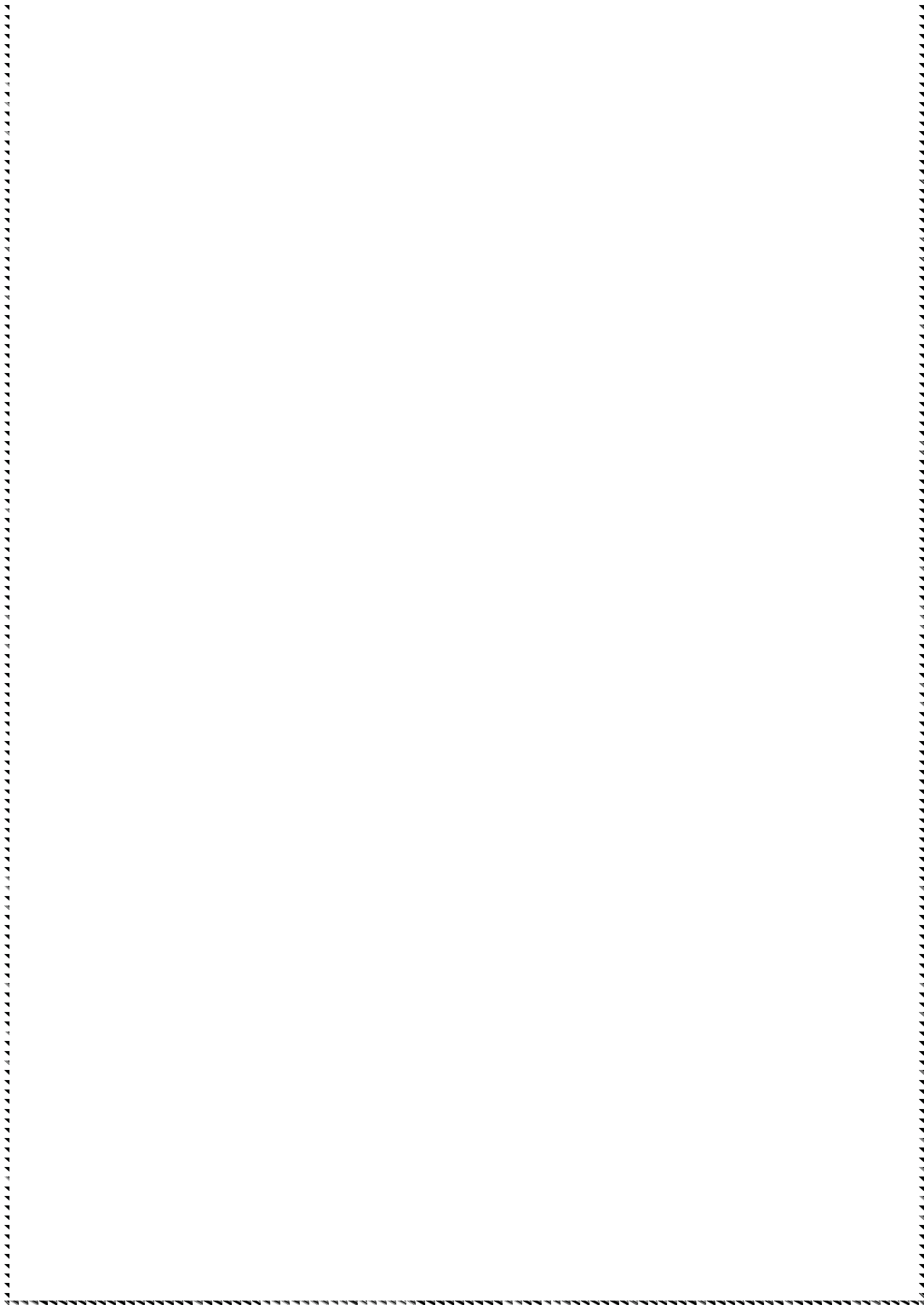


# **ENDLINE EVALUATION REPORT**

**February 2020**

## Acronyms

|                   |   |
|-------------------|---|
| CATI              | Computer Assisted Telephone Interviews      |
| CCEHiN            | Comprehensive Child Eye Health in Nigeria   |
| CDD               | Community direct distributors               |
| CMD               | Chief Medical Director                      |
| ECWA Eye Hospital | Evangelical Church Winning All Eye Hospital |
| GDPR              | Global Data Protection Regulations          |
| HANDS             | Health and development support programmes   |
| IDI               | In depth interviews                         |
| JUTH              | Jos University Teaching Hospital            |
| SiB               | Seeing is Believing                         |
| SMOH              | State ministry of health                    |
| SUBEB             | State University Basic Education Board      |
| NOA               | National Orientation Agency                 |
| TBA               | Traditional Birth Attendants                |
| UCH               | University college Hospital, Ibadan         |
| ToT               | Training of trainers                        |



## FOREWORD

One in 19 children in Nigeria between the ages of 0-18 years has significant visual impairment due to preventable causes. The leading causes of blindness in children are Cataract, Cornea-scarring resulting from trachoma, measles, Vitamin A deficiency, eye injuries, infections and harmful traditional practices. (Duke et al., 2013)

Over 50% of children die within 1-2 years of becoming blind as blinding conditions are also causes of child mortality (Gilbert and Awan, 2003). Delayed treatment in children can lead to irreversibly impaired sight. Because children have a lifetime of blindness ahead of them, the number of 'blind person years' resulting from blindness starting in childhood is second only to cataract (Parikshit and Gilbert, 2007).

The negative impacts of vision impairment for children include diminished quality of life, a lack of access to education, and challenges in finding employment in future, with negative effects on economic growth.

Despite the known fact that the eye is a very important organ of the body, people tend to take eyesight for granted, resulting to an increase in the burden of eye health conditions. The CBM led Seeing is Believing (SiB) programme, focused on addressing Child Eye Health conditions targeted at 1.5 million children within the age bracket of 0-14 years. The programme was implemented in eleven states divided into four clusters. The aim was to provide Comprehensive Child Eye Health services to children through promotion, prevention, treatment, education and rehabilitation of blind children and those with severe visual impairment.

The SiB Programme Evaluation Report outlines some of the achievements, lessons learnt and challenges encountered within the three years of implementation of the SiB programme in Nigeria and made recommendations for future Child Eye Health (CEH) programme development in Nigeria.

I therefore recommend the report as a good resource to all eye health stakeholders to guide future planning of eye health activities in Nigeria for maximum impact.



Mr. Bright Ekweremadu  
Country Director  
Christoffel Blindenmission, Nigeria Country Office.



## ACKNOWLEDGEMENT

The Comprehensive Child Eye Health in Nigeria (CCEHiN), Seeing is Believing (SiB) Programme Evaluation Study was conducted in order to take stock of the achievement of the programme in Nigeria. In order to examine the impact of the programme, compare its outcome against its stated objectives, as well as, recommend ways to improve on future programmes related to eye health in Nigeria.

The programme is sincerely grateful to the numerous SiB partners especially, professional associations including the Ophthalmological Society of Nigeria (OSN), Nigeria Optometric Association (NOA), the Nigeria Ophthalmology and Strabismus Society (NIPOSS), Medical Women Association and the Albino Foundation (TAF), who contributed to the success of the SiB programme in Nigeria.

We also recognize the efforts of the Tertiary Health Facilities (University College Hospital Ibadan, ECWA Eye Hospital Kano, Jos University Teaching Hospital (JUTH) and University of Calabar Teaching Hospital (UCTH). Most importantly, we recognize the contributions of our Community partners, Health and Development Support Programme (HANDS), Eleta Eye Institute (EEI) and Community Advancement Initiative for Self-Reliance for their doggedness towards ensuring that the programme targets were achieved.

