of acceptability, and if this requires changing of local beliefs and norms this may take some time. The project had planned some sensitisation activities prior to the screening process but it seems that project delays in procurement of spectacles meant that these initiatives did not happen. All teachers interviewed saw the lack of initial sensitisation of parents and communities, through ward and village leaders, as a key omission in the project. Not only is this felt to be important to overcome erroneous beliefs but also because many parents have not perceived their children to have a problem, so screening diagnosis and prescriptions are seen as an outsider telling them their child is sick, which may not be readily accepted. This issue is discussed further under section EQ8 in relation to the revolving fund for spectacles.

Teachers were also asked if there had been changes in other children in the classroom. A small number of teachers mentioned there was some bullying of children who were wearing spectacles but this seems a small number of instances (only three schools where spectacles had been dispensed), and several teachers said they had made efforts to sensitise other children to be accepting, so this was not found to be a significant issue.

In regard to gender equity and inclusion, the project has gender targets for the number of boys and girls to be reached and reporting data is disaggregated by gender. Project data shows that of the number of children receiving primary and secondary screening across the full project term, approximately 51% and 53% were girls, respectively. In addition, of all children who received prescriptions of glasses, or had glasses supplied, approximately 55% of each of these categories were girls. Without knowing the gender balance within the classes screened it is not possible to indicate if this demonstrates gender equity in the screening activities. As well as under the Sustainable Eye Care project, the Social Welfare Officers were also included as part of the team in the School Eye Health project and therefore will have been able to help identify specific vulnerable children and those families in need of exemption certificates for spectacles.

**The evaluation has therefore found a mixed picture of the successes and challenges experienced in the two years of the School Eye Health project.**

**Continuation of teachers conducting screening**

**The evaluation TOR also contained a question on whether teachers are expected to carry on assessing children beyond the duration of the project**[[39]](#footnote-39) **and interviews asked this question of education officers and teachers. Overall, teachers were satisfied with the screening training, although some said it was a lot to take in and would have liked longer training, and almost all were positive about continuing to conduct this sort of screening with children. However, there were various factors which teachers indicated were important to address before any continuation of screening, which would make the work easier and more effective.** One complaint was that number of teachers trained was not commensurate with the size of the school. As some schools have up to 1500 pupils this represented a massive workload for the trained teachers at those schools, whereas at other smaller schools, two trained teachers may have been more than adequate. In response to this, a few teachers said they had trained their colleagues to undertake primary screening as well. While this is a good initiative to help reach all children in a school, there would be questions around verifying the quality of the training, and protocols around reporting results.

Teachers said they would need strong assurance that secondary screening would happen, or if not then this should be clear and another referral system given to them so they could refer children on to some type of eye care services. There was an impression from interviews that teachers felt it was unethical to identify problems and not provide a solution or assistance of some kind.

**The teachers also stated that they would like clearer guidance on the overall aims and a proper schedule for the screening programme as a whole, e.g. the frequency with which it should be done, how to deal with new intake children, etc.** They felt uninformed about what the overall screening programme was for their school, so many of them had just conducted screening once and had waited for further instructions. This implies that there is also a crucial place for training or sensitisation of school management as well as teachers in order to establish a stronger, planned approach to screening. The need to account for staff attrition from retirement and relocation was also cited as important, as there is quite a high turnover of staff in the teaching profession.

The interviews also surfaced some apparent inefficiencies in the process by which the teachers thought they needed to report on screenings. Some sent their reports to head teachers, some to the district team (DECs/DEOs). Apparently, a standard procedure was not clear to them.

**It is understood by the evaluation that there is follow on funding for the school screening programme in Singida region from a unilateral international funder. Contracts have not been signed yet due to COVID-19 delays but should happen soon. This will mean continued support for this sort of programme. The evaluation findings could provide very useful learning for follow-on or future projects, and it is hoped these would include at least some continuation activity at the same schools. This will help embed current practice with teachers for incoming cohorts of children, and learning how to overcome the challenges mentioned above.**

**Recommendation 6: Any new funding for school eye health in the Singida region should include at least some** continuation activity at the same schools engaged under this project.

**Recommendation 7: Future school screening projects should ensure adequate and appropriate parental, child and community sensitisation prior to any screening activities, and to explicitly include ward and village leaders. Initial consultation with teachers in chosen districts should also be considered in support of this. Sensitisation activities should recognise that** different target groups: i) parents, ii) children, and iii) community, may require different approaches.

**Recommendation 8: Future school screening projects should ensure adequate and appropriate sensitisation of school management teams, (in addition to the primary screening training conducted for teachers) in order that a more coherent programme is developed.**

**Recommendation 9: Future school screening projects should give consideration to the size of the selected schools when determining numbers of teachers to be trained to conduct primary screening so that numbers of trained teachers are commensurate with pupil numbers.**

The school screening project has been implemented under a short time scale and is understood to have been the first of this type run by Sightsavers in Tanzania, and it may have been a rather steep learning curve which was exacerbated by some initial delays in procurements. It is therefore marked as **Attention** as there is a rich and valuable amount of learning generated by this project, and therefore a key opportunity for further investigation and learning to be incorporated in future programming. The learning generated from this will help to fully realise the potential for significant impact that this sort of project has on school children’s education and well-being.

Maono Singida School Eye Health - **Attention**

**Evaluation Question 6: *Sustainable Eye Care project* - Has the project advocacy achieved increased government commitment to eye health?**

This question considers whether project advocacy has influenced an increase in government commitment to eye health over the course of the project. In terms of overall project objectives, this relates to Objective 3: *Increased support and commitment to eye health from local and central government*, and the project has defined the indicator for measuring this as: *Eye Health Budget allocated in the participating districts.*

Considering data gathered for this indicator, the budget for the seven districts has varied over the course of the project but has risen considerably against the baseline year of 2015/16 when in many districts there was no allocation at all from government. It has fluctuated a little but remained fairly steady between 32,000,000 and 46,000,000 and slightly rising in the last two years during this project period, although falling slightly for financial year (FY) 19/20 (see Table 9 below). Broadly speaking, according to this indicator, government commitment to eye health has increased.

**Table 9: Government budget allocations by financial year across project districts**

| **Singida Region** | **Financial Year 15/16** | **Financial Year 16/17** | **Financial Year 17/18** | **Financial Year 18/19** | **Financial Year 19/20** |
| --- | --- | --- | --- | --- | --- |
|
|  |
|  | TZS[[40]](#footnote-40) | TZS | TZS | TZS | TZS |
| **TOTAL** | **6,600,000** | **33,562,978** | **32,220,000** | **46,326,001** | **42,382,500** |

However, when the total is broken down by district the allocation per district can be seen to fluctuate quite widely as shown in Figure 1 below.

The above table and figure below show government funding allocations are very variable from district to district. Ikungi, Mkalama and Singida District show similar trends of slight rises and falls, whereas Itigi and Singida Municipal show sudden more marked falls in budget allocation. However, Iramba after a large increase suffered a large fall in FY17/18, partially restored in the following year, whereas Manyoni managed to attract a huge increase.

Fluctuations may be in part a result of the new budgeting arrangements that bring opportunities, as well as possible challenges. The government changed the budgeting system from CCHP to Comprehensive Facility Health Financing in 2018, so that budgeting now begins from the facility level rather than district level. The project advocacy responded to this by lobbying health facilities using the project trained OAs and PHWs to argue for the allocation of funds for eye health. The relevant project report gives an example in Ikungi district, where two health centres were targeted (Ikungi and Ihanja) and the total budget allocated in the district for FY18/19 was 5,786,372 TZS[[41]](#footnote-41). Figure 1 shows that this level of funding was higher than the previous year, but has subsequently dropped significantly in FY19/20 to only 240,000 TZS. Although it appears that advocacy meetings were conducted during late 2018/early 2019 in the district and with RHMT[[42]](#footnote-42), this does not therefore seem to have resulted in sustained levels of funding at the district level.

**Figure 1: Government funding per district during the project term**

Another example of advocacy work is the December 2018 advocacy session in Manyoni which involved the top district management team in discussions as to how they had prioritised eye care, focusing on 1) allocation of funds for eye care services 2) assigning relevant staff to the newly constructed eye unit and 3) effective utilisation of ophthalmic equipment. In a subsequent Regional Planning Officer report (March 2019) it was indicated that in Manyoni district a total of 195 dispensaries and 17 health centres and the district hospital had allocated the sum of 23,785,000/=TZS to the financial year FY19/20 (see Table 10 above). This represents a nearly ten-fold increase of budget allocation in one district within one year, which indicates that the project investments to the Manyoni district eye health facilities alongside strong advocacy have resulted in far higher allocations of funding[[43]](#footnote-43).

It is interesting to note that in Figure 1, the three districts with the highest levels of funding are those where the new eye units have been established under the projects. Indeed, Manyoni District Council has allocated 13,122,127 TZS (USD 5,858) and Iramba District Council committing 9,927,230 TZS (USD 4,432) to the construction of their hospital eye units.[[44]](#footnote-44) This appears to be additional to the budget figures given in Table 10 above, suggesting that infrastructure improvements have led to a sustained higher level of commitment from these districts, beyond these investments, as a result of project engagement.

All health informants agreed that the trend of CCHPs increasing the budget for eye care services within the councils was evidence of commitment by government to eye health, with an increased percentage of hospital funds which go to eye care services in the Comprehensive Hospital Operation Plan (CHOP). One eye health partner commented *“before there was no budget for eye health but over four years the share has increased in the CCHP”* and *“sometimes [hospital managers] use available funds to buy equipment related to eye services, which was not done before the project”.*

While amounts are still small compared to likely levels of funding needed, and there is high variability across districts, the progression over the last four years is very promising and the investment by the project appears to have gone some way to stimulating this. Without expenditure data to compare to budget allocations it isn’t possible to make any strong conclusions, and it is not uncommon that allocated funds are not always fully disbursed. There is some ad hoc project reporting of expenditure, for example, it is reported that the region has spent 27,064,800 TZS (approx. 12,076 USD), of the allocated 32,220,000 TZS (approx. 14,384 USD), which is 84% of the funds allocated in 2017/18 government plans.[[45]](#footnote-45) However, systematic data for each financial year was not available to the evaluation.

The project team and partners have worked hard and very effectively at advocating for higher levels of government funding through continual advocacy in a variety of ways and within crucial decision-making mechanisms such as district and regional planning processes. Rather than allowing partners to become donor dependent, this has maintained the emphasis on the need for domestic funding sources. In terms of the impact of the advocacy this is rated as **Satisfactory,** as while the indications of influence are very good, budgets are still highly variable and may not represent a sustained and solid commitment to eye care in the future.

****Maono Singida Sustainable Eye Care – **Satisfactory**

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| 2.5. Sustainability |  |

**Evaluation Question 7: *Sustainable Eye Care project -* As per the MTR recommendation assessing progress against the implementation of the Sustainability Plan is a key component of the end of term evaluation (ETE). What is the current progress against the Sustainability Plan? How has the advocacy plan aligned (if at all) to support the implementation of the Sustainability Plan?**

**The Sustainability Plan**

Considerations of sustainability have been key feature of the Sustainable Eye Care project, not just in name. As early in the project as January 2017, a Situational Analysis of Eye health Financing was commissioned, and following this a draft Sustainability Plan was formulated by the same external consultant. A participatory workshop to discuss the draft Sustainability Plan was held in March 2017 which included sixty-five leaders attending, including the Regional Commissioner, District Commissioner, District Executive Directors, Council Chairs, DMOs and District Eye Coordinators. As a result of this high-level meeting, the region agreed to implement a cost-sharing model for eye care services, while also encouraging people in the region to pay for health insurance. The MTR reports some reactions captured through interviews which indicate that the participatory workshop was very well received and resulted in a strong feeling of ownership[[46]](#footnote-46). The final report ‘*Maono Project – Singida Region: Health Financing Sustainability Plan – Final Report*’[[47]](#footnote-47), which was made available to this evaluation is undated but according to project reports appears to have been completed later in 2017. It will from herein be referred to as the Sustainability Plan.

The Sustainability Plan aims to introduce alternative, innovative financing mechanisms, with the overall aim being to create a strategic framework for improving financial sustainability and reduce donor dependency for eye care services. The Sustainability Plan stated objectives are:

1. **Planning and Management:** To build managerial capacity of staff at health facilities, council and regional levels on efficient, effective planning and sustainable financial management by June 2019
2. **Private and community partnership:** To increase programme engagement of private sector, communities and organisations of vision challenged people to elevate eye health agenda and local funding

The Sustainability Plan concludes that these objectives will together lead to an increase in planned eye care activities in council health plans, an increase in allocation and stable funding for eye care from internal health system sources and increased enrolment overall in CHF/TIKKA.

**Formal monitoring of the Sustainability Plan and alignment with project Advocacy Plan**

In terms of formal M&E, of both the Sustainability Plan and the project advocacy, there are documents in place – the Sustainability Plan Logframe and the project Advocacy Plan.

The Sustainability Plan Logframe outlines objectives and outputs, and their indicators, and Activity Workplan and schedule for Year 2, 3 and 4 of the Sustainable Eye Care project. In addition, there is a Monitoring/Performance Framework for selected indicators, although these are in some cases differently worded so it is hard to map the Monitoring Framework to the Logframe. The idea is that a monitoring review of the Sustainability Plan is conducted each year, but it isn’t clear from the document who is responsible for doing this, nor to whom this information would be reported. The Sustainability Plan, also contains an Annex which appears to be the December 2018 monitoring report. This reiterates many of the issues already articulated in the Sustainability Plan itself but unfortunately does not report clearly against objectives. KIIs revealed that some of the eye health staff and managers were not aware of the Sustainability Plan itself as a document, but were definitely aware and involved in the health financing initiatives being undertaken in the project districts.

The project also has an Advocacy Plan dated 2017, and so is concurrent with the Sustainability Plan development. The Advocacy Plan corresponds to project Objective 3: Increased support and commitment to eye health from local and central government. This Advocacy Plan aligns with the Sustainability Plan in a number of areas, although its scope is wider by incorporating relationship building for further influence, and its overarching Change Objective is “Increased support and commitment to eye health from local to central government”.[[48]](#footnote-48) While there is not explicit alignment with the Sustainability Plan objectives, a focus on developing financing mechanisms is part of it, and there are examples of activity areas which link directly to the Sustainability Plan. For example, a focus on capacity building for eye care personnel, including eye care coordinators, at regional and district levels on budgeting, planning and lobbying for resource allocations within their context, and a key anticipated outcome of the Advocacy Plan will be enhancement of health financing mechanisms at eye care department at the regional hospital.

