ACHA Douala / Seeing is Believing

Programme Evaluation

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Prepared for: Right to Sight

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List of Abbreviations

ADH	ACHA Douala Hospital
CA	Capacity Area
CBM	Christian Blind Mission
CBW	Community-Based Worker
CSR	Cataract Surgical Rate
GIS	Geographic Information Systems
HRD	Human Resource Department
IAPB	International Agency for the Prevention of Blindness
MIS	Management Information System
MoE	Ministry of Education
MoH	Ministry of Health
MOU	Memorandum of Understanding
OCO	Ophthalmic Clinical Officer
OPD	Outpatient Department
PCC	Presbyterian Church of Cameroon
PHC	Presbyterian Health Centres
RAAB	Rapid Assessment of Avoidable Blindness
RTS	Right to Sight
SCB	Standard Chartered Bank
SIB	Seeing is Believing
WHO	World Health Organisation

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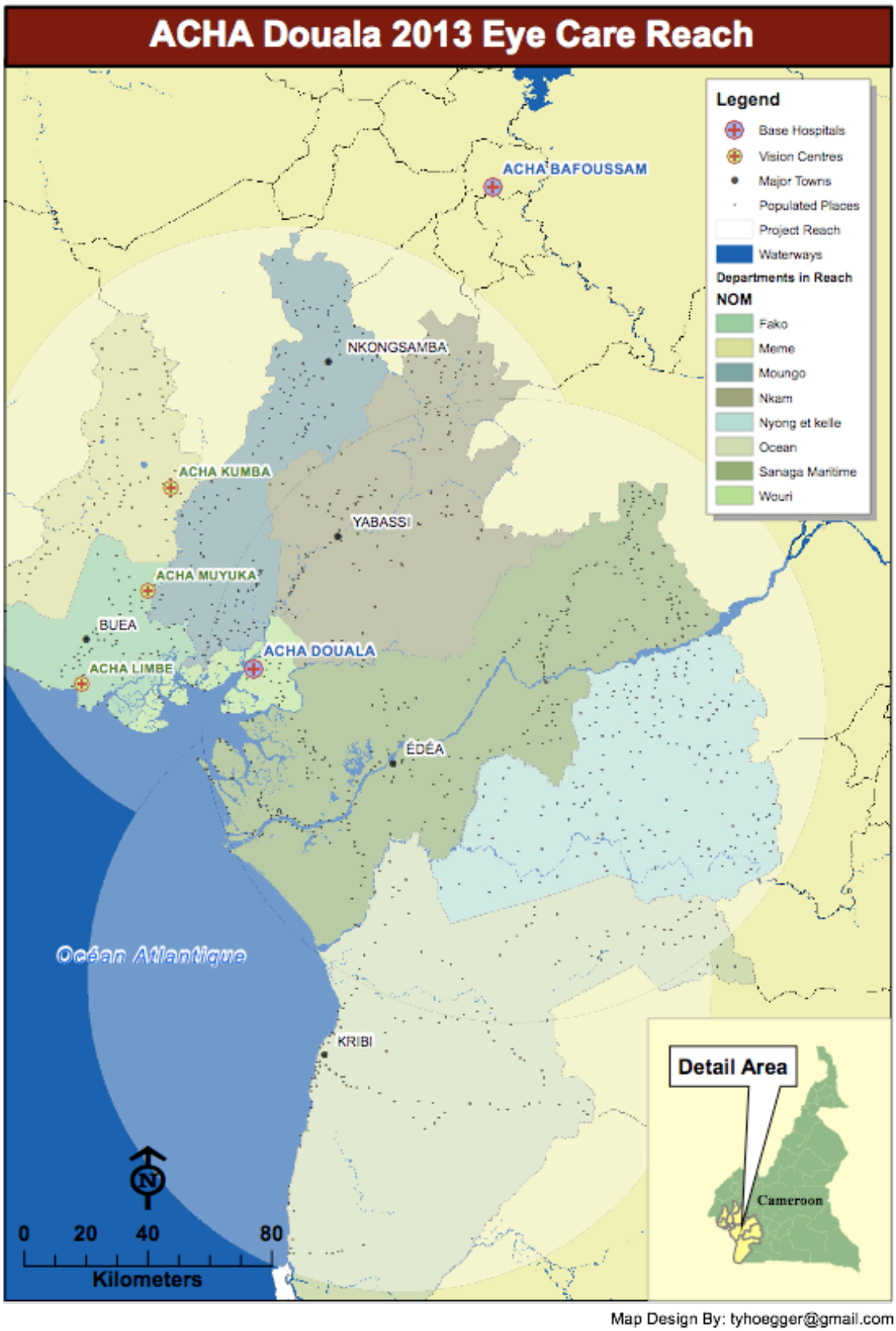
Map of Programme Reach



Map Design By: tyhoegger@gmail.com

Executive Summary

This document provides an assessment of the Right to Sight, Seeing is Believing: *"Increased access to affordable high quality eye care services in Douala, Cameroon"* programme at ACHA Douala Hospital, Cameroon.

The main goal of this programme was to significantly reduce the prevalence of blindness in Douala, improving the quality of life for the reversibly blind and those at risk of blindness. This evaluation assesses the programme implementation and results.

The programme objectives are as follows:

- To strengthen the eye care service delivery of the new ACHA Douala Hospital
- To achieve sustainability of the new ACHA Hospital in Douala
- To improve access to eye care services, especially for the indigent population
- To improve access to eye care services of school going children
- To render eye care services that are efficient and high quality

These five objectives and their specific targets are the focus area of the report.
Each objective is assessed and recommendations are provided.

The outreach strategy, although part of Goal 3, was given its own section of the programme evaluation because of the scale of the outreach strategy and outreach programme.

The RTS / SIB programme, despite getting off to a slow start in its first year, was an incredible success. The programme duration was 3 years, with an additional 9-month no cost extension. The capacity area assessment of the programme highlights the most impressive part of the programme – the ability of RTS and ACHA Douala Hospital to respond to the need for changes as a result of various internal and external factors. Programme management, strategic leadership and communication improved in years two and three. These years show a realistic and strategic attitude toward programme implementation with goals, targets and outputs revised according to the needs of the hospital and programme. The team approached these changes with confidence. Excellent management practices and strategic leadership ensured that the teams implementing these goals were aware of what was required to achieve these revised targets.

I. Evaluation Overview

1.1 Purpose of the Evaluation

The purpose of this evaluation was to evaluate the success of the *"Increased access to affordable high quality eye care services in Douala, Cameroon"* Right to Sight supported programme at ACHA Douala Hospital to determine what worked well, what didn't work and why.

The main goal of this programme was to significantly reduce the prevalence of blindness in Douala, improving the quality of life for the reversibly blind and those at risk of blindness.

The project duration was 3 years, with an approved extension of 9 months. As the implementation time frame has lapsed, there is a need to review the programme and assess if it has met the objectives above. There is a need to assess the impact of the programme and provide recommendations for programme improvement.

1.2 Aims and Objectives of the Evaluation

The aims of this evaluation are:

- To determine the successes and shortfalls of the programme
- To make recommendations on interventions required to address the shortfalls of the programme
- To determine if the activities and outputs of the programme were consistent with the overall goal
- To determine if the activities and outputs of the programme were consistent with the intended impacts

1.3 Evaluation Team

This evaluation consisted of three key members:

Bushra Razack - Programme Development and Management - Consultant
Tyler Hoegger - GIS - Consultant
Adolf Lyonga - In-Country Consultant

1.4 Evaluation Methodology

A participatory and interactive approach was used to conduct the programme evaluation. The aim in using this approach was to enable the donors, ACHA Douala and its staff to reflect on the programme and develop a sense of ownership of the outputs of the assessment, making it possible and practical for them to implement the recommendations. The activities undertaken in the evaluation process were:

- **Preparation / initial communication -** Introductory communication was established between evaluation consultants, in-country consultant and key hospital staff. The purpose was to outline the aims of the evaluation and the roles that different people involved would play.

- **Review of relevant documents -** The consultants reviewed the documents provided by Right to Sight and ACHA Douala Hospital. The following documents were provided to consultants:

  - SIB Final Proposal
  - SIB Revised Proposal
  - Letters of Variation
  - Monthly Performance Reports
  - Outreach Plan
  - Aravind Needs Assessment Report
  - SCB Bi-annual Reports
  - Case Studies

- **Preparation of interview schedule** - An interview schedule was created and respondents were notified in advance to ensure they were prepared. Respondents were divided by categories to allow for easier execution of the interview process. The entire interview process lasted 3 weeks. The in-country consultant was provided with interview guidelines, the interview list and selected locations for interviews. The table below outlines the interview schedule:

	Interviews Conducted
Week 1	Hospital staff, selected ACHA Douala Admin, Hospital Outreach Staff: 2 x Refractionists, 2 x Consultants, 1 x nurse, 1 x storekeeper, 1 x driver, selected patients / beneficiaries.
Week 2	5 x Community-Based Workers, selected Satellite Clinic Staff, Patients at Outreach Screening locations
Week 3	Hospital Administration, Programme Manager, Outreach Manager, Hospital Manager, Online interviews

Appendix 1 - Evaluation Interview List

- **Surveys conducted** - The in-country consultant was made aware of the survey information required and the locations in which the data had to be gathered. Deliverables and outputs were clear and time scales agreed upon. A series of questionnaires and surveys were conducted as part of the data collection process. These questionnaires included:

1. Outreach Team Questionnaire
The first survey was created for the outreach team and hospital staff involved in the implementation of the programme. The outreach programme was a significant part of the project and as a result, required its own survey.

Appendix 2 – Outreach Team Questionnaire

2. Programme Goals and Key Capacity Areas Survey
This survey looked at the programme goals individually and asked respondents to provide feed back as to why they felt each goal was achieved or not achieved. These surveys were multiple choice and provided respondents with an opportunity to assign a score (0 - 5) to each programme goal and its CA.

Appendix 3 – Capacity Area Survey

3. Beneficiaries Questionnaire
This was designed for the beneficiaries and was developed to gain an insight into their experience, their reasons for accessing the ACHA Douala services and to establish how satisfied they were with services provided.

Appendix 4 – Beneficiaries Questionnaire

4. Intended Beneficiaries Questionnaire
This group was made up of the intended beneficiaries that did not take up the services provided by ACHA Douala Hospital through the programme. These were beneficiaries that attended the screenings, or visited the hospital and were identified as needing eye care services – but chose not to access these services.

Appendix 5 – Intended Beneficiaries Questionnaire

- **Online interviews, surveys** - Online interviews conducted by consultants.

- **Direct observation** - The in-country consultant was provided with a comprehensive outline of the objectives of the evaluation. The in-country consultant was given clear targets and deliverables. The field notes and direct observations of the in-country consultant were considered an effective tool in information gathering and data analysis. The in-country consultant was active in the field and was able to provide valuable insights into the programme through his direct observations. This information was gathered over a three-week period. Information was documented and then discussed with consultants.

- **Collate data and analyse results** - The consultants collated data from the interviews, reviewed documents and research results. Consultants analysed results of surveys and interviews.

1.5 Capacity Area Assessment

Capacity areas of the programme were assessed. These CAs played a significant role in the organisations achieving / failure to achieve the intended goals of the programme. The capacity areas assessed were:

- Strategic Leadership - Commitment to mission, strategic planning and responsiveness to external impacts
- Programme Management - (overall management of the programme); results/ impact, sectoral expertise, technical and administrative support, stakeholder ownership.
- Management Practices - (specific management practices); information/ knowledge, staff meetings, participatory management, teamwork, application of learning, documentation and analysis, research, meetings, participatory management, teamwork, and documentation
- Communication - Internal, external and with donors / partners
- Beneficiary Satisfaction - Stakeholder ownership, satisfaction, fundraising capacity, donor relations
- Resource mobilisation and sustainability

Indicator Assessment

Respondents were asked about each programme activity and to consider the role that the different CAs played in the achievement of the programme activity. Respondents were asked to assign a score from 0 – 5 to each, zero being the lowest and five the highest.

1.6 Limitations of the Evaluation

The limitations of this evaluation were:

- The geographic location of the lead consultants - as the lead consultants were not based in Cameroon, the gathering of data and subsequent data review and analysis had to be done through the in-country consultant.
- The in-country consultant had intermittent internet connectivity making communication with in-country consultant challenging.
- The majority of the assessment was scheduled to be conducted during November and December, which are the busiest months for the hospital. This meant that interviews with key hospital staff needed to be postponed, as they were unavailable during this busy period.
- The last online interview responses were received in February 2014.
- A majority of the statistics provided to consultants were for programme years 2010 – March 2013. The programme ended in December 2013. It

wasn't until the second draft of the report was submitted that consultants were provided with the data from March - December 2013

- There were discrepancies in output numbers between the different project documents.

II. ACHA Douala Hospital and the SIB Programme

2.1 Background of ACHA Douala Hospital

The project is based in Douala in Southwest Cameroon. The hospital is located in a poor socio-economic area called Bepanda. Presbyterian Eye Services is a missionary, non-profit, charitable organisation and the leading provider of eye health services in Cameroon. It is run by the Presbyterian Church in Cameroon. Their vision is to provide devoted, sustainable, affordable, high quality eye care to all.

2.2 Background of the SIB / ACHA Douala Programme

At the outset of the programme, it was estimated that there were over 20,000 blind people in Douala, 10,000 of whom were blind due to cataract. There were also 60,000 people living with low vision. These rates were two to three times higher than the 0.5% rate acceptable by the WHO. According to the SIB final proposal, the Cataract Surgical Rate was estimated to be 677 surgeries per million people - far below what is required for Cameroon. The Vision 2020 plan recommends 2,000 surgeries per million (per annum). The problem was more evident in Douala where the surgical figures were even lower. The CSR in the Littoral Province was estimated to be at 700, as there were only two centres with surgical capacity, each doing approximately 350 surgeries per annum.

The incidence of blindness in the age group 0 to 15 was estimated at 1 per 1,000. There were 23 primary eye care centres, 2 secondary and 4 tertiary eye care facilities; almost all attached to general government hospitals.

The programme was designed to respond to the needs of the local community and the needs of the hospital.

2.3 Programme Goals and Objectives

Goal: *"The prevalence of blindness in Douala is significantly reduced and thus the quality of life of the reversibly blind and those at risk of blindness is improved"*

Objectives:

1. To strengthen the eye care service delivery of ACHA Douala Hospital
2. To achieve sustainability of the new ACHA Hospital in Douala
3. To improve access to eye care services, especially for the indigent population
4. To improve access to eye care services of school going children
5. To render eye care services that are efficient and high quality

Primary indicators for each objective:

1. To strengthen the eye care service delivery of ACHA Douala Hospital
    - To create 3 new vision centres
    - To establish a new hospital complex with secondary and subspecialty services
    - To raise awareness of blindness prevention and sight restoration through awareness campaigns targeting the communities in Douala

2. To achieve sustainability of the new ACHA Hospital in Douala
    - Human resource department is established with increased amount of local staff in leadership positions.
    - Training wing of the HRD is established
    - In-house training for the MoH Cameroon Residency Programme is provided
    - High profile of ACHAs services in Cameroon

3. To improve access to eye care services, especially for the indigent population
    - Outreach system is well established and linked to Presbyterian Health Centres
    - Capacity of the outreach team is strengthened
    - Networking systems are put in place to reach the community
    - Equity of access to services achieved

4. To improve access to eye care services of school going children
    - School Eye Health Plan established
    - The capacity of the School Eye Health Wing is strengthened
    - Networking with Ministry of Education and SCB to establish school-screenings

5. To render eye care services that are efficient and high quality
    - Monitoring and Evaluation unit is established and running
    - Quality assurance unit is established ad running
    - Research unit is established and research is published

2.4 Programme Beneficiaries

The main beneficiary groups were:

- The population of Douala that currently do not have easy access to affordable, high quality eye care services
- The blind and poor people of Douala
- The children of Douala

Beneficiary Targets and Estimated Beneficiaries:

The following table shows the beneficiary targets and the estimated numbers of each target population.