We wish to acknowledge the efforts of the following persons: CBM-UK Programme Manager, Louise Shute, CBM Country Director Mr Bright Ekwenmadu, the Seeing is Believing (SiB) Nigeria Programme Director, Dr Juliana Nathaniel and the Programme Manager, for Cluster 4, Dr Anne Ebri. We also acknowledge the contributions of the SiB Technical Advisors Professor Roseline Duke, Dr Tisan Bagaya and Dr Israel Balogun for their technical support.

I salute the steadfastness of Cluster Coordinators and the SiB programme support team and most importantly, the leadership provided by the SiB Steering Committee, Internal Agency for Prevention of Blindness and Standard Chartered Bank for their technical and funding supports.

Finally, thanks to the Market Trends International for conducting the SiB final Programme Evaluation Study.



Dr Juliana Nathaniel, Ph.D.  
Programme Director  
Seeing is Believing (SiB), Nigeria

## EXECUTIVE SUMMARY

There is a dearth of research to evidence a simple and yet devastating truth: visual impairment is taking lives at an alarming rate both locally and globally. This requires decisive commitment; and herein lies the pertinence of the CBM led Seeing is Believing (SiB) programme. This programme primarily aims at making comprehensive child eye health services available and accessible through promoting and providing medical care in terms of prevention and rehabilitation as well as through inclusive education among vulnerable children aged 0 – 14 years.

Like every worthy endeavour, the end of this 3-year programme should be followed up by a careful evaluation to the extent to which the programme activities processes and stakeholders surpassed, met, departed from or simply failed to meet the hitherto set benchmarks. To that end, a careful review of internal and external project documents was done. Insights from this review informed the choice of methodology to be used for the next phase; the need for in-depth interviews, the choice of the stakeholders to be interviewed, the number of respondents to target, the questions to ask and ultimately how best to meet the objectives of the evaluation.

Evidently, the SiB programme has recorded tremendous success across its cluster states and with all stakeholders. The programme has brought joy to families, restoring hope and faith in the Nigerian health system as well as in their future. Unfortunately, the sustainability of this programme's impact is not yet fully guaranteed. Based on a careful consideration of the achievements, challenges and prospects of the programme, recommendations have been made for various stakeholders and the ultimate goal of these is to ensure sustainability of the impact and to realise the prospects of the programme.

## **INTRODUCTION AND PURPOSE OF THE ENDLINE EVALUATION**

Comprehensive Child Eye Health in Nigeria (CCEHiN) is a three-year (2017-2020) SiB programme that seeks to make comprehensive child eye health services available and accessible through promotion, prevention, medical care and rehabilitation / inclusive education targeted at vulnerable children. The components of the project include; Promotion, Prevention, Medical, rehabilitation and education.

The SiB programme is being implemented in eleven (11) states of the federation and divided into four clusters as follows:

Cluster 1: Oyo, Ogun and Osun States;

Cluster 2: the Federal Capital Territory, Nasarawa and Plateau States;

Cluster 3: Kano, Katsina and Jigawa States;

Cluster 4: Cross River and Akwa Ibom States.

The Seeing is Believing programme kicked off in 2017 and would be concluded in January 2020. The programme aims include:

- Develop skilled and adequate manpower to provide comprehensive child eye health services at various levels of health care in the targeted project areas
- Improve the quality, accessibility and scope of eye health services to children
- Embed child eye health in the policies and programme work of the Ministries of Health and Education
- Pilot strategies for inclusive eye health
- Establish the school eye health programme as a sustainable model to deliver eye health services to children
- Improve the quality of early intervention and education of blind children and children with severe visual impairment

At the completion of the SiB programme, it is imperative to examine the impact of the programme, compare its outcome against its stated objectives as well as recommend ways to improve on future programmes relating to eye health in the future and what the government should be doing to energize the initiative.

Therefore, the purpose of this Endline Evaluation study is to find out how successful the implementation of the Seeing is Believing programme is at achieving the overall objective of the programme, which is to contribute to the reduction of avoidable blindness and visual impairment through the provision of comprehensive child eye health services to over 1.5 million children aged 0-14 in selected states of Nigeria.

## **EVALUATION OBJECTIVE**

With the numerous stakeholders involved in this programme, it is noteworthy to understand how they all corroborated a common goal – SiB programme implementation in Nigeria. The objective of the evaluation is to identify which objectives of the programme were successful, the level of impact, its

sustainability and what was ineffective. The feedback from the evaluation study is presented from the point of view of the core objectives, the outcomes attained and the challenges encountered.

## **RESEARCH QUESTIONS**

The key research questions are as follow:

1. What impact has the SiB programme had in increasing the coverage of primary eye health care in Nigeria?
2. Has the SiB programme contributed to the increase of the number of cataract surgeries for children at targeted tertiary hospitals, in comparison to pre-programme implementation?
3. Has the SiB programme contributed to an increase in the number of consultations of children at targeted secondary eye care institutions, in comparison to pre-programme implementation?
4. Has the SiB programme contributed to an increase in the number of institutions offering specialised refraction and low vision services, in comparison to pre-programme implementation?
5. What strategies/approaches of programme delivery have been effective and what has not been effective?
6. Is the implementation approach a sustainable model after the end of the SiB project?
7. Do the importance and the quality of the programme and associated outcomes justify the amount of resources used?

These questions have been captured by means of the discussion guides and the answers relevant to them are implicit in the findings as presented. This strategy highlights the connection between the research questions and the objectives, which is consistent with best practice.

## **STUDY METHODOLOGY**

The qualitative research paradigm was adopted to capture the desired insights. The qualitative paradigm is best suited to enable us understand the opinions of the various stakeholders on the successes, failures and challenges of the of the programme within the backdrop of the aforementioned objectives.

### **Data Collection Methods**

Specifically, we availed ourselves of two main data collection methods: document review, also known as desk research; and in-depth interviews. The extensive desk research enabled us to derive the much-needed insights to properly determine the specifics of the next phase – target stakeholders and respondents, drafting the discussion guides and identifying the gaps to be filled. The computer assisted telephone in-depth interviews (CATI-IDIs) were done consistent with best practice with unflinching commitment to enviable quality assurance protocols.

The team also had informal interviews with the SiB project team, Programme Director and Cluster Coordinators to provide contact information of the highlighted respondents.

Due to the timeline of this project, some of these informal interviews as well as all the formal in-depth interviews were conducted over the phone and recorded for onward transcription.

### **Desk Research**

Desk research was conducted at the inception of this study by sourcing secondary information from the clusters' inception report, semester activity reports, quarterly activity reports, monthly activity reports, baseline report as well as a programme background presentation conducted by the Programme Director. This phase enabled us gain insights into the implementation of the SiB programme in clusters 1, 2 & 3; collaboration among implementation partners as well as their progression throughout the project life cycle. It is from these insights that the appropriate research approach, discussion guides, and target respondents were determined.

### **In-Depth Interviews**

Given the exploratory nature of this study, we conducted CATI-IDIs with the key stakeholders to understand their personal experiences during their interaction and engagement with the programme. Discussion guides of semi-structured open ended questions were developed to explore their perception of the recently concluded programme, their expectations and realities and the challenges as well as proposed ways of improving the sustainability of the programme. In addition, the approach provided deep context into the involvement of stakeholders in the programme. The discussion guides are attached in the Annex.