The Advocacy Plan has additional focus on an analysis of government policy and hospital procedures in order to find solutions increase accessibility including for people with disabilities and sustainability of eye care services at SRRH and states the project commitment to the ‘leave no one behind’ agenda by mainstreaming disability and gender throughout its programming and operations.

While the Advocacy Plan document does not comprehensively support the implementation of the Sustainability Plan, probably because it has not been updated since the Sustainability Plan was finalised, the thrust of the project advocacy activities and focus are keenly aimed at developing initiatives for improving financial sustainability. Discussed below is the evidence of aligned activities and developments going on under the advocacy within the Sustainable Eye Care project, even if not specifically noted in the Advocacy Plan.

**Project advocacy and progress of the Sustainability Plan**

The Sustainability Plan is mentioned in six-monthly report from Yr2 reports onwards, although it is often referred to as the Health Financing Framework. It is clear from project reports that the project is actively engaged with the issues around sustainable financing and is making efforts to try to enhance the opportunities through insurance funds, and revolving funds for spectacles as well as lobbying senior levels for more government allocation of funding. Project activities and advocacy have aligned with many of the areas of work suggested by the Sustainability Plan as detailed below, and have been reported narratively in most of the project six-monthly reports.

**Capacity building for improved data tracking and collection and eye care planning**

Improvements in the capacity for data tracking, sharing and reporting, as well as seeking alternative sources of finance have been key areas of activity and advocacy within the project, as discussed earlier. Early in the project, the need to support and capacitate Eye Care Coordinators in financial tracking and planning was identified and specific support and training provided. Eye health staff informants pointed out that improvements in hospital records of patients receiving different eye care services over the past four years has indeed strengthened the case for increased funding to sustainability meet needs in the population. Eye health staff felt that seeing the results from different services and reports such as quarterly and annual reports, outreach activities made the CHMT aware of the magnitude of the eye care problems and realise the need. So HMIS and general reporting improvements to generate data on patient numbers and treatments have helped build the case for government commitment and investment.

**Improved cost recovery mechanisms – use of insurance schemes**

A key achievement of project advocacy on sustainability is at the national level, where the project team has successfully lobbied for the inclusion of recommendations from the Sustainability Plan to be included in the National Eye Care Strategic Plan 2018-2022[[49]](#footnote-49), and the NECSP 2018-22 strategies to be adopted now include integration of eye health in national insurance schemes (improved Community Health Fund (iCHF) and National Health Insurance Fund (NHIF))[[50]](#footnote-50). Project reports show regular RHMT meetings are undertaken every six months at least, with Regional Administrative Secretary present, as well as national level advocacy sessions to lobby for resources allocation for eye health. For example, a meeting with PO-RALG during the budget planning for Financial Year 18/19 was used as an avenue to raise senior figure’s awareness on eye health financing across the country. It is reported that during the advocacy session the Head of the Health Financing Plan, specifically acknowledged the Maono project approach, highlighting how the project has focused on the issue of the sustainability of eye health financing from the start. She went on to say, “*I am very interested on how the project is integrating Health Insurance Schemes with eye health”* and called on other regions to learn from what the project was doing, and instructed the Regional team to ensure that the improvements to infrastructure were sustained beyond the life of the project[[51]](#footnote-51).

At the district level, informants felt that the cost recovery scheme aspect of the project has also helped to attract attention to eye care within the health system. For example, it was cited that the contribution of the Iramba eye department in the hospital revenue e.g. operations and spectacles costs share revenue (cash and insurance) has increased. This is also corroborated by project reports which cite that the enhanced financial management capacity has improved implementation of cost recovery mechanisms and reporting. For instance, “*there have been efforts to improve the application processes for CHF and NHIF claims and establishing financial tracking mechanisms at health facilities*”[[52]](#footnote-52), which is important as the Sustainability Plan highlighted lost income due to inefficiencies in claims made to insurance companies for eye care treatment reimbursements as a factor which needed improving.

At the primary level, project advocacy has focused on encouraging the direct financing of primary eye care the facilities, and trained PHWs are now involved in planning at the facility level, as mentioned in section EQ6. For example, in Manyoni, one health centre allocated 2,080,000TZS and fifty-four dispensaries (each with a project trained PHW) allocated 6,500,000TZS to buy primary eye medicines to treat eye infections. In Singida rural district, 28 dispensaries allocated 6,448,000TZS while five health centres allocated 3,820,000TZS[[53]](#footnote-53). The allocation of funds at lower level facilities indicates that there is a change in attitude, and increased commitment which is felt to be a result of project advocacy, and the health-financing framework laid out in the Sustainability Plan.

It is clear that the project team and partners are engaged in key advocacy for financial sustainability at all levels and exerting a strong influence on senior decision makers, as well as at local primary levels of the eye health system.

**Challenges remain**

The above are very promising developments, but in relation to using insurance schemes as a source of eye health financing, challenges remain. The NHIF which covered government employees and their families only) refused to provide charging codes[[54]](#footnote-54) for refractive error in the districts lacking optometrists, this means that all districts supported with refractive error equipment through the project need to recruit an optometrist so that they can utilise this financing mechanism for refractive error funding. Even where an optometrist exists, the NHIF will only cover reading spectacles for 20,000TZS once every three years and does not insure distance spectacles.

The iCHF which covers most project target groups, also only covers the cost of consultation fees and eye drops, but not costs for surgery or spectacles. Sightsavers and regional management teams have agreed to discuss this with policy makers so that they can review the inclusion of eye health services in the iCHF, as proposed in the NECSP 2018-2022.

In evaluation interviews, eye health informants acknowledged the project’s role in influencing progress in the area of alternative financing, but also emphasised that many project activities would not continue post-project, such as outreach, and that the region’s eye health services were significantly funded by the Sustainable Eye Care project. There is still a long way to go for financial sustainability to be reached. Nevertheless, the creation of a financing framework strategy, albeit one that might be better documented and tracked, the general alignment with the Advocacy Plan and the clear examples of advocacy efforts and results which it has generated, demonstrate extremely good progress in a challenging aspect of eye health services. Despite the lack of a formal monitoring and evaluation process, and reliance on narrative reporting of progress, on the basis that this is a really promising start on a long journey to full sustainability, this section is rated **Excellent** in recognition of the major steps done in the area of sustainability, which many projects struggle to tackle**.**

Maono Singida Sustainable Eye Care - **Excellent**

**Evaluation Question 8: *School Eye Health project -* What is the status of the revolving fund for spectacles? Are teachers expected to carry on assessing children beyond the duration of the project?**

**Status of revolving fund for spectacles**

**The idea of the revolving fund for spectacles is that rather than being given free, as in many refractive error projects, spectacles are charged for, albeit at a fairly low price.** The revenue collected from these sales is used as a revolving fund for continued procurement of consumables and medicines as the project phases out.

Although this EQ is indicated for the school eye health project, it isn’t possible to distinguish between the School Eye Health project and the Sustainable Eye Care project, as revenue from spectacles in reported under the latter project, and where spectacles revenue is mentioned it does not always specify if this was from sales under one or other project. The evaluation will therefore report on the revolving fund in general. As a method of generating funds, it appears to have been working in the facilities setting but not so well in the school screening activities.

Maono Singida School Eye Health

Spectacles have been procured under both projects. Under the School Eye Health project,10,503 spectacles were planned to be dispensed, and by the end of the project 10,847 spectacles had been procured at a cost of 79,911USD [[55]](#footnote-55). This represents and average unit cost of 7.49USD. **The** price of spectacles sold under the School Screening project was agreed with partners at launch event to be 5,000TZS (approx. 2.25USD)[[56]](#footnote-56), as eye care coordinators had advised that charging, even at low prices, would show that spectacles were of value and encourage good care to be taken of them. This was decided to be a reasonable price for this project setting, but as can be seen would not be sufficient to cover the full costs of the spectacles.

In fact, under the School Eye Health project, teachers, DEOs and RSWO revealed that in most cases parents could not pay for spectacles, as many especially rural populations could not afford 5,000 TZS. One of the DEOs suggested if the price could be lowered to 2,500TZS it might be more affordable. Interviews showed that in many cases teachers had given the spectacles free to children at the schools when it was realised that parents could not afford them, and all teachers mentioned paying themselves for the child’s spectacles in certain cases. It was also reported that of those parents who could afford the price, many did not want to pay. The reasons for this were thought to be the following: it was seen that the project should provide them free as it came from donor money; and as all other provision in primary school is free, parents couldn’t understand why they should pay for spectacles. These perceptions were also amplified by the fact that parents had not perceived their children as in need of anything, but rather had been told by others that there was a health problem, therefore parents were less accepting of the idea something was needed. Although there is an exemptions process via the Social Welfare department, the disincentives above are likely to have deterred parents from making the effort to use this. There were also a couple of reports from informants that there is an impression that spectacles which are free are not of good quality. Indeed, one teacher mentioned that spectacles frames were defective and the lens fell out.

Given the degree of cultural barriers among parents to perceiving the need for children to wear spectacles, and myths that these can worsen eyesight or induce blindness, it may be that hoping they will be willing to pay is too high an expectation until attitudes have shifted to a more positive orientation. And as discussed under section EQ5, in many schools secondary screening and therefore dispensing of spectacles had not yet been provided in any case.

Maono Singida Eye Care

The revolving fund also operates in the Sustainable Eye Care project in much the same way, but with more success in generating funds.

According to the proposal, 7,000 pairs of spectacles were initially budgeted for at a unit cost of 7USD each, with a further 2,200 spectacles planned under the SiB extension project. However, only 4,915 were reported as having been bought by 30 October 2019 at a cumulative spend of 43,130USD up to this point[[57]](#footnote-57) (unit cost 8.7USD). As with school spectacles, poorer patients are able to claim exemptions, as guided by the Social Welfare Officers who will identify those who cannot afford to pay. The plan was also to use insurance schemes such as NHIF and the iCHF for those children who are covered by their parents’ or guardians’ membership[[58]](#footnote-58), although there are limitations to this as mentioned above in section EQ7.

In terms of tracking the income from spectacles sales under either of the projects, this is being established and is part of the REC/DECs monthly reports to DMOs, which is a good beginning in relation to developing a sustainable, trackable source of income for individual districts. However, it is not reported systematically in the project donor reports and there are no indicators on this.

Internal DEC reports do capture some information on spectacles sales. Although the DEC’s report forms do not distinguish between the projects, it is assumed that most of the revenue comes from facilities and adult outreach activity under the Sustainable Eye Care project, as income is reported on under that project, rather than the School Eye Health, and given the responses from education informants on the level of sales under the School Eye Health, it is assumed that most of the revenue is generated from the Sustainable Eye Care project. The DEC report formats give number of spectacles dispensed (disaggregated by gender and adult/child), and amount generated from insurance schemes, but do not include a category for direct sales to patients, so it is unclear if this is included elsewhere or is not producing a funding stream (see example of the DEC report template in Appendix 12). To track, report and assess the status of the revolving funds clearly would need all categories of income to be detailed and a mechanism for systematically collating this information on a monthly, quarterly or annual basis as needed. So at this point in time, the evaluation cannot assess the financial status of the fund.

Nevertheless, some of the project donor reports give updates on income generated. During April – Sept 2018, reporting indicates that Itigi generated 959,000TZS (426USD) during the surgical camp in August. This amount was subsequently used to buy consumables for Itigi Health Centre to continue to provide eye health services. The same report mentions that an analysis indicated that 66% of people who went to an eye clinic paid for services[[59]](#footnote-59) but it is not clear what this analysis was.

In the period Oct 2018 – Mar 2019 it was reported that there had been a large increase in funds from spectacles sold in all seven councils, and that the seven districts managed to generate 17,317,000 TZS from selling 1,368 spectacles (unit price 5.47USD). The prices are reported as being 10,000 TZS (4.3USD) for reading glasses, and 15,000TZS (6.5USD) for distance glasses, which apparently aligns with the regional pricing guidelines. The quarterly review meeting during this period requested all DECs to go back to their districts and ensure they buy a further stock of spectacles from the amount generated.[[60]](#footnote-60)

In the following period (April-September 2019), the project report indicates that 14,589USD had been collected overall to date from the seven districts and the SRRH outpatients department. The report notes that the amount would support the region to buy spectacles and consumables. However, it is not clear from the report how much of this 14,589USD was generated from spectacles and how much from other services, and this may be because the DEC report template does not have clear categories for information capture (see Appendix 12). There appears to have been a decision to increase the cost of spectacles sold at facilities during 2019, where seven districts agreed on the cost of eye services with an aim to sustain eye care services beyond the project. At both SRRH and district hospitals reading spectacles would now be sold for 6.5USD and distance spectacles for 10.9USD (the price excludes the extended range of more stylish frames). However, the same period it was reported that only 4,915 people (i.e. 39.7%) paid for their spectacles, some of which may have been because patients coming to SRRH could not get the required power of spectacles nor could find styles which they liked, which prompted SRRH to order a greater variety of frames.[[61]](#footnote-61)

Without access to the DEC’s reports, it isn’t clear how much is being generated from spectacles sales. However, if sales, revenue and purchases are being successfully tracked and recorded by DECs for review and planning with CHMTs and RHMTs to manage the revolving fund then this is important factor, even if not reported to the project. It seems that establishing systematic collection of sales income is taking a bit of time but has begun well.

A second issue to consider is the ability to cover the cost of procuring spectacles to make the scheme financially viable in the long run. As can be seen from the costs and income figures given above, sales prices often do not cover the full cost of procurement. Nevertheless, while not fully sustainable yet, this is clearly a key source of income for the eye health budgets in the region.

In relation to the revolving fund for both projects all informants like the approach in principle, but felt that the implementation challenges as outlined above, were significant constraints to generating funds.

To conclude, it is clear that spectacles sales are adding to income generated from eye care services, and that recording and reporting on this to the project is happening, although it is not clear to what extent, nor is it done in a way that allows for full assessment from project information.