Beneficiary Targets	Year 1	Year 2	Year 3	Total
Target Population	200,000	300,000	500,000	1,000,000
OPD Patients	10,000	25,000	40,000	75,000
Cataract Patients	1,200	2,600	4,050	7,850
Outreach Patients	2,700	4,200	5,100	12,000
School Pupils	6,000	8,000	11,000	25,000

2.5 Output Targets Over Project Life Cycle

Output Targets	Estimated Output			
	Year 1	**Year 2**	**Year 3**	**Total**
Centres Opened	1	1	1	3
Outreach Camps	16	24	30	70
Outpatients Seen	10,000	25,000	40,000	75,000
Children Seen	1,200	1,600	2,200	5,000
Cataract Surgeries	1,250	2,600	4,050	7,900
Other Surgeries	200	500	750	1,450
Total Surgeries	1,450	3,100	4,800	9,350

Output Targets	Estimated Output			
Refractions	3,200	8,000	12,800	24,000
Spectacles dispensed	2,000	5,000	8,000	14,000

2.5.1 SIB Programme Results Summary

In 2008, prior to the original SIB proposal, ACHA (Douala and Bafoussam) saw 94,424 outpatients, dispensed 12,663 pairs of glasses and performed 2,749 cataract surgeries. In addition to this, ACHA Douala had an extensive network for facilitating the identification of cataract and other eye diseases using a model similar to that used by Aravind Eye Care System in India. ACHA's cost recovery was regularly over 100 percent. As a result of this, Right to Sight identified ACHA as a priority partner.

A proposal entitled "Increased access to affordable high quality eye care services in Douala, Cameroon" was developed for Standard Chartered Bank's SIB Programme.

Appendix 6: Original Sib Proposal

2.6 Programme Overview

Below is a general summary of the programme to be followed by detailed discussions on the individual programme activities.

2.6.1 Programme Development

In 2009, Right to Sight in partnership with ACHA Presbyterian Health Services received the grant from Standard Chartered Bank's SIB Campaign. After the signing of the MOU between IAPB/SIB – RTS in December 2009, the initial stages of the programme began in 2010.

According to interview results with key respondents, the programme activity began a year late as a result of inefficient communication at the start of the programme cycle. The interview feed back referred to communication between Right to Sight and ACHA administration, as well as communication in-house. ACHA Douala was newly established and there was no hospital manager / administrator in place to oversee programme implementation. There was no permanent RTS presence at ADH in Cameroon.

First Steps

The initial programme targets as outlined in the original SIB proposal could have been more realistic and could have been better communicated to the key staff required to implement these goals. This again, is a result of a lack of organisational management at

a hospital level and ineffective programme management from RTS. Interviews revealed that critical members of hospital staff were unaware of the programme targets until the end of the second year of programme implementation.

One of the first activities of the original SIB proposal was the performance of a RAAB before the start and upon completion of the programme. This was unrealistic (given the cost and expertise required to conduct such a study) and not the most effective use of the programme budget. The RAAB was never conducted.

The start of the programme was slow. The programme planning did not consider that ACHA Douala Hospital was trying to establish itself and develop an effective staffing structure. The lack of a surgeon posted to ACHA Douala full-time initially made the hospital priorities different to the programme priorities. The lack of a second surgeon present when outreach began and an expected influx of patients would be coming through the theatres resulted in a slow start to the programme implementation.

2.6.2 Programme Implementation

It was unrealistic to expect the hospital to scale up to large numbers of patients while the hospital was still establishing the systems and practices necessary to treat a large influx of patients. As a result, there was an initial delay in programme implementation.

Another factor affecting programme implementation was poor management from RTS at the start of the programme. There was no permanent RTS presence at ACHA Douala Hospital, and in addition to this, poor programme management from the RTS head office. Interview results indicate that key ACHA Douala Hospital staff felt that the RTS Programme Manager at the start of the programme did not have a thorough understanding of programme implementation on the ground. This resulted in poor communication of programme requirements and activities. This was resolved when the current programme manager (Rachel Flynn) began. The interview respondents concluded that the current programme manager communicated effectively and was very successful in re-evaluating targets, understanding what was realistic in an “African context” and revising the programme outputs accordingly.

Once targets and outputs were communicated to staff, along with a new staffing structure within ACHA Douala, they were able to better take ownership of the programme and were more aware of what they were working towards. The increased autonomy over re-dispersal of agreed funds given to ACHA Douala staff increased staff ownership of the programme and involvement in the programme. This was accomplished in January 2013 after the authorisation of the LOV in December 2012.

2.7 Programme Variation

As programme implementation got off to a slow start, it was clear that programme goals would not be achieved within the original time frame. The budget did not reflect the most effective or efficient use of funds for programme goals. In addition, it was

evident that the originally proposed cataract surgery figures were not attainable within the time frame of the programme.

The introduction of the new RTS programme in 2012 was viewed as a turning point in programme implementation by the management staff at ACHA Douala Hospital. It was after this that programme targets and time frames were re-assessed and revised, making implementation and targets more realistic and achievable.

Letters of Variations were submitted and approved. The most significant changes to the original proposal are as follows:

- **Extension:** 9-month no cost extension to the programme.
- **Equipment:** In a response to the growing volume of patients and the establishment of new vision centres, new equipment was required.
- **Programme officer**: Recruitment of a full-time, Right to Sight programme officer to be based in ACHA Douala for 12 months beginning January 2013.
- **Improved outreach plan**: An integral component to the Right to Sight sustainability model has always been well-resourced outreaches that generate high patient volume leading to low unit cost. In order to achieve this and address backlog of cataract patients, consultants were hired to develop an in-depth local outreach strategy. This took place over a period of four weeks in early 2013 allowing the Programme Officer to begin implementing the strategy at the end of January 2013.
- **Outreach vehicle:** The purchase of a second vehicle to enable the hospital to bring more patients from rural areas for free surgery thus contributing to programme goals.
- **Extending outreach to Bafoussam** – RTS and SIB agree to extend support for outreach to ACHA Bafoussam hospital.
- **RAAB**: It was deemed unrealistic to achieve the two RAABs within the programme time frame and within the allocated budget. Funds for the RAABs were re-allocated to a strategic programme evaluation.
- **Training of OCOs:** The funding of the training of two OCOs in SICS. The OCOs will be fully trained and ready to begin operating by January 2015.
- **Training of State Nurses**: A State Registered Nurse in each PCC Hospital (not only eye hospitals) is trained in basic eye-health, diagnosis, referral and treatment as a move toward establishing ACHA as a centre of excellence for training.
- **Surgical scholarship**: Programme to offer a fully funded one-year surgical scholarship to a final year student from an African ophthalmology department.

- **IT training:** Training of 5 members of staff to facilitate improved data collection and management of the hospital IT system.

Appendix 7 – Letter of Variation

2.7.1 Variation of Targets

Outputs	Original Proposed Outputs	Revised Proposed Outputs	% of Original Proposed Outputs
No. Centres Opened	**3**	**3**	**100%**
No. Outreach Camps	**70**	**226**	**323%**
No. Outpatients Seen	**75,000**	**146,594**	**195%**
No. Children Seen	**5,000**	**15,201**	**304%**
No. Cataract Surgeries	**7,850**	**5,000**	**63%**
No. Other Surgeries	**1,450**	**1,812**	**125%**
No. Refractions	**24,000**	**40,939**	**171%**
No. Spectacles Dispensed	**14,000**	**15,082**	**108%**

2.7.2 Sustainability

The issue of programme sustainability was only actively pursued from the end of year two due to other hospital / programme priorities. ACHA Douala Hospital is currently operating under a sustainable business model. It is important to note that this model is not the original proposed model based on the Aravind / RTS model for sustainability.

This cross-subsidy model would need to be adapted to the local specific needs of the hospital and surrounding community as the basic demographics differ.

ACHA Douala can, like Aravind, consider creating differentiated experiences for varying levels of patients. The same operation can be priced very differently based on the accommodations associated with the surgery and the type of lens implanted. These options can go a long way allowing patients to elect a level of services and accommodations based on preference and ability to pay - effectively enabling ACHA Douala to discover the client's willingness to pay for services.

The elements of the programme that did encourage sustainability or will allow ACHA Douala to improve sustainability in the future were as follows:

- The Surgical Scholarship Initiative
- The introduction of community-based workers
- The establishment of an effective central accounting system
- A strong internal control system at the head offices in Buea
- The Auditors from the head office in Buea visit the hospital twice a year and are able to monitor the financial activities of the hospital in an effort to ensure that the activities are aligned with sustainability requirements
- There is a strategy in place for patients to pay for services
- The equipment needed were once-off purchases and the hospital will not have to make those purchases again

It is recommended that ACHA Douala, RTS and SIB consider the further development of a sustainable supply of African eye surgeons in future programmes.

2.8 SIB Programme Overview of Key Outputs

Outputs	Total Output Targets	Total Outputs Achieved Sept 12	H2Y3 Achievements	H1 Y4 Achievements	H2 Y4 Achievements	Cumulative Targets to Date	Cumulative Achievements to Date	Cumulative Achievements to Date (%)
No. Centres Opened	3	2		1	0	3	3	100%
No. Outreach Camps	221	85	44	65	20	221	214	97%
No. Outpatients Seen	146,594	97,094	27,799	35,728	19,276	146,594	179,897	123%
No. Children Seen	15,201	6,291	5,512	6,431	3,469	15,201	21,703	143%
No. Cataract Surgeries	5,000	1,710	997	2,133	655	5,000	5,495	110%
No. Other Surgeries	1,812	912	333	418	259	1,812	1,922	106%
No. Refractions	40,939	22,939	8,829	10,919	4,682	40,939	47,369	116%
No. Spectacles Dispensed	15,082	9,832	2,609	2,893	1,502	15,082	16,836	112%
No. Outreach Patients Seen	12,000	9,267	3,645	7,770	2,342	12,000	23,024	192%
No. of School Pupils Screened	3,167	698	969	1,905	2,595	3,167	6,167	195%

No. of People Trained		16	77	54	33		180	
Total Direct Outputs	240,016	148,759	50,770	68,251	34,833	240,016	302,593	126%
Indirect Outputs	759,984	835,757	227,283	508,704		759,984	1,571,744	207%
Total Outputs	1,000,000	984,516	278,053	576,955	34,833	1,000,000	1,874,337	187%

2.8.1 Programme Summary Timeline

Year	Notable Activities	Other Activities	Major Achievements
2010-2011	• IAPB / SIB – RTS MOU signed in December 2009 • In house planning meetings, Orientation and Planning Meeting with the consultants from the Aravind Hospital Team was held in Madurai on March 22, 2010	• The Needs Assessment visit took place between 26th and 28th March, 2010 • The Vision Building Workshop was held at the ACHA Douala Hospital site on the 29th March • Dr. Faustin advocated on the significance of eye care at the Fund Raising Ball of SCB in Douala in Oct, 2010	•6,942 new patients examined •147 cataract surgeries performed •Training hall developed and equipped
2011-2012	• Right to Sight and the Presbyterian Health Services signed a MOU regarding hospital services • A subsidised cataract surgery plan was introduced. • Dr. Faustin took charge as the Medical Director	• Fast-track outpatient department was introduced • In-house workshops on 'capacity versus potential', 'human resources', 'pricing policies' etc. were conducted •Mr. Amidu, OCO in charge of 2011 outreach camps, underwent a four week training on outreach management and social marketing in Nairobi, Kenya	•HRD was formed (interviews suggest that this was not done. SCB reports indicate that it was) •38,936 outpatients were examined; 1,041 surgeries were conducted and 4,322 spectacles dispensed. Of the 1,041 surgeries, 836 had been cataract surgeries
2012-2013	•Free cataract surgery for poor patients identified at outreach screenings •Dr. Patel reached an all-time high of performing 187 surgeries in March • Agreed upon 9 month, no cost extension	• Consultants develop a one year improved outreach plan to achieve new targets • RTS Programme Officer stationed at ACHA Douala to facilitate improved outreach plan •A series of educational sessions took place at the hospital •Free glaucoma screening for all patients and SCB staff during World Glaucoma Week	•1,820 surgeries conducted •4,678 spectacles dispensed •Of the 1,820 surgeries, 1,190 were cataract surgeries

Year	Notable Activities	Other Activities	Major Achievements
April 2013 - December 2013	•There was the visit of the CBM Regional Director for Central Africa this month •Kumba Vision Centre inaugurated on Aug. 7th •Echography Machine to retinal and vitreous problems mobilised and in use	•Dr. Faustin Ngounou was nominated as World Eye Health Leader for IAPB initiative for eliminating blindness •Dr. Rajesh Patel attended the SIB Workshop in Malaysia •New staff recruited and sent to Douala	•Outreach cataract operation goals are achieved: 1,663 cataract operations performed through outreach in 2013 •37,095 OPD in base hospital •3,871 Glasses Dispensed •3,796 pupils screened

III. SIB Programme Goals Evaluated

3.1 Goal 1: To Strengthen the Eye Care Service Delivery of ACHA Douala Hospital

Primary Objectives

- To create 3 new vision centres
- To establish a new hospital complex with secondary and subspecialty services
- To raise awareness of blindness prevention through campaigns directed towards the communities in Douala
- To promote the services provided by ACHA Douala

Work Plan Output Achievements

Outputs	Completed By	Success Status	Notes
Conduct Vision Building and Strategic Planning workshop	March - 2010	100%	This has been completed
Existing vision centres are equipped	February - 2013	100%	The vision centres are fully equipped
New vision centres are created	December - 2013	100%	Kumba, Limbe and Muyuka are all operational.
Secondary and subspecialty services is established.	December - 2012	100%	Subspecialty services have been developed at Acha Douala, most notably in glaucoma.
Communities in the Littoral Province and beyond are aware of possibilities of blindness prevention and sight restoration (and thus make use of ACHA's services)	February - 2013	100%	The extensive outreach programme at ACHA Douala has ensured that local population are aware and in use of the services.