### **Sampling**

Respondents were selected across the clusters, the level of intensity of activities, location of the tertiary hospitals and proactiveness of some stakeholders observed at the document review phase, influenced concentration of respondents in states like Oyo, Kano and Plateau.

We sampled 40 respondents broken down as follows:

| <b>S/N</b> | <b>Stakeholders</b>     | <b>Number</b>  |
|------------|-------------------------|----------------|
| 1          | Beneficiaries           | 24 respondents |
| 2          | Cluster coordinators    | 3 respondents  |
| 3          | Implementation partners | 9 respondents  |
| 4          | Government              | 4 respondents  |
|            | Total                   | 40 respondents |

Fig 1: Respondents' sampling



## Research Tools

We designed different research tools for the different segments of respondents identified. In total, four discussion guides were developed to elicit insights from the Cluster Coordinators, beneficiaries, implementation partners and Government representatives in the Ministry of Health and Education. The full discussion guides are included in the Annex.

## Other Considerations

In terms of data analysis, a triangulation of both narrative and thematic analysis was used. This is best suited to ensure that all the insights captured from the data collected are intelligibly presented as stipulated in the aforementioned framework. In other words, the narrative analysis was done under the following themes: outcomes of the programme; findings in relation to objectives; and implementation challenges. Consistent with the stipulations of the GDPR it is the parents of the beneficiaries who were interviewed since the beneficiaries are minors. For the other respondents, we ensured informed consent during the data collection procedure. To guarantee validity and reliability, the findings were submitted to a rigorous process of expert external and internal (SiB) review. This report was finalised only pursuant to that robust process.

## STUDY FINDINGS

### Outcomes of the Programme

According to World Health Organisation (WHO), globally, at least 2.2 billion people have a vision impairment or blindness, of whom at least 1 billion have a vision impairment that could have been prevented or has yet to be addressed.

In Nigeria, however, the Nigerian national blindness and visual impairment survey in 2007 estimated that 1,092,028 Nigerians (0.78%) are blind. It has been established that the leading causes of vision impairment, globally, are uncorrected refractive errors and cataracts.

Therefore, the importance of CBM SiB programme aimed at making comprehensive child eye health services available and accessible through promotion, prevention, medical care and rehabilitation / inclusive education among vulnerable children aged 0 – 14years cannot be overemphasized.

At the end of the SiB programme the key outcomes were:

1. Increased awareness and knowledge of visual impairment in children
  - *Parents became aware of visual impairment in their children*
  - *SiB programme exposed the burden of avoidable blindness*
  - *Awareness creation of the need for early intervention*
2. Increased prominence and awareness of health facilities and their services among the public
  - *Increased number of patients at hospitals*
  - *Increased number of surgeries and refraction were conducted*

3. Access to free child eye health services for disadvantaged and marginalised families
  - *Programme appreciated by everyone in the community*
  - *Payment of hospital bills for the more disadvantaged population*
  - *Improve quality of life for parents and children*
  - *New lease of life*
4. Increased number of skilled manpower for the provision of child eye health
  - Health and non-health workers were trained and integrated into the programme
5. High propensity for the continuity of child eye health programme if properly harnessed
6. Integration of child eye health in Ministry of Education and Ministry of Health policies

### **Increased awareness and knowledge of visual impairment in children**

While some parents were aware of their children's visual impairment but unable to provide the right treatment due to financial constraint, lack of knowledge and or access to quality eye health services, others became aware of these condition in their children after they were screened by SiB implementing partners – teachers, HANDS etc.

*"Her teacher informed us that she had an eye problem when she was 2 years old, we didn't know at first." Beneficiary, Cluster 1*

Parents who had prior knowledge of their children's visual impairment had made attempts at providing solutions to the problems by visiting both secondary and primary health facilities but to no avail. Some parents claimed that the child's eye problem were wrongly diagnosed.

The SiB programme, through its implementation partners, not only educated the public about visual impairment, early detection and how it can be avoided but also diagnosed the problem correctly giving parents' assurance and restoring their confidence in Nigeria's health care services.

Implementation partners like teachers, HANDS and different level of health care providers collaborated to bring awareness to the communities about child eye health. Some of the means of creating awareness include: radio jingle, TV programmes, billboards, t-shirts, screening at schools, community outreach, referrals at the different health facilities etc.

### **Increased prominence and awareness of health facilities and their services to the public**

Due to the community outreach and publicity created by the SiB programme, the implementing health facilities gained prominence among the public. The communities became aware of their services, perceiving them as affordable and caring towards the plight of the masses.

As a result, the health facilities have also witnessed an influx of patients from different locations and neighbouring states, increasing the workload for staff members and recognition in their respective locations.

*"It has increased publicity for us as a facility because at least left to us is that it would have been Abuja, Nasarawa and Plateau but other northern states have been coming, patients from Benue, Borno have been coming to access care, it has created awareness from the fact that we offer such services and also base on manpower development, it has also increase our skill and then service delivery."* Implementing partner, cluster 2 Jos University Teaching Hospital.

*"More people are visiting the hospitals to get screened and access treatment. We work so much now at the Kubwa hospital."* Cluster 2, implementation partner.

The SiB programme has also given rise to an increase in the number of surgeries conducted across the implementing hospitals. They attained new heights, reached more deserving populations and were able to make more of an impact through the SiB programme.

*"By now obviously because we did a baseline, I actually visited some of the primary facilities, the secondary facility too before the programme started, and I was just looking at the record, some maybe in a year they were seeing thirty children, that was the first I did and now they were seeing one hundred, now is high more now because of all the advertisement, all the organization, they see more now than before."* Cluster 2 coordinator.

*"It has also opened a door for us as long as eye health is concerned. Now as an organization we are looking at other intervention on eye from other donors, that's on the positive side for us as an organization, do you understand? So as an organization if you come into Osun state and you ask which organization is into eye health, they would readily call P.I which was not there before,"* implementing partner, Osun.

### **Access to free child eye health services for the disadvantaged families**

Among the beneficiaries – parents and caregivers, the ability to access quality eye care services for their wards at no cost to them was a dream come true and immensely appreciated across the communities and clusters. The SiB programme has short, medium, and long-term effects on the beneficiaries from different perspectives. Some of its unintended outcomes to the beneficiaries are:

- *Higher possibility of marriage for girls – "The gender, the girls we see are happier because, you know our society when a girl is blind nobody wants to marry her, they will just want to molest her and go. Now the girls will have more benefit."* Cluster Co-ordinator.
- *Inclusiveness – children in the school of the blind integrated themselves into the mainstream schools*
- *Children are willing to learn and return to school*
- *End of stigmatization in the family*
- *Community members and beneficiaries are genuinely happy and appreciative*
- *Reduced suffering and sadness in the family*



- *Children are no longer dependent on their parents for everything – they have a chance at opportunities and better livelihoods, children's futures are improved and more secure*
- *Helps to save money that would have been spent on hospital bills*
- *Families could see; cataract treated in children*
- *Improved quality of life*
- *Improved academic performance*
- *Health Monitoring Information System (HMIS) and Nigeria District Health Information System (DHIS) were supported by the SiB programme to make data available for proper planning.*

*".....they sleep very well now. One woman said she doesn't sleep in the night because the child will wake up at night and cry scratching his eye but now they sleep well." Cluster coordinator.*

*"If not for SiB intervention, many children would have gone blind due to poverty and ignorance. For the beneficiaries who ordinarily wouldn't have been able to pay for services. So many children whom would have become blind now can live on their own, return to school and later earn a living without depending on others." Implementing partner, Cluster 3.*

*"One of the teachers said that there were children that were failing in school because they were not seeing the board, but through the project they could see in a way, it also improved people's performance in school." Implementing partner, Osun.*

Despite its numerous impacts on the beneficiaries, several additional benefits were also recorded. Some of these are:

- No more stigmatization / Improved self-esteem and pride – child no longer called blind in the society
- Populace felt loved, appreciated and remembered
- Future turbulence averted – future eye problem and chaos
- Restoring home; put joy in people's heart
- Fluent reading is now amongst students, even in broad daylight

### **Increased number of skilled manpower for the provision of child eye health**

One of SiB implementation partner, HANDS, was regarded as the most effective across the stakeholders. It was gathered that, through their effective management, more training was conducted than proposed. They exceeded their target and reached out to more people.