**Indicators and systematic reporting of income and expenditure on spectacles (if not for all eye care services) should be developed and used to track revolving fund income and expenditures to understand and monitor the fund status and percentages spent on spectacles or other eye care services at any given point. Where financial management indicators and reporting within the health system already exist and are robust, these should be used to avoid creating parallel information systems. If this is already done by DECs within the CHMT process then this could be routinely reported by the project as well. This will help further with planning and budgeting.**

* **Recommendation 10: Indicators and systematic reporting of income and expenditure on spectacles (if not for all eye care services) should be enhanced to better understand the percentages generated from and spent on spectacles and other eye care activities. This data capture should use existing financial management indicators and reporting within the health system, if robust enough, where possible.**
* **Recommendation 11: Recognise the limitations of trying to generate income in poor and rural communities where individuals are less likely to have the means to pay for spectacles, or may have exemption certificates, and to factor this into any revolving fund for spectacles for school screening projects.**

In conclusion, while the establishment of a revolving fund for spectacles to support the funding of eye care services is an excellent idea and has begun well, there is not enough evidence that it is being implemented in a way that takes account of target groups for spectacles sales, nor is being tracked in a financially sound manner. Therefore, in relation to sustainability this is rated **Attention.**

Maono Singida School Eye Health – **Attention**

This EQ is directed towards the School Eye Health therefore the rating has been allocated accordingly, whereas it was found that most of the revolving fund activities, recording and reporting was going on under the Sustainable Eye Care project, as explained above. The EQ also enquired if teachers are being expected to continue the school screening after the project end. This has already been discussed under section EQ5.

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| 2.6. Scalability/replication |  |

**Evaluation Question 9: *Both projects -* What, if any, are the aspects of the projects that are replicable/scalable?**

Maono Singida Sustainable Eye Care

Investment in infrastructure and staff capacities is a solid way of raising the profile of eye health within the health system. This way of increasing capacity of service provision alongside demand stimulation has been proven by this project to be an excellent way of reaching good numbers of people. These concrete measures to increase eye health system capacity have the potential to be sustainable and also are shown to have generated income in the resourced districts, as well as attracting further funding

While the Sustainability Plan itself did not turn out to be a key strategic document, the process of developing it and the collaborative way of taking forward the initiatives for developing alternative means of financing seem to have been embraced by health staff, and help to build a stronger mind-set of sustainability beyond donor funding.

The collaborative manner in which the project has been launched and implemented with close working with all eye health staff and systems on the ground, as well as strong engagement with more senior level regional and national government staff means there is a very strong sense of partnership and buy-in by health partners.

These aspects are all well worth replicating in future projects.

Maono Singida School Eye Health

The School Eye Health project represents a very cost-efficient model of reducing burden on secondary and tertiary health levels by maximising the time of trained health staff to only screen those already diagnosed at primary screening level rather than the population level. It also engages teachers who can be key ambassadors for improving awareness and the educational importance of correcting refractive error. The project has shown it is a method which can reach very high numbers of children and reach out to an unmet need among communities. All informants were of the opinion that it is a highly replicable concept, but the method of implementation needs to be improved.

It is highly replicable and scalable, **but only if implementation is improved on aspects discussed above** such as, prior sensitisation of communities, more effective implementation of secondary screening, improved teacher guidance, protocols and schedules, and better measurement of possible outcomes.

The approaches to provision of eye care services are tried and tested methods, and have been implemented well in this context, so are rated as satisfactory. The school screening services are an excellent conceptual model but have not been implemented in a way which should be replicated. However, on balance replicability is rated as mostly met for this project, so long as the significant implementation learning is taken on board. Overall this criterion is rated as **Satisfactory** for both projects**.**

****Maono Singida Sustainable Eye Care - **Satisfactory**

Maono Singida School Eye Health - **Satisfactory**

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| 2.7. Coherence/coordination |  |

**Evaluation Question 10: *School Eye Health project -* How have the health and education sectors been brought together to coordinate for this specific project?**

For the School Eye Health project, an inception workshop and official launch was held in Feb 2018 and representatives of both MoEST and MoHCDGEC attended the event as well as members of PO-RALG, and district representatives from health and education departments, indicating a good level of engagement at the outset across both health and education sectors. The workshop included collaborative planning day, and the training manual was produced in collaboration with both MoHCDGEC and MoEST input. The project used the MoHCDGEC national teachers training manual for the project. As mentioned in section EQ5, the one-day training of teachers was conducted by eye health staff trained as trainers. School screening planning took account of revised primary school calendar, and in consultation with the Regional Education Officer.

In terms of implementation coordination, it is reported that school health officers (DEOH) have been engaged in all seven districts through regular project meetings on the importance of creating demand for eye care, and to review project data[[62]](#footnote-62). In addition, school screening data is all entered into the HMIS[[63]](#footnote-63). The project reports stress the capacity building for DEOs and DECs on use of project collation spreadsheets and HMIS for screening data, which feeds up to SRs and RHMTs, with the intention that this data is a key source of evidence for planning and advocacy. Yet, it is unclear if the data feeds into, or is of use to the education sector planning teams in any way. This may be a missed opportunity for coordinating further on advocacy to promote school screening in the education sector, to complement that done in the health sector. While school eye health naturally falls under the purview of health departments, project advocacy could perhaps have fostered support from education colleagues to help build a case based on the educational benefits of school screening. Thus, education partners become advocacy partners in efforts directed towards senior health decision makers and funders.

While the school screening is mostly initiated by the health departments, the education department supply school timetables and give support in logistics. Regional Medical Officers (RMOs) and DMOs naturally have the overall responsibility of the health activities taking place in schools. It is reported that the ophthalmologist carries out supervisory visits to screening teams, but there is no mention of this among the teachers interviewed, who in fact reported that they would have appreciated more follow up and support, so this supervision may only have extended to eye health staff. Beyond some mentions that DEOs and DECs are regularly brought together to discuss the importance of awareness raising/demand creation and data management for evidence in project reports, there is little reference of activities involving the DEOs/DEOHs. This does not of course mean this cadre were not involved but may be an indication that beyond school calendar timetabling they have not been very involved. Informants confirmed that the normal lines of management mean that health units plan for certain health service in schools, and education units support by providing calendar and other support needed. At the district operational level health and education counterparts seem to meet about 3 times per year according to informants, however although there is some joint planning, there does not seem to be a detailed shared implementation plan or schedule between them, and it was mentioned that some districts had no proper schedule. It was acknowledged that there may be a need for more alignment between the education and health department at both the regional and district level, so this is an area where implementation coordination might be improved.

As already discussed under section EQ5, the lack of community sensitisation was felt to be a key omission. This is an area where health and education staff, including teachers, could productively coordinate to give clear and meaningful messages to parents and communities about the value of a screening programme and use of spectacles. It appears that there could also be more coordination and communication between the planning of secondary screening outreaches by health teams and the teachers over secondary screening events and schedules, so that teachers were more closely informed of screening timetables and plans, to support teachers day to day communications with children and parents on the screening programme.

Education informants were also asked if they knew of any plans for school screening beyond the project term. Most did not have any knowledge of ongoing plans to continue the screening, although two districts indicated that there were ongoing plans. Indeed, Manyoni district had allocated 5,000,000TZS (2,222USD) for staff training on child eye health and outreaches which will include school children in 2020[[64]](#footnote-64), which shows a good commitment to school eye health in this district. “*We had a very good health plan including eye care, but the COVID-19 outbreak seems to have disrupted everything*”, one education informant responded. Of course, with COVID-19 uppermost in people’s minds, and with re-establishing a normal school calendar a priority for education departments, planning for additional elements such as health screening is likely to be postponed for a while.

The evaluation team understand that there is funding available from another donor which is in the pipeline for school screening in the Singida region, which means that a new project will be able to maintain the gains made under School Eye Health project. It is crucial that learning from this project is taken forward into any new phases or projects. Various recommendations have been made under other sections of this evaluation report, and there are no further ones made here, other than to reiterate the former one.

In terms of the Coordination criterion, this is rated as **Attention.** Although there was clearly good ministerial level coordination at the outset regarding the overall strategic aims of the screening programme, in the stages of more operational implementation it is felt there were gaps in the engagement with teachers about the overall aims and schedules for primary screening. Better coordination between health and education staff may have ensured that teachers were kept more informed and supported, and promoted the two sectors working closely together.

Maono Singida School Eye Health – **Attention**

### Conclusions and recommendations

##### Summary and conclusions

Maono Singida Sustainable Eye Care

Both projects have been found to be highly relevant to the eye health needs of the region. The Sustainable Eye Health project has increased awareness on women’s eye health needs among eye health partners and managers, and considerable effort has been made to encourage women in communities to come for treatment, but social and cultural norms mean that it is still challenging to reach the proportions of women who are likely to have need of eye care services. The Sustainable Eye Care project’s implementation has been very well integrated into existing health systems and has considerably strengthened the eye health provision capacity through infrastructure, human resource training and HMIS investments, and its effectiveness is therefore rated as satisfactory. The project also has the recognition and support from senior health department figures, which has been due to its collaborative nature and sustained advocacy. This has influenced levels of funding for eye health and helped establish a financing framework. This is an excellent start for establishing sustainable sources of income for eye care.

Maono Singida School Eye Health

The School Eye Health project has been welcomed by health and education staff and has reached very high numbers of children in just two years. However, contextual community and parental attitudes need to be taken into consideration through targeted and tailored sensitisation before screening and spectacles dispensing is conducted, in order to overcome the strong cultural myths and perceptions which do not support the wearing of spectacles by children. There have been a number of challenges and aspects of implementation which could be improved such as better coordination with school management, tailoring numbers of teachers trained to school size, and developing a more detailed understanding of likely numbers of children who may present a visual abnormality in order to support effective and efficient provision of secondary screening for all those identified. Nevertheless, the anecdotal evidence of the impact of spectacle wearing for children in the project primary schools demonstrates the benefits and very encouraging for future projects of this type.

Both projects therefore have elements which are suitable for replication and/or scale-up.

##### Lessons learnt

Maono Singida Sustainable Eye Care

* Consistent relationship building and collaborative project design/implementation and engagement with health partners and the Regional Authority improves the opportunities for raising the profile of eye care and eye care coordinators within the wider health management system, and for advocating for more resourcing for eye care.
* The collaborative development with senior health and eye care staff of a sustainability framework for financing of eye care services has aided it’s progress. The systematic capture of eye care services income/expenditure data, and the training support for financial management for clinical eye care staff, have both helped create an important focus on financial sustainability of the eye care services within and beyond the project life. In particular, this has brought a more commercial approach to the dispensing of spectacles, and raised awareness of opportunities for making more efficient use of health insurance mechanisms as a source of income for eye care service provision.

Maono Singida School Eye Health

* School screening for vision abnormality by trained teachers can be a very cost-effective way of assessing very large numbers of children. Teachers can be willing and committed to undertaking these activities.
* The number of teachers trained needs to be commensurate with size of school so that teachers in large schools are not over-whelmed, nor those in small schools under-utilised.
* Anecdotal evidence from trained teachers indicates that diagnosis of URE and provision of spectacles can make a significant difference for individual children in terms of improved reading and writing abilities, more ease in following lessons and being more willing to attend school. More systematic capture of outcomes for children who have received dispensed spectacles would help demonstrate value of school vision screening projects.
* It is important to ensure that secondary screening capacity is enough to screen all those children identified at primary screening to avoid implementation challenges, either by reducing the numbers of schools involved in a project to match existing optometrist staffing capacity, or by developing more accurate understanding of the likely prevalence of vision abnormalities and uncorrected refractive error.
* Establishing, and informing teachers of, referral protocols for children identified with a vision abnormality would be an advisable contingency mechanism if secondary screening is not likely to be possible at the school level.
* The high resistance among parents and communities to spectacle wearing for children, especially in poorer more rural communities must not be underestimated. The importance of prior tailored and targeted sensitisation of parents, children and community leaders to encourage uptake and dispel cultural myths is critical.
* The need for good coordination and sensitisation of school management boards and teacher involvement in planning is important in order to achieve an ongoing sustainable screening programme that will continue beyond the project term activities.

##### Recommendations

**Recommendation 1:** Detailed analysis of gender disaggregated project data should be conducted to better understand trends in uptake, for instance, according to service delivery type (i.e. outreach or static facility) and by district, and use this in combination with upcoming barrier analysis study to develop additional strategies for reaching more women.

**Recommendation 2:** Ensure that there is cross country learning occurring from other Sightsavers projects, and other SiB projects in East Africa or similar contexts of any successful strategies employed elsewhere to encourage the uptake of eye care by women.

**Recommendation 3**: The newly trained AMOO at Sokoine should be provided with as much opportunity to consolidate surgical skills learnt by conducting surgeries at other facilities which have appropriate equipment or conducting surgeries at outreach.

**Recommendation 4:** In future projects, to report on patients treated across all treatment categories disaggregated by services provided at static facilities versus outreach events in order to better understand any emerging trends of patients accessing different types of service. This will support planning and also provide more detailed evidence of changes in numbers accessing all types of eye health services.

**Recommendation 5:** In future school screening projects, consider capturing and reporting a) number of children identified with an eye problem at primary screening, and b) cases of OM as well as OM treatment given, and to use analysis of such data, as well as supervision visits, to review screening practice to improve efficiency and effectiveness of screening, if necessary.

**Recommendation 6: Any new funding for school eye health in the Singida region should include at least some** continuation activity at the same schools engaged under this project.

**Recommendation 7: Future school screening projects should ensure adequate and appropriate parental, child and community sensitisation prior to any screening activities, and to explicitly include ward and village leaders. Initial consultation with teachers in chosen districts should also be considered in support of this. Sensitisation activities should recognise that** different target groups: i) parents, ii) children, and iii) community, may require different approaches.