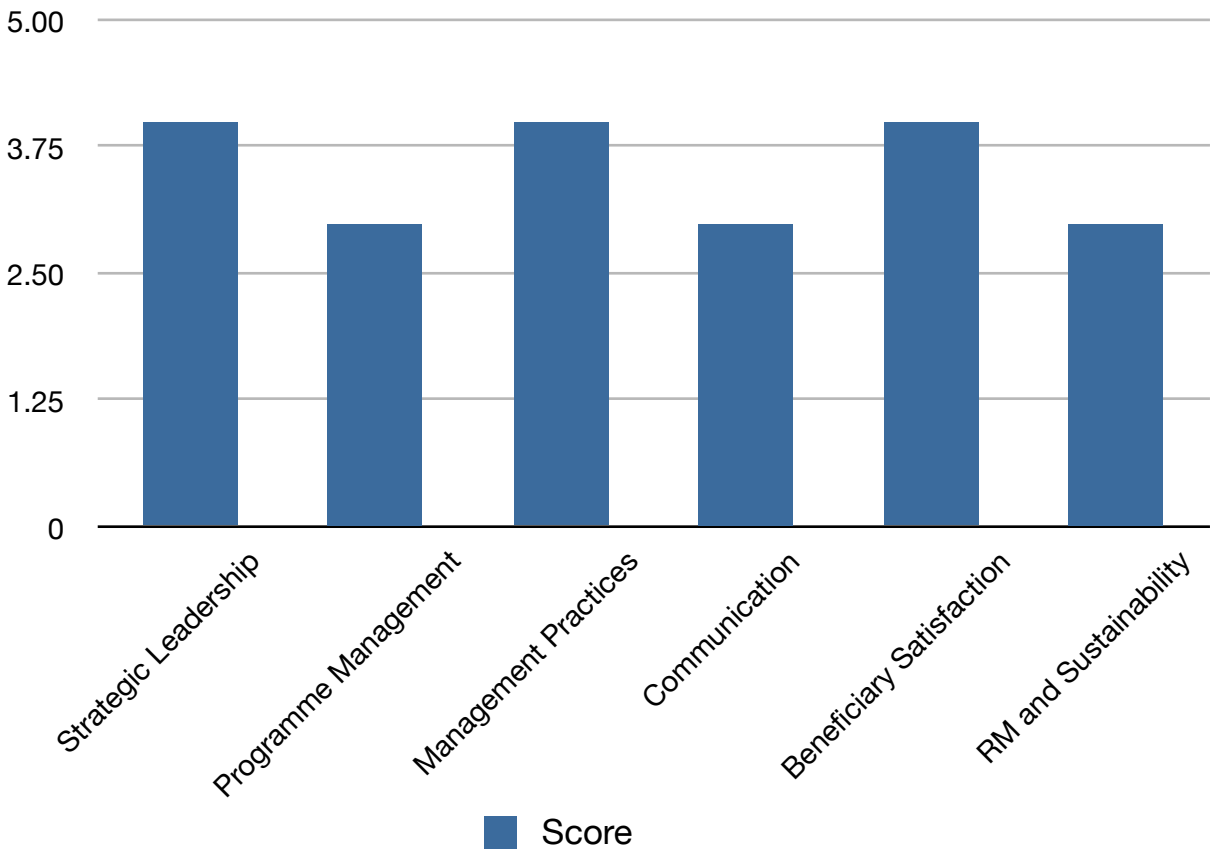
Success Indicators

Description	Target	Success Status	Notes
Increased number of trained eye care personnel	26	Yes	
Number of patients with restored vision	9,350	No	4,720 IOL
Patient satisfaction on quality of service improved	Systems put in place to monitor patient satisfaction	Yes	Patients are requested to complete satisfaction questionnaires
Number of centres operating	1 secondary hospital and 3 vision centres	Yes	The vision centres are operating in Limbe, Kumba and Muyuka
Number of patients	75,000 outpatients 9,350 surgeries	Outpatient - Yes Surgeries - No	131,089 outpatients 6,930 surgeries
New hospital block functioning		Yes	
Number of specialised treatment in every subspecialty of Retina, Glaucoma and Diabetic Retinopathy	400	Near	Glaucoma Surgery: 2011 - 53 2012 - 91 2013 - 207 **Total: 351**
Number of patients requesting treatment at ACHA sites increases over the project life cycle	Increases over 400%	No	207 % increase in OPD

Goal 1 Capacity Area Survey Results

Respondents were provided with a list of capacity assessment areas that explained what each CA entailed. Respondents were asked to consider the effectiveness and success of each capacity area in implementing each individual programme goal. Respondents were asked to assign a score of 0 - 5 to each capacity area. The results provided an indicator of which area of programme implementation was most

responsible for the success of the goal. For Goal 1, respondents felt that strategic leadership, effective planning and strategic planning were responsible for achieving this goal. Despite the start up difficulties, planning was not affected and the goal was implemented. As a result, beneficiary satisfaction was high. Respondents shared case studies of grateful beneficiaries who were able to make use of vision centres. The results of the CA survey poll are as follows:



Key Findings:

- Three vision centres have been established (Limbe, Kumba and Muyuka) and are all successful. The hospital continues to receive positive feed back on the new complex.
- There is potential for improving referral capacity of these centres. Feed back from patients who visited these centres indicated that they were not made aware of the comprehensive services available at ACHA Douala.
- Staff has attempted to contribute towards improving eye health awareness. An example of this is the fact that eye health education has been introduced in the morning prayers. The content of these talks is approved by the hospital.

- An active attempt at advocacy is clear in hospital activities and events (eg World Sight Day and World Glaucoma Week). This has been successful. There is still a need for increased lobbying and amplified attempts at engaging with government and MoH.

Recommendations:

- The staff at the vision centres need to be aware of ACHA Douala services, costs and details. Vision centre staff should be made aware of the importance of referring patients to ACHA Douala. Consider creating a basic pamphlet with ADH location, contact and other basic information to give to patients who are being referred.
- ADH needs to recognise the potential of these vision centres to help generate income for the hospital, to improve screenings in the area and increase awareness of hospital activities.
- ADH needs to improve the working relationship with the MoH and consider lobbying local government as part of its regular activities. A member of staff involved in the implementation of the hospital's operations manual could be sent on a policy and advocacy / health advocacy short course. The aim of this course would be to equip staff with the knowledge and processes required to make a case at the government level for policy changes that affect the hospital and its service delivery.
- Although advocacy was addressed, it came as a by-product of the hospital's participation in already established events and functions. ACHA Douala needs to identify opportunities for specific advocacy activities run by the hospital. Interviews with patients at the hospital as well as intended beneficiaries who had eye problems but had not accessed eye care services revealed that more than half of the patients were unaware of the different services provided by ACHA Douala Hospital. None of these patients were aware of blindness prevention methods or basic eye care practices. It should be noted that these were cataract patients and not patients attempting to access any other services. However, it is still an indicator that not all of ACHA Douala's services are known by the public.

3.2 Goal 2: To Achieve Sustainability of the New ACHA Hospital in Douala

Primary Objectives

- Human Resource Department is established
- Training wing of the HRD is established.
- In-house training and training for the MoH Cameroon Residency Programme is provided
- High profile of ACHAs services is known in Cameroon

Work Plan Output Achievements

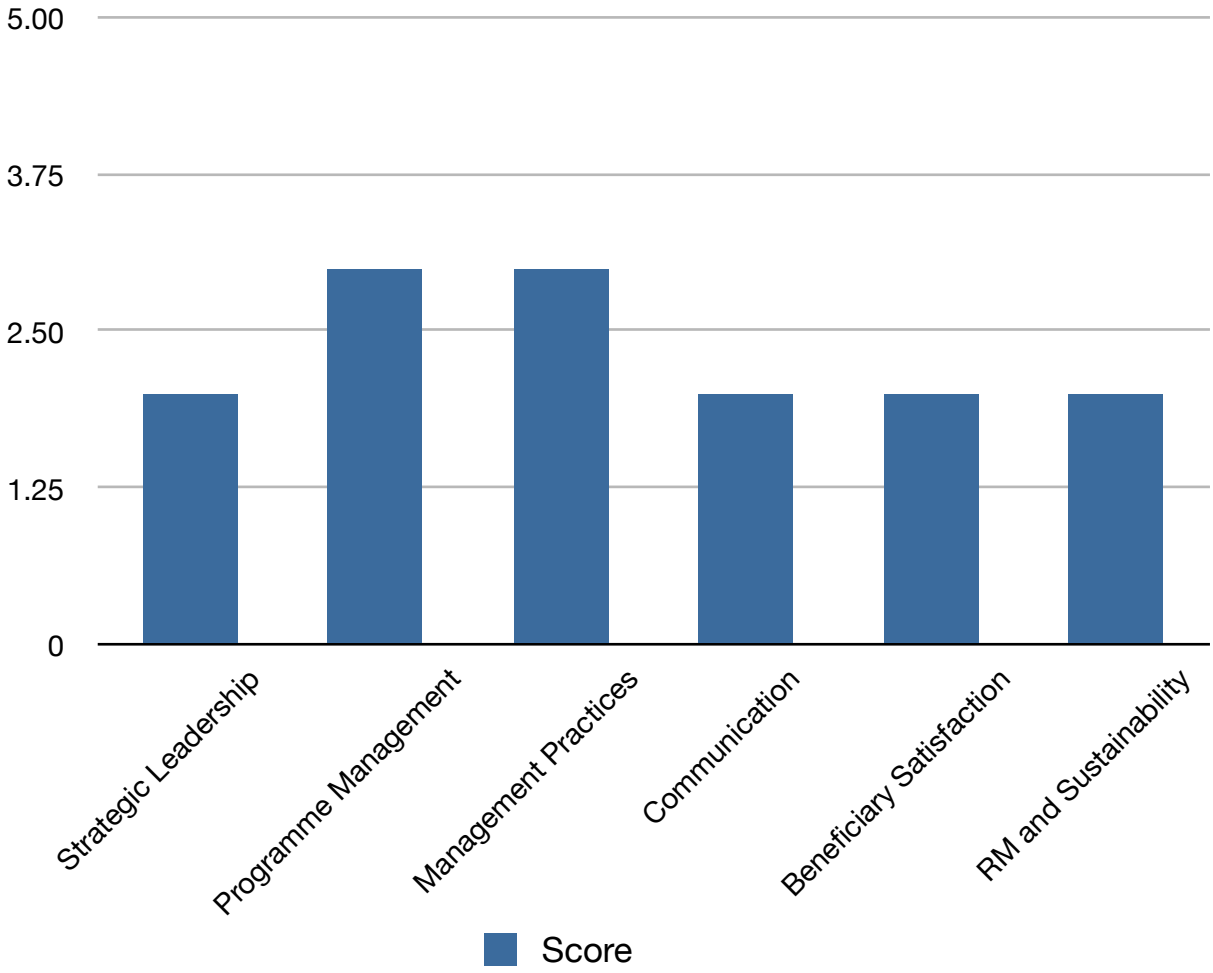
Outputs	Completed By	Percent Complete	Notes
Human Resource Department (HRD) is established and ACHA Douala centre leadership is of Cameroon origin	March - 2012	100%	New administrator Mr. Fru has completed training and has taken the position as hospital co-ordinator from March 2011
Training wing of the HRD is established and in house training and training for the Cameroon Residency Programme is provided	February - 2013	100%	The training of ophthalmic nurses and the residency programme at ACHA Douala have both been established.
High profile of ACHA's services is known in Cameroon	February - 2013	100%	The already strong reputation built by ACHA has been further strengthened by the extensive outreach campaign.
The training of the OCOs in cataract surgery	December - 2013	100%	Three candidates have been trained as OCO's.

Success Indicators

Indicator	Target	Success Status	Notes
Retention of permanent and trained staff	80%	Yes	
Staff satisfaction		Yes	
Number and percentage of local staff	90%	Yes	96% Cameroonian staff in leadership positions
Number and percentage of local staff in leadership positions	90%	Yes	
Number of trained persons	30	Yes	180 individuals trained
Number of Awareness and health education campaigns with PHC staff	135	Insufficient Data	Health awareness and education is included in daily aspects of hospital activities
Number of referrals from the outlying area surrounding Douala	3,000	Yes	Greater than 3,000
Growth of OPD patients	10,000 Year 1 20,000 Year 2 45,000 Year 3	Yes	

Goal 2 Capacity Area Survey Results

Respondents felt that although all targets were not met, management was able to communicate the reasons for this to staff through regular meetings (during years two and three) and programme updates. As a result, that staff understands why this goal was not achieved and what would need to be done should a similar target be set for them in the future. The results of the CA survey poll are as follows:



Key Findings:

- No human resource department established.
- No training wing of HRD established.
- Only limited in-house training and training for the MoH Cameroon Residency Programme was completed.
- Although ACHA Douala is a small hospital, and it can be argued that a HRD is not necessary for a facility of its size, feed back from interviews and surveys reveal that issues affecting staff, the outreach team and CBWs need to be addressed. The current hospital organisational structure does not allow for this to happen. The staff does not have a person/department to report grievances to. These grievances can impede performance and need to be addressed.
- Increased efforts have been made to improve awareness of ACHA Douala's services to intended beneficiaries, particularly through the outreach programme. This information dissemination should be expanded to include the corporate and private sector, which should also be made aware of the hospital's services. They can be a useful vehicle for sustainability and support.
- The goal of establishing a training wing of the HRD, as well as in-house training and training for the MoH Cameroon Residency Programme, was not realistic.

- One of the main factors that will contribute to the sustainability of the hospital and its programmes is dedicated, skilled staff. Feed back reveals that ACHA Douala Hospital encountered much difficulty in recruiting staff capable of conducting surgery. This was addressed in 2013 with the commencement of the surgical scholarship and the hiring of the second ophthalmologist for Douala.
- As a result, it was suggested that funds allocated to train OCOs in SICS would be better used to train a senior nurse as an OCO to provide the best support possible to the doctors when operating.
- The instalment of the pilot MIS module and subsequent training of four ACHA staff was successful. Although under-utilised, this system can play a vital role in the sustainability of the programme.

Recommendations:

- In place of a HRD, the hospital should consider a grievances panel or an alternative platform to address staff anxieties.
- During the interviews it was established that the increase in hospital activity, outreach and other activities directly affects staff performance as staff are overworked and not well managed. This is in no way a fault of the hospital manager. The programme targets meant that staff needed to be assigned to the activity areas that they were needed to fulfil a programme activity, but were taken away from their regular activities and not replaced. An alternative to an HRD could deal with these issues.
- The introduction of community-based workers was a new and extremely successful strategy to enhance the outreach programme. These CBWs are essential to the future of the outreach programme and their achievements were recognised by all staff and key informants. However, as they were new and began working immediately to achieve programme targets, they had not undergone any entrance process or received adequate training. In order to keep these CBWs, there needs to be an active human resource department or alternative dealing with their contracts, remuneration and training.
- Hospital administration should compile a list of public sector companies and private companies that could be future programme partners or supporters. Hospital should consider a *corporate social responsibility* profile of company, interest area and the company's history of supporting local programmes. These companies should be approached and provided with comprehensive documentation on the hospital and its services. This can be done as a once-off exercise or can be linked to the already existing outreach programme. Companies should be invited to attend and sponsor screenings. Their staff can also be invited to assist at screenings. This will increase the profile of ACHA Douala services at a new level.
- The hospital underwent internal changes over the four years and has only now established a more long-term organisational structure. It would thus be valuable to review the existing staff and see if any training is still needed.

- Proper handling and maintenance of equipment will ensure equipment does not need to be purchased again unnecessarily. A budget does not need to be allocated to equipment.