HANDs coordinated and trained teachers, TBA, community members, nurses, community health extension workers (CHEW) etc to enable them increase visibility, knowledge and awareness of the SiB programme.

Teachers were selected from both special schools and mainstream schools to conduct screening for students and properly diagnose them.

The cluster coordinators had much to say in this regard:

*"They (HANDS) really tried in organising the training and they were good at it. During the training, they overshot their target; for example, in Kano instead of 88 teachers that is 2 teachers per local government because we have 44 local government, we have one hundred plus teachers. Then in Katsina also instead of 34 teachers or 64, we had more numbers. They were able to manage and increase the number of people they trained so that number of people they trained help in generating more mile for their people. So, they tried". – Cluster 3 Co-ordinator.*

*"..... there are nurses trained, there are traditional birth attendants trained, there are community members, in fact there were three thousand ordinary people in the community that were trained, young men and girls who were not health professionals but we trained them in a day that in their various villages if they see any child with disorder, they inform, both radio announcement, TV announcement, training of villagers, training of health workers, all have been boosted in and put in place at the secondary facilities." Cluster 2 Co-ordinator.*

### **High propensity for the continuity of child eye health programme if properly harnessed**

With the series of training conducted among the community members, teachers, CHEWs, nurses, TBAs etc on the child eye health, there is a tendency for the programme to be sustained at the community level. Community members, especially parents of the beneficiaries, are advocating for the continuity of the programme; they are likely to encourage school administrators to implore teachers to keep screening the children and diagnose them. While they might not have immediate solutions to the problem once diagnosed, the consciousness of adequate eye health care has been awakened in the public and many will desire to see it sustained.

This could also be an opportunity for private sectors to leverage on this momentum and introduce health insurance targeted at eye care for the public. Subsidized eye health care with equal standard as demonstrated by the SiB programme can increase the uptake of such offering/programme.

### **Integration of child eye health in ministry of education and ministry of health policies**

This was a major feat as only Osun state implementation partner claimed to have succeeded in incorporating the child eye health programme into the Ministry of Health policies. The implementation partner also claimed that the Government has agreed to support health check in schools on a regular basis.

While this is not the case in other locations, there is a need to intensify engagement with the government to get their commitment in the programme in order to ensure its continuity.

*"Before the project started in Osun state, there was no...ordinarily people don't take the issue of eye health seriously, so in our engagement with the Government we discovered that eye health was not even part of their plan so through our advocacy we were able to entrench eye health in the activities of*

*the government. That is a lasting impact that the project will have.”*  
*Implementation partner, Osun.*

### **Findings with relation to the Objectives of the Programme**

In this section, the findings are examined in relation to the 6 core objectives of the SiB programme. It should be considered that the aforementioned research questions targeted, the attainments of the research objectives as should be expected. Given that both mainly serve the purpose of enabling the evaluation of the impact, relevance and sustainability of the programme, it makes sense begin with an examination of the findings in their relation to the objectives.

#### **Objective 1: Develop skilled and adequate manpower to provide comprehensive child eye health services at various levels of health care in the targeted project areas**

Through key implementing partners like HANDS, PI and tertiary institutions, it became clear that there is a growing pool of trained manpower in eye health care in the selected states. The programme did not assume that professional health workers are knowledgeable in eye health care treatment; this has proven to be very beneficial as experienced health workers with 4 – 7 years of work experience claimed to have acquired new skills from the training and are better equipped and informed to help visually impaired patients regain their sights.

*“...we were happy that we have everything to work with as in resources because SIB also helped in providing us with some equipment that we need for comprehensive child eye health services to be provided at the tertiary centre. Personally, the programme has also helped me with further strengthening and establishing our skill in terms of the services.” – Senior registrar in child eye care in the hospital, Implementing partner cluster 2.*

In the same vein, it was observed that health teachers who were selected for eye health care training from mainstream and special schools have also changed the face of service delivery. As this approach is more accessible, informal, less intimidating and feasible for the people at the grassroot. Seeing that they already have an existing relationship with the teachers, the parents and caregivers are more inclined to be stripped of any cultural or religious bias that might have ordinarily prevented them from seeking eye health care. Consent can be freely given to children to proceed with the exercise.

This initiative is an enduring one as teachers also conduct Training of Trainers programme and the knowledge is cascaded across the different cadre of teachers and instructors.

While other people like Traditional Birth Attendants, media, stability committee, base distributors and the local Government officials also got trained on the eye health care services and treatment, a few people believed that minimal impact will be generated from this category of trainees. This could be attributed to the fact that they have more pressing priorities in the case of TBA – saving the lives of mother and child – and for local Government officials, they do not directly interface with the children.

*"There are some aspects of the implementation of the program that was a barrier and that was one of the trainings they did which I saw as a waste of resources and the engagement with the traditional birth attendance which did not yield a good result". Implementation partner, Osun.*

*"The strategy that I'll consider effective is the capacity building, we have done much on the program because we've trained a lot of people using this program which it has been a success. The community first, we trained much of them. I think we trained 68 across the states not in a particular area. It will be in 17 LGA. We picked the nurses we trained. We trained particularly the based distributor. We trained over 1000 in the state, we trained traditional birth attendants, the media and the stability committee. So, we selected people from there, private institute, we trained them in respect of SiB. So, in that respect of capacity building, we have done a lot. We have tried in that aspect." Government official, Ministry of Health.*

## **Objective 2: Improve the quality, accessibility and scope of eye health services to children**

Across the stakeholders – implementation partners, beneficiaries, Cluster Coordinators and Government – it was acclaimed that the SiB programme service delivery was thoughtfully implemented. The quality of service at the different levels of health care and the quality of consumables provided were of high standard. The children were happy to be screened, wear their spectacles, use their drugs and undergo the surgeries.

*"Those that couldn't afford glasses, at least they were given glasses for free for correction; because there is no way they would have been able to afford eyeglasses on their own." Beneficiary, Kano.*

Although some of the parents of the beneficiaries are educated with academic backgrounds ranging from school leaving certificate, NCE to BSC, their standard of living and disposable income is low. Therefore, they have been unable to provide the right eye treatment for their children. As such, some of the children who benefited from the SiB programme have been visually impaired for 1 – 13 years. During the interviews, we gathered that many people at the grassroots have resigned to fate due to financial constraints in accessing quality eye health care.

The introduction of the SiB programme, ushered in increased access of impoverished people to quality eye health care.