**Recommendation 8: Future school screening projects should ensure adequate and appropriate sensitisation of school management teams, (in addition to the primary screening training conducted for teachers) in order that a more coherent programme is developed.**

**Recommendation 9: Future school screening projects should give consideration to the size of the selected schools when determining numbers of teachers to be trained to conduct primary screening, so that numbers of trained teachers are commensurate with pupil numbers.**

**Recommendation 10: Indicators and systematic reporting of income and expenditure on spectacles (if not for all eye care services) should be enhanced to better understand the percentages generated from and spent on spectacles and other eye care activities. This data capture should use existing financial management indicators and reporting within the health system, if robust enough, where possible.**

**Recommendation 11: Recognise the limitations of trying to generate income in poor and rural communities where individuals are less likely to have the means to pay for spectacles, or may have exemption certificates, and to factor this into any revolving fund for spectacles for school screening projects.**

### Appendices

### Appendix 1: Evaluation Criteria Rating

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

### Appendix 2: Sightsavers Terms of Reference

Maono Singida- Sustainable Provision of Eye Care &

Maono Singida- School Eye Health

**End of term evaluation**

1. **Background**

|  |  |  |
| --- | --- | --- |
| **Projects information** | | |
| **Number & name** | 24027 Maono Singida- Sustainable Provision of Eye Care | 24030 Maono Singida- School Eye Health |
| **Duration** | 1st April 2016- 30th June 2020 | 1st January 2018- 31st December 2019 |
| **Budget** | $ 1,562,500 USD (incl. extension) | $ 375,000 USD |
| **Area** | Seven districts in Singida: Singida Municipal, Singida Rural, Ikungi, Iramba, Itigi, Manyoni, Mkalama | |
| **Partners** | Kilimanjaro Centre for Community Ophthalmology  Tanzania League of the Blind | Ministry of Education, Science and Technology |
| Ministry of Health, Community Development, Gender, Elderly and Children  Singida Regional Authority  President’s Office- Regional Administration and Local Government (PO RALG) Tanzania | |

**1.1. General information on project area**

Tanzania is the largest country in East Africa with an estimated population of 56.3 million (2018)[[65]](#footnote-65). The country’s major economic activity is agriculture and over 37 million people reside in rural areas[[66]](#footnote-66). Despite its rich biodiversity and growing tourism industry, 70% of Tanzania’s population live in poverty[[67]](#footnote-67).

Centrally located in the Tanzania mainland is the Singida region, home to 1.5 million[[68]](#footnote-68) of people dispersed across its seven districts listed in the table above. Singida has experienced a significant growth of population in the recent years. It is an underserved area with the second lowest levels of GDP per capita in the country and second lowest HDI score[[69]](#footnote-69) . It is estimated that 51% of Singida’s population live in poverty[[70]](#footnote-70). The region is known for producing both food and cash crops. Rearing livestock is also an important economic activity in the region.

Tanzania’s health system works in an environment of very limited financial and human resources. At the central level, the Ministry of Health and the PO\_RALG manage the human resources, infrastructure developments and procurement of consumables and medicines. The local level is accountable for the service delivery and the management providing supervisory visits and capacity building to health facilities across the country. The region of Singida was not prioritised in the National Eye Care Strategic Plan (NECSP) 2011-2016, yet it is one of the most underserved regions in the central zone. The shortage of staff, equipment and consumables negatively impacts on the accessibility of quality eye care in the area. The recently conducted Rapid Assessment of Avoidable Blindness (RAAB)[[71]](#footnote-71) revealed that cataract surgical coverage[[72]](#footnote-72) (CSC) is only 53.6% in Singida (M 65.9%, F 43.9%) and highlighted that women are particularly disadvantaged when it comes to accessing health services.

In response to this, Maono Singida[[73]](#footnote-73) project funded by the Standard Chartered Bank was launched in April 2016 to contribute to the sustainable provision of eye care services in the region, focusing on demand creation and improvements in current delivery mechanisms. The project was centred on treating adult cataract.

In 2017 Standard Chartered Bank provided Sightsavers with an opportunity for expansion of the project to reach school children and teachers and in January 2018 Maono Singida School Eye Health project commenced. The project aimed to address visual impairment of primary school children in the region which was found to be around 5%[[74]](#footnote-74) and increase with age[[75]](#footnote-75). The prevalence of uncorrected presbyopia in Tanzania was estimated at 47%[[76]](#footnote-76) among people 35 years and above. To address this, the Maono Singida School Eye Health project proposed to reach 50% of all school children in Singida to ensure the children with low vision can continue to learn, participate fully in society and have the best chance to be economically active in the future. To tackle adult presbyopia, the project also screened teachers who were then linked to the main Maono Singida project for adult refraction services.

In 2018 the Standard Chartered Bank invited Sightsavers to apply for additional funds for the original Maono Singida project to further strengthen the impact of the initiative. An additional grant has been subsequently awarded to Sightsavers to build on the existing work. The funding covered the period between January 2019 and June 2020.

Given that both projects are addressing gaps in eye health services in the same project areas it has been recommended to carry out a joint evaluation assessing their impact.

**1.2 Projects’ goals and objectives**

The Maono Singida- Sustainable Provision of Eye Care project is funded by Standard Chartered Bank providing $ 1,250,000 USD for the main project and $ 312,500 USD for its extension. The project is implemented between 1st April 2016 and 30th June 2020. The school eye health component is also funded by the Standard Chartered Bank providing $ 375,000 USD and is implemented between 1st January 2018 and 31st December 2019.

Both projects work with the Ministry of Health, PO RALG, Tanzania Community Development, Gender, Elderly and Children and Singida Regional Authority. In addition, each project has specific partners:

Maono Singida Sustainable Provision of Eye Care partners with Kilimanjaro Centre for Community Ophthalmology and Tanzania League of the Blind.

Maono Singida School Eye Health partners with the Ministry of Education, Science and Technology.

Both projects contribute towards sustainable provision of eye health services in the Singida region of Tanzania. Each of them has a set of project-specific objectives:

|  |  |
| --- | --- |
| **24027 Maono Singida Sustainable Provision of Eye Care** | **24030 Maono Singida School Eye Health** |
| **Objective 1:** Strengthened eye health systems to deliver eye health services in all six districts of the Singida region.  **Objective 2**: Men and women with visual impairment access eye health services in the six districts of Singida.  **Objective 3:** Increased support and commitment to eye health from local and central government. | **Objective 1:** Strengthened human resources and health facilities to deliver refractive error services.  **Objective 2:** Girls and boys with refractive error and visual impairment access eye health services. |

Together the projects intend to reach over 300,000[[77]](#footnote-77) beneficiaries, consisting of eye care patients and health personnel.

1. **Purpose of Evaluation**

The end of term evaluation will review the achievements of the project against the above-mentioned objectives. Through secondary and primary data, the evaluation will explore the extent to which the projects’ objectives have been accomplished and what have been the factors affecting or influencing the achievements including experienced challenges. Equity is a cross cutting issue that the evaluation will consider, including assessing if there were any specific barriers for women / girls or people with disabilities to access the project’s activities.

The assessment will use the following criteria which will be the basis for evaluation, analysis and reporting: relevance, effectiveness, efficiency, impact, sustainability, scalability/replicability and coherence/coordination[[78]](#footnote-78).

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 evaluation will also assess the extent to which it has been possible to implement the agreed mid-term review (MTR) recommendations and associated action plan formulated in the Management Response. The learning, findings and recommendations emerging from this evaluation will be important for Sightsavers’ and partners’ wider programming design and decisions.

**2.1 Evaluation criteria- questions**

Both projects will be assessed against the six criteria below. Project-specific questions are included under each of them.

**Relevance** – the extent to which the projects are suited to the priorities and policies of the target beneficiaries, national partners, and donors, where applicable.

* Maono Singida Eye Care- the mid-term review highlighted further support around reaching women. What has been done to explore and overcome barriers women might face when accessing eye health services? How have the gender mainstreaming workshop’s recommendations and actions plans been implemented and what has been the result?
* Both projects: How were the projects aligned with national health systems policies/ government priorities for eye health/ implementing partners?

**Effectiveness –** the extent to which the projects have attained their objectives.

* Maono Singida Eye Care: How effective has the project been in strengthening the existing health system[[79]](#footnote-79) in: service delivery, health workforce, health information systems, access to essential medicines, financing and leadership/ governance?

**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.

* Both projects: How efficient were district-based teams (members of the Council Health Management Teams, District Eye Coordinators, Social Welfare Officers and teachers) in completing end of year project plans in a timely manner and overcoming unexpected challenges?

**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.

* School Eye Health: Have the children or teachers self-reported any changes in the classroom since the distribution of spectacles?
* Maono Singida Eye Care: Has the project advocacy achieved increased government commitment to eye health?

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

* Maono Singida Eye Care: As per the MTR recommendation assessing progress against the implementation of the Sustainability Plan is a key component of the ETE. What is the current progress against the Sustainability Plan? How has the advocacy plan aligned (if at all) to support the implementation of the Sustainability Plan?
* School Eye Health: What is the status of the revolving fund for spectacles? Are teachers expected to carry on assessing children beyond the duration of the project?

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

* Both projects: What, if any, are the aspects of the projects that are replicable/scalable?

**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.

* School Eye Health: How have the health and education sectors brought together to coordinate for this specific project?

The commissioned consultant/team will be expected to further refine or develop the key questions during the Inception phase, in order to ensure the conceptual and practical scope of the evaluation is clear and appropriate, in consultation with relevant technical leads and project staff in Sightsavers and partners.

**2.2. Evaluation scope**

The projects will be evaluated against the following periods:

Maono Singida Sustainable Provision of Eye Care: 1st April 2016- 31st December 2019

Maono Singida School Eye Health: 1st January 2018- 31st December 2019

Although the extended Maono Singida project finishes at the end of June 2020, its performance will be compared against project targets up to the end of 2019, rather than the full project targets, since the fieldwork is planned for Q1-Q2 2020 and the complete results will not be available.

The evaluation will use a variety of methods, which will include a combination of documentation and data review, skype interviews and a field trip.

1. **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 Tanzania.

**3.1 Safety and risk management**

In planning the evaluation, the situation in Tanzania 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.

1. **Methodology**

The evaluators should detail the approach and methodologies to be used to indicate how they will fulfil the requirements of the Terms of Reference and address the evaluation objectives and EQs. These will include qualitative and quantitative tools as appropriate to conduct this evaluation. 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.

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

1. Review relevant reference material and data, as listed in Section 5 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](https://www.sightsavers.org/wp-content/uploads/2018/08/Sightsavers-Safeguarding-Policy-Aug-2018.pdf) 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](https://agora.unicef.org/course/info.php?id=2173), or equivalent, before embarking on the evaluation.

1. **Project Documentation**

**List of indicative key project documents**

* Proposal
* Budget
* Implementation Plan
* Logframe
* List of facilities and locations
* Donor narrative reports and appendices
* IAPB visit reports, and action plans
* Thematic QSATs
* Mid-term review (MTR)
* MTR management response and action plan
* Project narrative and financial reports
* Collation Project Data spreadsheets
* Singida Rapid Assessment of Avoidable Blindness (RAAB) 2018
* Programme Oversight Reporting reports
* District Data Collation Sheets

Further documentation will be made available on request, or as emerges during the Inception phase and beyond.

**6.** **Outputs/ deliverables**

The timeframe for the evaluation will be between January 2020 and June 2020. It is expected that work on the Inception phase will start in January 2020 with the fieldwork planned for March/April. All fieldwork needs to be completed before May due to the upcoming general election. The final report will be signed off by Sightsavers no later than 2nd June 2020 to meet the deadline for the final evaluation report on 30th June 2020.

**6.1. Indicative structure and phasing of evaluation**

| **Phase** | **Activity** | **Timeframe (TBC)** |
| --- | --- | --- |
| ***Phase I – Desk study: Review of documentation and elaboration of field study*** | Desk research /literature and data review | February 2020 |
| Inception Report | February 2020 |
| Revision of collection methods and  tools based on inception report  comments | February/March 2020 |
| ***Phase II: Field Data Collection*** | Field visits and data-collection[[80]](#footnote-80) | March/April 2020 |
| ***Phase III – Analysis and production of evaluation report*** | Debriefing (in-country) | April 2020 |
| Data analysis and preparation of Draft Report | May 2020 |
| Review of Draft Report from feedback. | May 2020 |

**6.2. 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.

**6.3. Draft Report**

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

**6.4. Final Report**

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

**6.5. Key findings presentation**

The evaluation team will also submit a short PowerPoint presentation (no more than 20 slides) of the key findings from the evaluation for Sightsavers to distribute or use as appropriate.

**6.6. 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.

**Support and Advice**

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 with the successful applicant 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.

1. **Budget and contract**

Contracted under the Framework Agreement 2019-2020, Tropical Health should submit to Sightsavers a proposal of the evaluation team, their roles and responsibilities and number of days input, as well as a work plan and budget including team members’ daily rates for the assignment and any other anticipated expenses.

Sightsavers will cover the following directly, but the budget should outline the following costs likely to be incurred for the assignment:

* Economy class airfares,
* In-country transportation,
* Hotel accommodation and meals,
* Meeting venue hire and associated equipment e.g. projectors.

The consultant/team is expected to cover all other costs and materials not mentioned above related to this exercise as part of their daily fees or equipment (e.g. laptops).

**SCHEDULE OF PAYMENT**

The following payment schedule will be adhered to:

* On acceptance and approval of technical and financial proposal: 40%
* On acceptance and approval of final report: 60%.

### Appendix 3: COVID-19 Overview

**COVID-19 pandemic**

Coronavirus disease 2019 (COVID-19) is an infectious disease that was first identified at the end of 2019 in China’s Hubei province. It has since spread globally and, with local transmission recorded in a large number of countries, WHO declared a pandemic on 11 March 2020. Countries that are most affected thus far are located on the Asian, European and American continents, but it can be expected that countries in Africa will be affected in the near future. Containment measures taken by governments across the globe include amongst others, travel restrictions, social distancing, closure of all public gathering sites including schools, and behavioural messaging e.g. around hand washing.

**COVID-19 impact on the four 2020 SiB projects evaluations**

Sightsavers have commissioned Tropical Health under their mutual evaluation framework agreement to undertake end term evaluations of five SiB projects in three countries (Zambia, Tanzania and Pakistan) between February and July 2020. All evaluations were meant to include field work, which will no longer be possible considering the containment measures described above.

**Tropical Health’s overall response**

During the current global COVID-19 pandemic, Tropical Health is committed to providing Sightsavers with quality desk-based evaluations which will involve fully remote work for all staff, consultants and stakeholders. The evaluations will be designed so no travel is required and without the use of face to face meetings. We will employ other methods of data collection to ensure the evaluations provide relevant and accurate findings and conclusions. We will re-purpose limited resources saved due to the cancellation of any travel, to evaluations re-planning given the changing context, reinforcing data collection and providing an additional evaluation summary and/or learning product.