3.3 Goal 3: To Improve Access to Eye Care Services, Especially for the Indigent Population

Primary Objectives

- Outreach system is well established and linked to PHCs
- Capacity of the outreach team is strengthened
- Networking systems are put in place to reach the community
- Equity of access to services is achieved

Work Plan Output Achievements

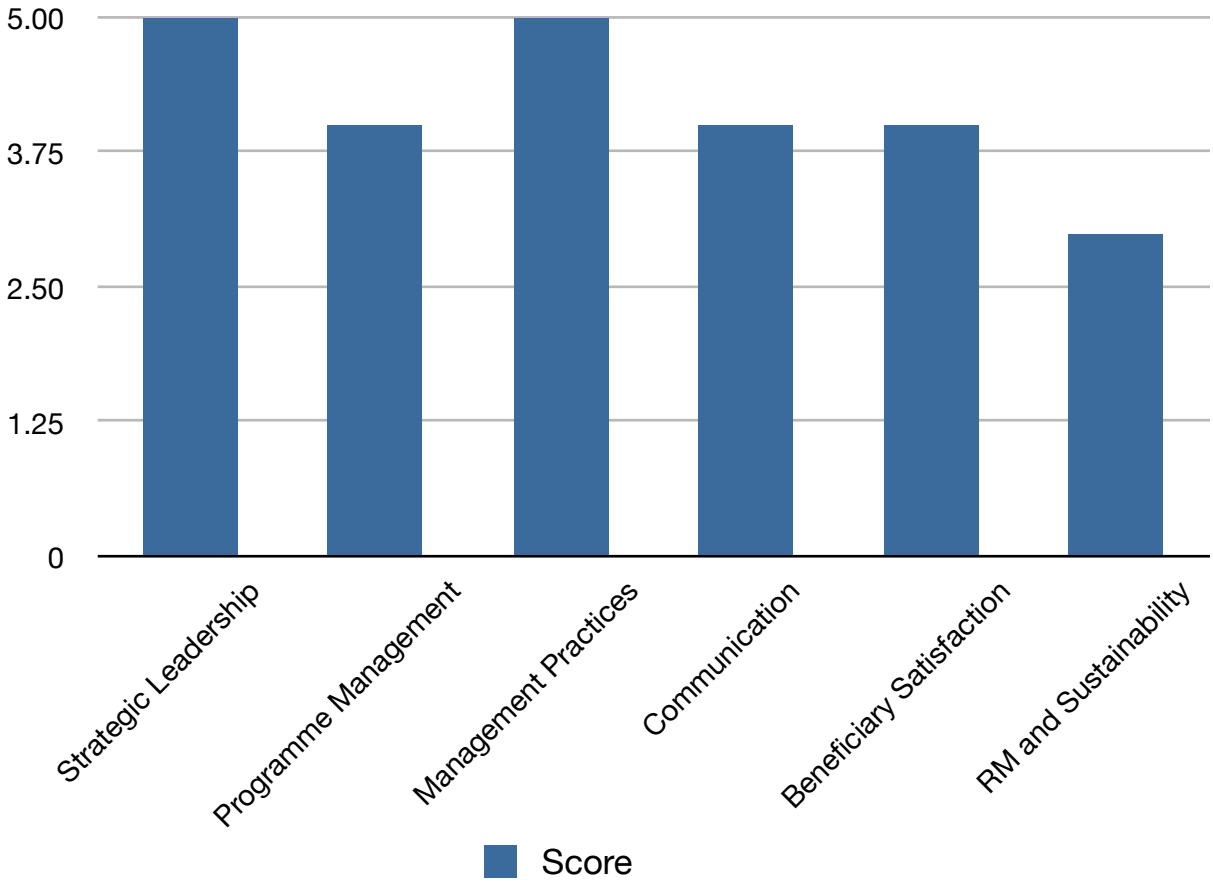
Outputs	Completed By	Percent Complete	Notes
Outreach system is well established	February - 2013	100%	An excellent outreach strategy has been developed for ACHA and is currently being executed showing excellent results surpassing all expectations.
Outreach team's capacity is strengthened and coordination effective	February - 2013	100%	The outreach team have all received full training and demonstrating strong coordination and knowledge.
Networking systems put in place	December - 2013	100%	The strengthened outreach strategy which has been implemented has put extensive networks in place throughout the surrounding communities through the use of Community Based Workers (CBWs) teaching staff and community leaders.

Success Indicators

Indicator	Target	Success Status	Notes
Number of vision centres	3	Yes	
Uptake of services in outreach camps		Yes	Especially in 2013
Number of effective referrals from vision centres	2,000	Yes	Greater than 2,000
The RAAB survey by end of year 3 will show an increase in service to sub-groups (e.g. gender, ethnicity and urban poor)	30% increase	No	No RAAB was completed as the budget was reallocated for a strategic evaluation

Goal 3 Capacity Area Survey Results

Respondents felt that this was the most successful goal of the programme. They felt that this was a result of strategic leadership on the part of the hospital and Right to Sight. The revised targets were realistic and the outreach strategy well planned and effective. Regular staff meetings made staff aware of goals and how close they were to achieving them. This made them feel more motivated despite often feeling overworked. Staff felt documentation was excellent. Results of the CA survey poll are follows:



Key Findings

- This was discovered to be the most successful of the programme goals.
- The achievement of this goal started slowly as a result of poor planning, lack of strategy and unrealistic targets.
- ACHA Douala and RTS responded to this in a very positive manner at the end of year two by recognising that they were falling short of achieving this goal and developed a strategy to address the shortcomings.
- The 9-month extension helped address the backlog of cataract patients.
- The design of the improved outreach programme and introduction of community-based workers played a significant role in the development of effective systems to reach the community as required by this goal.
- The transfer of 563 projected target cases from ACHA Bafoussam to ACHA Douala had an obvious impact on programme targets.
- Although the equity of access had increased significantly, there was still room to improve this as interview feed back revealed that there were still many under-served outreach areas, as well as many cases of patients who were unable to access surgery because others who could afford it were given free surgery.
- It was also suggested by respondents that the hospital seek out donors to offer a wider range of free services ensuring equity of access. The outreach team felt that glaucoma surgery should be considered for “free surgery” in the future as this condition can lead to irreversible blindness. Large numbers of glaucoma patients were encountered at the screenings.

- As the specifics of the outreach programme were so detailed, the outreach programme was given its own section of the report. Section IV of the evaluation gives an in-depth analysis of the successes and shortcomings of the 2013 outreach programme.

Recommendations:

A method to identify the patients unable to afford care has to be developed. This way the hospital can request part/full payment from patients who are able to afford the surgery. This improves access and contributes to the financial sustainability of the programme.

3.4 Goal 4: To Improve Access to Eye Care Services of School Going Children

Primary Objectives

- School Eye Health Plan established
- Capacity of the hospital's School Eye Health Programme is strengthened
- Networking between the MoE and SCB to ensure a school-screening system is well established and linked to PHCs

Work Plan Output Achievements

Outputs	Completed By	Percent Complete	Notes
School Eye Health Plan established	February - 2013	100%	The school screening programme was developed as part of the overall outreach strategy and is currently running successfully.
School Eye Health wing's capacity is strengthened and coordination effective	February - 2013	100%	The outreach team have all received full training and demonstrating strong coordination and knowledge.
Networking with Education authorities put in place	December - 2013	100%	Systematic school screenings and teacher training have been established.

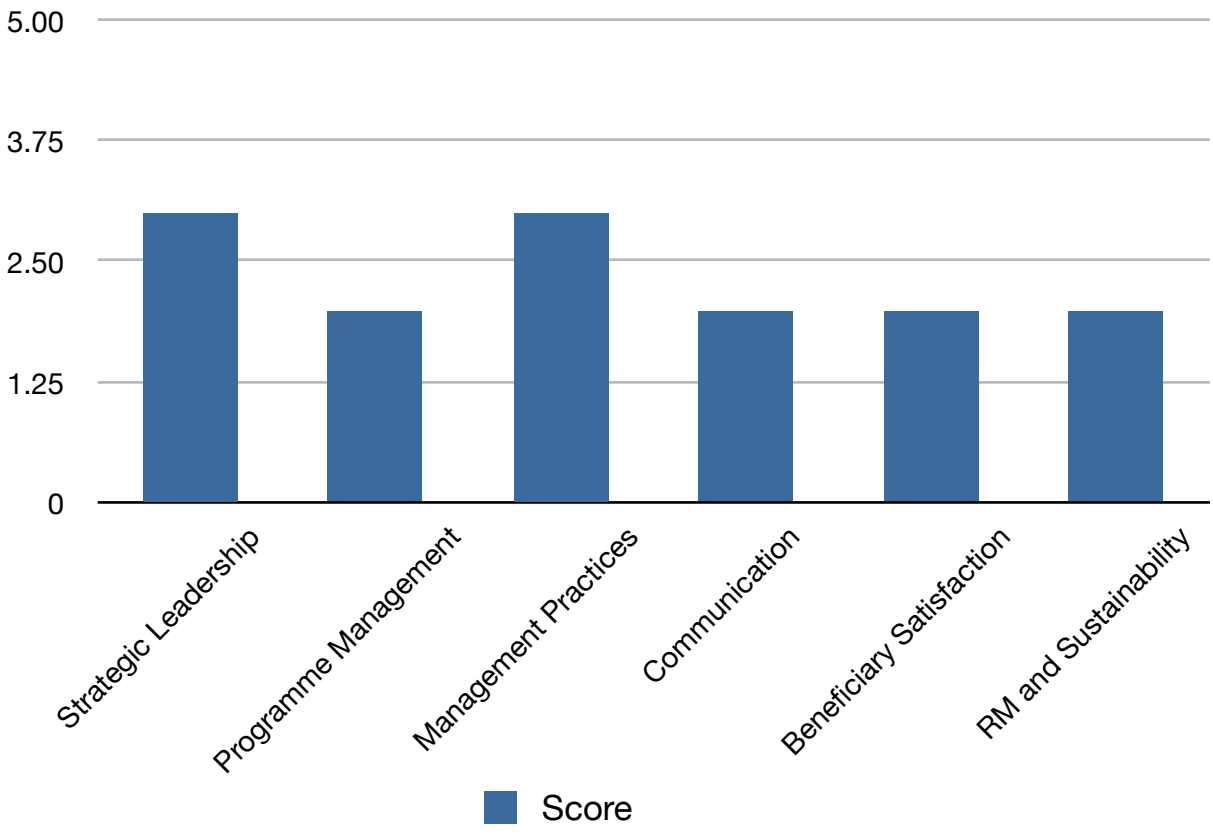
Success Indicators

Indicator	Targets	Success Status	Notes
Number of Schools participating	50	No	21
Number of effective referrals	5,000	Near	4,967

Indicator	Targets	Success Status	Notes
Teachers Training and School-Screenings held in places and timings approved by the coordination committees	Teacher Training - 50 School-Screenings - 150	Yes	132 Teachers trained

Goal 4 Capacity Area Survey Results

Staff recognised the effort put in by hospital management to fully achieve these goals but felt that the programme plan and sustainability had to be worked on. Respondents felt that the costs incurred by school children needed to be reduced, otherwise school children would not access this service and the school programme would not be sustainable. Results of the CA survey poll are as follows:



Key Findings

- The target of improving eye care service access for school-going children was not met. This was in part because of unrealistic targets set at the start of the programme.

- ACHA Douala was unable to get government support for the implementation of this goal. Support from the MoE was promised but never provided. The problem was that to roll out school-screenings, the hospital needed to obtain ethical permission from the MoH to operate / work in these government schools. Approval took over 6 months to obtain.
- There were not enough human resources at the hospital to create and manage a school-screening programme.
- As a result of this, school-screenings were only introduced in January 2013 with the employment of the programme officer in late 2012.
- The number of children screened in school was below the original target of 25,000. The hospital was unable to achieve this target and a new cumulative target of 3,167 was agreed upon.
- There was no dedicated school-screening budget and this revised target did not affect programme budget.
- It was discovered that even if schoolchildren were identified as having refractive / other problems, they did not follow it up as they were unable to afford this. Interview respondents felt that if a future programme like this should be implemented, resources should be allocated to subsidise the costs incurred by students. Hospital staff and key personnel were unaware of the programme goals until the second year of the programme. Had they known the goals, they would have attempted to begin establishing the school programme earlier in the programme cycle.

Recommendations:

- In the future, planning of programmes need to consider government response time and the process of obtaining ethical permission for activities.
- If screenings are marketed as activities providing free cataract surgery, and the school-screenings are a part of these screenings, this service needs to be made available to schoolchildren.
- Schools are under-utilised as a vehicle for advocacy and raising awareness of eye care problems. Teachers can be identified in selected schools to receive basic eye care training. If these teachers are able to identify eye problems in children, they can be addressed immediately.
- These teachers can also be trained on the different methods they can use to improve the learning experience of visually impaired, low vision children.
- A specialised screening can be arranged at selected intervals where the hospital can provide comprehensive paediatric eye care and specialised services (eg a Low Vision Therapist). These schools can also be involved in the advocacy programmes and events like World Sight Day etc.

3.5 Goal 5: To Render Eye Care Services that are Efficient and High Quality

Primary Objectives

- Monitoring and evaluation unit is established and running
- Quality assurance unit is established and running
- Research unit is established and research is published

Work Plan Output Achievements

Outputs	Completed By	Percent Complete	Notes
Monitoring / Evaluation / Quality assurance that the unit is established and running	March - 2011	100%	The standard of care at ACHA Douala exceeds the best practice WHO standards and is constantly being monitored by Right to Sight.
Research unit is established and research is published		0%	This is not realistic at this stage of the programme. Once training is firmly established and the programme is further developed there will be opportunities to conduct and publish research.

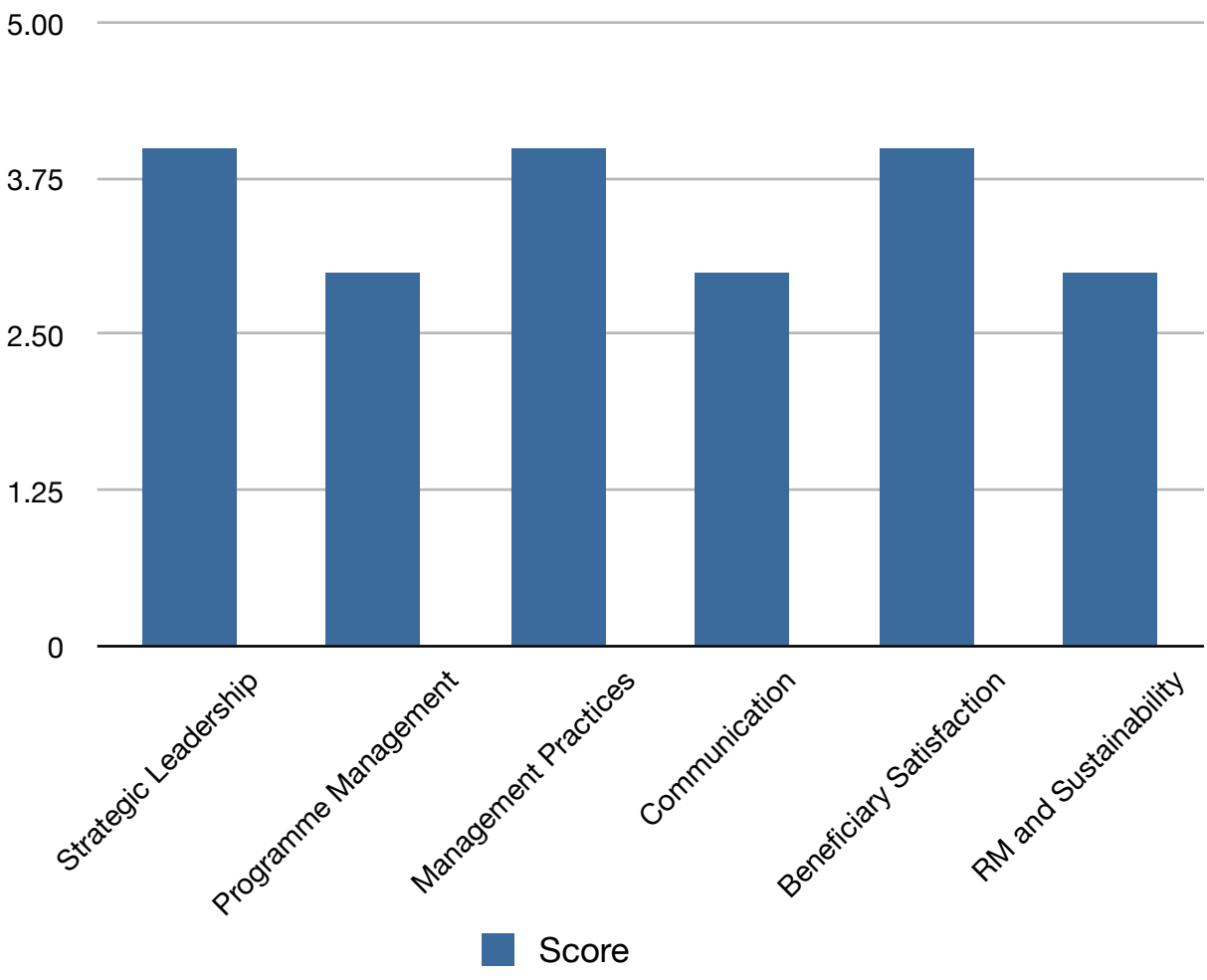
Success Indicators

Indicator	Target	Success Status	Notes
Number of Monthly reports	36	Yes	Monthly Reports over the cycle of the programme
Number of research projects completed	(2 RAAB and 3 KABP surveys)	No	Evaluation completed in place of RAAB

Indicator	Target	Success Status	Notes
Establish Research Unit	1 Research Unit	No	Not currently realistic

Goal 5 Capacity Area Survey Results

The respondents all felt that they had contributed to the accurate collection and recording of data. They felt that the indicators and information required for data collection at the base hospital and on screenings was clearly conveyed. Respondents knew what they were looking for. A system was in place to gather relevant information for reporting purposes. This was done daily, weekly and monthly. Reports to RTS and donors were regular and all aspects of the programme well monitored. This data can be better used for research and publication purposes. Results of the CA survey poll are as follows:



Key Findings

- Although monitoring and evaluation / quality assurance unit was not established, these activities were implemented through already existing hospital channels. The monitoring of programmes, in particular the outreach results and patient information was excellent.