*"My expectations were really met because my child having this eye infection really brought shame and disgrace to me in the neighbourhood, because often times she was called a blind person by her peers and other people, but I really thank God for curing her through this program." - Beneficiary, Osun.*

*"Yes, it is the first time I have benefited something free from Nigeria." Beneficiary, Oyo.*

*"There was a girl since she was born she has not been seeing and imagine with this program and the help of God, I look at her seeing and I am happy for her.*



*So without this program they would not have had that awareness or they will not have the money and maybe she would end up her life like that without seeing so look at the positive part of it. The programme bring awareness and it put joy on the faces of many families". Beneficiary, Niger state.*

The impact of SiB programme is felt across all the clusters and word of mouth is also driving its coverage beyond the intended locations. With the extensive campaign launched via radio, TV – Nasoa, billboards, door-to-door, hospital referrals, schools etc., the SiB programme has increased the coverage of primary eye health care across the study locations. More people are aware of eye health care, myths are debunked, and hope is restored. In fact, beneficiaries have become ambassadors of SiB programme and are now advocating for more people within their network to visit the health care providers and get treated for free as well. According to the Cluster Coordinators and implementation partners, there are a lot more people visiting the hospitals and pleading for treatment for themselves and their wards.

*"SiB is present in many schools as well as the community." Cluster coordinator.*

In addition, the SiB programme has also contributed to the increase in the number of cataract surgeries in children at targeted tertiary hospitals in comparison to pre-programme implementation. Prior to SiB programme, people at the grassroot never thought of visiting tertiary hospitals due to the perception that they could never afford such services. However, with referrals and assurance from their primary health centres or children's school, they visited the tertiary hospitals and they received great treatment. This increased their faith in the programme and their advocacy among their peers.

*"I think there were more children because most of the kids that their parents or caregivers could not afford the money for the surgery but when SiB came, I think the children even those in a very rural areas came out and their surgeries were done free of charge to them, more people are visiting the hospital during and post sib." Implementation partner, Oyo & Jos.*

*"There are more number of cataract surgeries in children compared with other interventions in the past. For instance, at the first phase of sib project in 2011 to 2013, we struggled to achieve our target of 540 children cataract surgeries but this time around 1286 cataract surgeries were done and they were still coming even after the programme has ended." Implementation partner, Kano.*

*"Around 960 surgeries conducted in cluster 3 against about 400 pre-SiB and there are still more cases on ground" – Cluster Co-ordinator.*

Not only has the SiB programme increased the number of cataract surgeries, it has also contributed to an increase in the number of consultations of children at targeted secondary eye care institutions in comparison to pre-programme implementation. During and post-SiB programme, the general hospitals witnessed a surge in the consultation for eye treatment. This is due to the impactful campaigns rolled out by the implementation partners. The hospitals enjoyed high referral when school is in session, during dry season and between

March and June when crops have been harvested. Lowest referral time are during the school holiday, during rainy season and Ramadan fast.

*"Major challenge was patients not coming to access care when we needed some, we were able to go around that because when I reported that challenge to my hospital management, my CMD that is the Chief Medical Director and the other management staff took it upon themselves and then they went to the media houses to also create the jingle within the hospital from the hospital fund which is not part of the SiB expenditure. The hospital just took its money, went to the media and then created publicity for the programme for us, that was how we were able to cope with that challenge and then at the end of the day, we are now able to have patients many people came in. At the end of the day, the programme ended and we are still having more patients coming in that they wanted to access care."* Implementation partner, Cluster 2.

*"There is increase now because we've already certified some communities and they have health workers on eye health for quick intervention."* Implementation partner, HANDS.

On this issue of whether the SiB programme has contributed to an increase in the number of institutions offering specialised refraction and low vision services in comparison to pre-programme implementation, the implementation partners and cluster coordinators have differing opinions. While the cluster coordinator claimed that there are more institutions offering specialised refraction and low vision services, implementation partners and government official believed that this has not increased. From our interaction with beneficiaries, we discovered that most of them have to make long trips and spend a lot of money on transportation fare before they could access eye health care. While some beneficiaries claimed that refraction was conducted for them at the school within their community, others had to make long trips to obtain these services.

*"No... the hospitals, you know it's only the JUTH now, it's only the JUTH that has been doing that for both the three states. So, I think we need more if possible, even the secondary hospital the tertiary hospital would be put in place for this surgery because JUTH alone is not enough."* Government official, Ministry of Health.

*"It is very far because I stay at Ife and the medical centre is at Ibadan."* Beneficiary, Osun state.

*"It was really stressful in a way, because I had to take medications for malaria when I got home due to the whole stress, I was even asked to come back for check-up but I could not go due the fact I don't have enough money to transport my daughter and I to the medical centre."* Beneficiary, Osun.

*When we got to your doctor, the guy didn't ask for anything and they said, they would give us glasses or so, though the Nigerian factor came to play that we had to hold on for a while. – Beneficiary, Oyo state*

*"It's very far oh the health centre from Ila down to Ibadan; up to 3 hours journey. At least for me and my son we spent up to N8000."* Beneficiary, Oyo state.

*"You will go very early in the morning by 5am and you will still meet people there so if they are not good people will not be patronizing them. I say people were more than hundred in that hospital everyday." Beneficiary, Niger state.*

### **Objective 3: Embed child eye health in the policies and programme work of the Ministries of Health and Education**

To ensure the sustainability of the SiB programme, it is imperative for it to be integrated into existing frameworks and processes. As far as the SiB programme is concerned, the programme has been successfully integrated into the Ministry of Health and Ministry of Education programme for screening and awareness creation. The officials of the ministries have been actively involved in the implementation of the programme from inception, desk officers have been appointed to oversee the school child eye health service across all the local governments, and monitoring team have been set up to ensure the programme is sustained in the short to medium term.

However, its long-term plan is not ascertained as the Government is yet to approve the MoU to take up the initiative and provide free eye health care for the vulnerable children.

*"In the Ministry, I'll be writing to them any program we do. I'll write and report to the Ministry, to the state at large. We have been pleading for sustainability which they've not done anything about it but we're still waiting for their response. Their positive response." Government official, Ministry of Health.*

*"The SIB, they have been the one sustaining whereby the government has not done anything about it. You know our government today when it comes to work like that and it involves resources, you'll write an MOU which has not been signed but SIB has been the one doing it. They have the capability of sustaining it if they so wish." Government, Ministry of Health.*

### **Objective 4: Pilot strategies for inclusive eye health**

The pilot strategies for inclusive health was successful across all its locations. The SiB and ministries have established the School Eye Health Program to deliver eye health services to children across all the LGA and it has improved the quality of the education for the visually impaired children. Some teachers in the special schools were trained to screen and refer these children to secondary and tertiary hospitals for further treatment.

Through this screening, some parents have become aware of their child visual challenge, others have successfully received refraction, low vision services and or surgical procedure.

### **Objective 5: Establish the school eye health programme as a sustainable model to deliver eye health services to children**

The SiB programme in conjunction with the ministries of health and education have successfully created a sustainable model that is both inclusive and SMART (specific, measurable, achievable, realistic and time-bound). The school eye health programme has been designed to incorporate the different arms of

government to collaborate and foster the success of the programme in order to deliver long term benefits for the populace.

Currently the teachers have been trained to screen the children, conduct basic tests and refer them to the appropriate cadre of health care. The ministries have appointed a desk officers in all the prevailing local government areas to monitor and supervise the execution of the programme at the end of the SiB programme.

However, the state government of the respective study locations is yet to own the programme and ensure its sustainability.

While the Government is yet to take ownership of the programme, some officials in the ministries expect continued funding of the SiB programme by international donors.

*"If the resources are there, it can be sustained... they were trying for us and training us so that the government can sustain it. SIB cannot start a program and leave it..." Government, Ministry of Health.*

#### **Objective 6: Improve the quality of early intervention and education of blind children and children with severe visual impairment**

The SiB programme has enlightened the society, especially the Government and individuals, on the need for early intervention and education of visual impairment and blindness in children.