**Revised evaluation approach**

The evaluation consultants will closely be supported by the Tropical Health team to revise each evaluation approach in detail. Anticipated revisions in the typical key evaluation steps are likely to include:

* **Evaluation Terms of Reference (ToRs)**: It was agreed between Sightsavers and Tropical Health that ToRs will not be revised but rather each evaluation team will comment in their respective evaluation inception report, on which evaluation questions will be affected by the revised methods and how. In case of a large amount of questions being affected, the team will propose alternative questions.
* **Kick-off meetings**: Under normal circumstances, the evaluation kick-off meetings take place remotely and therefore these will take place as normal.
* **Overall methods**: The data collection will continue to include both qualitative and quantitative methods. Additional support may be required from country offices to organise the remote consultative process to ensure maximum uptake. Additional time may be needed to provide adequate notice to participants and for arranging and following up with the interviewees to arrange the schedule. Due care and attention will be paid to the process and additional time will be given to country offices staff, where needed, in case there are competing priorities.
* **Documents and quantitative data review**: Equally, systematic review of project documentation and quantitative data is normally done desk-based and thus will proceed as planned. Each evaluation will be assessed separately, and the evaluator will use the documents and quantitative data to provide a more in-depth review where applicable, and depending on the evaluation questions.
* **Primary qualitative data collection**: Will not involve face to face meetings or focus group discussions in person. Instead, the consultants will utilise skype, zoom or similar to conduct interviews. The consultants will work closely with Sightsavers country offices to review stakeholders and potential key informants, and to arrange interviews to ensure an adequate sample of views and perspectives are collected in order to be as representative and inclusive of key project stakeholders as possible. The team will equally consult with the country offices to make sure that the mode of communication is appropriate and allows for inclusion of all types of stakeholder representatives. More time will be given to this process. Remote communication technology permitting, interviews will be recorded to ensure accurate documentation of respondents’ views. Where FDGs would normally be employed, we will consider interviews or larger online meetings for multiple attendees. Where adequate stakeholder representation or inclusion will have been hampered by the revised evaluation delivery approach (i.e. all done desk-based), this will be acknowledged in the evaluation reports as an overall limitation or one in relation to specific evaluation questions only, as applicable. The need to consequently treat the concerned evaluation findings with caution will be flagged.
* **Debriefing meeting**: After data collection and before drafting the evaluation report, a remote meeting will be organised between the consultants and Sightsavers key staff. This will be an opportunity to discuss the preliminary findings and develop the recommendations.
* **Evaluation summary and/ or learning product**: To assist with dissemination we will include in our approach a communication output, likely in the form of a power point presentation or a 2-3 page summary document with top level findings and recommendations and an infographic, as relevant (any specific format required to be shared by Sightsavers). These can either be used by Sightsavers for internal dissemination purposes or to share for wider learning. Resources permitting (to be confirmed upon review of all evaluations budgets), one of the four evaluations will offer a learning internal seminar facilitated by the evaluation team lead, with Sightsavers personnel as the primary audience.

**Potential risks and limitations and mitigation**

| **Risks and limitations** | **Mitigation** |
| --- | --- |
| Reduced live interactions with country office staff may reduce understanding of the evaluated projects and their context | Organise additional short check-in meetings with country team to review data collection process and discuss potential recommendations |
| Likely inability to consult with representatives from lower level of project implementation, especially services beneficiaries, leading to potential bias in perspectives gathered through interviews | Consult with country offices and maximise opportunities to be as inclusive as possible in selecting stakeholders to be interviewed by phone (i.e. from all levels of project implementation and from all constituencies, including vulnerable groups) |
| Inability to use observations | This cannot be mitigated against apart from relying on any secondary data source that summarises findings from observations; in such cases, data source will be clearly marked. Where that is not possible, it will be noted as a limitation in the evaluation report |
| Loss of informal and less structured discussions outside KIIs | Our team will build a rapport with the country team that will allow interactions outside structured interviews |
| Limited number of participants available due to ill-health, self-isolating or redeployment | More time will be given to working with the Sightsavers’ country offices to consider stakeholders and to ensure adequate numbers are interviewed. Flexibility over timings will be shown |
| Communications with stakeholders may be difficult | We will work with the Sightsavers country teams to explore best modes of communication. Those allowing recording of the interviews will be favoured |
| Staff may be diverted away from front line activities | We will be transparent and open in our correspondence, and flexible when arranging and scheduling meetings, we will be clear that future support will not be affected if the staff member is needed elsewhere. |

**Opportunities**

Whilst the revised approach presents obvious limitations compared to a traditional model involving in-country fieldwork, it also presents a number of opportunities:

* Ability to increase geographical reach as the team is not limited by travelling time
* Possibility to increase the number of interviews due to less travel time
* More flexibility to accommodate key informants availability than if the interviews had to happen during a short specified period of field work
* Reallocation of resources to develop outputs to support the dissemination of evaluation findings.

**Ethical and safeguarding considerations**

As written informed consent cannot be gained in person, the consultant will secure consent from respondents verbally, clearly stating the purpose, procedures, confidentiality and withdrawal options from the evaluation, at the beginning of the interview. Where feasible, consent forms will be shared ahead of the interviews and consent obtained verbally at the beginning of the call or a signed version returned. Interview records will provide back-up documentation of consent. As always, all data will be kept securely and only those directly involved in the evaluation will have access to them.

### Appendix 4: Detailed evaluation workplan



### Appendix 5: Key Informants

**Key Informant Interviews undertaken by telephone/skype for the evaluation**

| **Informant category** | **Organisation** | **District** | **Position** | **Method** | **Persons to be consulted -target** | **No. of KIIs -target** | **No. of KIIS actually undertaken** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Grant Manager | Sightsavers | n/a | Country Director | Skype | 1 | 1 |  |
| n/a | Programme Manager | 1 | 1 |
| n/a | Project Officer | Skype | 1 | 1 | 1 |
| n/a | Project Coordinator | 1 | 1 |
|  |  | n/a | Finance and Operations Manager | Telephone |  |  | 1 |
| Partner | Health Department | Singida Municipal | Medical Officer in Charge | Telephone | TBC | TBC | 1 |
| Singida Municipal | Regional Eye Care Coordinator (REC) | Telephone | 1 | 1 | 1 |
| Education Department | Singida Municipal | Regional Education Officer (REO) or  RSAO | Telephone | 1 | 1 | 2 |
| Health staff | Singida Regional Referral Hospital | Singida Municipal | Assistant Medical Officers in Ophthalmology (AMOOs) | Telephone | 1 | 1 | 1 |
| Singida Regional Referral Hospital | Singida Municipal | Ophthalmic Assistants (OAs) | Telephone | 1 | 1 | n/a |
| Education staff | District primary schools | Singida Municipal | School teachers | Telephone | 6[[81]](#footnote-81) | 6 | 6 |
| Health staff | District health facility | Iramba | Hospital Manager (DMO) | TBC | TBC | TBC | 1 |
| Iramba | District Eye Care Coordinator (DEC) | Telephone | 1 | 1 | 1 |
| Iramba | AMOO | Telephone | 1 | 1 | n/a |
| Iramba | OA | Telephone | 1 | 1 | n/a |
| Education staff | District Educational department | Iramba | DEOs or DSAOs | Telephone | 1 | 1 | 1 |
| District primary schools | Iramba | School teachers | Telephone | 6 | 6 | 6 |
| Health staff | District health facility | Manyoni | Hospital Manager (DMO) | Telephone | TBC | TBC | 1 |
| Manyoni | District Eye Care Coordinator (DEC) /AMOO | Telephone | 1 | 1 | 1 |
| Manyoni | AMOO | Telephone | 1 | 1 |
| Manyoni | OA | Telephone | 1 | 1 | n/a |
| Education staff | District Educational facilities | Manyoni | DEO or DSAOs | Telephone | 1 | 1 | 1 |
| Manyoni | School teachers | Telephone | 6 | 6 | 6 |
| Education staff | District Educational department and facilities | Singida DC | DEO or DSAOs | Telephone | 1 | 1 | 1 |
| Singida DC | School teachers | Telephone | 6 | 6 | 6 |
| Education staff | District Educational department and facilities | Mkalama | DEO or DSAOs | Telephone | 1 | 1 | 1 |
| Mkalama | School teachers | Telephone | 6 | 6 | 6 |
|  |  |  |  |  | **46** | **46** | **47** |

### Appendix 6: Informed consent form for KIIs and FGDs

**MAONO SINGIDA- SUSTAINABLE PROVISION OF EYE CARE & MAONO SINGIDA- SCHOOL EYE HEALTH: End of Term Evaluation Information and Consent to Participate in Review**

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

You are invited to participate in an end of term evaluation of the Sightsavers’ **Maono Singida- Sustainable Provision Of Eye Care & Maono Singida- School Eye Health**, because you are one of the stakeholders in one or both of these projects. The evaluation is being conducted by a small team of evaluators from an international health consultancy named Tropical Health. Your participation in this evaluation is entirely voluntary.

**Purpose of the review**

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

**Procedure**

You will be asked a series of questions about your experience of the Maona Singida Eye Care and School Screening projects. We will record the conversation to ensure we capture what you say accurately, BUT this recording will not be heard or used beyond the evaluation team.

**Potential risks and discomforts**

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

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

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

**Payment for participation**

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

**Confidentiality**

Any information obtained in connection with this evaluation and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained at all times and we will not use your name in any of the information we get from this study or in any of the reports. 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 study in any way we think is best for publication or education. Any information we use for publication will not identify you individually.

**Participation and withdrawal**

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

**Identification of the in-country evaluators**

[NAMES, EMAILS]

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Signature of Respondent(s)  
Date:  
KII/FGD

### Appendix 7: KII Topic Guide: Interviews with Key Informants

###### MAONO SINGIDA- SUSTAINABLE PROVISION OF EYE CARE &

###### MAONO SINGIDA- SCHOOL EYE HEALTH

**Interviewer Instructions**

**Purpose and respondents:** This topic guide is to be used for key informant interviews (KIIs) with stakeholders at health facilities and community levels, such as eye care staff and managers, education staff and any other project partners. The guide follows the key evaluation criteria described in the ToR.

**Asking Questions:**

* This is a semi-structured interview guide.
* Not all topics will be relevant to all informants. The questions will be tailored according to the respondent’s involvement in the programme and area of expertise. For example, see Table A below for indicative relevance of Evaluation Questions to KIIs.
* 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.
* Although the questions are numbered, they may be asked in a different order, and topics that have already come up spontaneously in the interview may be skipped.
* Standard probes will be used to encourage respondents to elaborate (“can you tell me more about that”), and to ensure that the respondent has nothing further to add on a topic (“anything else?”)
* As data collection progresses, questions will be refined based on information obtained and 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.
* In some cases, this topic guide will be used to interview two or more individuals at the same time. Where more than one respondent is present, the evaluator will use prompts to encourage reflective discussion and exchange between the informants (e.g. of challenges, lessons learned, areas for improvement, etc.).

**Table A – Indicative guide to interview schedules**

|  | **Key Informant** | **Evaluation Question to explore through semi-structured interview** |
| --- | --- | --- |
| SI | Sightsavers staff | 1, 3, 4, 6, 7, 8, 9 |
| ECS | Eye Care staff – i.e. AMOOs and OAs | 1, 3, 4, 9 |
| REC/ DEC | Regional/District Eye Care Coordinators | 1, 2, 3, 4, 6, 7, 9, 10 |
| HM | Health managers | 1, 2, 3, 6, 7, 9 |
| REO/ DEO | Regional/District Education Officers | 2, 4, 5, 8, 9, 10 |
| R/DSAO | Regional/District Social Affairs Officers | 1, 4, 8, 9 |
| T | Teachers | 2, 4, 5, 8, 9 |

**Introduction of the interview to the respondent:**

* [Introduce self]
* I have been asked to evaluate the Maona Singida Eye Health project supported by Sightsavers, an international organization working to help prevent avoidable blindness.
* 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.
* Our goal is to understand and document your experience so that we can learn from it and make recommendations for future programmes.
* The questions will take about 1 hour [state longer time if more than one person being interviewed].
* Whatever you tell me will be kept confidential, and I will only share it with our evaluation team. Any information or reported findings that we include in our report will not identify you directly.
* Do you have any questions for me before we begin?

**All respondents to sign information and informed consent sheet, and be given a unsigned copy.**

|  |
| --- |
| **Interview and respondent information to be recorded** |
| * Date of interview |
| * Length of interview (start/end time) |
| * Name |
| * Gender |
| * Location of interview |
| * Any notes on interview context and persons present |