Recommendations

- The head surgeon conducted the monitoring and evaluation during the first 3 years of programme implementation. The data captured was both excellent and consistent. The head surgeon was responsible for all documents and monitoring reports. Although everyone had access to this, only the head surgeon knows the data collection process. There is a danger in having only one person within the institution having this knowledge and it is recommended that a hospital staff member, preferably one working within administration be trained and involved in document creation. This will ease the workload of the head surgeon, make the information more central and ensure consistent monitoring and evaluation continues should the head surgeon for any reason have to leave.
- With the absence of the 2 RAAB studies, the outreach programme and individual screenings can act as a highly effective method to gather valuable data on the indigent populations within each screening location to monitor achievements and assess the impact of the screening services in these areas. Information on location, population, economic circumstance, health, etc., can be very valuable and with continuous visits, ACHA Douala can compare the results and better calculate a location specific community impact.

IV. 2013 Outreach Strategy

4.1 2013 Outreach Strategy Overview

As outreach played a major role in the success of all the programme's objectives, this section analyses the successes and failures of the implementation of the 2013 outreach strategy.

The outreach strategy designed for 2013 focused on addressing the barriers to service uptake identified in the 2011 and 2012 outreach programme. The primary obstacles fell under the umbrella areas of community sensitisation and planning. To address these obstacles, the outreach strategy focused on informed outreach location selection and the use of CBWs to work within the selected locations. These two aspects of the outreach strategy proved the most effective and will be expanded upon in sections ***4.5*** and ***4.6*** of the report.

4.2 Outreach Targets 2013

The targets for the 2013 outreach strategy were mainly focused on cataracts. The targets set were as follows:

Outreach Cataract Surgery Overview	
Cataract surgeries from outreach (Annual)	**1,100**
Average cataract surgeries (Monthly)	**95**

4.3 Annual Outreach Statistics from Programme Inception

The ACHA Douala Outreach Programme performed *31* cataract operations in 2011 and *210* in 2012. The goal of the Outreach Strategy for 2013 was to increase this number to *1,100* cataract surgeries performed through outreach. As of December 2013, there have been *1,663* cataract operations performed through outreach for the year.

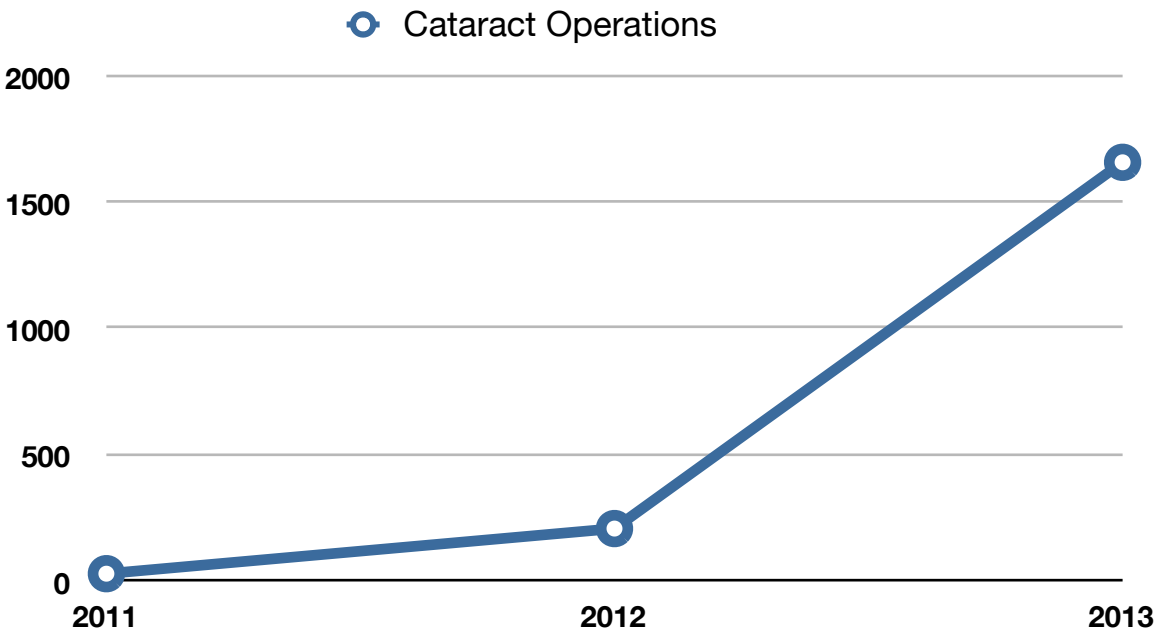
The table below summarises ACHA Douala's Outreach results from 2011, 2012 and 2013.

Outreach Impacts in 2011, 2012 and 2013

Year	No of Screenings	OPD	Refraction Done	Glasses Dispensed	Cataract Identified	Cataracts Operated
Total 2011	40	3,185	1,393	399	174	**31**
Total 2012	56	3,766	1,862	492	365	**210**
Total 2013	115	12,946	5,950	1,326	2,695	**1,663**

The outreach results in 2013 saw an astounding increase in all categories. Cataract operations increased by 1,435 and there were 834 more pairs of glasses dispensed in 2013 than in 2012. There were a total of 59 more screenings held in 2013 than in 2012. A total of 12,946 people were seen at screenings. That is 9,180 more people than were seen in 2012.

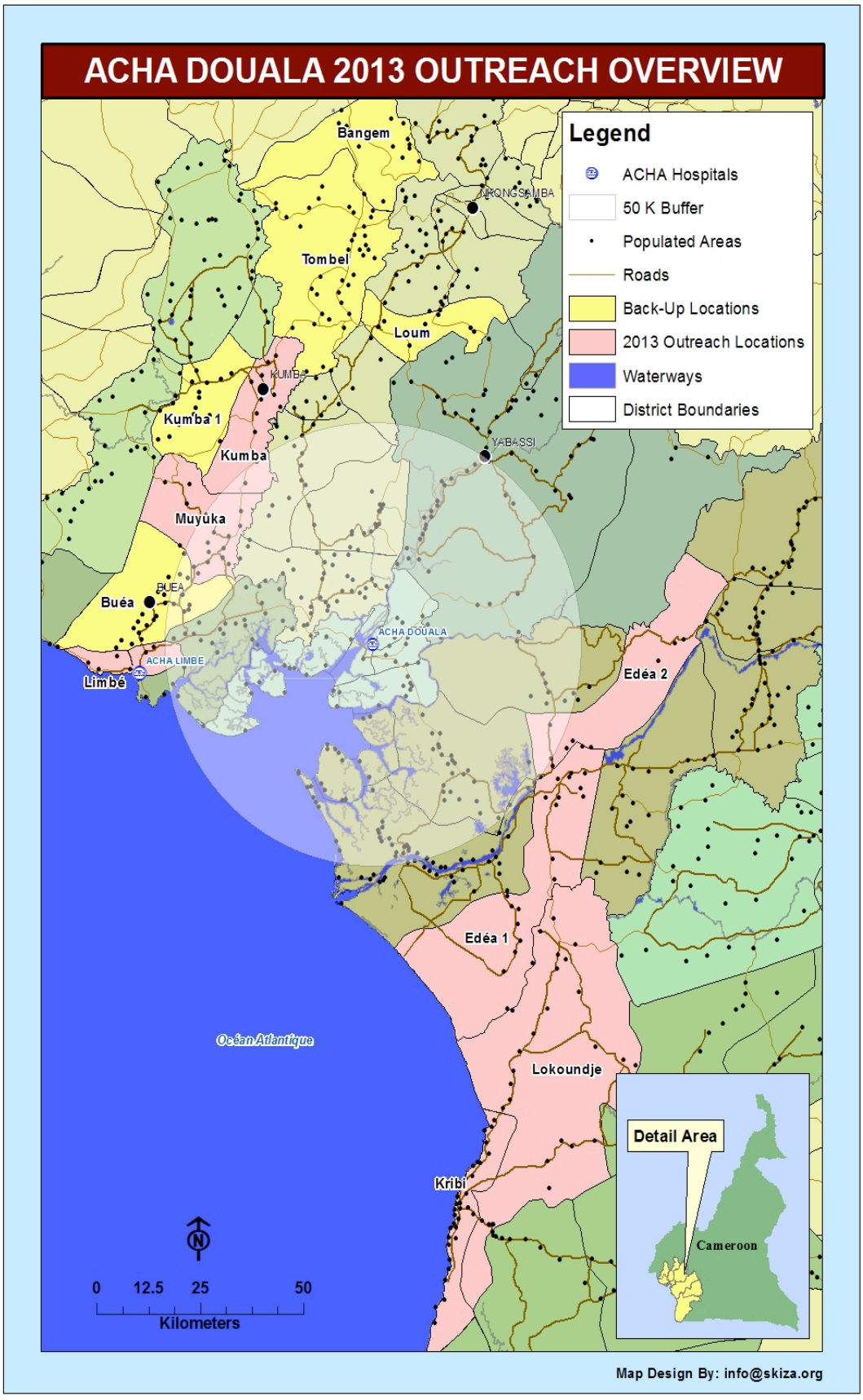
Cataract Surgeries through outreach in 2011, 2012 and 2013



4.4 2013 Outreach Overview Map

The following map exhibit shows the areas selected for outreach screenings to be conducted and an overview of the project catchment area. Of all the cataract

operations performed through outreach, 74% the patients were identified at screenings in these selected outreach locations.


ACHA DOUALA 2013 OUTREACH OVERVIEW
Legend
ACHA Hospitals
50 K Buffer
Populated Areas
Roads
Back-Up Locations
2013 Outreach Locations
Waterways
District Boundaries
Bangem
MBONGSAMBA
Tombel
Loum
KUMBA
Kumba 1
Kumba
YABASSI
Muyuka
BUEA
Buéa
ACHA DOUALA
ACHA LIMBE
Limbé
Edéa 2
Edéa 1
Océan Atlantique
Lokoundje
Kribi
Detail Area
Cameroon
0 12.5 25 50
Kilometers
Map Design By: info@skiza.org

4.5 Outreach Locations Selection

This section and section 4.6 (CBWs) are being explained in more detail as they are the two major reasons the 2013 outreach programme was so successful.

After analysing the hospital's planned 2013 screening locations, there was an obvious need to reduce the amount of locations and make more strategic outreach location selections. GIS, spatial analysis, historical outreach data as well as national eye health data allowed for strategic outreach locations to be identified. Factors such as population density, centralised locations, demographic and socio-economic data, infrastructure and road access were analysed in the process of selecting the outreach locations.

With this analysis, a selection criterion was developed to identify and select project locations for 2013. The criteria were as follows:

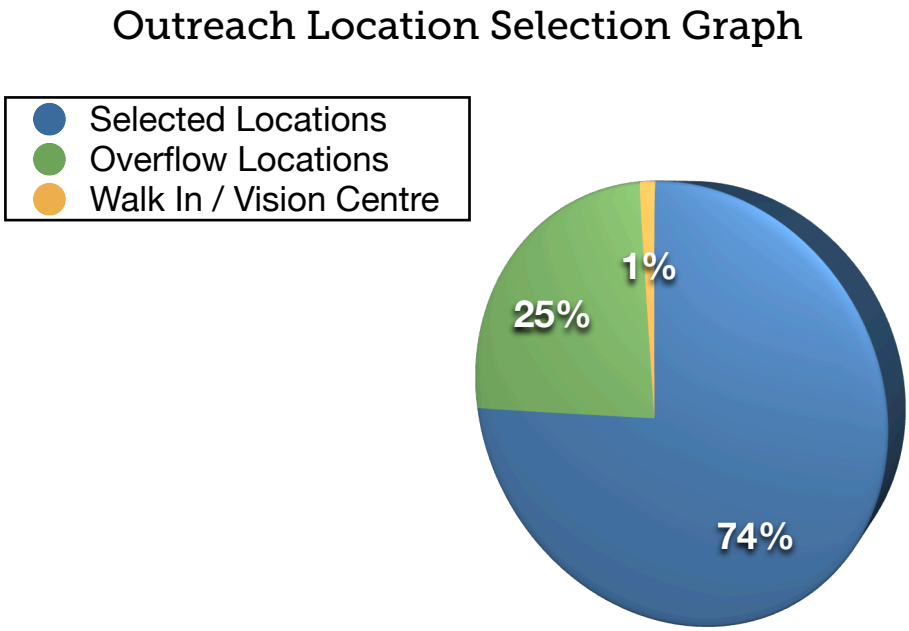
- Areas outside of the 50 km buffer agreed upon between RTS and ACHA Douala Hospital
- Districts with a high population
- Districts with multiple population clusters
- Distance from the base hospital
- Existing Health Care Facilities, PCC centres in the areas
- Infrastructure and road networks
- Trained health care workers in the area
- 2012 screening outcomes
- Previous Bafoussam outreach locations

A total of seven Project Locations were selected. These locations were to be visited on a rotating monthly basis for screenings throughout 2013.

These locations were identified and the need for a more permanent ACHA Douala/Right to Sight presence on the ground was addressed. The community contact person being used for community sensitisation was not effective and had in some incidences been an obstacle to the success of the screenings. The possibility of a full time community-based worker for each project location was discussed and the hospital and RTS Programme Officer agreed that this was the most effective way to address the current shortfalls in sensitisation, community mobilisation and screening awareness.