Through the School Eye Health Programme at school, posters at the hospitals and word of mouth, advocacy of the beneficiaries of the SiB programme, it is believed that more people will continue to create awareness for this programme.

*"We have the desk officer, State University Basic Education Board (SUBEB), we have been working together with him when it comes to screening, we go and see how the screening is done because we have our alternate nurses that are the ones that were trained for... they are the ones that are the resource person. So, if it comes to screening, they are the ones doing the screening and would have to go for periodic supervision and assessment to see how the work is going in collaboration with the HANDS." Government, Ministry of health.*



## **Implementation Challenges of the SiB Programme**

Despite the widespread success of the programme, there are also a number of challenges that stakeholders encountered. While some challenges were generic, a few were specific to the different stakeholders.

### **Beneficiaries**

The main challenges that the beneficiaries were confronted with was the distance and waiting period to hold their consultation.

*Distance from home to hospitals:* Since selected tertiary institutions were equipped and selected to hold surgeries, beneficiaries within the cluster but outside the state had to travel to the designated hospitals to complete the surgical process. Some who were within the state but in the rural area also had to go through 1 – 3 hours commute.

*Waiting time:* Long queues at the hospital is another bane for the beneficiaries. Some arrived at the hospital as early as 7am and departed about 5:30pm due to long waiting lines. If the process can be automated in such a way that beneficiaries send a code and get a slot a time of consultation with the doctor, the waiting time will be reduced, and people can return to their economic activities.

*"Distance from home to ECWA hospital is N2000 for one person; so for me and my son, let's say N5000."* Beneficiary, Cluster 3.

*"Lots of queue, we were very much, in fact, on the first day, they called about an hundred people."*– Beneficiary, Cluster 1.

### **Implementation Partners**

Given the number of implementation partners in the different clusters, there are numerous challenges the partners were confronted with. They have different issues around:

- Communication
- Internal bottleneck with SiB project team
- Lack of cooperation from the community
- Poor turnout due to low referral and poor publicity at inception

### **Communication issue**

The implementation partners complained of poor communication among the team especially in the North. Cluster 3 complained that short meeting notice sometimes prevented meetings or training from being held as scheduled.

In addition, communication and process issues prevented them from starting the programme in January but they finally kick-off in December 2017 in Cluster 2.

### **Internal bottlenecks**

- Cluster 2 & 3 complained of late supply of consumables as well as late procurement of equipment due elongated processes from central operations

- Inconsistency in SiB staffing affected the progress of the project

*"For instance, those that planned the project were different from those that implemented. Also, in the middle of implementation, some staff also resigned their appointment making it difficult for the new persons to adapt." – Implementation partner, cluster 3.*

- Difference in exchange rate. The workplan exchange rate for funds is different from the rate received from bank. Also the rate implementation partners were expected to spend was different from the two above. The implementing partners receive a rate for conversion to Naira on a monthly basis from the SiB office which makes documentation cumbersome
- Poor motivation packages in form of incentives and recognition for the workforce in the programme
- Delayed payment in the North

### ***Lack of cooperation from the community***

In Osun, it was recorded that some communities did not allow screening to be done in their local Government areas for cultural reasons. Other parents in other clusters refused to accept that their children have visual impairment despite several attempts at discussion and education.

### ***Poor turnout due to low referral and poor publicity***

- Cluster 2 had issue with cataract target because there were no much patients coming from the field with cataract need. This could be attributed to poor publicity at the time as such, target was moved to Cluster 3.

*"Mobilization from the field, we weren't having the children coming at a time we wanted them to come, now imagine the SIB project is over, it is now that the children are now coming in to access care." – Implementation partner, Cluster 2*

- Low referral from Jigawa and Kastina states at the initial stage was due to fears from their various governments
- Poor publicity at inception affected the poor turnout of patients

*"At the beginning publicity was not done so it was difficult to get the right people it was at the tail end of the program that advertisement concerning the program was let into the air, therefore, it was a problem." Implementing partner, Cluster 1.*

### ***Cluster Coordinators***

*In the lifespan of the SiB programme, the Cluster Coordinators have concerns that bordered on payment, logistics, communication and bureaucracy at the CBM office.*

- Late payment of participants by HANDS
- HANDS failure to provide ample time to schedule training; thereby some training did not hold at the agreed time
- SIB underbudgeted and it affected execution of some activities

- CBM appointment of a consultant (*to coordinate the programme in Cluster 1*) who wasn't a part of the planning phase and was unable to deliver for 4 months; the project was delayed for that long until he was removed
- Need to always get approval from CBM for every decision and activities delayed the speed of implementation
- In cluster 2, the Government failed to integrate the child eye health initiative into its policies therefore, the project sustainability is questionable

*"The problem HANDs had was the case of not giving out or not paying the participants (trainees) on time so what I understood later was that the account details of the training participants were wrong and instead of the account officer of HANDs to follow up with them, the guy just kept quiet. He later explained to the participants and payments were made. I think in future I want HANDS to improve on its payment strategy." Cluster 3 Co-ordinator.*

## **Government**

The major challenge confronting the Government officials is the inability of Government to own the SiB initiative and fund it in a more sustainable way and continue to bring relief to the people at the grassroots.

According to the Government officials from the Ministry of Health and Education across the clusters sampled in this study, Government involvement has been to provide human resources to collaborate with the programme but no monetary commitment so far.

## **CONCLUSION**

The SiB programme has recorded tremendous success across its cluster states with stakeholders clamouring for its extension. The programme has been impactful in the awareness creation of visual impairment and blindness in children; its prevention, treatment and early intervention; as well as capacity building for health and non-health workers across different states.

The SiB programme has achieved the following:

- Invested in the capacity building of health and non-health workers for the provision of comprehensive child eye health services at various levels of health care in the targeted project areas
- Noticeable increase in the coverage of primary eye health care in the study locations
- More people benefitted from the free cataract surgeries at the targeted tertiary hospitals
- More people were screened and attended consultation at secondary eye care institutions compared to pre SiB programme implementation
- Successful execution of the pilot of the inclusive eye health service. A lot of blind and visual impaired children were reinstated into school. This has led to an increase in enrolment, performance at school and education of girls

- All national documents developed by SiB at the National level was endorsed by the Honourable Minister and recommended for use by all States. The CEH treatment Guideline was adopted at the 62nd National Council on Health in September 2019 at Asaba, Delta State and all Executives of the 36 States plus the FCT endorsed the manual
- In line with programme sustainability, some States have included a budget line for eye health e.g. Cross River, Jigawa, Kano and Ogun State.

The SiB programme failed to achieve the following:

- There are still few hospitals offering refraction and low vision services across the study locations as beneficiaries still need to make long trips to access the facilities and usually need to endure a long waiting time to see a doctor
- While the CEH treatment guideline has been adopted by the state governments, some of them are yet to commit to the adoption of the programme in their states
- As such, the sustainability of the SiB programme is not guaranteed. Some of the state governments are yet to take strong action on helping the Nigerian children to be rid of blindness and reclaim their future.

## **RECOMMENDATIONS**

Based on insights derived from the evaluation, the following recommendations prove quite constructive and consistent with best practice:

### **Recommendations for the Government**

- Ministry of health and Education to collaborate and ensure that refresher courses are held quarterly for the trained workforce in order to retain the knowledge gained and pass on to others
- Ministry of Health should ensure that children born at the different health facilities undergo eye health screening before they are discharged. In addition, routine eye checks should become mandatory for children who visit health facilities
- National Primary Health Care Agency should integrate Child Eye Health into the regular routine immunization programme and the Maternal Newborn and Child Health week event.
- As part of the admission process at schools, Ministry of Education needs to introduce routine eye checks to curb the menace of eye problem and promote early intervention
- Ministry of health to draft more health facilities into the CCEHiN in order to make eye health care accessible to the grassroots. Also need to integrate eye health into pre-service curriculum of Community health extension workers and that of midwives. So that at graduation, they are able to examine and treat eye conditions in children.
- Federal and State Government to prioritize eye health by creating a budget line for eye health and releasing allocated funds and making child eye health services free for all children.