| **Q** | **Topic** |  |
| --- | --- | --- |
| **Introduction: Programme Involvement** | | |
|  | [Greetings, informal conversation]  Please tell me about your involvement and role in the eye health services provided in your area. | All |
| **Evaluation Question 1: Maono Singida Eye Care-** the mid-term review highlighted further support around reaching women. What has been done to explore and overcome barriers women might face when accessing eye health services? How have the gender mainstreaming workshop’s recommendations and actions plans been implemented and what has been the result? | | |
| a) | The project mid-term review highlighted the need for further support around reaching women:  What has been done under this Eye Health project to fully understand why women/girls might face barriers to eye care treatment?  P: What has been learnt during the course of the project?  P: What is done differently now?  P: What gaps/challenges remain? | ECS  REC and DECs  HM  SI |
| b) | Did you take part in the Sightsavers gender mainstreaming workshop?  If YES, what do you feel you learnt? What do you do differently now?  P: How have the gender mainstreaming workshops recommendations been implemented and what has been the result? | SI  R/DSAOs  REC and DECs[[82]](#footnote-82) |
| **Evaluation Question 2: Both projects -** How were both projects aligned with national health systems policies/ government priorities for eye health/ implementing partners? | | |
| a) | What do you see as the priorities for eye health at the national level? | REC and DECs  HM |
| b) | What do you see as the national priorities for school screening? | REO  DEOs  T |
| **Evaluation Question 3:** **Maono Singida Eye Care -** How effective has the project been in strengthening the existing health system[[83]](#footnote-83) in: service delivery, health workforce, health information systems, access to essential medicines, financing and leadership/ governance? | | |
| a) | Have you received any training under these projects?  P: Can you tell me what the training was for, and what you do differently as a result of it? | ECS  REC DECs |
| b) | Has any infrastructure support or equipment been provided by the project in this district/facility? (e.g. refurbished units, eye care equip, computers, screening kits)  P: Are these running satisfactorily?  P: What do you do if any equipment breaks down?  P: Is there any provision for equipment replacements after the project ends? | SI  ECS  REC DECs  HM |
| c) | Have there been any changes in the supply/access to eye care medicines and consumables (e.g. tetracycline, surgical lens, spectacles) in this district/facility during the last 4 years (2016-2019)?  P: If so, what difference has this made to service delivery? | SI  ECS  REC DECs |
| d) | Have there been any changes in the Health Management Information systems and health data recording in this district/facility during the last 4 years (2016-2019)?  P: Has this affected your work, either positively or negatively? | SI  ECS  REC DECs  HM |
| e) | In your view, have there been any significant changes in the way eye health services are managed during the last 4 years (2016-2019) in this district?  P: Has this affected your work/service delivery, either positively or negatively?  [If appropriate - P: In regard to transfer of management of SRRH, and devolvement of budgets to facilities level?] | SI  ECS  REC DECs  HM |
| **Evaluation Question 4:** **Both projects** - How efficient were district-based teams (members of the CHMTs, DECs, Social Welfare Officers and teachers) in completing end of year project plans and overcoming unexpected challenges? | | |
| a) | What has gone well in implementation of these eye care and school screening projects?  P: What has been challenging in this eye care/school screening project?  P: How did you try to overcome challenges experienced? | SI  ECS (if CHMT member)  REC and DECs  REO  DEO  RSAO  DSAO  T |
| **Evaluation Question 5: School Eye Health -** Have the children or teachers self-reported any changes in the classroom since the distribution of spectacles? | | |
| a) | **For REO/DEOs:**  Has there been any recording of changes in the classroom since the distribution of spectacles in 2018 and 2019?  P: Is there any educational performance, or other data to indicate if children who are now wearing spectacles are more able to do better at school?  Do you have any suggestions about how any benefits could be monitored or learning captured more systematically in the future? | REO  DEOs |
| b) | **For Teachers:**  What has been your experience of your involvement of the school-base screening for Refractive Error (RE)?  P: Do you feel the training was adequate for the task? | T |
| c) | What changes, if any, (e.g. emotional, educational, other) have you observed in individual children who were diagnosed with RE and prescribed spectacles? | T |
| d) | Have you perceived any changes among the other children in the classroom? e.g. in their attitudes to those children newly acquiring spectacles? | T |
| e) | Do you think there are any obstacles to children maintaining the wearing of spectacles at school?  P: Have any children lost their specs or repeatedly forget to/don’t wear them? | T |
| f) | If you have observed or heard about benefits of these children wearing spectacles, do you have any suggestions about how these benefits could be monitored or recorded systematically to demonstrate the importance and value of school screening and spectacle wearing by school children? | T |
| **Evaluation Question 6: Maono Singida Eye Care:** Has the project advocacy achieved increased government commitment to eye health? | | |
| a) | Do you think government commitment to eye health has changed in the last 4 years?  P: In what ways? | SI  REC/  DECs  HM |
| b) | What do you think have been the main reasons/influencing factors for that?  P: Can you let us know of any evidence to support this view? | SI  REC/  DECs  HM |
| **Evaluation Question 7:** **Maono Singida:** What is the current progress against the Sustainability Plan? How has the advocacy plan aligned (if at all) to support the implementation of the Sustainability Plan? | | |
| a) | What are the main sources of funding for eye care in this region/district/facility? [delete as appropriate]  P: How do Management Teams/Facility Managers resolve any limitations from government sources of funding for eye care? | SI  REC DECs  HM |
| b) | What is the current progress against the Sustainability Plan?     Who is responsible for and what is the mechanism/process for monitoring the Sustainability Plan? (Logframe etc)?  P: is there any documentation relating to this?  What progress has been made on Outputs and Objectives of the Sustainability Plan since 2017?  Has the Sustainability Plan been useful in supporting moves towards sustainable financing? If so in what ways? | SI  REC DECs  HM |
| c) | Are there any specific project advocacy activities or events which can be shown to have been influential in any decisions for increases the eye health budget and spending, and progress of the Sustainability Plan?  P: Can you identify any key evidence to support this? (e.g. minutes, documents, events reports, policy statements etc) | SI  REC DECs |
| **Evaluation Question 8: School Eye Health:** What is the status of the revolving fund for spectacles? Are teachers expected to carry on assessing children beyond the duration of the project? | | |
| a) | How has the cost recovery scheme for spectacle provision worked under this project?  P: What has worked well, and where? What has been more challenging?  How might this be sustained after the project has finished? | SI  T  REC  DECs |
| b) | Are teachers expected to carry on assessing children beyond the duration of the project?  If YES, are there any obstacles or challenges you anticipate for teachers to continue eye health screening in schools after the project ends?  If NO, will school screening continue in any way? | SI  T  REO  DEOs |
| **Evaluation Question 9:** What, if any, are the aspects of both projects that are replicable/scalable? | | |
| a) | In your view, what aspects of this project were most successful and should be replicated elsewhere, or could be scaled up? | All |
| **Evaluation Question 10:  School Eye Health:** How have the health and education sectors brought together to coordinate for this specific project? | | |
| a) | Who has responsibility for planning and running the school eye care screening events, and integrating this programme into the school calendar?  P: Did you, or Do you have a shared implementation plan with the REC/DECs or REO/DEOs? (delete as appropriate)  P: How often do you meet for planning and/or implementation? | REC  DECs  REO  DEOs |
| b) | What is the Regional/District Authority’s plans or programme for school screening in the coming years? | REC  DECs  REO  DEOs |
|  | FINAL COMMENTS |  |
|  | Are there any other lessons learned from this programme that you wish to share?  [Closing / thank for time]  [RECORD INTERVIEW END TIME] | All |
| **Closing** | | |

### Appendix 8: Document review checklist

SiB Maono Sustainable Singida Eye Care documents

| Folder | Documentation | Provided for review | Prioritised for review by TCO | Date Added to Sharefile | Reviewed |
| --- | --- | --- | --- | --- | --- |
| Advocacy | | | | | |
|  |  |  |  |  |  |
| Baseline & Endline | | | | | |
|  |  |  |  |  |  |
| Budget | | | | | |
|  | 2015 24027 Phase V Tranche 3 SiB Proposal Budget Notes | Yes |  | 02.03.20 |  |
|  | 2015 24027 Phase V Tranche 3 SiB Tanzania Proposal Budget | Yes |  | 02.03.20 | Yes |
| Contract | | | | | |
|  | 2016 - 24027 SiB Tanzania Phase 5 Tranche 3 - signed contract | Yes |  | 02.03.20 |  |
|  | 2016 24027 PFA | Yes |  | 02.03.20 |  |
|  | 2018 24027 Singida Regional Authority CoC | Yes |  | 02.03.20 |  |
| Data Collection Log | | | | | |
|  | 2016 24027 SIB Tanzania Data Collection Log | Yes |  | 02.03.20 | Yes |
| Donor Reports | | | | | |
|  | 2016H1 - 24027 Maono Singida Eye Care | Yes |  | 02.03.20 | Yes |
|  | 2016H1 - 24027 Maono Singida Eye Care- Appendices | Yes |  | 02.03.20 |  |
|  | 2016 H2 24027 SIB Tanzania Donor Report | Yes |  | 02.03.20 | Yes |
|  | 2017 - 24027 - Y2H1 SIB Tanzania Six Months Progress Report - 31-Oct-2017 | Yes |  | 02.03.20 | Yes |
|  | Sightsavers Maono Singida Y2H2 Progress Report April 2018 - 18.5.2018 | Yes |  | 02.03.20 | Yes |
|  | SIB MAONO Singida Y3H1 - Progress Report final-revised 141118 | Yes |  | 10.03.20 | Yes |
|  | SIB Maono Appendices 1-7 Final Y3H1-revised 141118 | Yes |  | 10.03.20 | Yes |
|  | SIB MAONO Singida Y3H2 Narrative Report- 30-Apr-19 | Yes |  | 10.03.20 | Yes |
|  | Appendices 1 to 7 SiB 24027 Tanzania Y3H2 30-Apr-19 corrected | Yes |  | 10.03.20 | Yes |
|  | SiB Maono Y4H1 - Narrative Report - revised 27-Nov-19 | Yes | YES | 10.03.20 | Yes |
|  | SiB Maono Y4H1 - Report Appendices + review 19-Nov-19 | Yes |  | 10.03.20 | Yes |
|  |  |  |  |  |  |
| Financial Reports | | | | | |
|  | SIB Maono Singida Report \_Financial and Appendices final 011118 |  |  |  | Yes |
|  |  |  |  |  |  |
| Implementation Plan | | | | | |
|  | 2016 24027 Implementation Plan | Yes | YES |  | Yes |
| Logframe | | | | | |
|  | 2016 24027 Maono Singida Eye Care Logframe | Yes | YES |  | Yes |
|  | MRT SIB Tanzania Data Collection Log FINAL 05 August 2018 |  |  |  | Yes |
| M&E Plan | | | | | |
|  |  |  |  |  |  |
| Mid-Term Review | | | | | |
|  | Maono Singida 24027 MTR- Management Response Final (working doc) | Yes | YES |  | Yes |
|  | Maono Singida Tanzania MTR Final Report | Yes | YES |  | Yes |
| Monitoring Reports | | | | | |
|  | 2016 Q1 24027 MAONO Project - Quarter 1 Progress Report | Yes |  |  | Yes |
|  | 2016 Q3- 24027 MAONO Project | Yes |  |  |  |
|  | 2017 Q2 24027 narrative report | Yes |  |  |  |
|  | 2017 Q3 24027 SIB Tanzania Y2H1 Progress Report | Yes |  |  |  |
|  | 2017 Q4 24027 MAONO Project - quarterly narrative report | Yes |  |  |  |
| Other | | | | | |
|  | 2016- 24027 MAONO Project -Inception Workshop Report | Yes |  |  | Yes |
|  | Singida\_RAAB\_Report\_Jan 2018 | Yes |  |  | Yes |
|  | Tanzania Gender workshop report 14.03.17 |  |  |  | Yes |
|  | Final-NECP-Tanzania\_2011-2016 |  |  |  | Yes |
|  | EHSA |  |  |  | Yes |
|  | Maona Project - Singida Region – Situational Analysis: Health Financing and Challenges for Sustainability of Eye Health Services |  |  |  | Yes |
|  | Maona Project - Singida Region – Health Financing Sustainability Plan |  |  |  | Yes |
|  | Ministry of Health and Social Welfare National Eye Health Strategic Plan 2018-2022 |  |  |  | Yes |
|  | Integration of eye health into primary care services in Tanzania: a qualitative investigation of experiences in two districts  [Emma Jolley](https://www.ncbi.nlm.nih.gov/pubmed/?term=Jolley%20E%5BAuthor%5D&cauthor=true&cauthor_uid=29237503),1 [Milka Mafwiri](https://www.ncbi.nlm.nih.gov/pubmed/?term=Mafwiri%20M%5BAuthor%5D&cauthor=true&cauthor_uid=29237503),2 [Joanna Hunter](https://www.ncbi.nlm.nih.gov/pubmed/?term=Hunter%20J%5BAuthor%5D&cauthor=true&cauthor_uid=29237503),3 and [Elena Schmidt](https://www.ncbi.nlm.nih.gov/pubmed/?term=Schmidt%20E%5BAuthor%5D&cauthor=true&cauthor_uid=29237503)1  [BMC Health Serv Res](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5729236/). 2017; 17: 823. |  |  |  | Yes |
|  | MAONO - CAS QSAT Singida - Action Plan |  |  |  | Yes |
|  | Cataract QSAT (EN) Singida - draft Feb-18 |  |  |  | Yes |
|  | Merck Singida CEC Pilot Overview1 |  |  |  | Yes |
|  | Education Sector Development Plan (2016/17-2020/21 Ministry of Education, Science and Technology, Government of Tanzania |  |  |  | Yes |
| Proposal | | | | | |
|  | 2015 24027 Phase V Tranche 3 SiB Tanzania PROPOSAL | Yes | YES |  | Yes |
|  | Sightsavers SiB Tanzania extension - Proposal 9-Oct-18 |  |  |  | Yes |
| Total documents reviewed to date | | | | | **34** |

Maono Singida – School Eye Health Component documents

| Folder | Documentation | Provided or sourced for review | Prioritised for review by TCO | Date Added to Sharefile | Reviewed |
| --- | --- | --- | --- | --- | --- |
| Advocacy | | | | | |
|  |  |  |  |  |  |
| Baseline & Endline | | | | | |
|  |  |  |  |  |  |
| Budget | | | | | |
|  |  |  |  |  |  |
| Contract | | | | | |
|  | 2018 24030 Singida Regional Authority CoC | Yes |  |  |  |
|  | 2018 Q1 24030 PFA - School Eye Health | Yes |  |  |  |
|  | SiB Tanzania extension contract | Yes |  |  |  |
| Data Collection Log | | | | | |
|  | 24030 Collation sheet | Yes |  |  | Yes |
|  | 24030 Maono Singida School EH DCL | Yes |  |  | Yes |
| Donor Reports | | | | | |
|  | School Eye Health - Y2H1 Annual Report Appendices | Yes |  |  |  |
|  | School Eye Health - Y2H1 Progress Report | Yes |  |  | Yes |
|  | School Eye Health - Y2H2 Annual Report Appendices | Yes |  |  |  |
|  | School Eye Health - Y2H2 Progress Report-July to Dec 2019 | Yes | Yes |  | Yes |
|  | Sightsavers Maono School Eye Health - Y1H1 Appendices - 31-Jul-18 | Yes |  |  |  |
|  | Sightsavers Maono School Eye Health - Y1H1 Progress Report - 31-Jul-18 | Yes |  |  | Yes |
|  | Sightsavers Maono School Eye Health - Y1H2 Appendices - 31-Jan-19 | Yes |  |  |  |
|  | Sightsavers Maono School Eye Health - Y1H2 Progress Report - 31-Jan-19 | Yes |  |  | Yes |
| Financial Reports | | | | | |
|  |  |  |  |  |  |
| Implementation Plan | | | | | |
|  | 24030 Maono Singida School EH Logframe\_implementation plan | Yes | Yes |  | Yes |
|  |  |  |  |  |  |
| Logframe | *See above* | Yes |  |  | Yes |
|  |  |  |  |  |  |
| M&E Plan | | | | | |
|  |  |  |  |  |  |
| Mid-Term Review | | | | | |
|  |  |  |  |  |  |
| Monitoring Reports | | | | | |
|  | Quarterly narrative report-school eye health project January to March 2018-Q1 - Revised | Yes |  |  | Yes |
| Other | | | | | |
|  |  |  |  |  |  |
| Proposal | | | | | |
|  | SiB Tz School eye health 15 Nov 17 | Yes | Yes |  | Yes |
| Total documents reviewed to date | | | | | **10** |