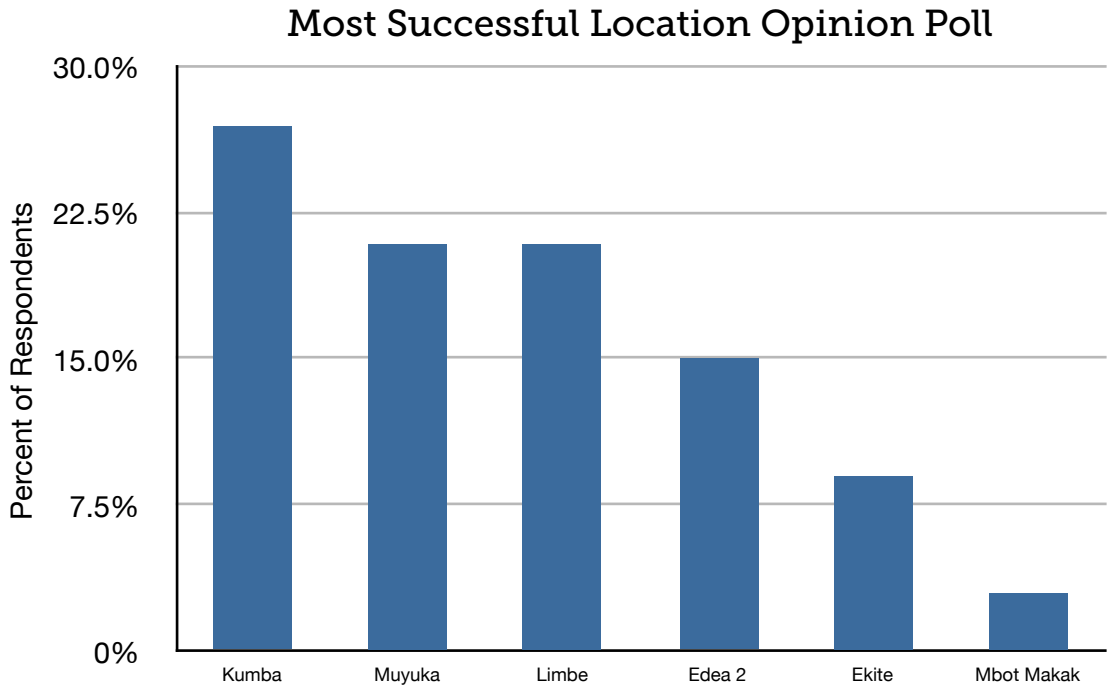
4.5.1 Location Selection Analysis

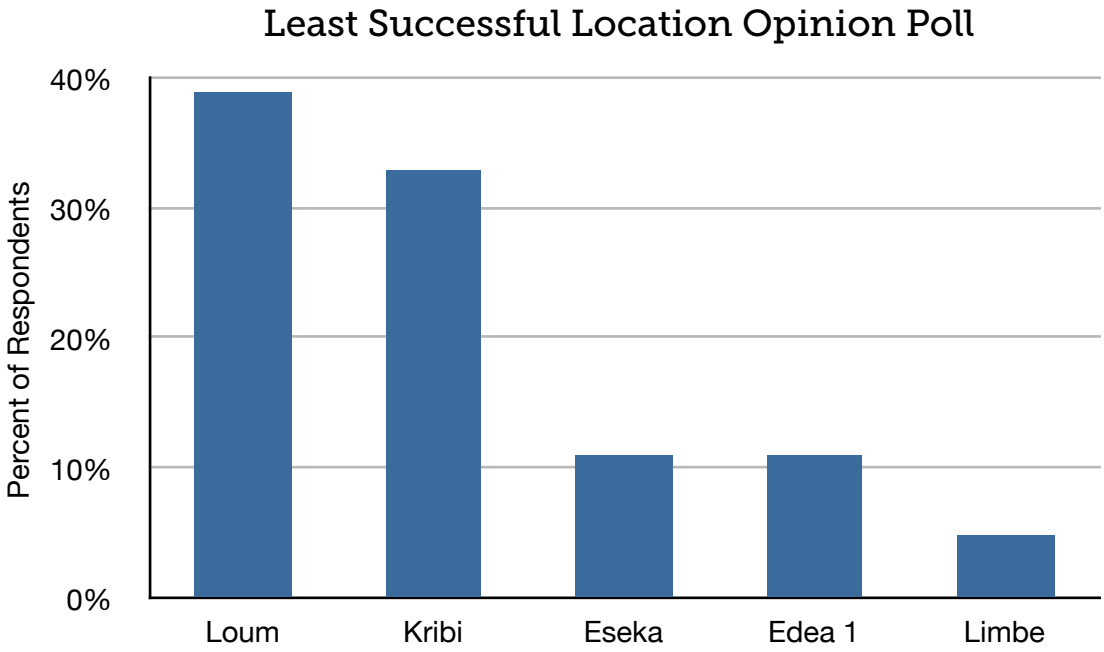
The following chart shows the percentage of cataract patients that were identified in the selected outreach location areas versus back up (or overflow) locations, as well as walk in patients at the vision centres.



4.5.2 Opinion Polls for Outreach Locations

The outreach team was surveyed to determine what were the most successful locations in their opinion. The results were as follows:





From the surveys it was determined that the major factors for making these outreach locations unsuccessful were:

- Low population / population densities
- Traditional beliefs and belief in witchcraft
- Low trust and scepticism in the programme / hospital due to lack of awareness

4.6 Community-Based Workers

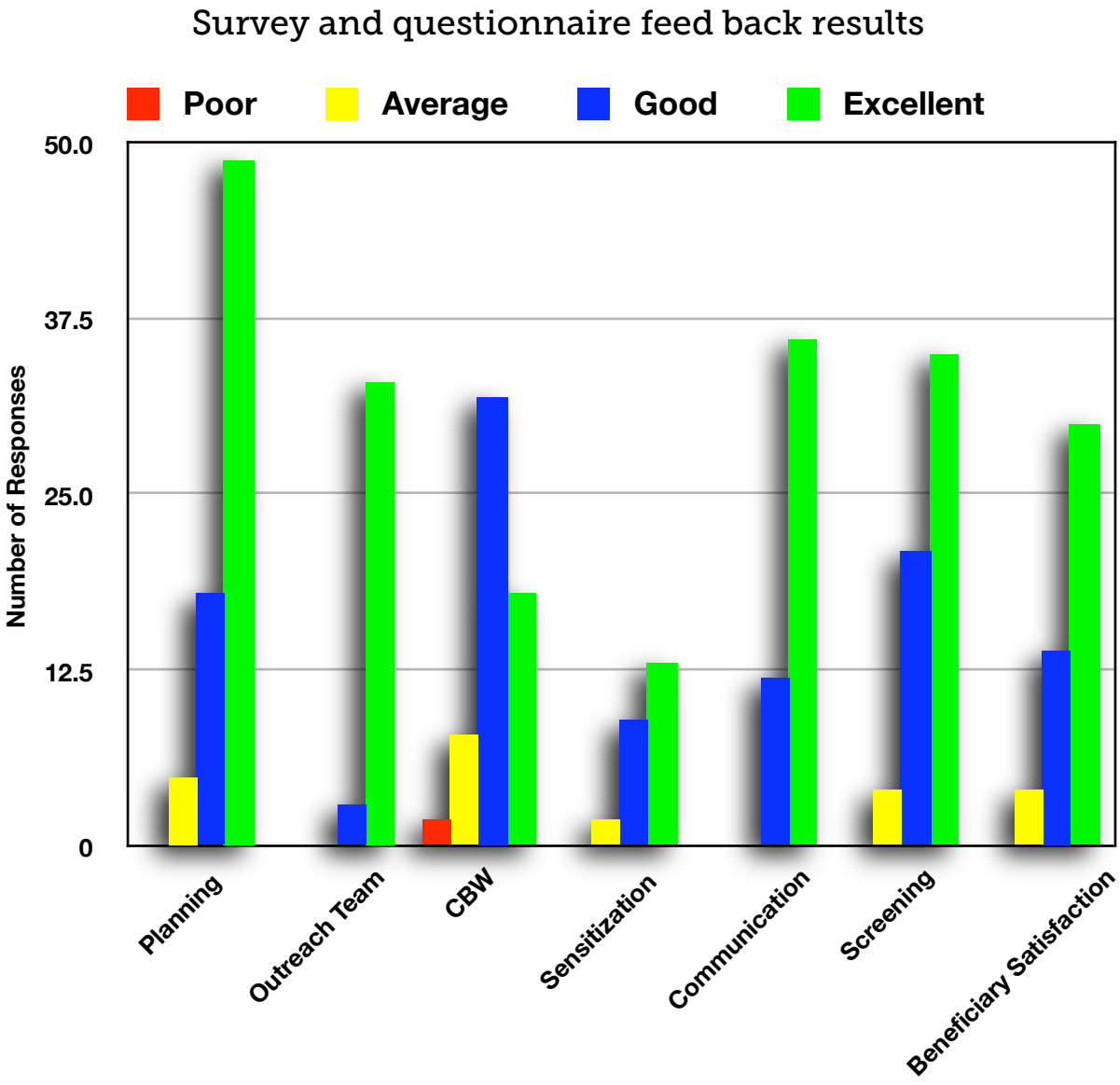
The outreach strategy recommended assigning a community-based worker for each project location. This created a team of seven community-based workers, each designated their own outreach location, to be co-ordinated and managed by the Right to Sight Programme Officer. The duty of the CBWs was to actively sensitise the community on eye health, the work of ACHA Douala Hospital and RTS, to inform the community of upcoming screenings and to select the screening venues based on centralised locations, ease of access, etc. The CBWs were also in charge of identifying potential cataracts and arranging for these patients to attend the community screening nearest them.

This community-based workers were hired on short-term contracts with ADH (three months was the suggested contract time). Their targets and deliverables were clearly defined. In the final focus group discussion, the CBW contract and terms of reference was discussed with the Right to Sight Programme Officer, Ophthalmologist in Charge and Hospital Co-ordinator. The CBWs financial compensation was linked to the achievements of set targets in cataract identification and patient turnout at screenings in their location.

4.7 Outreach Programme Survey Results

The questionnaires asked people to rate the performance of different aspects of the outreach programme. Respondents were given the following response options: poor, average, good and excellent.

Each question had to be rated according to these options. The questions all related to the key capacity areas as identified earlier in this report. Results were tallied to give an understanding of the overall feed back of the staff in relation to these focus areas.



A majority of respondents perceived all aspects of the outreach implementation were 'good' or 'excellent'.

4.8 Barriers to the Outreach Programme Success

Through feed back from hospital staff, outreach staff, patients and community members, there were a number of barriers identified in the outreach process. These barriers will be examined in the following sections of this document.

4.8.1 Shortfalls and Constraints of the 2013 Outreach Programme

1. Poor road infrastructure - certain outreach locations can only be accessed during dry season. June, July and August proved to be the most difficult months to reach isolated outreach locations and screening venues due to heavy rains.

2. Lack of a helper to come with the patients to take advantage of free surgeries. (This constraint was identified in the outreach strategy and was suggested that if a helper was available, there should be a stipend available to them for transport, food, lodging, etc., so they can accompany the patient to and from the hospital.

3. Lack of community volunteers to increase publicity for outreach screenings. CBWs were effective at this. In many communities people expect compensation and are unwilling to help without any incentives.

4. Lack of money to feed themselves prevents patients from coming for free surgeries. Although the surgery and transportation is free, the patient still needs to have money to feed themselves and purchase any other essentials they may need during their stay at the hospital.

5. Lack of community participation. Similar to number three, there is no incentive or compensation for the community to participate in sensitisation.

6. Fear and traditional beliefs made some patients not to take advantage of the free surgeries and transportation being offered. Witchcraft and other beliefs were a constraint identified in the outreach strategy and proved to be a factor in the 2013 outreach programme. The outreach location with the predicted highest number of cataract surgeries (Kribi) fell short as a result of traditional beliefs in the community.

7. CBWs could have been more knowledgeable about the project, the hospital, screenings and eye care. CBW training was included in the implementation stages of the 2013 Outreach Plan (Stage 9). This stage must not have been followed through in the process.

8. Screening venue selection. The CBWs were in charge of selecting the screening venues within their project locations. Churches were one of many recommended venues included within the 2013 outreach programme, but they tended to be the exclusive screening venues selected. Questionnaires and interviews revealed that this was problematic because community members that were not of the same

denomination of the church felt isolated and were not comfortable attending the screening.

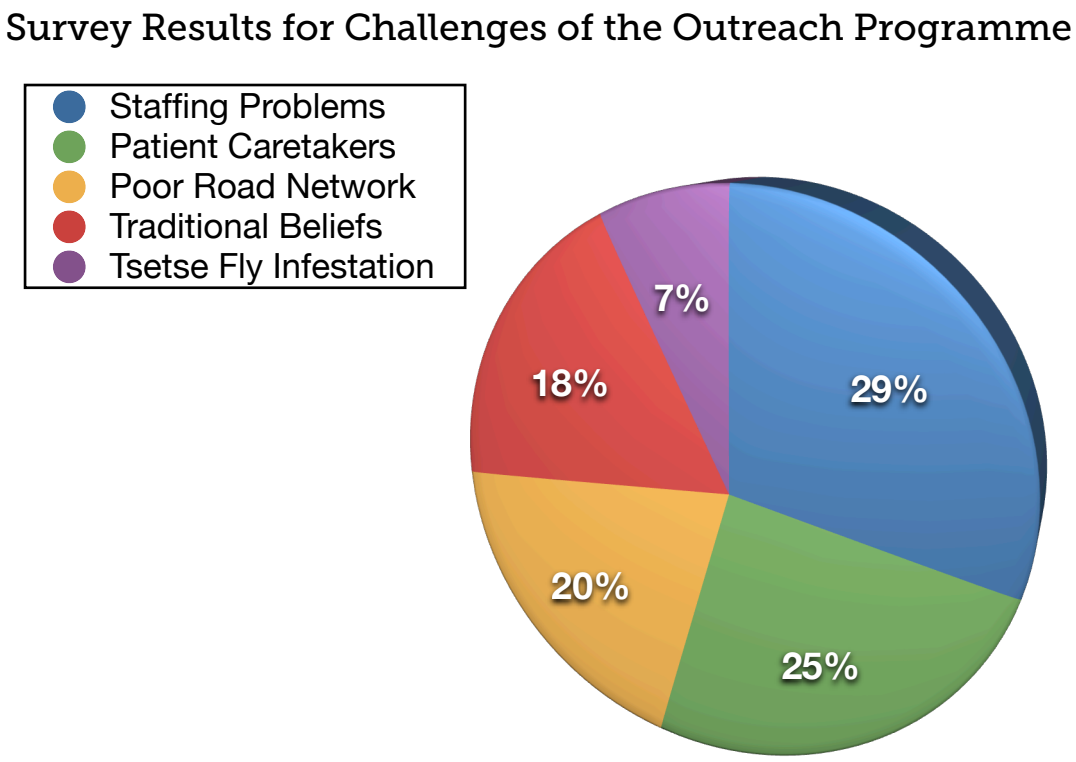
9. The outreach team is understaffed and overworked.

4.8.2 Outreach Challenges Survey Results

In all the surveys and questionnaires conducted, key informants were asked what major challenges were presented to the outreach programme. The most common response was the lack of staff. This referred to lack of staff for outreach as well as lack of staff at the hospital to keep up with the influx of patients identified during outreach screenings.

A patient caretaker was also one of the major challenges in getting cataract patients to travel to ACHA Douala for surgery. Either the patient didn't have a caretaker, or the caretaker was unable to afford the costs required to travel and stay at the hospital.

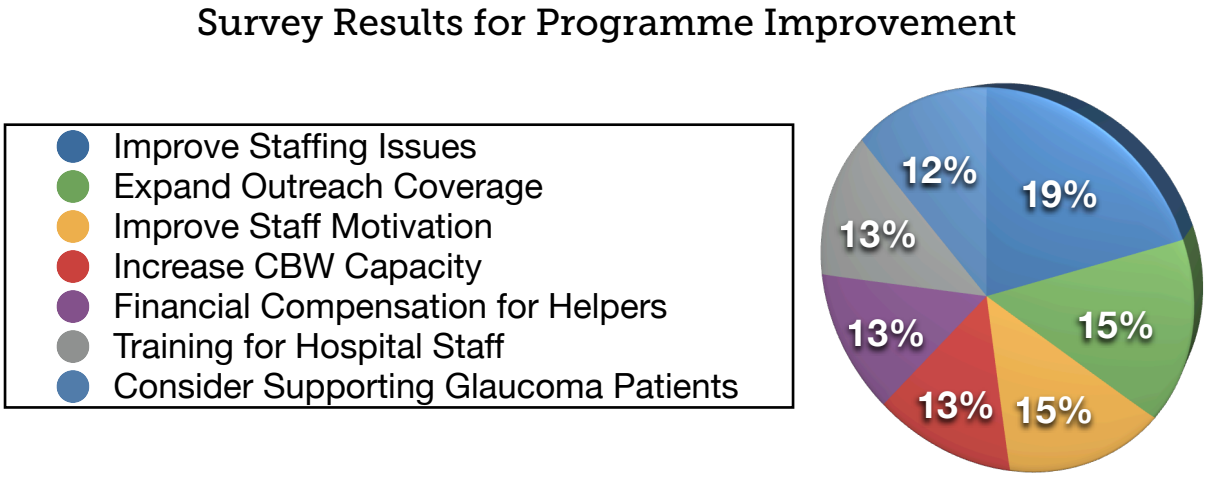
The poor condition of the roads during rainy season was also a major obstacle for reaching screening venues. In terms of travel, June, July and August were the worst months due to the heavy rains.