- In the event of prolonged deliberation of Government on the sustainability of the SiB programme, we recommend that private sector operators are invited to develop schemes and programmes that will make eye health care affordable for the public.

### **Recommendations for the Implementation Partners**

- Develop framework to consolidate the work of the implementation partners across the various clusters.
- CBM programme and financial processes should be streamlined to reduce bureaucracy and improve engagement with the implementation partners. It is also important to reduce attrition rates on projects to ensure seamless continuity of projects
- Plans should be in place for pre, during and post publicity of future intervention programmes so as to sustain awareness and high turnout of patients during the lifecycle of the programme.

### **Recommendations for the Beneficiaries**

- Engage more with communities in future to increase their participation and enthusiasm in the programme.

## **ANNEX: DISCUSSION GUIDES**

### **Discussion guide for Cluster coordinators**

1. Kindly introduce yourself – name, age, academic background, previous work experiences, current designation etc.
2. As a cluster coordinator, please tell us the cluster you represent and share with us your role in this programme
  - a. How would you describe the implementation of this programme? What were your exact responsibilities? Which of them were you able to deliver on and which did you fail to fulfil? What was responsible for this?
  - b. How do you feel working on the programme?
  - c. In the course of our desk review, we noticed that some quotas were moved from cluster 1, 2 & 4 to cluster 3 – 100 major surgeries, 200 cataracts and 250 cataracts? Why did this happen? Apart from that, what were the other challenges encountered in the course of implementing this programme within your cluster?
3. You worked with a number of implementing partners during the duration of this programme, can you please name them and state their roles?
  - a. Which of the implementing partners would you consider as the most vital to this programme? Why were they so important?
  - b. How did they perform during the lifespan of this programme? What are those attributes that were exceptional about them?
  - c. In which areas would you advice they improve on to deliver impeccable services in future?
  - d. Which of the implementing partners were the least important? How about those that were the least effective? Why were they classified in this space? Please state your reasons
  - e. Wat could they have done better?
  - f. How valuable were the results of implementing partners, CBM, the communities involved?
4. Given that you had to deal with a large number of stakeholders, how were you able to manage communication across board?
  - a. Were their certain challenges that arose as a result of poor communication? What are these issues?



- b. Were you able to resolve them in the end? How did you resolve them?
  - c. Were there cases of conflicts among the different stakeholders within your cluster? How about within the programme as a whole?
  - d. What conflicts resolution mechanism was adopted among implementing partners to enhance seamless working environment? What mechanism worked and what did not work?
  - e. Which would you recommend for the sustainability of this programme?
5. Would you say this programme has positively or negatively impacted its recipient communities? Why do you say that?
- a. Comparing activities before and after the intervention, in your opinion, what would you consider as the key changes brought about as a result of this programme? Please list them
  - b. Who would you consider as the major beneficiaries in terms of gender, age, inclusiveness etc? Were there specific gender and age quota implemented in service recipient? What are the major benefits/ disadvantage accrued to them?
  - c. What was the quality of the programme design and content?
  - d. How well was the programme implemented and adapted as needed? Kindly state the specific ways the SiB programme has increased or reduced coverage of primary eye health care in Nigeria?
  - e. Did the intervention produce the intended results in the short, medium and long term? If so, for whom, to what extent and in what circumstances?
  - f. If you were to compare pre-SiB and post-SiB era, how would you rate the number of cataract surgeries conducted in children at targeted tertiary hospitals? Would you say there are more or less cataract surgeries conducted when you compare the past 4 years and now? Can you quantify the increment or reduction?
  - g. What unintended results – positive and negative – did the intervention produce? How did these occur? What were the barriers and enablers that made the difference between successful and disappointing intervention implementation and results?
  - h. To what extent did the programme represent the best use of available resources to achieve results of the greatest possible value to participants and the community?
6. Would you say there are more or less number of consultations of children at targeted secondary eye care hospitals when you compare the past 4years and now? What are the specific factors responsible for this change? Can you quantify the increase or reduction?

7. In the past 4 years and now, would you say there are more hospitals offering specialised refraction and low vision services? How much increase or reduction?
8. What strategies of the programme delivery have been effective and what has not been effective?
9. Do the importance and the quality of the programme justify the amount of resources used? Please give examples and explain
10. In your opinion, how do you think the SiB programme will fair across the spectrum once the project come to a close? How long do you envisage the programme will run for? How sustainable is the SiB model?
11. Thinking about the sustainability of this programme, what are the key things that should be put into consideration to increase its longevity?
12. Is the mass training of teachers in the primary and junior secondary schools different from the training of teachers in low vision mainstreaming? How were the participants selected?
13. How do you identify children who require cornea transplant across the clusters, low devices, spectacle or other treatment?
14. **Specific to Cluster 1 coordinator:** Cluster 1 (Ogun) low beneficiary recorded in Sagamu was as a result of the dilapidated state of the link roads to access the service. Was this issue rectified? How was this rectified to increase access to service? Did it lead to increase or reduction in access to service?

**Thank you**



**Discussion guide for Implementing partners - Key hospitals - PHC, SHC, Tertiary hospitals, HANDS, Traditional Birth Attendance (TBAs), Community Health Extension Workers (CHEWs), CDD etc**

1. Kindly introduce yourself – name, age, academic background, previous work experiences, current designation etc.
2. As an implementing partner to the SiB programme, can you please explain your roles and involvement with the programme to us.
  - a. How did you become involved? How were you selected? How many years did you participate in this programme?
  - b. How would you describe the implementation of this programme – introduction, training, field engagement, practical work etc ?
  - c. How do you feel working on the programme?
3. Can you please describe the process of collaboration with CBM?
  - a. Please explain to us who you interfaced with and the channel of communication
  - b. What are your key responsibilities as a partner? How were your service agreement evaluated?
  - c. How well were you able to meet your target as documented in the MoU with CBM?
  - d. How were you remunerated or compensated for your involvement?
  - e. What challenges did you encounter in your communication and entire engagement on this programme? Please list them on a scale of great to least influence. Probe for: timely / untimely receipt of funds, consumables; quality of consumables, impact of screening time on students academics, sufficient / insufficient publicity to the right people within the community, convincing people to visit the hospitals, cultural barriers, bureaucracy, selection of partners/teacher etc to participate in the study.
  - f. Of all these challenges, which would you consider the most impactful challenge? Were you able to resolve them? How was it resolved?
  - g. Which issues were left unresolved at the end of the programme?
  - h. What are the best possible ways to create lasting solutions to the problems?
4. How well was the programme implemented and adapted as needed?
  - a. Which strategies/approaches of programme delivery have been effective and what has not been effective?
  - b. When is the lowest and highest referral time? What is usually

responsible for this? What is the most trying solution to increase the number of referral or surgeries conducted YOY?