### Appendix 9: Quantitative data table



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### Appendix 10: MTR Recommendations Action Plan – validated self assessment

| **Evaluation Recommendations  (A)** | | **Accepted/**  **Rejected**  **(B)** | **Priority**  **High/**  **Medium/**  **Low**  **(C)** | **If “Accepted”, Action plan for Implementation or if “Rejected”, Reason for Rejection**  **(D)** | **Responsibility**  **(E)** | **Timeline**  **(F)** | **Status – Completed, Partially completed, Not completed** | **Evidence / explanation** | VALIDATION DURING THE END OF TERM EVALUATION  Status –  Completed  Partially completed  Not completed |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | Review the logframe to:   1. Reflect seven districts (currently it reflects six) 2. Remove either output indicator 3.6 or 3.7[[84]](#footnote-84) to support the implementation of the Sustainability Plan, such as conduct sustainability advocacy meetings with community leaders to generate buy-in towards sustainability” (Output 5.2. of the sustainability plan). 3. Include clear definitions for measuring the success of outputs (targets and achievements) related to objective 3. For example, clearly define if an indicator’s target and achievement is cumulative across the project’s time-period, or measured according to the latest progress made. | Accepted | High | 1. To Revise the Log frame to reflect the recommended changes. (The revised log frame will reflect seven districts instead of six ) 2. We have added one more indicator i.e. 3.8 to support the implementation of the developed sustainability plan 3. All target and actual have been clearly defined in the project proposal; however we are reporting based on target and actual performance. The under achieved indicators are carried forward to the next year of implementation phase (half’s years) therefore during the next ETE, the thoughtful consultant will be advised to use the donor reporting Appendices 1, 6 and 7 to gauge the performance rather than original proposal in some indicators. | Edwin Maleko | 24th Sept 2018 | 1. Completed 2. Completed      1. Completed | 1. Revised log frame reflect seven districts and not six 2. One indicator to capture the implementation of the developed sustainability plan added 3. Donor reports submitted to the consultant | Collation sheet has 7 districts  A new indicator has been added to the Data Collection Log - 3.8 Number of sustainability advocacy meetings with CHMTs, RHMT and community leaders to generate buy-in towards eye care financing (sustainability plan) – although no data has been formally recorded against this. |
| **2** | Revise the following targets:   1. Increase output 2.4 “Number of women groups trained for eye health community awareness and provided with IEC materials” and ensure they are equally dispersed across the seven districts. 2. Increase the target for output 3.2 “Number of eye care personnel who participate in decision making structures at regional and district level” | a) Rejected  b)Accepted | Medium | 1. Increasing the number of women groups would affect financial resources. However, more women groups will be reached during community sensitization campaign which would make it possible to reach more women with no budget implications. 2. More decision makers that includes Regional and District health management team members will be reached during health financing strategic framework dissemination. | TCO programme team | Oct – Dec 2018 | a) Completed  b) Completed | We trained women groups per the project target, however we intensified sensitization campaigns through PA system and radio programs with specific messages to raise awareness among women.  District Medical Officers and Regional Medical Officers were involved during the health financing strategic framework dissemination. | Confirmed by donor reports and collation spreadsheet as evidenced in the Quantitative Data tool – Appendix 9 of this report.  High level promotion of women messaging by senior figures has been undertaken.  Documentation and interviews confirm this. |
| **3** | Update the following documentation:   1. Documentation on Targets[[85]](#footnote-85) to reflect target revisions and include all sex disaggregated targets. Also, include target definitions, particularly if they are cumulative or refer to latest achievement. 2. In preparation for the ETE, ensure that the latest valid and quality assured data are found in the latest final donor report. Then adopt the policy that the latest valid and quality assured data are found in the latest, final donor report and communicate this to the evaluation team. | Accepted | High | 1. Targets will be revised and collation sheets will reflect both donor and portal data reported. 2. Taken for future evaluation i.e. ETE. The project team will review data shared in the donor report Vs the collation sheet before sharing with engaged consultant. | Edwin Maleko and evaluations team/PSMT | a) 30th September 2018  b)April 2020 | a)Completed  b)Completed | Data variances explained to ETE evaluation team | The ECSA Monitoring Manager has reported that the portal and collation spreadsheet do not align still.  Was instructed to use the collation sheet as data source, but later the team was told other figures should be used. This created some confusion and meant evaluation data analysis could not be completed fully. |
| **4** | Add to the bi-yearly donor reports:   1. A section on “Gender” in the narrative part of the reports in order to monitor more closely efforts in targeting women for eye care services. This section will report on efforts the project is taking to target women for eye care services. 2. For the quantitative outputs under objective 3 (3.1, 3.2, 3.4 and 3.5), report on them directly and explicitly against the log frame either in the narrative report, if it is made clear which log frame indicators are being referred to, or in the output table (Appendix 7) | Accepted | High | 1. More strategic methodologies to address gender aspect are continuously considered as to ensure increased participation of women during screening and surgeries. Future donor narrative report will be evidence this learning. 2. We are reporting output 3.1, 3.2, 3.4 and 3.5 by using five levels of influence. We report the outcome of conducting advocacy meetings and not the number of leaders involved in decision making | TCO programme staff | Ongoing starting from Oct 2018 | 1. Partially completed 2. Completed | We have conducted Gender study to inform challenges facing women – unfortunately we can not impalement some of the recommendations from the study due to time frame and limited financial resources under this project (To be included into the next designs)  We aligned with donor reporting format | The evaluation has not seen the gender study concerned by understand it is in draft.  There is no evidence that the Levels of influence are being used. No document on this was provided to the evaluation team. They were directed to the narratives of the donor reports for advocacy achievements. |
| **5** | With the donor, discuss and review the current donor engagement strategy with particular focus at country level. | Accepted | High | To arrange meeting and discuss country level engagement strategies with Standard Chartered Bank CEO | TCO programme staff | Oct – Dec 2018 | Completed |  | No evidence or explanation provided and no record so cannot verify |
| **6** | Further support and follow-up from the gender mainstreaming workshop. This could involve following-up and reviewing the workshop actions and building the capacity of local stakeholders in completing primary data collection and gender analysis. | Accepted | High | To follow up on Gender action with focal persons. I.e. Trained Social Welfare Officers and Regional Eye Coordinator. | Edwin Maleko | Quarterly starting from Q3 2018. | Partially completed | We allocated funds to support in conducting gender study so that we can come up with implementable recommendations (ref activity under Extension project) | The RSWO confirmed that the workshop had been useful and various follow up actions had been undertaken.  The evaluation has not seen the gender study concerned by understand it is in draft. |
| **7** | Where funding is available, complete the market/observational study on barriers of women accessing eye care, particularly in rural areas, and assess how effective methods used to target women are. | Accepted | Low | Market survey will have financial impact on the restricted resources available. In the current funding the project will not undertake market research as there are no funds. However; TCO team consider resources for observational study in the coming project designing such as UKAID. | TCO programme staff | TBC upon new funding opportunities. | Completed | But not aligned with the recommendation implementation time frame (Ref to Gender study report of April 2020) | The evaluation has not seen the gender study concerned by understand it is in draft. |
| **8** | Where funding is available, develop a Singida Region gender mainstreaming strategic plan in partnership with local implementing partners and base this on the findings of the market/observational study. | Accepted | Low | To make sure that \District Eye care coordinator understand their performance and use their eye care data collected to inform their budget allocation in planning. | TCO programme staff | TBC upon new funding opportunities. | Not completed |  | No comment to add |
| **9** | For the remaining two years of the project, target training more female rather than male community leaders. | Accepted | Low | Training of community leaders was completed in year 1 and therefore there are no more resources to support other trainings on the agenda. However, the project will consider increasing the number of female community health workers in the ongoing training activities. | TCO programme staff | Ongoing starting from October 2018. | Partially completed | In every village they have 1Female and 1Male community health workers therefore it was not possible to get more women. (50.7% Female trained) | Completed given the constraints of existing gender balance of community health workers |
| **10** | Review the project’s community awareness strategy and, where funding is available, conduct formative research or exploratory data collection on eye care seeking behaviours and successful strategies to disseminate health messaging[[86]](#footnote-86). An opportunity for this research could be adding it to the market/observational study noted above. Based on this review and research, develop a comprehensive concept note detailing the project’s health communication approach, including who will be targeted, how and why. [[87]](#footnote-87) | Accepted | Low | Through project community, awareness strategies will continue to be deployed as a means of enabling men, women and children at large to participate fully for accessing eye care services using the available resources. Documentation on these strategies will be done as to influence the learning.  Fund restriction poses a challenge to conduct a formative research and this would be linked with market research upon funding availability. | TCO programme staff and Sightsavers Research staff | TBC upon new funding opportunities. | Not completed |  | No comment to add |
| **11** | Establish a systematic, but not too time and resource consuming, follow-up structure for community leaders, VHWs, and women’s groups trained as part of the project. The purpose of this follow-up structure is to monitor the progress of these stakeholders in raising community awareness. For example, the District Eye Coordinator (DECs) could follow-up via phone on a monthly basis with these community groups and report these follow-up calls or meetings in the quarterly monitoring tool used by the Project Coordinator. Also, if budget and time allows, post-training follow-up for these community groups could be carried-out, such as a 1-hour Q&A session where they refresh knowledge and answer questions. | Accepted | High | Follow up structure will be incorporated In RHMT and CHMTs quarterly supervisory visit, to ensure that the trained Primary Health Workers (PHWs), Community leaders and VHWs raise awareness on eye health within their areas. | Edwin Makelo | 10th Dec 2018 | Partially completed | Discussed during quarter review meetings with RHMT and CHMTs. Few district i.e. Ikungi, Singida rural, Iramba achieved to distribute HMIS books for PHWs to record patients with eye conditions and providing referrals. | Confirmed that reports indicate that PHWs are using book 16 for referrals. |
| **12** | Increase the project’s engagement of national government stakeholders in order for learnings from the project to influence the broader eye care movement in Tanzania. | Accepted | High | To engage partner closely in project activities so as to increase their learning and experience which as a result will spearhead the ongoing initiatives of making the project’s activities sustainable. | Edwin Makelo | Ongoing/ starting from Q3 2018. | Partially completed | No specific engagement meeting with national government stakeholders, however TCO SMT attended various forums and involved in the designing of National Eye Care Strategic Plan 2018/2022 | The project and TCO engagement at national level seems very sound and Sightsavers has influence at a national level. |
| **13** | Refresh the training of eye care planning, resource mobilisation and lobbying for Eye Care Coordinators and Planning Officers and do so in alignment with the Sustainability Plan. | Accepted | High | To conduct advocacy meeting to train planning officer on fund allocation and prioritization of eye health services | Edwin Makelo | Ongoing/ starting from Q3 2018. | Completed | Refer to quarterly project review meetings with partners | Project reports indicate training has been conducted satisfactorily |
| **14** | Communicate to project stakeholders the status of the completion of the Sustainability Plan | Accepted | High | Final sustainability plan will be disseminated to partner for mutual agreement. | Edwin Makelo | 12th Oct 2018 | Completed | Final sustainability plan disseminated to partner after their participations in reviewing the plan. DECs, DMOs and RHMT involved throughout the process | Final Sustainability Plan has been reviewed by the evaluation, but it is not clear that all stakeholders are aware of the Plan. |
| **15** | Review the advocacy plan and ensure it is aligned to support the implementation of the Sustainability Plan. For example, the following indicator could be added: “conducting sustainability advocacy meetings with community leaders to generate buy-in towards sustainability” (Output 5.2. of the sustainability plan). | Accepted | High | Indicators to be added to reflect advocacy meeting for sustainability plan. | Edwin Makelo | 30th Sept 2018 | Completed |  | The project Advocacy Plan has not been updated, but does align reasonably well with the Sustainability Plan in its narrative and objectives. |
| **16** | Consider including the following as key areas of assessment for the ETE:   1. The implementation of the Sustainability Plan 2. The impact of the change in management of SRRH from the Regional Authority to the MoHCDGEC. 3. The impact of the change in the region’s budgeting process from the district to the health facility level | Accepted | High | The suggested areas will be included in the forthcoming End Term Evaluation:   1. The implementation of the Sustainability Plan will be assessed during ETE 2. This will be documented during the ETE to assess how the restructuring have contributed to either positive or negative improve | TCO programme staff, Evaluation team | 2020 | Completed |  | The evaluation addressed all questions presented in the evaluation TOR. These included a question on the Sustainability Plan progress, but not on the impact of changed management of SRRH, nor explicitly on the change in regional budgeting process, although the evaluation did consider this. |

### Appendix 11: Table used in MTR to assess Gender Mainstreaming workshop action plan

| **Actions from the gender mainstreaming workshop and progress in implementing them** | **Progress as reported in the MTR** | **Progress as identified in the End of Term Evaluation** |
| --- | --- | --- |
| The project team will share workshop feedback and findings with regional management teams by 15th Feb 2017 | Reported by the TCO that Regional Social Welfare Officers shared workshop feedback with regional health management team. | Project reports and key informant interview indicate that this has been done. No further progress appears to be needed |
| Review of hospital/clinical data reports will aim to be completed by end of Feb 2017 (led by Project Coordinator and regional team with SIWG) for secondary data collection | The project has developed data collation sheets for collecting district achievements against the project indicators. The tool disaggregates the data by sex (Male and Female) and age (Male Child and Female Child). The tool is completed every month by District and Regional Eye Coordinators and supervised by Sightsavers’ Project Coordinator26. | Confirmation that this Collation spreadsheet is used by the project and it was provided to the evaluation team for the end of term evaluation. |
| Reviewing surgical camps report and data aim to be completed by end of Feb (Project Coordinator and regional team with SIWG) using 4 A’s framework | Reported by the TCO that the surgical camps report forms now provide sex disaggregated data, e.g. men and women reached during outreach. | Surgical camp forms were not reviewed in the end of term evaluation, but disaggregated outreach data is reported in the Collation spreadsheet, although not disaggregated specifically for outreach as opposed to services at static facilities. |
| Primary data collection - Interviewing different groups based on gender, age and disability will aim to be completed by end of April (led by Project Coordinator, regional team and SIWG using 4A’s) | In February and March 2017 Regional Social Affair Officers completed primary data collection in three councils, Singida DC, Singida Municipal and Manyoni DC, with Social welfare officers, Community development officers and women groups.27 [[88]](#footnote-88) | The MTR already reports that this womens study had not be felt very useful because it was qualitative rather than quantitative. It was not explained what this might mean…  Asked for report in an email – check sent and follow up. |
| Identifying community activities to be integrated with eye health services will aim to be completed by June 2017 (led by Project Coordinator, regional team and SIWG) | E.g. TCO reported that motorcycle riders were identified to be screened and also training of women’s groups. These could not be verified by the evaluation consultant | The report cited by the MTR was not provided for the end of term evaluation.  A further 22 women’s groups have been trained in year 3 giving a total of 55 by the project end.  It isn’t clear to this evaluation what this action has to do with gender mainstreaming so it is not possible to comment. |