4.8.3 Suggestions for Improvement Survey Results

The most frequent suggestions for improvement were to address staffing issues (increasing staff and reducing workload), increasing the geographic reach, adding additional outreach locations, improving employee incentive in various ways and increasing the capacity of the CBWs.

A major part of the 2013 Outreach Strategy was CBW training and rotation. It was recommended that all CBWs spend time in the hospital, familiarising themselves with the work of ACHA Douala and getting hands on, practical experience, thus increasing their capacity. The training of CBWs seems to have been overlooked in the implementation phase of the programme.



V. Key Programme Outputs

5.1 Key Outputs of the SIB Project Life Cycle

The following table summarises the cumulative performance of ACHA Douala Hospital during the SIB Project life cycle (April 2010 - December 2013). This table shows cumulative targets, cumulative achievements and the percent of targets achieved over the project life-cycle. Almost all targets were achieved and many were surpassed. The feedback received from interviews and surveys conducted with ACHA Doula staff indicate that team members feel school screenings were not successful, despite RTS data indicating a 195% cumulative achievement for said target.

Outputs	Cumulative Targets to Date	Cumulative Achievements to Date	Cumulative Achievements to Date (%)
No. Centres Opened	3	3	100%
No. Outreach Camps	221	214	97%
No. Outpatients Seen	146,594	179,897	123%
No. Children Seen	15,201	21,703	143%
No. Cataract Surgeries	5,000	5,495	110%
No. Other Surgeries	1,812	1,922	106%
No. Refractions	40,939	47,369	116%
No. Spectacles Dispensed	15,082	16,836	112%
No. Outreach Patients Seen	12,000	23,024	192%
No. School Pupils Seen	3,167	6,167	195%
Total Direct Outputs	240,016	302,593	126%
Indirect Outputs	759,984	1,571,744	207%

Outputs	Cumulative Targets to Date	Cumulative Achievements to Date	Cumulative Achievements to Date (%)
Total Outputs	1,000,000	1,874,337	187%

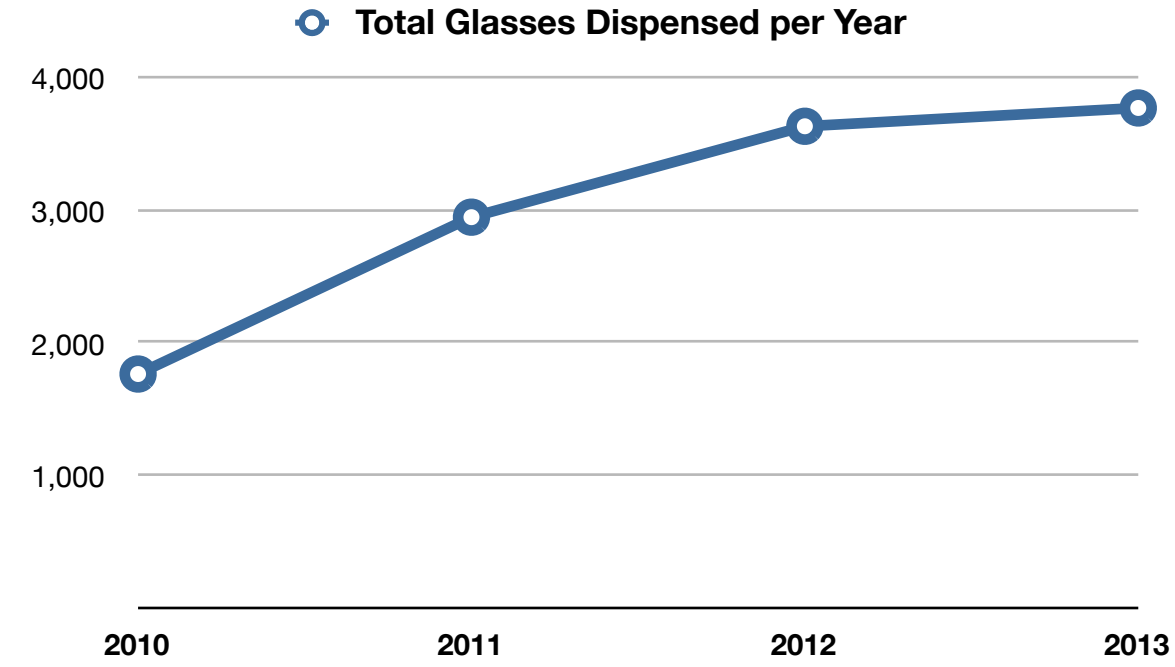
5.1.1 Training Programme Outputs

Type of Training	Programme Target	Cumulative Achievements	Cumulative Achievements %
Administrator	1	1	100%
OT Technician	2	2	100%
Outreach Management	1	1	100%
OCOs	2	1	50%
Nurses: State Registered Nurse, Primary Eye Care	11	12	109%
Surgical Scholarships	1	1	100%
IT Training - clinical and administrative	6	12	200%
Teachers	no target	136	n/a
Community-based workers	6	14	233%
Total Individuals Trained	30	180	-

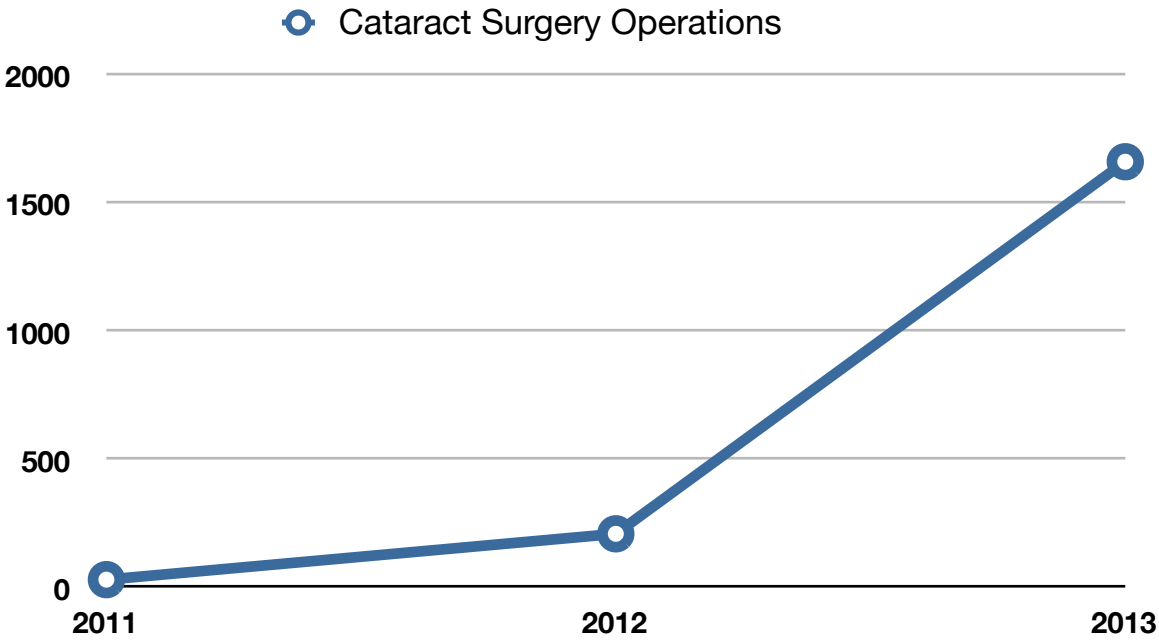
5.2 Graphs of Key Outputs

The following graphs show the annual improvements of key outputs of the programme:

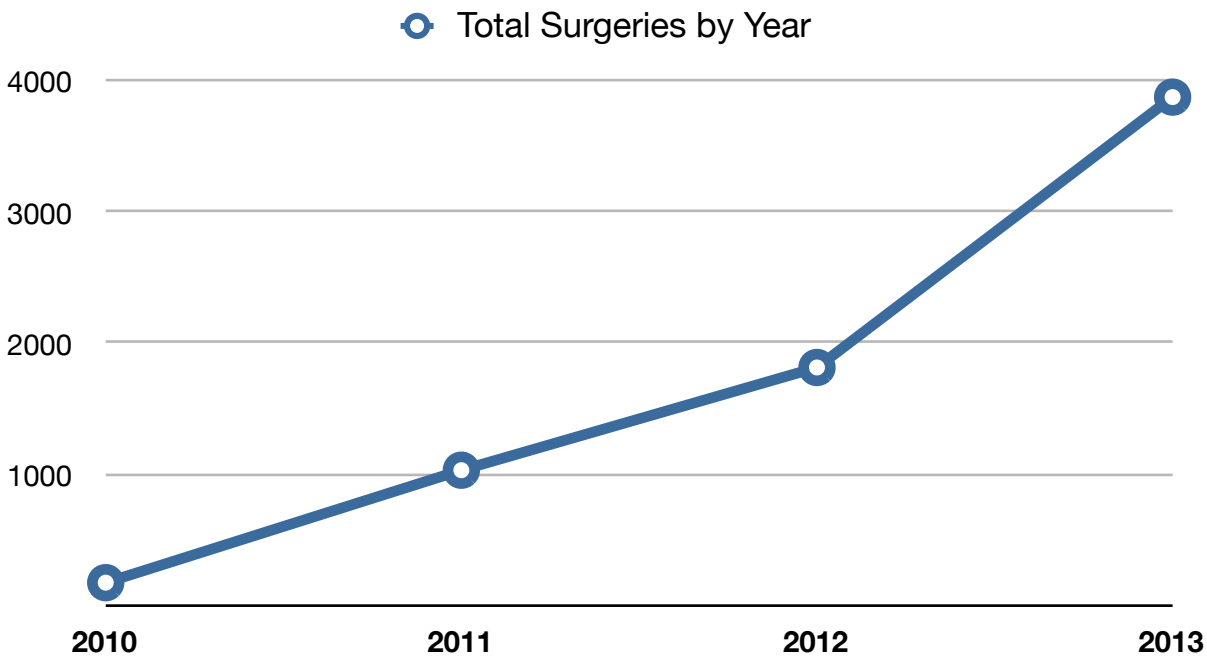
Spectacles Dispensed per Year



Cataract Surgeries through Outreach per Year



Total Surgeries by Year



VI. Conclusion

The *"Increased access to affordable high quality eye care services in Douala, Cameroon"* programme at ACHA Douala Hospital in Cameroon was an incredible success.

Despite getting off to a slow start in its first year, the programme picked up momentum, particularly during the 9-month no cost extension period. This is when a large portion of the overall programme objectives were achieved. The staff of ACHA Duala showed exceptional management skills by adapting to the changes in programme implementation with confidence.

The interview respondents felt that the most successful aspect of the programme was the outreach programme. However, it should be noted that it is a high cost model designed to achieve a backlog of cataract targets in a short space of time. ACHA Douala needs to re-examine the model moving forward.

The interview results reflected that respondents felt that the least successful aspect of the programme was the attempt to improve access to eye care for school going children through school screenings. Another negative issue that was brought up in most of the interviews was that the hospital was often short staffed. This staffing issue was a problem during outreach programmes as many staff members were in the field, and staff at the base had to tend to all the patients identified during screenings.

It must be noted that most of the comments relating to the negative aspects of the programme were not true reflections of the programme. The comments referred to bad weather, road networks and other elements beyond the control of the programme implementation team.

Everyone interviewed felt that the programme was a success. All those interviewed were not only very positive about programme implementation; they also shared a genuine satisfaction with programme outcomes. Interviewees felt that through the programme they had been able to contribute to addressing needless blindness in the region. This was an indicator of ACHA Douala's ownership of the programme and its activities.

Standard Chartered Bank was able to improve the health of the bank's region thereby contributing to the economic growth of the bank's community. There is an opportunity for ACHA Douala to engage more actively with the local bank. There is also an opportunity for the staff at the local bank to volunteer at ACHA Douala.

Key Seeing is Believing staff were present from the start of programme implementation. They engaged with ACHA Douala and RTS regularly. The communication, monitoring and involvement on the part of SIB was consistent. They were able to offer support,

encouragement and direction when necessary. This hands-on involvement proved invaluable particularly during Year 2 (mid point). This was a time of initial slow training and slow delivery of outputs.

The involvement of Right to Sight staff needs to be recognised. The turning point, according to interview results and the obvious acceleration in program activity, was as a result of the most RTS recent Programme Manager (Rachel Flynn) as well as the placement of a full time RTS Program Officer based at ACHA Douala Hospital.

ACHA Douala was successful in implementing the programme plan. The staff appear to be hard working and dedicated to achieving the programme goals. The Head Surgeon has a highly commendable work rate, which played a major role in achievement of programme goals. ACHA Doula needs to consider if they will manage to achieve similar goals without this head surgeon.

Staff felt that four people in particular deserved special mention for their contribution to ensuring the achievement of the programme goals. These people mentioned were:

Dr. Rajesh Kumar Patel – Head Surgeon
Mr. Esseme Elias Tong – RTS Programme Officer
Neba Christian Shu Abongwi – Outreach Manager
Rachel Flynn – RTS Programme Manager

It is recommended that SIB and RTS host a short workshop at ACHA Douala Hospital aimed at addressing how ACHA Douala will continue with its activities without the support of its donors. This workshop will allow staff to reflect on the programme and its outcome and to recognise those who have worked hard to contribute to its success. It can look at how to improve the capacity areas identified in this report. This workshop can also look at the pros and cons of the Cross Subsidy Model and its potential to be adapted to meet ACHA Douala's needs. This workshop should examine ACHA Douala's vision for the future.

The programme was a great success, and has gone a long way towards strengthening the eye care service delivery of ACHA Douala Hospital and improving access to eye care services, especially for the indigent population of Cameroon.

Appendix 8 - Quotes from interviews and surveys

Appendix 1. Evaluation Interview List

The aim of the interviews are to allow people playing different roles in the project process to share their feedback on different parts of the programme.

Right to Sight

- Sarah Connellan (Right to Sight Communications and Development Manager)
- Rachel Flynn (Right to Sight Programme Manager)
- Eseme (Right to Sight Programme Officer in Cameroon)

ACHA Douala Hospital Staff

- Dr. Ngounou (Medical Director of ACHA)
- Dr. Patel (Head Surgeon at ACHA Douala)
- Mr. Fru (Douala hospital administrator)
- Pascale Balem, Head of Corporate Affairs, SCB Cameroon
- ACHA Doulala Outreach Team
- Hermine (ACHA hospital administration)
- Random selection of hospital staff
- Random selection of patients
- Staff trained at Aravind
- Main staff at vision centres
- Random selection of individuals (patients and non-patients) from outreach locations
- Selected staff at Vision Centres
- All Community Based Workers

Seeing is Believing

- Sally Crook (Seeing is Believing London)
- Susan Evans (Seeing is Believing London)

Appendix 2. Outreach Team Questionnaire

Name:

Describe your role in detail.

Were you aware of the Outreach Program targets for 2013?