- c. Did the intervention produce the intended results in the short, medium and long term? If so, for whom, to what extent and in what circumstances? Probe for: Increase in enrolment, Increased attendance at school, Increase participation of girl-child at schools, participation at school, high traffic at hospitals, increase economic activities etc.
  - d. What unintended results – positive and negative – did the intervention produce? How did these occur?
  - e. What were the barriers and enablers that made the difference between successful and disappointing intervention implementation and results?
  - f. How valuable were the results to other implementing partners, CBM, government and the communities involved in this programme?
  - g. To what extent did the intervention represent the best possible use of available resources to achieve results of the greatest possible value to participants and the community?
  - h. Are any positive results likely to be sustained? In what circumstances?
5. Would you say this programme has positively or negatively impacted its recipient communities? Why do you say that?
- a. Comparing activities pre and post SiB intervention, in your opinion, what are the differences you have noticed? What would you consider as the key changes brought about as a result of this programme? Please list them
  - b. Who would you consider as the major beneficiaries? Were there specific gender and age quota implemented in service recipient? What are the major benefits/ disadvantage accrued to them?
  - c. What was the quality of the programme design and content in terms of strategies deployed for sensitizing the community members, referrals, scheduling for spectacles receipt, logistics, minor and major surgeries, logistics etc.
6. In your opinion, when you compare pre and post SiB, would you say there are more or less number of cataract surgeries in children at targeted tertiary hospitals? What do you assume is responsible for this? Please give circumstances
7. Considering pre and post SiB programme, has there been an increase or decrease in the number of consultations of children at targeted secondary hospitals in your community?

8. In the past 4 years and now, would you say there are more hospitals offering specialised refraction and low vision services in your community? Can you quantify the increment or reduction? What is the impact of this change? How is this affecting the overall goal of your engagement with SiB?
9. How well did the programme represent the best use of available resources to achieve results of the greatest possible value to participants and the community?
10. In your opinion, how do you think the SiB programme will fair across the spectrum once the project come to a close? How long do you envisage the programme will run for? How sustainable is the SiB model?
11. Based on your involvement with the programme since the past few years, what enduring methods would you suggest for the success and sustainability of the SiB programme?

**Thank you**

## **Discussion guide for government – Ministry of Health, Ministry of Education / SUBEB, National Orientation Agency**

1. Can we meet you please - kindly introduce yourself – name, age, academic background, previous work experiences, current designation etc.
2. As an external evaluator, we would like to understand your relationship with the CBM SiB programme?
  - a. Why did you decide to partner with them?
  - b. What role did your ministry play in the programme?
  - c. How did you contribute to the implementation of the programme?
  - d. What is your assessment of the programme in relation to the objectives of the ministry?
  - e. How do you feel working on the programme?
3. How well was the programme implemented and adapted as needed?
  - a. In the course of your engagement with the programme, what strategies would you consider effective in the overall implementation and collaboration?
  - b. Which strategies were ineffective and should be discarded?
4. Has the SiB programme, in any way, contributed to the increased coverage of eye health care in Nigeria? How did they achieve this?
  - a. Comparing activities before and after the intervention, in your opinion, what would you consider as the key changes brought about as a result of this programme?
  - b. In which cadre of healthcare is this apparent? Probe specifically for primary (screening), secondary (spectacles and minor surgeries) and tertiary (major surgeries and cornea grafting surgery)
  - c. From your statistics, would you say that there are more hospitals offering specialised refraction and low vision services in the implementing communities?
  - d. Who would you consider as the major beneficiaries of this initiative?
  - e. Did the intervention produce the intended results in the short, medium and long term? If so, for whom, to what extent and in what circumstances?
  - f. What unintended results – positive and negative – did the intervention produce? How did these occur?
  - g. What were the barriers and enablers that made the difference between successful and disappointing intervention implementation

and results?

- h. To what extent did the programme represent the best use of available resources to achieve results of the greatest possible value to participants and the community?
5. How were you able to integrate the SiB programme into the ministry objectives? What are the perceived benefits of these integration?
- a. How is the programme integrated into the ministry of health objectives as well as the school calendar and policies; what is the impact of its integration into the school programme?
6. As a member of the community and government official with vast experience in development work, do you think the SiB has a sustainable model? Why? What are the measures that have been put in place for its continued efficiency?
- a. For instance who will be responsible for the proposed periodic monitoring and supervision of school screening within the cluster states? What will be the frequency? How will it be financed? What are the processes put in place if a new government assumes power?
  - b. Is the implementation approach a sustainable model after the end of the SiB project?
  - c. Do the importance and the quality of the programme (and associated outcomes) justify the amount of resources used?

**Thank you**

### **Discussion guide for beneficiaries**

1. Can we meet you please - kindly introduce yourself – name, age, family size, what you do, academic background etc.
2. Please share with us how you became aware of the CBM SiB programme?
  - a. Who told you about them? Where did you hear of them – radio jingle, flyers, during hospital visits etc?
  - b. How soon after your first interaction with the programme did you become convinced of its authenticity?
  - c. Did you get approval from anyone else before you attended the first consultation - husband, family member, Imam, pastor, traditional leader, friends etc?
3. How did you know that your child has an eye defect? How long has it been?

- a. What have you done about it prior to the SiB programme? What were the constraint to obtaining proper eye care for you child prior to the launch of the SiB programme?
4. Can you please talk us through the process of attending your first consultation?
  - a. How far away from your home is the health center? In minutes or hours
  - b. How much did it cost you to get to the health center? What was the name of the eye center? Who directed you there?
  - c. Who did you meet with? What was the waiting period? Was there a lot of queue? What was the ambience of the eye health center like?
  - d. Did you fill any paper or form? What are those? In what language? Were they easy to translate, lengthy or short etc?
  - e. Did you make any payment? If yes, how much? How did it make you feel?
  - f. How many kids were present? How was your kid selected to participate in the treatment?
  - g. Do you think the selection process was free and fair?
  - h. What was the result at the end of the first consultation? Probe for given spectacle, scheduled for surgery etc
  - i. How did you feel about the entire experience?
  - j. Did it meet your expectation, surpassed it or disappointed you? Why do you feel this way?
5. **For those who successfully received either spectacle or surgery:** can you please describe the process to us?
  - a. How long from the first consultation, did you get your spectacles or conducted the surgery?
  - b. Where did it happen – same hospital or a different one?
  - c. Who conducted the surgery or hand over the spectacle?
  - d. Did you feel they were well trained or not? Did you feel you were well taken care of? Were there enough and relevant equipment?
  - e. How much did you pay to collect the spectacle or get the surgery done?
6. **For those who were unsuccessful in receiving the required treatment:** kindly share with us your experience with the failure to receive the required treatment for your child?

- a. Which hospital did you visit? What went wrong? Who communicated with you? Did you conduct any test at all? Was the quota exceeded, what was responsible for this event?
  - b. What could be done to improve your experience in future?
  - c. What feedback would you like to share with the SiB programme?
7. In your engagement with SiB, what did they do right and what went wrong? How do you feel about the programme after your engagement with them?
8. Would you say this programme has positively or negatively impacted you and member of your community? Why do you say that?
  - a. Comparing activities before and after the intervention in your community, in your opinion, what would you consider as the key changes brought about as a result of this programme? Please list them
  - b. Who would you consider as the major beneficiaries in terms of gender, age? How about age bracket? What are the major benefits/ disadvantage accrued to them?
  - c. Were more male or female attended to or given preference?
  - d. Which age bracket was given priority?
  - e. How well was the programme implemented and adapted in your community?- did they speak your local language, did they look like indigene of your community, do you have reasons to trust them etc?
  - f. Did the intervention produce the intended results in the short, medium and long term? If so, for whom, to what extent and in what circumstances?
  - g. What unintended results – positive and negative – did the intervention produce? How did these occur?

**Thank you**