### Appendix 12 DEC Report Template



1. ‘maono’ is the Swahili for ‘ability to see’ [↑](#footnote-ref-1)
2. DAC Criteria for Evaluating Development Assistance <https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm> plus one additional Sightsavers criterion – Scalability/Replicability [↑](#footnote-ref-2)
3. National Bureau of Statistics and Singida Regional Secretariat (2017) [↑](#footnote-ref-3)
4. ‘maono’ is the Swahili for ‘ability to see’ [↑](#footnote-ref-4)
5. Barasa E, Oteineo SA, Karimurio J (2013) Journal of Ophthalmology of Eastern Central and Southern Africa, *The prevalence and pattern of visual impairment and blindness among Primary School pupils in Kitale Municipality, Kenya* [↑](#footnote-ref-5)
6. 121,988 under Maono Singida including the extension. 182,290 under Maono Singida school eye health. [↑](#footnote-ref-6)
7. WHO Health System Building blocks - Leadership and governance, Service delivery, Health system financing, Health workforce, Medical products, vaccines and technologies, Health information systems <https://extranet.who.int/nhptool/BuildingBlock.aspx> [↑](#footnote-ref-7)
8. DAC Criteria for Evaluating Development Assistance <https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm> plus one additional Sightsavers criterion – Scalability/Replicability [↑](#footnote-ref-8)
9. Held on 13th March 2020 th and 4th May 2020 with the Tropical Health Evaluation Team and representatives from Sightsavers Head Quarters and Sightsavers country office staff from Tanzania. [↑](#footnote-ref-9)
10. Pope C, Ziebland S, Mays N. Qualitative research in health care. Analysing qualitative data. BMJ. 2000;320(7227):114-6. [↑](#footnote-ref-10)
11. The dataset used in the evaluation was that which had been used for donor reporting, as there were formulae errors in the collation spreadsheet data regarding allocation of actuals between the two projects. [↑](#footnote-ref-11)
12. Kabona, G. 2018 Report on Rapid Assessment of Avoidable Blindness (RAAB) in Singida Region, Tanzania, 31st January 2018 [↑](#footnote-ref-12)
13. Ibid [↑](#footnote-ref-13)
14. CSC – Cataract Surgical Coverage is the proportion of patients with operable cataract who have received cataract surgery. [↑](#footnote-ref-14)
15. Project donor report Nov 2019 - Maono Singida Sustainable Eye Care, Project period Y4H1 Apr – Sept 2019, Sightsavers, Dar es Salaam [↑](#footnote-ref-15)
16. See Appendix 9 - Quantitative Data Tool [↑](#footnote-ref-16)
17. Project donor report Nov 2018 - Maono Singida Sustainable Eye Care, Project period Y3H1 Apr – Sept 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-17)
18. Project donor report Nov 2018 - Maono Singida Sustainable Eye Care, Project period Y3H1 Apr – Sept 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-18)
19. Maono Sustainable Eye Care project proposal [↑](#footnote-ref-19)
20. National Eye Health Strategic Plan 2018-22 [↑](#footnote-ref-20)
21. Mwakyusa, N; Katunzi, G; Shilio, B et al. 2017. *Eye Health System Assessment Report, Mainland Tanzania*. MOHCDGEC: Dar es Salaam, Tanzania [↑](#footnote-ref-21)
22. Ministry of Health Community Development, Gender, Elderly and Children National Eye Health Strategic Plan

    2018-2022, September 2018 [↑](#footnote-ref-22)
23. Education Sector Development Plan (2016/17-2020/21), Ministry of Education, Science and Technology, June 2017, updated July 2018 [↑](#footnote-ref-23)
24. Based on the WHO health system strengthening six building blocks <https://extranet.who.int/nhptool/BuildingBlock.aspx> [↑](#footnote-ref-24)
25. Kabona, G. 2018 Report on Rapid Assessment of Avoidable Blindness (RAAB) in Singida Region, Tanzania, 31st January 2018 [↑](#footnote-ref-25)
26. Project donor report Apr 2017 - Maono Singida Sustainable Eye Care, Project period Y1H2 Oct 2016- Mar 2017, Sightsavers, Dar es Salaam [↑](#footnote-ref-26)
27. Exact indicator wording “% of facilities systematically measuring quality of visual outcomes using the WHO standard visual outcomes monitoring tool, or similar tool” [↑](#footnote-ref-27)
28. Better Operating Outcomes System Tool (BOOST) [↑](#footnote-ref-28)
29. Kabona, G. 2018 Report on Rapid Assessment of Avoidable Blindness (RAAB) in Singida Region, Tanzania, 31st January 2018 [↑](#footnote-ref-29)
30. Project donor report Nov 2019 - Maono Singida Sustainable Eye Care, Project period Y4H1 Apr – Sept 2019, Sightsavers, Dar es Salaam [↑](#footnote-ref-30)
31. Project donor report Nov 2018 - Maono Singida Sustainable Eye Care, Project period Y3H1 Apr – Sept 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-31)
32. Project donor report Nov 2019 - Maono Singida Sustainable Eye Care, Project period Y4H1 Apr – Sept 2019, Sightsavers, Dar es Salaam [↑](#footnote-ref-32)
33. Project donor report Apr 2019 - Maono Singida Sustainable Eye Care, Project period Y3H2 Oct 2018- Mar 2019, Sightsavers, Dar es Salaam [↑](#footnote-ref-33)
34. Project donor report Nov 2018 - Maono Singida Sustainable Eye Care, Project period Y3H1 Apr – Sept 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-34)
35. Project donor report Nov 2018 - Maono Singida Sustainable Eye Care, Project period Y3H1 Apr – Sept 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-35)
36. Project donor report Apr 2018 - Maono Singida Sustainable Eye Care, Project period Y2H2 Oct 2017- Mar 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-36)
37. Project donor report Apr 2018 - Maono Singida Sustainable Eye Care, Project period Y2H2 Oct 2017- Mar 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-37)
38. Quotes have been translated from the original Swahili by the interviewer [↑](#footnote-ref-38)
39. PLEASE NOTE: **This TOR question was included under EQ8 on the revolving fund for spectacles, however the evaluators feel it makes more sense to discuss this question in this section along with the above analysis of the screening project** [↑](#footnote-ref-39)
40. Tanzanian Shillings [↑](#footnote-ref-40)
41. DEC March 2018 report cited in Project donor report Apr 2018 - Maono Singida Sustainable Eye Care, Project period Y2H2 Oct 2017- Mar 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-41)
42. Project donor report Apr 2019 - Maono Singida Sustainable Eye Care, Project period Y3H2 Oct 2018- Mar 2019, Sightsavers, Dar es Salaam [↑](#footnote-ref-42)
43. Project donor report Apr 2019 - Maono Singida Sustainable Eye Care, Project period Y3H2 Oct 2018- Mar 2019, Sightsavers, Dar es Salaam [↑](#footnote-ref-43)
44. Project donor report Nov 2017 - Maono Singida Sustainable Eye Care, Project period Y2H1 Apr – Sept 2017, Sightsavers, Dar es Salaam [↑](#footnote-ref-44)
45. Project donor report Nov 2018 - Maono Singida Sustainable Eye Care, Project period Y3H1 Apr – Sept 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-45)
46. Tropical Health (2018) *Maono Singida Eye Care Project Mid-term Review* *Final Report*, Sightsavers [↑](#footnote-ref-46)
47. Njau, F. (undated) *Maono Project – Singida Region: Health Financing Sustainability Plan* Final Report, Sightsavers/Standard Chartered Bank/Seeing is Believing [↑](#footnote-ref-47)
48. Advocacy Plan Sightsavers Tanzania Country Office Maono Project Singida, 2017 [↑](#footnote-ref-48)
49. Project donor report Apr 2019 - Maono Singida Sustainable Eye Care, Project period Y3H2 Oct 2018- Mar 2019, Sightsavers, Dar es Salaam [↑](#footnote-ref-49)
50. NECSP 2018-22 [↑](#footnote-ref-50)
51. Project donor report Apr 2018 - Maono Singida Sustainable Eye Care, Project period Y2H2 Oct 2017- Mar 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-51)
52. Project donor report Nov 2017 - Maono Singida Sustainable Eye Care, Project period Y2H1 Apr – Sept 2017, Sightsavers, Dar es Salaam [↑](#footnote-ref-52)
53. FY 19/20 CCHP report in Project donor report Apr 2019 - Maono Singida Sustainable Eye Care, Project period Y3H2 Oct 2018- Mar 2019, Sightsavers, Dar es Salaam [↑](#footnote-ref-53)
54. NHIF has a “charging code” for each health services and/or department, therefore if the district has no optometrists they are automatically not qualified to have charging codes for refractive error services. [↑](#footnote-ref-54)
55. School Eye Health - Y2H2 Annual Report Appendices [↑](#footnote-ref-55)
56. Project donor report Jul 2018 - Maono Singida School Eye Health, Project period Y1H1 Jan - Jun 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-56)
57. 2019 - Nov SiB Maono Y4H1 - Report Appendices + review 19-Nov-19 [↑](#footnote-ref-57)
58. Project donor report Jul 2018 - Maono Singida School Eye Health, Project period Y1H1 Jan - Jun 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-58)
59. Project donor report Nov 2018 - Maono Singida Sustainable Eye Care, Project period Y3H1 Apr – Sept 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-59)
60. Project donor report Apr 2019 - Maono Singida Sustainable Eye Care, Project period Y3H2 Oct 2018- Mar 2019, Sightsavers, Dar es Salaam [↑](#footnote-ref-60)
61. Project donor report Nov 2019 - Maono Singida Sustainable Eye Care, Project period Y4H1 Apr – Sept 2019, Sightsavers, Dar es Salaam [↑](#footnote-ref-61)
62. Project donor report Jan 2019 - Maono Singida School Eye Health, Project period Y1H2 Jul - Dec 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-62)
63. Project donor report Jan 2019 - Maono Singida School Eye Health, Project period Y1H2 Jul - Dec 2018, Sightsavers, Dar es Salaam [↑](#footnote-ref-63)
64. Project donor report Nov 2017 - Maono Singida Sustainable Eye Care, Project period Y2H1 Apr – Sept 2017, Sightsavers, Dar es Salaam [↑](#footnote-ref-64)
65. The World Bank (2018) <http://data.worldbank.org/country/tanzania> [↑](#footnote-ref-65)
66. The World Bank (2018) <https://data.worldbank.org/indicator/SP.RUR.TOTL> [↑](#footnote-ref-66)
67. The World Bank (2015) <https://www.worldbank.org/en/country/tanzania/publication/tanzania-mainland-poverty-assessment-a-new-picture-of-growth-for-tanzania-emerges> [↑](#footnote-ref-67)
68. National Bureau of Statistics and Singida Regional Secretariat (2017) [↑](#footnote-ref-68)
69. Tanzania Human Development Report 2017 (2018) <http://hdr.undp.org/sites/default/files/thdr2017launch.pdf> [↑](#footnote-ref-69)
70. Ibid. [↑](#footnote-ref-70)
71. Rapid Assessment of Avoidable Blindness (2018) Singida Region Health Department & Sightsavers [↑](#footnote-ref-71)
72. Cataract Surgical Coverage is the number of individuals with bilateral cataract causing visual impairment, who have received cataract surgery on one or both eyes. CSC is used to assess the degree to which needs are met by cataract surgical services; at least 85% coverage is needed to meet the needs and the demands of a population. [↑](#footnote-ref-72)
73. ‘maono’ is the Swahili for ‘ability to see’ [↑](#footnote-ref-73)
74. Barasa E, Oteineo SA, Karimurio J (2013) Journal of Ophthalmology of Eastern Central and Southern Africa, *The prevalence and pattern of visual impairment and blindness among Primary School pupils in Kitale Municipality, Kenya* [↑](#footnote-ref-74)
75. Ibid. [↑](#footnote-ref-75)
76. Mashayo, ER et. al (2015) Clinical and Experimental Optometry, *Prevalence of refractive error, presbyopia and spectacle coverage in Kahama District, Tanzania: A rapid assessment of refractive error* [↑](#footnote-ref-76)
77. 121,988 under Maono Singida including the extension. 182,290 under Maono Singida school eye health. [↑](#footnote-ref-77)
78. DAC Criteria for Evaluating Development Assistance <https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm> [↑](#footnote-ref-78)
79. Based on the WHO health system strengthening six building blocks <https://extranet.who.int/nhptool/BuildingBlock.aspx> [↑](#footnote-ref-79)
80. It has been indicated that a minimum of two days per district selected for fieldwork will be required, with additional consideration for travel. [↑](#footnote-ref-80)
81. Please note, only 1 teacher per school was interviewed, therefore this represents 6 schools per district equally a total planned 30 schools reached [↑](#footnote-ref-81)
82. Depending on whether they took part in the gender mainstreaming workshop [↑](#footnote-ref-82)
83. Based on the WHO health system strengthening six building blocks <https://extranet.who.int/nhptool/BuildingBlock.aspx> [↑](#footnote-ref-83)
84. 3.6 Number of proposals from SRRH developed on ways to prioritise finance for eye care and 3.7 A detailed plan addressing eye care financing is developed [↑](#footnote-ref-84)
85. Baseline and Targets Excel Document – November 2016. [↑](#footnote-ref-85)
86. Particular areas to focus the review on include: i) The number of women’s groups targeted in each district; ii) The design of IEC materials, the number of materials printed and where these materials are used; iii) The appropriateness of radio as a channel for community awareness; iv) The community awareness messaging focusing more on the promotion of hygiene and other prevention strategies and raising awareness about the NHIF and CHF available; and v) Where opportunities lie for raising community awareness with the new paediatric arm of the Singida project. [↑](#footnote-ref-86)
87. A useful resource could O’Sullivan, G.A., Yonkler, J.A., Morgan, W., and Merritt, A.P. A field guide to designing a health communication strategy. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs; March 2003. [↑](#footnote-ref-87)
88. 27 Sightsavers and Singida Regional Administrative Secretariat. Report: *Women’s groups.* Singida, Tanzania: Sightsavers and Singida Regional Administrative Secretariat; 2017. [↑](#footnote-ref-88)