How often did you meet as an Outreach Team?

How often did you meet to evaluate screenings?

Did you feel that the Right to Sight Program Officer and Acha Douala Hospital team worked well together?

Were you satisfied with pre-screening planning?

Did you notice a difference in beneficiaries awareness of the screening as a result of the Community Based Workers?

What was the average number of people at a screening?

How many screenings were you involved in?

Were you able to manage balancing your work on the outreach team as well as your duties as hospital staff?

Was there effective communication between the outreach team and the hospital?

Was the hospital always prepared for the volume of patients brought in through the screenings?

Was the hospital ever short staffed?

Were you satisfied with the logistics and transport coordination during screenings?

Would you say that the screenings were a success?

Would you say that the glasses dispensing was a success - were patients happy with prices and did patients make use of this service?

Did you notice a larger volume of patients in 2013 than in 2012?

Did you think the new screening locations were effective?

Do you have any recommendations for future outreach programs?

Appendix 3. Capacity Areas Survey

A) Personal Information
A1) Name:
A2) Age:
A3) Sex:
A4) Job Title:

B) General Feedback
B1) Was the project successful? Y/ N

B2) Why?

B3) Describe the Challenges of the Programme:

C) Rate the following (Please circle your rating of each: Poor, Average, Good, Excellent):

C1. PLANNING:
C1.1) How well were the individual screenings were planned by the outreach team?
Poor, Average, Good, Excellent

C1.2)Did the outreach team and hospital staff work well together to create a schedule that was practical and effective?
Poor, Average, Good, Excellent

C1.3) How well was planning and coordination done prior to each screening?
Poor, Average, Good, Excellent

C1.4)How adequate were screening supplies for each screening ie reading glasses, eye drops etc?
Poor, Average, Good, Excellent

C1.5) How well was the hospital prepared for each screening in terms of staff members available?
Poor, Average, Good, Excellent

C1.6) How good was the use of available transportation controlled?
Poor, Average, Good, Excellent

C1.7) How successful was planning for Goal 1?
Poor, Average, Good, Excellent

C.1.8) How successful was planning for Goal 2?

Poor, Average, Good, Excellent

C.1.9) How successful was planning for Goal 3?
Poor, Average, Good, Excellent

C.1.10) How successful was planning for Goal 4?
Poor, Average, Good, Excellent

C.1.11) How successful was planning for Goal 5?
Poor, Average, Good, Excellent

C2. OUTREACH TEAM:
C2.1) How well did the Outreach Team work together?
Poor, Average, Good, Excellent

C2.2) How effective was communication between Right to Sight Program Manager and Outreach Team?
Poor, Average, Good, Excellent

C2.3) How effective was communication between Outreach Team and Acha Douala?
Poor, Average, Good, Excellent

Notes:

C3. COMMUNITY BASED WORKERS:
C3.1) How effective were the CBWs?
Poor, Average, Good, Excellent

C3.2) How effective were CBWs in selecting successful screening venues?
Poor, Average, Good, Excellent

C3.3) How effective were CBWs in sensitizing the community on upcoming screenings?
Poor, Average, Good, Excellent

C3.4) How knowledgeable were the CBWs on general program information?
Poor, Average, Good, Excellent

C3.5) How knowledgeable were the CBWs on general eye care information?
Poor, Average, Good, Excellent

Notes:

C4. SENSITIZATION:
C4.1) How aware were the beneficiaries of the services provided by the program?
Poor, Average, Good, Excellent

C4.2) How aware were beneficiaries of the costs involved?

Poor, Average, Good, Excellent

Notes:

C5. COMMUNICATION:

C5.1) How clear were instructions conveyed to Outreach Team?
Poor, Average, Good, Excellent

C5.2) How effective was communication between outreach team and hospital?
Poor, Average, Good, Excellent

C5.3) How effective was communication between outreach team and right to sight program officer?
Poor, Average, Good, Excellent

C5.4) How effective was communication between right to sight program officer and hospital?
Poor, Average, Good, Excellent

C5.5) How effective was communication between Outreach team and satellite clinics?
Poor, Average, Good, Excellent

C5.6) How effective was communication between CBWs and outreach team?
Poor, Average, Good, Excellent

C5.7) How effective was communication between the hospital and you for Goal 1?
Poor, Average, Good, Excellent

C.5.8) How effective was communication between the hospital and you for Goal 2?
Poor, Average, Good, Excellent

C.5.9) How effective was communication between the hospital and you for Goal 3?
Poor, Average, Good, Excellent

C.5.10) How effective was communication between the hospital and you for Goal 4?
Poor, Average, Good, Excellent

C.5.11) How f effective was communication between the hospital and you for Goal 5?
Poor, Average, Good, Excellent

C6. SCREENINGS

C6.1) How successful were screenings in cataract identification?
Poor, Average, Good, Excellent

C6.2) How successful were screenings in creating eye health awareness?

Poor, Average, Good, Excellent

C6.3) How successful were screenings in communicating the work of Acha Douala?
Poor, Average, Good, Excellent

C6.4) How successful were the screening in terms of eye glasses sales?
Poor, Average, Good, Excellent

C6.5) How successful were the screenings in terms of the amount of patients seen?
Poor, Average, Good, Excellent

Notes:

C7. BENEFICIARY SATISFACTION:
C7.1) How satisfied were stakeholders who attended screenings?
Poor, Average, Good, Excellent

C7.2) How satisfied are patients who visit Acha Douala making use of services provided by the programme?
Poor, Average, Good, Excellent

C7.3) How well were stakeholders needing cataract surgery treated?
Poor, Average, Good, Excellent

C7.4) How satisfied are the school children needing eye care services?
Poor, Average, Good, Excellent

C7.5) How satisfied are the beneficiaries you meet at the hospital?
Poor, Average, Good, Excellent

Notes:

D) Roles and Responsibilities:
D1) Describe the RTS / SiB programme?

D2) Describe your role in the programme?

D3) Do you think you were successful in carrying out your responsibilities?

D4) Who did you report to?

D5) Please rate your performance from 1- 10 (1 being poor and 10 excellent)

D6) What can be done to improve your performance?

E) Project Schedule and Timelines

E1) How often did you meet with hospital admin to discuss Programme goals?

E2) Were you aware of the Programme objectives and schedules listed on the sheet provided?

E3) How often did you have team meetings?

E4) Where you aware of the annual project goals and the start of each year?

F) Project Partners

F1) Who are the project Partners?

F2) Describe RIght to Sight?

F3) Describe Seeing is Believing?

G) Project Goals

G1) What were the main Programme Targets?

G2) Were targets achieved?

G3) Most successful aspect of Programme?

G4) Least successful aspect of programme?

G5) Most successful aspect of Outreach Programme?

G6) Lease successful aspect of Outreach Programme?

H) Project Feedback

H1) - Would you do anything differently next time? If so, briefly explain.

H2) - Do you have any suggestions to improve project next time?

H3) - Is there any team member who went above and beyond what was necessary to fulfill his / her job role?

Appendix 4. Beneficiaries Questionnaire

Name:
Age:
Sex:

If the beneficiary a screening, please ask them the following questions:
Which Screening did you attend?

How did you hear about the screening?

Did you know about Acha Douala before the screening?

Did people in your community know about the screening?

Did you see any posters advertising the screening?

Did you hear about the screening in a Church?

Did you hear about the screening on radio?

Did you read about the screening in a newspaper?

Did you hear about the screening at a community meeting?

How was your experience at the screening?

What was the diagnosis?

Were you spoken to by a counselor?

Did you attend with a helper?

Was the helper allowed to accompany you to the hospital?
Did the helper incur any costs?

Beneficiary Questions:

What was the total cost of your treatment?

How long were you at the hospital for?

Were you satisfied with the way you were treated?

Were you happy with the facilities?

Were you satisfied with service?

Do you have any comments?

Appendix 5. Intended Beneficiaries Questionnaire

Name:
Age:
Sex:
Which Screening did you attend?

Or How did you hear about the hospital?

What problems are you experiencing with your vision?

Did you visit the Acha Douala Hospital?

Did you attend a screening?

What was your experience?

Why did you not access eye care services?

Is there any way the hospital can encourage you to make use of their services?

Do you have any comments?

Appendix 6. Original SIB Proposal

Seeing is Believing - Request for Proposal Phase IV

This document has not been included in this section as it is a ‘stand alone’ document and has been included as an attachment.

Appendix 7. Letter of Variation

21st November 2012

To Whom It May Concern:

Right to Sight's Senior Programme Manager, Rachel Flynn, spent three weeks in Cameroon in August assessing the progress of the Right to Sight/Seeing is Believing programme at ACHA Eye Hospital in Douala. Based on this trip and an assessment of achievements to date it became clear that the budget no longer reflected the most effective or efficient use of funds for programme goals. In addition, it was evident that the originally proposed cataract surgery figures are not attainable within the time frame of the programme.

It is worth noting that the failure to meet cataract surgery targets is no reflection on the success of the hospital or the utility of Seeing is Believing's investment in the hospital, rather an error on Right to Sight's part in proposal planning. An assumption was made that the hospital would be operating at 'best practice' capacity from the outset, whereas realistically this standard is normally achieved in year three. This is the only original target that will not be met; all other targets will be met or exceeded. In addition, the revised cataract target of 5,000 represents the best practice 'Cataract Surgery Rate', similar to that at Aravind, the world leader in eye-health services (See Appendix I: Output Comparison).

In light of the budget no longer reflecting the best use of funds and lower than expected surgical rates it was decided in discussion with Seeing is Believing staff that Right to Sight should submit a new proposal reflecting current needs at the hospital, realistic surgical targets and a nine-month no cost extension (See Appendix II: Budget Comparison)

Please consider this letter and the attached proposal as a request to alter outputs (mostly revised up except cataract surgery figures which are revised down), to reforecast the budget, and to extend the programme from March 2013 to December 2013.

Yours Sincerely,

Rachel Flynn
Senior Programme Manager
Right to Sight
Dublin

1. **Applicant Organisation Costs (Overall Increase of $35,435)**
   a) **Salary of Staff (ACHA)**
   This category remains unchanged.
   b) **RTS Consultancy**
   This category shows an increase in cost of $11,983. The reason for this is the employment of a local programme officer for the remainder of the period, including the 9-month extension. RTS feel that this level of supervision is required to ensure that the programme reaches its targets.
   c) **Equipment**
   This category shows an increase in cost of $23,452. The reason for this is that it is difficult at the beginning of a programme to compile an exact list of the equipment that will be required. The requirements have changed slightly over the last 2 years in particular the vision center requirements.

2. **Support to Local Implementing Partner (Overall Increase of $18,477)**
   a) **Partner Infrastructure Costs**
   This category remains unchanged.
   b) **Programme Maintenance**
   This category remains unchanged.
   c) **Running Cost of Douala Hospital (ACHA)**
   This category remains unchanged.
   d) **IT**
   This category shows an increase in cost of $18,477.The reason for this is that the original allocation was not sufficient. The hospital requires the installation of wireless broadband throughout the hospital which will require considerable rewiring. In addition, in order to accurately record the hospital information additional computers and systems will be required.

3. **Service Delivery Costs (Overall Increase of $842)**
   a) **Medicines & Consumables**
   This category shows a large decrease of $223,116. The reason for this is that it is easier to show a total cost per operation rather than split it down into components such as medicines and consumables. Therefore we have in effect absorbed this cost into the Fund for the Sick and Poor.
   b) **Hospital Capital Costs**
   This category shows a decrease of $19,937. The reason for this is that we will not be purchasing a chair unit for the vision center. We have concluded that it is more cost effective to purchase the equipment separately rather that the chair unit.
   c) **Fund for the Sick and Poor**
   This category shows a large increase of $158,895. The reason for this is as described under Medicines & Consumables above. We have absorbed this cost in order to allow a total cost per operation.
   d) **Outreach**
   This is a new category in this section showing a total cost of $85,000. As described in the revised proposal, outreach forms an integral part of the ACHA Douala programme. Without a revised outreach strategy the programme will not come close to delivering its targets. Therefore it is an essential aspect to the

service delivery of ACHA Douala.

4. **Training (Overall decrease of $39,729)**
   a) **Training of Douala Staff**
   This category shows a decrease of $43,312. The reason for this is that the training budget in the original proposal was very high. We have revised the cost down as we will not need the amount originally allocated. It can be put to more effective use elsewhere.
   b) **E-learning & Telemedicine**
   This category shows an increase of $400. The reason for this is simply a slight amendment to pricing.
   c) **Vision Building**
   This category shows a decrease of $6,817. The reason for this is that vision building is a regular, cost free occurrence which is performed in house at the hospital by the senior members of staff. The funding is not required.
   d) **Locum Leave**
   This is a new category and shows a cost of $10,000. Previously we have been able to arrange locum cover at ACHA Douala hospital free of charge however given the time of the required leave (December 2012) over the Christmas period we will be required to cover the cost. Visiting surgeons use the opportunity to conduct sub specialty training at the hospital for the staff e.g. Dr Sebastian Briesen, glaucoma training.
5. **Other Project related Activity (Overall increase of $12,836)**
   a) **Public Relations**
   This category shows an increase of $12,836. The reason for this is that in order to improve the cataract surgical figures at the hospital it is important to increase the advertising of services both within the hospital (case study posters and educational material) and in the surrounding community.
6. **Monitoring & Evaluation (Overall decrease of $27,862)**
   a) **Monitoring & Evaluation**
   This category shows a decrease of $11,860. The reason for this is that due to the increased RTS consultancy cost for a local programme manager, a reduced monitoring and evaluation cost will be required.
   b) **Research & Publications**
   This category shows a decrease of $4,602. The reason for this is that the original allocation was too high. The funding is not required.

   c) **RAAB**
   This category shows a decrease of $11,400. The reason for this is that due to ethical approval issues a RAAB did not take place at the beginning of the programme. As such a reduced funding allocation is now required which will be used to conduct a RAAB before the end of the programme.

Appendix 8. Quotes

Positive Quotes:

“The programme showed good leadership/Management and Governance especially for the outreach programme”

“ I was very happy with the Commitment and efficiency of some of the CBWs in publicity and in mobilizing the community. We did not expect they would do this”

“We are blessed to always have very Good relationship between the hospital and patients”

“Our best strengths are our Committed outreach teams and their good relationship with patients. As well as our management, it is very good”

“It is good that we had a Committed RTS program Officer who also played the role of counselor. It is good because now we know what RTSmeans”

“Another big success is the quality of the outcome of operations. This is because of an excellent surgeon”

“The outreach program made us aware of the whole RTS programme. We knew the name before but did not understand the relationship”

“They have a good positive ethos at the organisation. Considering how far they were from the original targets after 2 years, it is commendable that they got themselves back on track when SiB have challenged them, and not let them drift off into other work / possibly low-output / other comfort zone…..”

“It was a very successful programme and we need to congratulate leadership for making this happen”

“It was a complete success, and it made Acha Douala Team stronger and more ready to work together in the future”

Negative Quotes:

“The worst part of the prgramme was the poor road network especially in the raining season”

“The whole programme was a success, but the only problem was in outreach, with the actual care givers, there was a lack of patient care-takers to help bring patients to hospital because it is costly for them”

“We did not really help many school children bcause we do no offer them financial help or free surgery or glasses”

“Poverty on behalf of the patients was the biggest negative. They are all so poor so it makes life hard for them and they don’t want to spend nay money on eye care”

“Fear of the unknown and bad experiences from other friends whose operations from other service providers were not positive”

“Competitors tearing or removing our publicity papers posted was not good for screening”

“We were often short staffed. Many staff were at outreach screenings and many people were brought back, but there were not enough people working at hospital to meet need”

“Need to expand from just identifying and paying for cataract to glaucoma and other eye diseases”